STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576 SS=B	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal	F 576		12/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/14/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 576	Continued From page 1 law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail to the residents on Saturdays. Findings include: An interview was conducted on 11/14/18 at 9:30am with the resident council members. There were 8 residents present. The residents reported they did not receive mail regularly on Saturdays. The residents reported the mail was delivered to the residents on Saturdays only if the activity assistant was present. An interview was conducted on 11/16/18 at 1:38pm with the Activity Director. She reported mail only was delivered to the residents on Saturdays if her activity assistant worked. She reported her assistant only worked Saturdays if she had not put in 40 hours of work during the week. She reported her assistant was out on medical leave at present. The Activity Director reported usually mail was delivered to the facility on Saturdays and was kept at the nurses' station until Monday. An interview was conducted with the administrator on 11/16/18 at 4:40pm. She reported it was her expectation that the residents received mail every Saturday.	F 576	F576 1. A Management Team Meeting was held on 12/6/18 to discuss mail delivery. It was determined there was no set process for delivering mail on Saturdays and therefore Residents did not always receive their mail until Monday. Meeting was held with the Resident Council on 12/13/18 to discuss Saturday mail delivery and newly proposed process. Residents are in agreement with new process. 2. Resident in the facility have the potential to be affected by this alleged practice. A new process was put into place to ensure mail delivery occurs every Saturday. The North Hall Nurse and/or designee is responsible to deliver all resident personal mail every Saturday. Education has been provided to all Nurses regarding this procedure by the Administrator and/or Staff Development Coordinator. Education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will receive education prior to their next scheduled shift. 3. 5 residents will be interviewed each week for the next 4 weeks and then 10 residents a month for the following 2 months to determine if the Saturday mail was delivered. Resident Council members will also be interviewed at each of the next 3 Resident Council meetings to ensure Saturday mail is delivered.	

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F 576	Continued From page 2	F 576	Interviews and Council Meeting interviews will be completed by the Activity Director and/or Social Worker. 4. All interview data will be summarized and presented to the facility Quality Assurance Performance Improvement meeting each month for 3 months by the Activity Director. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance. 5. The Activity Director is responsible for implementing and maintaining the acceptable plan of correction, which will be completed by 12/14/18.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		12/14/18

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F 600	Continued From page 3 Based on record review and staff interviews, the facility failed to protect 1 out of 3 residents (Resident #267) from verbal abuse. Findings include: Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267's most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. Active diagnoses included Chronic Obstructive Pulmonary Disease, Sleep apnea, and problems related to psychosocial circumstances. A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18. A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18. The report was initiated by the Social Worker. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 5-day investigation report revealed the dietary aides who witnessed the altercation were disciplined and the employee who argued with the resident was terminated. An interview was conducted with the dietary manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 of an incident that occurred on 6/23/18 between him and the cook on the evening shift. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. She	F 600	F 600 1. No action can be completed for Resident #267 as he no longer resides in the facility. 2. Residents in the facility have the potential to be affected by this practice. Resident interviews were completed by 12/7/18 with all Residents who scored 8 or above on BIMS, by the Administrator. Interviews included asking questions related to abuse situations, offering examples, while resident in the facility. Observations were completed for other residents who score below 8 BIMS using the CMS Resident Interview and Observation 20050 Form. No other issues related to abuse or abuse that was not reported were identified. 3. All staff in the facility will receive education regarding resident abuse reporting, their responsibility to report immediately to their Supervisor any alleged or potential abuse. Staff education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will be required to complete prior to their next scheduled shift. Education will be given by the Staff Development Coordinator and/or Administrator. 4. Random interviews/observations will continue with 5 resident per week for 4 weeks, then 5 residents a month for 2 months. Interviews/observations will include residents of all cognitive levels.	

