STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING ______ B. WING ______	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	**801 GREENHAVEN DRIVE GREENSBORO, NC 27406**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/21/18. Event ID# 6CH011.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge 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;	F 623		1/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/21/2019

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 623	Continued From page 1 (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, 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	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §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 reviews, staff interviews, and ombudsman interview, the facility failed to provide written notification to the resident, or resident's representative and the ombudsman when the residents were discharged to the hospital and/or home. This was evident for 3 of 4 residents reviewed for discharge (Resident #80, Resident #82, and Resident #180). Findings included: 1. Resident # 80 was admitted to the facility on January 18, 2017 with diagnoses that included type 2 diabetes mellitus, edema, contractures of both hands, bipolar disorder, pain in left knee,	F 623	F623, Discharge notification to Ombudsman How the corrective action was accomplished for those residents affected by the deficient practice. The Administrator notified the ombudsman of discharges for resident 80, 82, and 180 on 1-18-2019 by email. How facility identified other residents potentially affected by the deficient practice. On 1-18-2019, the Administrator audited all discharges for the past 90 days for	

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muscle weakness and lack of coordination.

A review of a quarterly Minimum Data Set (MDS) dated July 13, 2018 for Resident #80 revealed his cognition was intact.

Review of the departmental notes revealed Resident #80 was discharged with family on October 4, 2018 to another state. Further review of the resident's medical record revealed, no written notice of the resident's discharge was provided to the Ombudsman or resident.

During an interview with the Social Worker on December 19, 2018 at 11 am revealed the facility had not completed written notification to the resident, resident's representative or the facility ombudsman when a resident was discharged to the hospital or home. The Social Worker indicated no knowledge of how to do this.

During an interview with the Ombudsman by phone on December 20, 2018 at 2:00 pm, she revealed that she had not received any written documentation from this facility when residents were discharged home and/or the hospital.

During an interview the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed she had only been employed at the facility since October 2018. The DON stated she was not familiar with some of the new regulations, however her expectation was that the Social Worker would have completed written notification to the resident, resident's representative and the Ombudsman per the regulation.

During an interview with the Administrator on December 20, 2018 at 2:45pm he indicated it was

F 623

notification of the ombudsman. On 1-18-2019, the Administrator via email notified the ombudsman of all discharges with locations for 90 days preceding the survey date.

Identified the measures or systemic changes taken to ensure deficient practice will not recur.
On 12-19-2019, the social worker was in-serviced by the facility consultant on notification of the ombudsman of resident discharges including discharges to home or hospital. Starting on 1-9-2019 and finishing on 1-18-2019, the SDC in-serviced nursing staff, including agency, and social worker for notification of resident and their responsible party when a discharge occurs, including documentation of this notification. After 1-18-2019, no nursing staff will be allowed to work until in-serviced, and it was added to the orientation for all newly hired nursing staff, including agency, and social workers.

How facility plans to monitor performance. The Administrator and/or designee will review all discharges weekly x 4 weeks and monthly x 2 months to ensure notification of the ombudsman and the resident and/or resident representative occurred and is documented. The results will be presented by the Administrator and/or designee to the QA Committee monthly x 3 months and will determine if further action is needed.

The title of the person responsible for

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F 623	Continued From page 4 his expectation that the Social Worker and staff would follow the regulations for discharging residents from the facility. 2. Resident #82 was admitted to the facility on September 8, 2018 with diagnoses that included cardiac arrhythmias', shortness of breath, and Crohn's disease. A review of the admission Minimum Data Set (MDS) dated September 15, 2018 for Resident #82 revealed the resident's cognition was intact and she was able to make her needs known to the staff during her stay. Review of the departmental notes revealed Resident #82 was discharged home on September 20, 2018. Further review of the resident's medical record revealed no written notice of the resident's discharge was provided to the Ombudsman or resident. During an interview with the Social Worker on December 19, 2018 at 11 am revealed the facility had not completed written notification to the resident, resident's representative or the facility ombudsman when a resident was discharged to the hospital or home. The Social Worker indicated no knowledge of how to do this. During an interview with the Ombudsman by phone on December 20, 2018 at 2:00 pm, she revealed that she had not received any written documentation from this facility when residents were discharged home and/or the hospital. During an interview the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed she had only been employed at the facility since	F 623	implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction.	

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F 623	Continued From page 5	F 623		

October 2018. The DON stated she was not familiar with some of the new regulations, however her expectation was that the Social Worker would have completed written notification to the resident, resident's representative and the Ombudsman per the regulation.

During an interview with the Administrator on December 20, 2018 at 2:45pm he indicated it was his expectation that the Social Worker and staff would follow the regulations for discharging residents from the facility.

3. Resident #180 was admitted on September 3, 2018; discharged on November 25, 2018 and re-admitted on December 13, 2018 with diagnoses that included anemia, diabetes mellitus type 2, hypertension, colon cancer and stage 5 kidney disease.

A review of the Quarterly Minimum Data Set dated November 25, 2018 for Resident #180 revealed her cognition was intact and he was able to make his needs known to staff at the facility.

Review of the departmental notes revealed Resident #180 was discharged to hospital on November 25, 2018. Further review of the resident's medical record revealed no written notice of the resident's discharge to the hospital was provided to the Ombudsman or resident's representative.