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F 600	Continued From page 4 reported she had a meeting with the cook on 6/27/18 as the cook was not working on 6/26/18. The dietary manager reported the cook admitted she lost her temper with Resident #267 and cursed at him. The dietary manager immediately terminated the cook. She reported she did a written counseling with the two dietary aides who witnessed the altercation. An interview was conducted on 11/16/18 at 2:26pm with Dietary Aide #1. She reported on 6/23/18 around 5:00pm the kitchen staff was told that the residents would eat in their rooms that evening due to the facility being short staffed. She reported Resident #267 was already in the dining room. She stated the cook asked her and the other dietary aide to go tell the resident that he would have to eat in his room. The dietary aide reported Resident #267 got upset easily so she did not want to go tell him. The cook went out and told the resident that all residents were eating dinner in their rooms. The dietary manager reported Resident #267 got upset and started yelling and cussing at the cook. The cook then told the resident not to mess with her because she could not give him what he wanted. The dietary aide stated Resident #267 then cursed at the cook and she yelled the same curse word back to the resident and made an inappropriate hand gesture. The dietary aide stated she did not notify any management personnel because her immediate supervisor was the cook. She reported the dietary manager was not present that evening and she thought that the incident was something that she needed to report face to face. She reported she worked with the cook the next day and there were no problems noted between the cook and any of the residents including Resident #267. An interview was conducted on 11/16/18 at	F 600	Any accusation of abuse or sign of abuse as indicated on CMS form 20050 will result in immediate investigation and suspension of any accused individual. Results of these interviews/observations will be reported to the Quality Assurance Performance Improvement Meeting monthly. Any issues or trends identified will be addressed by the committee as the arise and the plan will be revised as necessary, to ensure continued compliance. 5. The Administrator is responsible for implementing and maintaining the acceptable plan of correction to ensure compliance by 12/14/18.	

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F 600	Continued From page 5 4:30pm with the administrator. She reported it was her expectation that no staff verbally or physically abuse any of the residents.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to follow the abuse policy with the requirement to report abuse within 2 hours of notification of the allegation on 1 out of 3 residents (Resident #267) reviewed for alleged abuse investigations by the facility. The facility staff failed to immediately report abuse to administration on 1 out of 3 residents (Resident #267) reviewed for alleged abuse. The facility also failed to protect residents in 1 out of 3 residents (Resident #267) reviewed for alleged abuse. Findings include: A review of the facility's "Abuse Investigation and Reporting" policy dated July 2017 revealed in part "An alleged violation of abuse, neglect, or exploitation or mistreatment will be reported immediately but no later than 2 hours if the	F 607	F607 1. No action can be completed for Resident #267 as he no longer resides in the facility. 2. Residents in the facility have the potential to be affected by this practice. An audit of the last 3 months of Abuse Investigations was completed to determine if other resident were not protected or abuse was not reported immediately. No other incidents were identified. 3. All staff in the facility will receive education regarding resident abuse reporting, their responsibility to report	12/14/18

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F 607	Continued From page 6 alleged violation involved abuse or has resulted in serious bodily injury." The facility's policy also stated that "any employee witnessed to abuse is to report it to administration immediately." Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267's most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. The resident's cognitive impairment was not completed. A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18. A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18 with no time noted. The report was initiated by the Social Worker. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 24 Hour Initial Allegation Report fax (facsimile) cover sheet was time stamped as being sent to the state on 6/26/18 at 4:39pm. An interview was conducted with the SW (Social Worker) on 11/16/18 at 12:15pm. She reported she was given the incident on 6/26/18 but doesn't remember what time. The SW reported when she initiated the allegation report she viewed the incident as an argument and sent the report in as a 24-hour report. The SW acknowledged that she put the incorrect date on the 24 hour report, it should have been 6/23/18. The SW reported she realized now that any form of abuse needed to be reported within 2 hours. An interview was conducted with the dietary	F 607	immediately to their Supervisor any potential abuse situation or alleged abuse and their responsibility to protect the residents from all forms of abuse. Staff education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will need to complete education prior to their next scheduled shift. Education will be given by the Staff Development Coordinator and/or Administrator. 4. Audit will continue for every alleged abuse situation that is investigated. Investigation will be recorded on audit to ensure alleged abuse is reported immediately and appropriate steps are taken to protect residents. Audit will continue for the next 3 months and results will be reported to the Quality Assurance Performance Improvement Meeting monthly by the Administrator. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance is achieved. 5. The Administrator is responsible for implementing and maintaining an acceptable plan of correction to ensure compliance by 12/14/18.	

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F 607	Continued From page 7 manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 at 10:00am of an incident that occurred on 6/23/18 between him and the cook on the evening shift. She reported she notified the administrator immediately and was told to notify the SW which she did around 10:30am on 6/26/18. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. She reported she had a meeting with the cook on 6/27/18 as the cook was not working on 6/26/18. The dietary manager reported the cook admitted she lost her temper with Resident #267 and cursed at him. The dietary manager immediately terminated the cook. She reported she did a written counseling with the two dietary aides who witnessed the altercation. An interview was conducted on 11/16/18 at 4:30pm with the administrator. She reported it was her expectation that any observed or reported abuse, physical or verbal, needed to be reported immediately to management and an Initial Allegation Report be sent to the state within 2 hours.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		12/14/18

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F 609	Continued From page 8 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report allegations of abuse to the North Carolina Division of Health Service Regulations within the 2-hour timeframe on 1 out of 3 (Resident #267) reviewed for abuse allegations. Findings included: Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267's most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. No cognition impairment was documented. A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18.	F 609	F609 1. No action can be completed for Resident #267 as he no longer resides in the facility. 2. Residents in the facility have the potential to be affected by this practice. An audit of the last 3 months of Abuse Investigations was completed to determine if other reports to the State Survey Agency were not completed with the 2 hour timeframe. No other incidents were identified. 3. The Administrator and Director of Nursing received education regarding resident abuse reporting within the 2 hour	

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F 609	Continued From page 9 A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18. The report was initiated by the Social Worker, but she reported she doesn't remember what time the dietary manager informed her of the incident. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 24 Hour Initial Allegation Report fax (facsimile) cover sheet was time stamped as being sent to the state on 6/26/18 at 4:39pm. An interview was conducted with the SW (Social Worker) on 11/16/18 at 12:15pm. She reported she was given the incident on 6/26/18 but doesn't remember what time. She stated she knew it was in the morning of 6/26/18. The SW reported when she initiated the allegation report she viewed the incident as an argument and sent the report in as a 24-hour report. The SW reported she realized now that any form of abuse needed to be reported within 2 hours. An interview was conducted with the dietary manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 at 10:00am of an incident that occurred on 6/23/18 between him and the cook on the evening shift. She reported she immediately reported the incident to the administrator and was told to notify the SW (Social Worker). The dietary manager reported she notified the SW around 10:30am. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. The dietary aides were given written counseling regarding notifying abuse allegations.	F 609	timeframe by the Clinical Services Director on 11/20/18. 4. Audit will continue for every alleged abuse situation that is reported to the State Survey Agency for the next 3 months to ensure the 2 hour timeframe is adhered to. Results of these audits will be reported at the Quality Assurance Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. 5. The Administrator is responsible for implementing and maintaining an acceptable plan of correction to ensure compliance by 12/14/18.	

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F 609	Continued From page 10 An interview was conducted on 11/16/18 at 2:26pm with Dietary Aide #1. She reported on 6/23/18 around 5:00pm the kitchen staff was told that the residents would eat in their rooms that evening due to the facility being short staffed. She reported Resident #267 was already in the dining room. She stated the cook asked her and the other dietary aide to go tell the resident that he would have to eat in his room. The dietary aide reported Resident #267 got upset easily so she did not want to go tell him. The cook went out and told the resident that all residents were eating dinner in their rooms. The dietary manager reported Resident #267 got upset and started yelling and cussing at the cook. The cook then told the resident not to mess with her because she could not give him what he wanted. The dietary aide stated Resident #267 then cursed at the cook and she yelled the same curse word back to the resident and made an inappropriate hand gesture. The dietary aide stated she did not notify any management personnel because her immediate supervisor was the cook. She reported the dietary manager was not present that evening and she thought that the incident was something that she needed to report face to face. She reported she worked with the cook the next day and there were no problems noted between the cook and any of the residents including Resident #267. She reported she had not seen the dietary manager to report the incident before the resident reported it to the dietary manager. An interview was conducted on 11/16/18 at 4:30pm with the administrator. She reported it was her expectation that all allegations of abuse be reported immediately, and the Initial Allegation Report be sent to the state within 2 hours.	F 609		
F 623	Notice Requirements Before Transfer/Discharge	F 623		12/14/18