During an interview with the Social Worker on December 19, 2018 at 11 am revealed the facility had not completed written notification to the resident, resident's representative or the facility ombudsman when a resident was discharged to the hospital or home. The Social Worker

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F 623	Continued From page 6 indicated no knowledge of how to do this. During an interview with the Ombudsman by phone on December 20, 2018 at 2:00 pm, she revealed that she had not received any written documentation from this facility when residents were discharged home and/or the hospital. During an interview the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed she had only been employed at the facility since October 2018. The DON stated she was not familiar with some of the new regulations, however her expectation was that the Social Worker would have completed written notification to the resident, resident's representative and the Ombudsman per the regulation. During an interview with the Administrator on December 20, 2018 at 2:45 pm he indicated it was his expectation that the Social Worker and staff would follow the regulations for discharging residents from the facility.	F 623		
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 record review and interview with staff the facility failed to accurately code the Minimum Data Set (MDS) in 1 of 5 residents reviewed for immunizations. (Resident #130) Record review revealed on 10/23/18 the responsible party (RP) of Resident #130 signed a	F 641	F641, Accuracy of assessments How the corrective action was accomplished for those residents affected by the deficient practice. On 1-18-2019 the DON modified the discharge MDS dated 11/6/18 to	1/18/19

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F 641	Continued From page 7 consent to decline the influenza shot. Record review of the MDS Nursing Home Discharge Set dated 11/6/18 in Section O Influenza Vaccine was coded as "no" to whether Resident #130 received the influenza vaccination. However, "99" was coded for why the resident had not received instead of 4# being coded because the vaccine had been offered and declined by RP. Interview on 12/19/18 at 12:30 PM with the MDS corporate representative revealed the coding was incorrect and should have been coded #4. Interview on 12/19/18 at 12:45 PM with the MDS nurse (who coded the MDS) stated she did not remember why she coded the MDS inaccurately.	F 641	accurately reflect the influenza status for resident 130, which was submitted on 1-18-2019 by MDS Coordinator to the national repository and accepted on 1-18-2019. How facility identified other residents potentially affected by the deficient practice. By 1-17-2019, the RAI reimbursement auditor audited the last 90 days of comprehensive and discharge MDS assessments to ensure the influenza vaccine was accurately coded. Any negative findings were corrected immediately. Identify the measures or systemic changes taken to ensure deficient practice will not recur. The MDS nurse was in-serviced by the RAI reimbursement auditor on correct coding the of the MDS assessment on 1-17-2019, and any newly hired MDS nurses will be in-serviced. How facility plans to monitor performance. The DON and/or designee will audit 10 completed comprehensive and discharge assessments weekly x 4 weeks and monthly x 2 months to ensure immunization status is coded correctly. The QA committee will monitor the results of the assessment review monthly for 3 months and determine the need for continued monitoring. The title of the person responsible for implementing the acceptable plan of	

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F 641	Continued From page 8	F 641	correction. The DON is responsible for implementing the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		1/18/19

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F 656	Continued From page 9 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interviews the facility failed to develop a care plan for 3 of 15 residents (Resident #61, Resident #8 and Resident #36) who had a diagnosis of dementia and/or were receiving psychotropic medications. Findings included: 1.Resident #61 was admitted to the facility on 5-14-18 with multiple diagnoses that included dementia, major depression, diabetes and congestive heart failure. Resident #61's care plan dated 10-9-18 did not mention how staff was going to care for the resident regarding her dementia nor did the care plan include how staff was going to monitor/assess the resident who was receiving psychotropic medications. The quarterly Minimum Data Set (MDS) dated 11-19-18 revealed that Resident #61 was severely cognitively impaired and needed extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene, supervision with one person for eating and total care with one person for bathing. The MDS also revealed that Resident #61 received antipsychotic	F 656	F656, Psych meds in care plans How the corrective action was accomplished for those residents affected by the deficient practice. On 1-17-2019, the RAI reimbursement auditor updated the care plan for resident 61 to include care of dementia, psychotropic medication monitoring, and assessment. On 1-17-2019, the RAI reimbursement auditor updated the care plan for resident 8 to include goals and interventions for the psychotropic medication use. On 1-17-2019, the RAI reimbursement auditor updated the care plan for resident 36 to include the use of psychotropic medications. How facility identified other residents potentially affected by the deficient practice. On 1-18-2019, the DON audited the care plans for all residents on psychotropic medications to ensure care plans are in place to include goals, interventions, and monitoring, and negative findings were corrected. On 1-18-2019, the DON audited the care plans for all residents with a diagnosis of dementia to ensure	

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F 656 Continued From page 10
and antidepressant medications 7 out of 7 days.

A review of Resident #61's December 2018 Medication Administration Record (MAR) revealed the resident received Zoloft (antidepressant) 50 milligrams by mouth daily and Aricept (dementia medication) 10 milligrams by mouth daily.

An interview with Resident #61 occurred on 12-18-18 at 11:05am. The resident stated she just wanted to be left alone to watch her television. Resident noted to have a flat affect and poor eye contact. The room was noted to be dark with no calendar or clock and her family photos were placed behind her where she could not see them.

During an interview with nurse #1 on 12-18-18 at 11:10am who provided care for Resident #61 stated she had not noticed Resident #61 being depressed but also stated she had not assessed the mental health of the resident. The nurse also denied noticing any problems with Resident #61's memory but stated she had not assessed the resident's memory. Nurse #1 denied assessing the resident for side effects from her psychotropic medications but denied that she ever saw any side effects. The nurse also denied knowing if Resident #61's care plan included care for her dementia or her psychotropic medications.