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FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

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F 623 SS=D	Continued From page 11 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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F 623	Continued From page 12 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 13 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing when 1 of 3 residents (Resident #24) transferred to the hospital. Findings include: Resident #24 was admitted to the facility on 1/10/13 with diagnoses that included cerebral infarction, Diabetes Mellitus, and hemiplegia. A review of Resident #24's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and dated 10/6/18. The resident was coded with no cognitive impairment. Active diagnoses included hypertension, diabetes mellitus, and cerebrovascular accident. A review of Resident #24's care plan dated 10/6/18 revealed the resident was care planned for constipation. A review of Resident #24's medical record revealed the resident was hospitalized 11/8/18-11/9/18 with diagnoses of abdominal	F 623	F623 1. The Ombudsman was notified of the failure to notify her of Resident #24 being transferred to the hospital. 2. The Social Worker was educated by the Administrator on 12/11/18 of the requirement to notify the Ombudsman of resident transfers to the hospital. She was provided a log to maintain and send to Ombudsman by the 10th of each month, as per agreement with Ombudsman. 3. The transfer/discharge log was completed for all residents who experienced a transfer to the hospital for the last 3 months. Completed log was faxed to the Ombudsman on 12/9/18, she	

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F 623	Continued From page 14 hernia and constipation. An interview was conducted with the SW (Social Worker) on 11/16/18 at 10:25am. She reported nursing took care of notifying the ombudsman of hospital transfers. An interview was conducted with the DON (Director of Nursing) on 11/16/18 at 11:00am. She reported no one sent the ombudsman notice of resident transfers to the hospital. She reported it was her expectation that the ombudsman was notified monthly of any hospital transfers.	F 623	was notified that the practice would continue on a monthly basis. The Social Worker is responsible for notification and producing fax confirmation or email confirmation that information was sent by the 10th of each month. The Ombudsman will also continue to be notified of all discharges to home or another level of care as soon as is practicable before transfer or discharge. The Social Worker is also responsible for notifications to the Ombudsman of discharges to home or another level of care. 4. The completed transfer/discharge log will be presented by the Social Worker for 3 months at the Quality Assurance Performance Improvement meeting. The Committee will make changes and/or recommendations as indicated. 5. The Social Worker is responsible for implementation of the plan of correction and ensuring compliance by 12/14/18.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #58) reviewed for unnecessary medications and 1 out of 6 residents	F 641	F641 1. The coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manuel	12/14/18

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F 641	Continued From page 15 (Resident #26) reviewed for nutrition. Findings included: 1.Resident #58 admitted to the facility on 6/17/18 with diabetes mellitus, major depressive disorder, Chronic Obstructive Pulmonary Disease, neuromuscular dysfunction bladder, and Methicillin Resistant Staphylococcus Aureus right foot. A review of Resident #58's most recent MDS (Minimum Data Set) dated 11/14/18 was coded as a significant change assessment. The resident was coded as cognitively intact. Active diagnoses included heart failure, neurogenic bladder, diabetes, depression, and chronic pain. A review of Resident #58's medical record revealed a physician's order dated 10/23/18 that read Amitriptyline 10mg (milligrams) at bedtime for insomnia. An interview was conducted on 11/16/18 at 10:24am with the MDS Coordinator. She reported it was her responsibility to correctly code all MDS assessments. She reported Resident #58 should have had the diagnosis of insomnia coded on his significant change MDS assessment. An interview was conducted on 11/16/18 at 5:00pm with the administrator. She reported it was her expectation that the MDS coordinator correctly code all MDS assessments. 2. Resident #26 was admitted to the facility on 10/30/12 and diagnoses included end stage renal	F 641	for Residents #58 and #26. Resident #58 had a modification of Section I completed to reflect accurate medical diagnosis for Assessment Reference Date 10/24/18. Resident #26 had a modification of Section K completed to reflect accurate coding of therapeutic diet for Assessment Reference Date 10/19/18. 2. The MDS Coordinator will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during November to verify accurate coding of Sections I and K of the Minimum Data Set per the Resident Assessment Instrument Manual guidelines. If needed, modifications will be completed by the MDS Coordinator per the RAI Manual guidelines. 3. The District Director Care Manager will provide education to the Interdisciplinary Team members who participate in MDS coding of Sections I and K related to accurate coding of MDS according to the RAI Manual on 12/7/18. The MDS Coordinator will randomly audit 5 completed MDSs weekly for 4 weeks and then 5 random MDSs monthly for an additional 2 months to verify accurate coding of Sections I and K of the MDS. One to one education will be provided if opportunities for corrections are identified as a result of these audits. Modifications to the MDS will be completed as needed 4. The results of these audits will be presented by the Director of Care Management monthly for 3 months at the	