Resident #61's nursing assistant (NA) 2 was interviewed on 12-19-18 at 10:00am. NA #2 stated she felt Resident #61 "has just given up." She stated the resident no longer leaves her room and had told the NA that she just wanted to be left alone. NA #2 stated she had informed the charge nurse but could not remember the nurses

F 656

care plan is in place to ensure care is addressed and any negative findings were corrected.

Identified the measures or systemic changes taken to ensure deficient practice will not recur.
On 12-20-2018, the MDS nurse was in serviced by the RAI reimbursement auditor on care plan development, which will be part of the orientation for any new MDS nurse.

How facility plans to monitor performance.
The DON and/or designee will audit 10 resident care plans weekly x 4 weeks and monthly x 2 months to ensure care plans are present for dementia and/or psychotropic medications as appropriate. The QA committee will review the results of the care plan review monthly for 3 months and determine the need for continued monitoring. The DON or designee will present findings to the QA committee for further oversight.

The title of the person responsible for implementing the acceptable plan of correction.
The DON is responsible for implementing the plan of correction.

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name.

During an interview with the Administrator and Director of Nursing on 12-20-18 at 2:35pm the Director of nursing stated she expected that each resident had their disease process care planed and that their psychotropic medications be care planned to identify side effects, if the medication was working and the medications use.

2. Resident #8 was admitted to the facility on 4-27-18 with multiple diagnoses that included anxiety disorder, mood disorder, dementia and diabetes.

A review of Resident #8's care plan dated 8-14-18 revealed no goals or interventions for the use of his psychotropic medications.

The quarterly Minimum Data Set (MDS) dated 10-11-18 revealed Resident 361 was severely cognitively impaired, had verbal and other behavioral symptoms 1-3 days and rejected care 1-3 days. The MDS also revealed the resident needed extensive assistance with one person for bed mobility, extensive assistance with 2 people for transfers and toileting, total assistance with 2 people for dressing and total assistance with one person for personal hygiene and bathing. Resident #8 was also coded as receiving an antipsychotic medication 6 out of 7 days and antianxiety medication 7 out of 7 days.

Resident #8's December 2018 Medication Administration Record (MAR) revealed that the resident received: Ativan (antianxiety medication) 0.25 milligrams by mouth twice a day and 0.5 milligrams by mouth in the evening, Depakote Sprinkles (mood stabilizing medication) 250

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F 656	Continued From page 12	F 656		

milligrams by mouth three times a day and Risperdal (antipsychotic medication) 1 milligram by mouth daily.

During an interview with a nursing assistant (NA) #4 on 12-20-18 at 9:30am she stated Resident #8 often refused care and she would inform the nurse and then request help from other staff. The NA stated she did not observe the resident for any medication side effects "that is not part of his care plan."

Resident #8 was interviewed on 12-20-18 at 9:35am. The resident was sitting in his wheelchair moving back and forth rubbing his left leg. The resident stated he was in pain and needed pain medication. The residents voice was loud and demanding. Resident #8 was unable to answer any questions regarding his medications "I don't know what I take but I know I get pain medication."

An interview with the nurse for Resident #8 on 12-20-18 at 10:00am, revealed she did not know the resident well enough to answer any questions.

During an interview with the Director of Nursing on 12-20-18 at 9:45am she stated she was aware the Resident #8 was on psychotropic medications and believed that the residents care plan had interventions for the nursing staff to follow regarding the medications.

The Administrator and Director of Nursing was interviewed on 12-20-18 at 2:35pm. The Director of Nursing stated she expected residents who are on psychotropic medications be care planed for those medications to monitor side effects and to

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F 656	Continued From page 13 assess if the medication was working. 3. Resident #36 was admitted to the facility on 10/15/18 and diagnoses included anxiety disorder and dementia with combative behaviors. Review of the physician orders for Resident #36 revealed an order for Ativan (an antianxiety medication) 0.5 milligrams (mg) twice daily and 1 mg every evening, an order for Haldol (an antipsychotic medication) 2 mg twice daily and 3 mg every evening and an order for Zoloft (an antidepressant medication) 25 mg daily. An admission minimum data set (MDS) dated 10/22/18 for Resident #36 revealed she had received an antipsychotic medication, an antianxiety medication and an antidepressant medication for 7 days of the look-back period. The resident had displayed verbal behaviors towards others for 1 to 3 days of the look-back period and the care area assessment summary indicated a care plan would be developed for the use of psychotropic medications. A review of the care plans for Resident #36 revealed no care plans for the use of psychotropic medications. An interview on 12/19/18 at 9:35 am with the MDS Consultant revealed she had completed the admission MDS dated 10/22/18 for Resident #36. She stated a care plan should have been developed for the use of psychotropic medications that included interventions for monitoring the use of these medications. An interview on 12/19/18 at 5:52 pm with the	F 656		

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F 656	Continued From page 14 Director of Nursing (DON) revealed it was her expectation that psychotropic medications were care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interviews and observation the facility failed to revise resident care plans to accurately reflect a	F 657	F657, ADL in Care Plans How the corrective action was	1/18/19

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F 657	Continued From page 15 resident's decline in their abilities to perform their activities of daily living (ADL). This was evident for 2 of 6 residents (Resident #41 and Resident #44) reviewed for ADL care. Findings included: 1.Resident #41 was admitted to the facility on 7-16-18 with multiple diagnoses that included chronic pain, polyneuropathy, major depression and dyspnea. Resident #41's care plan dated 8-15-18 revealed a goal that the residents Activities of Daily Living (ADL) care would be completed with staff support as appropriate to maintain highest level of functioning. The interventions for that goal were as followed: bathing 2-person physical assist, dressing physical assistance of staff limited, transfers 2 people with mechanical lift and bed mobility independent. The quarterly Minimum Data Set (MDS) dated 12-15-18 revealed Resident #41 was cognitively intact and needed extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for dressing, toileting and personal hygiene and bathing was total assist with one person. During an interview with Resident #41 on 12-17-18 at 11:29am the resident stated he was unable to move in the bed on his own and that 2 staff must help him. He also stated he can help with his bathing, but 2 staff must wash most of his body and move him in the bed. Resident #41 stated he was transferred out of bed using a mechanical lift with 2 staff members.	F 657	accomplished for those residents affected by the deficient practice. On 12-26-2018, the MDS Coordinator updated the care plans for residents 41 and 44 to accurately reflect the current ADL status. How facility identified other residents potentially affected by the deficient practice. By 1-18-2019, the DON completed a review of all residents' current ADL status, then compared to current care plans, and any negative findings were addressed immediately. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-20-2018, the RAI Reimbursement Auditor in-serviced the facility MDS nurses on care plan development and revision, which will be part of the orientation for any new MDS nurses. How facility plans to monitor performance. The DON and/or designee will audit 10 residents weekly x 4 and monthly x 2 to ensure that ADL's are correctly reflected on the resident care plans. The QA Committee will monitor the care plan reviews monthly for 3 months and determine the need for continued monitoring. The DON and/or designee will present findings to the QA Committee for further oversight. The title of the person responsible for implementing the acceptable plan of	

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F 657	Continued From page 16 An attempt was made to observe ADL care on 12-19-18 at 10:30am but Resident #41 refused. The resident did allow the surveyor to observe the transfer from his bed to the wheelchair with the mechanical lift and 2 staff members. During an interview with NA #2 on 12-19-18 at 11:00am she stated Resident #41's ADL care was always provided by 2 staff members because of the resident's inability to assist in bed mobility but that the resident can assist in dressing but needed "a lot" of assistance from staff. The Administrator and Director of Nursing was interviewed on 12-20-18 at 2:35pm. The Director of Nursing confirmed Resident #41's care plan had not been revised to reflect his current ability to perform ADL's and that she expected the care plans to be revised timely and as needed to reflect the residents current need of care. 2. Resident #44 was admitted to the facility initially on 6-12-17 and then readmitted after a hospitalization on 10-20-18. The resident was admitted with multiple diagnoses that included anxiety disorder, congestive heart failure and difficulty walking. Resident #44's care plan was revised on 10-9-18 revealed a goal that the resident would receive physical assistance with her Activities of Daily Living (ADL) routinely and as needed. The interventions for that goal were as followed: bed mobility with one person to physically assist, transfers two people with total dependence, toileting one person with total dependence. The care plan did not have any interventions for bathing or personal hygiene.	F 657	correction. The DON is responsible for implementing the plan of correction.	

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The quarterly Minimum Data Set (MDS) dated 10-27-18 revealed that Resident #44 was cognitively intact and had rejected care 1-3 days. The MDS also revealed the resident needed extensive assistance with 2 people for bed mobility, dressing and personal hygiene, total assistance with 2 people for transfers, toileting and bathing.

During an interview with Resident #44 on 12-17-18 at 1:51pm the resident stated she had to have 2 staff members assisting her in her care because she was unable "to do much for myself." She also stated she could wash her face if given the wash cloth but was unable to participate in washing the rest of her body. Resident #44 stated she was transferred out of bed in a lift by 2 staff and that any time her brief needed changed 2 staff would have to use the lift and put her back in bed.

An observation of ADL care with Resident #44 was completed on 12-19-18 at 9:20am. ADL care was provided by NA #2 and NA #4. The resident was noted to be given choices on what she wanted to wear and how she wanted to be washed. The NA's were noted to explain to the resident what they were going to be doing and was noted to wash the resident appropriately. Resident #44 was noted to be tearful when the NA's were turning her in the bed and stated she was "scared." NA #2 stated "that is why we have 2 people to help bath and turn the resident." No issues were noted during ADL care.

During an interview with NA #2 on 12-19-18 at 9:35am she stated Resident #44 needed 2 people for ADL care because the resident became scared when staff had to turn her, and

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F 657	Continued From page 18 the resident was limited in what she could do for herself. The NA also stated bathing and personal hygiene was not on Resident #44's care plan but staff who worked with the resident knew they needed 2 people to help with the resident's care. The Administrator and Director of Nursing was interviewed on 12-20-18 at 2:35pm. The Director of Nursing confirmed Resident #44's care plan had not been revised to reflect his current ability to perform ADL's and that she expected the care plans to be revised timely and as needed to reflect the residents current need of care.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain the bed in a low position for a resident with repeated falls. This was evident for 1 of 4 residents reviewed for accidents (Resident #54). Findings Included: Resident #54 was admitted to the facility on 10/12/18 and diagnoses included cervical disc disorder, muscle spasms, low back pain, psychosis and schizophrenia.	F 689	F689, Low bed intervention How the corrective action was accomplished for those residents affected by the deficient practice. On 1-17-2019, the Assistant DON observed resident 54 in bed with the bed in lowest position. How facility identified other residents potentially affected by the deficient practice.	1/18/19