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F 641	Continued From page 16 disease, diabetes and congestive heart failure. A quarterly minimum data set (MDS) dated 10/9/18 for Resident #26 did not identify that she received a therapeutic diet. Review of the November 2018 physician orders for Resident #26 revealed an order for a consistent carbohydrate, no added salt, 1200 milliliter (ml) fluid restriction. The diet had an initiation order date of 7/30/18. An interview on 11/15/18 at 2:15 pm with the MDS Nurse revealed Section K of the 10/9/18 MDS for Resident #26 should have been coded for a therapeutic diet. An interview on 11/16/18 at 3:29 pm with the Director of Nursing revealed it was her expectation that MDS ' s were coded correctly to reflect the resident ' s physician ' s orders.	F 641	Quality Assurance Performance Improvement meeting. The committee will make recommendations or changes as indicated. 5. The Director of Care Management is responsible for the plan to correct and ensuring compliance by 12/14/18.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide a bath for a resident that was dependent for Activities of Daily Living (ADL ' s). This was evident for 1 of 3 residents that were reviewed for ADL ' s (Resident #6). Findings Included:	F 677	F677 1. The facility failed to provide a bath for a resident that was dependent for Activities of Daily Living. The Director of Nursing on 11/19/18 completed an interview with resident #6 regarding the alleged deficient practice of providing care needs including	12/14/18

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F 677	Continued From page 17 Resident #6 was admitted to the facility on 3/6/09 and diagnoses included diabetes, chronic kidney disease, agoraphobia with panic disorder, depressive disorder and low back pain. A quarterly minimum data set (MDS) dated 8/23/18 for Resident #6 identified she was totally dependent on staff for bathing, required extensive one-person assist with personal hygiene, was always incontinent of bowel and bladder and her cognition was intact. A care plan dated 9/11/18 for Resident #6 stated she had a ADL self-care performance deficit related to impaired balance and limited mobility. An intervention included for staff to provide extensive assistance with bathing, toileting and personal hygiene as needed. An observation and interview with Resident #6 on 11/13/18 at 11:41 am revealed the resident was awake and lying in bed. There was a very strong offensive odor present. Resident #6 stated she hadn ' t had a bed bath since Sunday (11/11/18). She stated she didn ' t like to take showers, but she did want a bed bath daily. The resident stated she had a yeast infection and denied needing to have her brief changed. An observation and interview on 11/13/18 at 1:15 pm with Resident #6 revealed she was lying in bed eating her lunch. A strong offensive odor remained present. The resident stated she had still not received her bath. An interview on 11/14/18 at 3:23 pm with NA #1 revealed she was familiar with the Resident #6, but she wasn ' t on her assignment today. She	F 677	bathing, being met and addressed appropriately. Nursing Assistant #4 was re-educated on 12/7/18, and Nursing Assistant #3 was re-educated on 11/19/18 by the Director of Nursing. Both were re-educated that residents who are unable to carry out activities of daily living including bathing receive the necessary services to maintain good grooming and personal hygiene. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. Interviews and observations were completed by the Director of Nursing regarding their care needs (bathing) being met, this was completed by 11/20/18. Any concerns identified were addressed. 3. Re-education was completed for Nursing Assistants by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator regarding the provision of a bath to residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene. This re-education will be completed by 12/14/18. Any remaining Nursing Assistants will have re-education completed prior to working their first scheduled shift after this date. This education will be provided upon hire for all Nursing Assistants. 4. Audit observation of 5 resident baths will be conducted weekly for 4 weeks then	