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F 689	Continued From page 19 An admission minimum data set (MDS) dated 10/19/18 for Resident #54 revealed no fall history or falls since admission, resident was totally dependent with two person assist for bed mobility and transfer activity had only occurred once or twice during the look-back period. A care plan dated 11/1/18 for Resident #54 identified he was a risk for falls characterized by actual falls, injury and multiple risk factors. Interventions included bed in lowest position, call bell pinned to gown when in bed, fall mat on floor when in bed and have commonly used articles within easy reach. The incident reports for Resident #54 from admission to present were provided by the Administrator and revealed the resident had fallen on 11/12/18, 11/13/18, 11/18/18, 11/21/18 and 11/29/18. The resident did not obtain any injuries from the falls and the facility had implemented new fall interventions. An observation of Resident #54 on 12/17/18 at 3:39 pm revealed the resident was lying in bed. The bed was not in a low position. An observation on 12/18/18 at 1:55 pm of Resident #54 revealed he was lying in bed. The bed was not in a low position. An interview on 12/18/18 at 2:03 pm with Nurse #3 revealed Resident #54 had rolled out of bed numerous times. She stated the residents bed was supposed to be kept in the low position with a fall mat and pillows for positioning. Nurse #3 added the Nursing Assistants (NAs) were made aware of the fall interventions for residents by	F 689	On 1-17-2017, the Assistant DON audited all residents with the care plan intervention for the bed in the lowest position to ensure intervention was in place, and any negative findings were corrected. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-20-2018 the DON began an in-service with all nursing staff, including agency, on ensuring care plan interventions are in place including bed in the lowest position. This in-service was complete 1-18-2019, and no staff will be allowed to work after that date until in-service is completed. On 1-16-2019, the SDC added it to the orientation for all new nursing staff, including agency. How facility plans to monitor performance. The DON and/or designee will observe 5 residents daily 5 times per week to ensure bed is in lowest position if on resident care plan. The QA committee will monitor the results of the low bed review monthly for 3 months and determine the need for continued monitoring. The DON or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	

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F 689	Continued From page 20 checking the care plans. An interview on 12/18/18 at 2:10 pm with NA #3 revealed Resident #54 was on his assignment. He stated the resident preferred to stay in bed because he had a lot of pain. NA #3 added he didn ' t think the resident had any falls, but they did keep a mat on the floor and his bed was supposed to be in the low position. An observation on 12/18/18 at 2:15 pm with Nurse #3 and NA #3 revealed Resident #54 was lying in bed and the bed was in the regular position. Nurse #3 stated the bed should have been in the low position and she wasn ' t sure why it wasn ' t. She added the staff may have forgotten to return it to the low position after the resident ate lunch. The resident care guide for Resident #54 was provided by the Administrator. He stated this was the document the NAs used to know what type of care the residents required. The care guide for Resident #54 was dated 10/15/18 and did not include any fall interventions. An observation of Resident #54 on 12/19/18 at 11:00 am revealed he was lying in bed. The bed was not in a low position. An interview on 12/19/18 at 5:43 pm with the Director of Nursing revealed it was her expectation that fall interventions were identified on the resident care guide and these interventions were completed by the staff.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		1/18/19

F 698 Continued From page 21

F 698

§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide a physician's order for 1 of 1 residents (Resident #15) to attend dialysis treatment and a physician's order for staff to monitor and assess the resident's dialysis port.

Findings included:

Resident #15 was admitted to the facility on 10-5-18 with multiple diagnoses to include chronic kidney disease, hypertensive heart disease, cirrhosis of the liver and muscle weakness.

The admission Minimum Data Set (MDS) dated 10-12-18 revealed Resident #15 was not cognitively impaired and needed extensive assistance with 2 people for bed mobility, total assist with 2 people for transfers and toileting, total assistance with one person for dressing, personal hygiene and bathing. The MDS also revealed the resident was coded for dialysis treatment.

Resident #15's care plan dated 10-10-18 revealed a goal that the resident would not experience complications from dialysis. The intervention for the goal were as followed; communicate with the dialysis treatment center and do not draw blood or take a blood pressure in arm with access site.

F698, Orders for dialysis and port assessment

How the corrective action was accomplished for those residents affected by the deficient practice.
On 12-18-2018, the DON obtained a physician order for resident's dialysis treatment and to monitor and assess dialysis port.

How facility identified other residents potentially affected by the deficient practice.
By 1-16-2019, the Assistant DON audited all residents on dialysis to ensure a physician order is in place for the dialysis treatment and to monitor and assess the dialysis port. Any negative findings were corrected immediately.

Identified the measures or systemic changes taken to ensure deficient practice will not recur.
An in-service was started by DON on 1-14-2019 for all licensed nurses, including agency, on obtaining orders for dialysis and to monitor and assess dialysis port for each dialysis resident. This in-service was complete by 1-18-2019, after which no licensed nurse

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A review of Resident #15's medical record from 10-5-18 to 12-18-18 revealed that there were not orders for resident #15 to have dialysis treatment or for staff to monitor and assess the residents access site.

During an interview with nurse #1 on 12-18-18 at 3:30pm she stated the resident should have an order for dialysis and for the nursing staff to monitor and assess the resident's dialysis site at least every shift. The nurse also stated staff would then initial on the medication record they had assessed the dialysis site that shift. Nurse #1 was unable to find the order or a place on Resident #15's medication record to initial that she had assessed the dialysis site "I guess there needs to be a new order."

An interview with the physician occurred on 12-18-18 at 3:45pm. The physician stated he could not remember if he had written an order for resident #15's dialysis but upon reviewing his orders for Resident #15 he realized he had not written any orders for the resident's dialysis and wrote them prior to leaving the facility.

The Director of Nursing and the Administrator were interviewed on 12-18-18 at 4:30pm. The Director of Nursing stated there had not been an order for Resident #15 to attend dialysis treatment or for staff to assess the resident's dialysis site but that the physician had written them today (12-18-18). The Director of Nursing stated she expected when a new resident was admitted to the facility and needing dialysis that orders would be written, and that staff would check the new resident's dialysis site as stated in the physician orders.