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F 677	Continued From page 18 stated the resident was oriented and could make her needs known. She added the resident would turn on her call light when she needed something. NA #1 stated the resident received bed baths on 1st shift and she typically worked on 2nd shift. An interview on 11/14/18 at 3:31 pm with Nurse #1 revealed Resident #6 was scheduled to have showers on Wednesdays and Saturdays on 1st shift. She stated the NAs were supposed to document if the resident refused to be bathed and report it to the nurse. Review of the shower book, provided by Nurse #1, did not contain any records for the month of November for Resident #6. An observation on 11/14/18 at 8:30 pm of Resident #6 revealed she was lying in bed and there continued to be a strong offensive odor present. An interview on 11/15/18 at 9:18 am with Resident #6 revealed she had not received a bath yesterday (11/14/18), but her Nursing Assistant (NA) was going to give her a bed bath today. An observation on 11/15/18 at 10:04 am was conducted of bathing and personal hygiene for Resident #6. A full bed bath was performed. The resident ' s genital area appeared very red. An interview on 11/15/18 at 11:03 am with NA #2, who had completed the bath for Resident #6, revealed the resident required total care, was usually reliable and did not refuse care. Review of the staff schedule, provided by the	F 677	3 baths weekly for 2 months. All data will be summarized and presented to the facility Quality Assurance Performance Improvement committee for 3 months by the Director of Nursing. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance. 5. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction and ensure continued compliance by 12/14/18.	

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F 677	Continued From page 19 Director of Nursing (DON), identified NA #3 was assigned to Resident #6 on first shift for 11/12/18 and NA #4 was assigned to Resident #6 on first shift for 11/13/18. A phone interview with NA #3 was attempted on 11/15/18 at 12:50 pm. NA #3 did not answer the phone and a message could not be left due to the voice mail box being full. An interview on 11/15/18 at 12:58 pm with the Administrator revealed NA #4 was currently suspended for not providing resident care. She stated she was investigating an incident that had been reported by another resident that NA #4 had not provided required care. The Administrator stated she would add Resident #6 to the investigation since NA #4 had also been assigned to her. An interview on 11/16/18 at 3:26 pm with the DON revealed it was her expectation that residents were clean, odor free and bathed daily.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		12/14/18

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F 690	Continued From page 20 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews and Physician Assistant interview the facility failed to insert the correct size indwelling urinary catheter as ordered by the physician for one of two residents reviewed for urinary catheters (Resident #39). Findings included: Resident #39 was admitted to the facility on 4/19/2016 with diagnoses of pressure ulcer to sacrum, diabetes, dementia, cognitive communication deficit and bilateral amputations. A review of the quarterly Minimum Data Set	F 690	F690 1. An assessment was completed by the Director of Nursing on 11/16/18 and found indwelling foley catheter to be patient and functioning properly. The MD was called and catheter order changed to reflect the current catheter size for Resident #29. Nurse #6 was educated by the Director of Nursing on 11/16/18 to insert the correct size indwelling urinary catheter as ordered by the MD. 2. All other residents with indwelling urinary catheters have the potential to be	