F 698

will be allowed to work until in-service is completed. This in-service was added to the orientation for all newly hired licensed nurses, including agency on 1-16-2019 by SDC.

How facility plans to monitor performance. The DON and/or designee will randomly audit dialysis residents weekly x 4 weeks and monthly x 2 to ensure physician orders are present for the dialysis treatment, assessment, and monitoring of the dialysis port. The QA committee will monitor the results for 3 months and determine the need for continued monitoring. The DON or designee will present the findings QA committee for further oversight.

The title of the person responsible for implementing the acceptable plan of correction.
The DON is responsible for implementing the plan of correction.

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F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to develop a care plan which included how the staff were providing treatment for dementia for 1 of 4 residents (Resident #61) who had a diagnosis of dementia. Findings included: Resident #61 was admitted to the facility on 5-14-18 with multiple diagnoses that included congestive heart failure, major depression, dysphagia, diabetes and dementia. The quarterly Minimum Data Set (MDS) dated 11-19-18 revealed the resident was severely cognitively impaired and needed extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene and was a total assistance with one person for bathing. Resident #61's care plan dated 10-9-18 revealed that there was no plan in place to treat her dementia. A review of Resident #61's medication record revealed that she was prescribed Aricept (a medication used for dementia patients) 10 milligrams to be given by mouth daily and that the medication was given daily in the month of	F 744	F744, Dementia Care Plans How the corrective action was accomplished for those residents affected by the deficient practice. On 12-26-2018, the MDS Coordinator updated resident #61's care plan to include how the staff were providing treatment to the resident's diagnosis of dementia. How facility identified other residents potentially affected by the deficient practice. By 1-15-2019, the RAI reimbursement auditor audited all residents with a diagnosis of dementia to ensure a care plan is in place that includes how the staff is providing treatment to the resident for the diagnosis. Any negative findings were corrected immediately. Identified the measures or systemic changes taken to ensure deficient practice will not recur. An in-service was done by MDS Consultant on 12-20-2018 for the MDS nurses on developing a care plan for residents with a diagnosis of dementia to include treatment and will be provided to	1/18/19

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F 744	Continued From page 24 December 2018. During an interview with Resident #61 on 12-18-18 at 11:05am she stated she enjoyed watching television when she was asked what day it was and asked to be left alone when she was asked what holiday was in December. The room was noted not to have a calendar, or a clock and the residents family photos were noted to be positioned behind her. An interview with nurse #1 occurred on 12-18-18 at 11:10am. The nurse stated she had only seen Resident #61 in her room watching television and denied knowing that the resident was diagnosed with dementia "her memory seemed fine to me." She also stated that most of the residents had a clock in their rooms and calendars to help with orientation but did not realize Resident #61 did not have these items and denied assessing Resident #61's orientation when she interacted with the resident. During an interview with the Director of Nursing and the Administrator on 12-20-18 at 2:35pm the Director of Nursing stated she was unaware that Resident #61 was not care planned to receive treatment for her dementia and that she expected all the residents to be care planned and receive treatment for their diagnoses.	F 744	any new MDS nurse. How facility plans to monitor performance. The DON and/or designee will audit 10 resident care plans weekly x 4 weeks to ensure if residents have a diagnosis of dementia and if a care plan is in place that addresses how the staff will provide treatment to the resident. The QA committee will review the results monthly for 3 months and determine the need for continued monitoring. The DON or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		1/18/19

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F 758	Continued From page 25	F 758		

categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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F 758	Continued From page 26 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 6 residents (Resident #12) reviewed for unnecessary medications. Findings include: Resident #12 was admitted to the facility on 10/4/18 with diagnoses that included vascular dementia, restlessness and agitation, and major depressive disorder. A review of Resident #12's most recent MDS (Minimum Data Set) dated 10/11/18 was coded as an admission assessment. The resident was coded as cognitively impaired. Active diagnoses included Non-Alzheimer's dementia, depression, restlessness, and agitation. Under the medication section of Resident #12's MDS it was revealed that the resident received antipsychotic medications 7 out of 7 days in the look back period. Under the behavioral section of the MDS it was coded that Resident #12 had physical behavioral symptoms directed towards others every 1-3 days. A review of Resident #12's care plan dated 10/9/18 revealed that the resident was care planned for problematic behavior in which the resident acts are characterized by ineffective coping and agitation/combativeness related to cognitive impairment.	F 758	F758, Psych PRN med duration orders How the corrective action was accomplished for those residents affected by the deficient practice. On 1-18-2019, the Assistant DON obtained a physician order for medication for resident #12□, which was discontinued. How facility identified other residents potentially affected by the deficient practice. On 12-20-2018, the Pharmacy Consultant audited all resident medication administration records for as-needed psychotropic medications. Any as needed psychotropic medications were reviewed for duration, and if duration was not present, documentation from physician was reviewed by auditors to ensure compliance with regulation. Any negative findings were addressed immediately. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-27-2018, the SDC began an in-service with licensed nurses, incusing agency, on as-needed psychotropic medication duration. This in-service was completed by 1-18-2019, and no licensed nursing staff will be allowed to work after that date until in-service is completed.	