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F 690	Continued From page 21 (MDS) dated October 17, 2018 revealed Resident #39 had an indwelling urinary catheter, required extensive to total dependence for activities of daily living (ADLs) and had moderately impaired cognition. Review of a progress note dated June 15, 2018, revealed Resident #39 had pulled her indwelling catheter out and was found sitting on her bed. A #16 French catheter was re-inserted. Review of a progress note dated August 14, 2018 revealed Resident #39 had a #24 French catheter inserted. Review of a physician ' s order dated September 13, 2018 for Resident #39 stated may change catheter #16 French with a 10-cubic centimeter (cc) balloon as needed every 24 hours for leaking, malfunction or dislodgement. Review of Resident #39 ' s care plan dated November 14, 2018 revealed she was at risk for urinary tract infections. Interventions included catheter care to be done every shift as needed, position catheter bag and tubing below the level of the bladder. During an interview with Nurse #6 on November 15, 2018 at 1:00 pm revealed the physician had ordered a #16 French catheter for Resident #39. During an interview with the Physician Assistant on November 15, 2018 at 1:10pm revealed if a resident had a #16 French catheter replaced with a #24 French catheter their urethra would be stretched and could potentially cause some organ damage.	F 690	affected by the alleged deficient practice. No other concerns were identified. 3. Licensed Nurses received education by the Director of Nursing, Staff Development Coordinator and Assistant Director of Nursing to reconcile correct size indwelling urinary catheter with MD order prior to insertion. Education was completed by 12/14/18. Any remaining PRN Nurses will receive education prior to next scheduled shift and all newly hired Nurses will receive education during orientation. 4. The Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing will complete indwelling urinary catheter audits to ensure correct size of indwelling catheter as ordered by the MD, monthly for 3 months. If any concerns with correct size of indwelling urinary catheter, the Director of Nursing will be notified immediately. All data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee monthly for 3 months by the Director of Nursing. Any issues and trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance. 5. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction and continued compliance by 12/14/18.	

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F 690	Continued From page 22 An observation of Resident #39 on November 15, 2018 at 1:40pm revealed there was a #24 French catheter present. Several phone calls were made to staff that were identified as inserting the #24 French catheter in Resident #39 and no return calls were received. During an interview with the Director of Nurses on November 16, 2018 at 3:10 pm she stated it was her expectation that catheters are placed according to the size ordered by the physician.	F 690		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the annual recertification survey on 1/26/18. This was for 1 recited deficiency in the area of: Accuracy of Assessments (F641). Findings include: This tag is cross referenced to: F641 Accuracy of Assessments: Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #58) reviewed for unnecessary	F 867	F0867 1. The Quality Assurance Improvement Committee met on 12/13/18 to address plan of correction for recent survey and repeat deficiency for F641. Root cause for F641 determined to be that the Interdisciplinary Team members responsible for Sections I and K did not validate for accuracy the actual status of each resident (Residents #58 and #26) during the observation period resulting in an inaccurate Minimum Data Set being closed and transmitted.	12/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 23 medications and 1 out of 6 residents (Resident #) reviewed for nutrition. During the recertification survey dated 1/26/18 , the facility was cited for F641 for failing to accurately code the opioid medications on 1 out of 5 residents (Resident #74) reviewed for unnecessary medications, to accurately code the weight changes on 1 out of 5 residents (Resident #36) reviewed for weight changes, to accurately code falls involving 1 out of 1 resident (Resident #52) reviewed for falls, and to accurately code oxygen on 1 out of 1 residents (Resident #48) reviewed for respiratory care. During the recertification survey dated 1/26/18, the facility was cited for F867 for the QAA (Quality Assessment and Assurance Committee) failing to maintain implemented procedures and monitor interventions that the committee put into place following the 1/26/18 recertification survey. During the current annual recertification survey dated 11/16/18, the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/26/18 annual recertification survey. An interview was conducted with the Administrator on 11/16/18 at 5:00pm. She reported it was her expectation that the QAA committee would implement and monitor interventions put into place.	F 867	2. The Committee determined that random audits of MDS accuracy will continue monthly for 3 months. If accuracy is not confirmed, Interdisciplinary Team members responsible will be addressed one to one and audits will be extended beyond the 3 months until accuracy is achieved. Any inaccurate MDS will be corrected and transmitted following correction process. 3. Audits will be brought to the monthly Quality Assurance Performance Improvement Committee meeting for review and recommendations if necessary. Any inaccuracy that is found will be immediately addressed with the Interdisciplinary Team member responsible and correction made. The District Clinical Director will review the facility Quality Assurance Performance Improvement Committee meeting minutes monthly for 3 months to ensure accuracy is achieved and make recommendations if necessary. 4. The Administrator is responsible for implementing the plan of correction, Chairing the Quality Assurance Performance Improvement Committee and ensuring the plan of correction is complete and sustained so that compliance is achieved.	