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F 758	Continued From page 27 A review of Resident #12's medical record revealed a physician's order written on 10/3/18 that read 'Ativan 0.5mg every 8 hours prn (as necessary) agitation.' The medical record for Resident #12 also had a physician's note dated 10/3/18 that revealed the resident had diagnoses that included chronic depression and agitation. The physician note read 'Lorazepam 0.5mg by mouth every 8 hours as needed Continue plan of care and monitor for any changes. A review of Resident #12's medical record revealed a pharmacy consult dated 10/10/18 that read to follow up with nursing and the physician for prn Ativan. A pharmacy consult note to the attending physician/prescriber was written on 10/11/18 that read: 'This resident has the following prn psychotropic order. Ativan 0.5mg every 8 hours prn agitation. CMS guidelines limit the duration of PRN psychotropic orders to 14 days. If the prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration of the PRN order. Please either discontinue the above order for document the rational for continued use and specify the duration of use. Treatment: anxiety, agitated behavior.' The pharmacy recommendation was signed by NP (Nurse Practitioner) on 11/6/18 with no documentation or change/order noted. Pharmacy consult notes dated 11/14/18 and 12/19/18 reported resident continued with an order for Ativan prn with no physician follow up noted. A review of Resident #12's MAR (Medication Record Administration) for October and	F 758	This in-service will be part of the orientation for new licensed nursing staff, including agency. How facility plans to monitor performance. The DON and/or designee will audit 10 resident medication administration records weekly x 4 weeks and monthly for 2 months to ensure if resident is on as-needed psychotropic medications for an appropriate duration or documentation is in place. The QA committee will monitor the results for 3 months and determine the need for continued monitoring. The DON or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	

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F 758	Continued From page 28 November 2018 revealed the resident had one prn dose of Ativan on 10/23/18 and none administered in November. A review of Resident #12's medical record revealed a nurse practitioner's note dated 11/16/18 which read that the resident was on Zoloft 100mg daily, Seroquel 25mg daily and Lorazepam (the generic name for Ativan) 0.5mg every 8 hours prn. The note reported no unusual behaviors and the care plan was to continue the current medications. An interview was conducted on 12/20/18 at 8:45am with the DON (Director of Nursing). She reported it was her expectation that all prn psychotropic medications be reevaluated every 14 days per the regulation. An interview was conducted on 12/20/18 at 9:25am with the Nurse Practitioner. She reported she was not aware she needed to reassess prn psychotropic medications every 14 days. She reported she did not address Resident #12's Ativan prn order when she saw the resident in October or November 2018. An interview was conducted on 12/20/18 at 1:00pm with the Administrator. He reported it was his expectation that all prn psychotropic medication be reassessed for effectiveness every 14 days.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		1/18/19

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F 759	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on 28 opportunities for error during the medication pass observation, staff interviews, interview with the consultant pharmacist, interview with the attending physician and record review the facility had 5 errors resulting in a 17.86% medication error rate. (Resident #20 and Resident #27) Findings included: a. Record review of the December 2018 physician orders for Resident #20 included: " Scopolamine transdermal 1.5 mg (milligrams) every 72 hours at was 9 AM. " Folic acid 1 mg every morning via the peg tube (gastrostomy tube) at 9 AM " Nexium 40 mg in 15 cubic centimeters (cc) daily via the peg tube at 9 AM. " Vitamin C 500 mg via peg tube every morning at 9AM " Neurontin 800 mg twice a day via peg tube scheduled at 9 AM and 5 PM. " Amlodipine 5 mg (2 tab) once a day via peg tube at 9 AM " Baclofen 5 mg every 8 hours via peg tube at 6 AM, 2 PM and 10 PM " Fentanyl transdermal 75 mcg/hr every 72 hours at 9 AM. " Promethazine 25 mg every 6 hours via peg tube whenever necessary for nausea " Oxycodone solution 5 mg via peg tube every 4 hours when necessary for pain. " Vitamin D3 1000 U 1 tab every day via peg tube at 9 AM Observation on 12/18/18 at approximately 10 AM	F 759	F759, Medication Errors How the corrective action was accomplished for those residents affected by the deficient practice. On 12-18-2018 the DON assessed resident # 20 for any negative effects related to the medication errors, and none were reported. On 12-18-2018 the DON assessed resident #27 for negative effects related to medication error, and the patient denied any issues. On 12-18-2018, the DON notified the physician of the medication errors with no new orders received. How facility identified other residents potentially affected by the deficient practice. From 12-23-2018 to 1-16-2019, the DON and Assistant DON completed medication administration audits for all residents with medication administration via gastrostomy tube, ophthalmic preparation, and/or transdermal application. Any negative findings were corrected immediately. Identify the measures or systemic changes taken to ensure deficient practice will not recur. On 12-18-2018, the SDC began an in-service with licensed nurses, including agency and nurses 4 and 5, on medication administration policy, which was completed 1-18-2019, and no licensed nursing staff will be allowed to work after this date until in-service is	

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F 759	Continued From page 30 during the medication pass revealed Nurse #5 did not have Scopolamine transdermal patch to administer. Nurse #5 prepared, poured, crushed and in separate cups diluted 30 cc of water the Folic acid, Vit C, Promethazine (due to complaint of nausea), Neurontin, Amlodipine, Vitamin D3 and Baclofen. Nexium was dissolved in 15 cc of water in a separate cup. Oxycodone solution 5 mg was poured into a separate medication cup. There were 9 separate medication cups containing each of the above medications. One of the 9 medication cups spilled onto the overbed table with a scant amount of medication remaining in the bottom. There was no method to identify which medication had been spilled. Although, one of the crushed medications had spilled, Nurse #5 added water to the spilled medication cup and administered all the medications without the ability to identify the spilled medication. Nurse #5 did not flush between medication administration via the peg tube. Interview on 12/18/18 at 10:41 AM with Nurse #5 revealed she administered the medications including the spilled one because there was some residual in the spilled cup. Nurse #5 stated she does not usually flush between administration of medications. There was no response to why the Baclofen was administered during the 9 AM pass. Continued interview with Nurse #5 who stated the Scopolamine patch was not available and needed to be ordered from the pharmacy. Interview on 12/18/18 at 2:39 PM with the attending physician revealed Scopolamine was used because of resident's complaints of nausea.	F 759	completed. This in-service will be part of the orientation for new licensed nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON and/or designee will audit 10 resident medication administrations weekly x 4 weeks and monthly x 2 months to ensure medication is administered correctly according to policy and procedure. The QA committee will monitor the results for 3 months and determine the need for continued monitoring. The DON and/or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	

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F 759	Continued From page 31 Interview on 12/19/18 at 8:35 AM with the consultant pharmacist revealed Nurse # 5 should have prepared all the medications again for Resident #20 since an accurate identification could not be completed. Interview on 12/19/18 at 9:19 AM with the Administrator and Director of Nurses (DON) was held. The DON stated her expectation for staff was to repour each medication when medications cannot be identified. The DON stated she expected staff to flush between medications administered via the peg tube. b. Review of the December 2018 physician orders for Resident #27 included Refresh tears. Observation on 12/17/18 at 4:33 PM with Nurse #4 the medication administration pass revealed Refresh tears were not administered to Resident ##27. Nurse #4 stated during the pass the label on the Refresh tears was marked opened on 7/26/18, was out of date and so "I did not give." Interview on 12/19/18 at 8:35 AM with the consultant pharmacist revealed Nurse #4 could have given the Refresh tears using the actual expired date on the bottle.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to administer a blood pressure medication as ordered by the physician.	F 760	F760, Significant Medication Errors How the corrective action was	1/18/19

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F 760

Continued From page 32

This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #36).

Findings Included:

Resident #36 was admitted to the facility on 10/15/18 and diagnoses included hypertension, heart failure, diabetes, nephrotic syndrome and anxiety disorder.

An admission minimum data set (MDS) dated 10/22/18 for Resident #36 revealed her cognition was intact and she required extensive one person assist with her activities of daily living (ADL ' s).

Review of the December 2018 physician orders for Resident #36 included an order for a catapres patch (a medication to treat high blood pressure) 0.2 milligrams (mg) per 24 hours; apply 1 patch to skin weekly.

Review of the December 2018 medication administration record (MAR) for Resident #36, provided by the Administrator on 12/19/18 at 9:30 am revealed an order for a catapres patch 0.2 mg / 24 hours; apply 1 patch to skin weekly. The MAR was blocked off for the patch to be administered every Wednesday of the month at 9:00 am. The MAR was blank for administration of the catapres patch on 12/18/18.

An observation of Resident #36 on 12/19/18 at 10:00 am with Nurse #2 revealed the resident was lying in bed. A catapres patch was located center chest and was dated 12/11/18. The resident stated the patch was put on a couple of days ago.

An interview on 12/19/18 at 11:06 am with Nurse

F 760

accomplished for those residents affected by the deficient practice.
On 12-19-2018, the DON assessed resident # 36 for any negative effects related to the medication error, blood pressure was 110/80 and there were no adverse reactions reported.

How facility identified other residents potentially affected by the deficient practice.
On 1-11-2019, the Assistant DON completed medication administration reviews for all residents with medication administration via transdermal application, and there were no issues.

Identified the measures or systemic changes taken to ensure deficient practice will not recur.
On 1-16-2019, the SDC began an in-service with licensed nurses, including agency on medication administration policy, which was completed by 1-18-2019, and no licensed nursing staff will be allowed to work after date until in-service is completed. This in-service will be part of the orientation for new licensed nursing staff, including agency.

How facility plans to monitor performance.
The DON and/or designee will audit 10 resident medication administrations weekly x 4 weeks and monthly x 2 months to ensure medication is administered correctly according to policy and procedure. The QA committee will monitor the results for 3 months and determine the need for continued monitoring. The

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F 760	Continued From page 33 #3 revealed she was the nurse for Resident #36 on 12/18/18 and 12/19/18. She stated she had administered the catapres patch on the residents left upper chest on 12/18/18, but she had forgotten to remove the old patch. She added when she observed the resident this morning only the catapres patch dated 12/11/18 was present. Nurse #3 stated she didn ' t know what happened to the patch dated 12/18/18, but it must have come off. She added she removed the patch dated 12/11/18 and applied a new catapres patch dated 12/19/18. Nurse #3 stated she had forgotten to sign the MAR indicating she had placed the catapres patch on 12/18/18. Review of a nurses note written by Nurse #3 dated 12/19/18 at 12:50 pm stated Resident #36 ' s catapres patch was not on the residents left chest that was applied yesterday. The patch was replaced and dated with today ' s date. Notified physician that resident was without episode of high blood pressure. Will continue to monitor. The December 2018 documented blood pressure readings for Resident #36 were provided by the Nurse Consultant. The readings were as follows: 12/7/18 - 120/91, 12/6/18 - 138/82, 12/6/18 - 138/70, 12/5/18 - 100/81 and 12/4/18 - 108/83. An interview on 12/19/18 at 2:03 pm with the Nurse Consultant revealed the residents didn ' t have their vital signs (including blood pressure) checked routinely unless ordered by the physician or if there was an identified concern. She stated the blood pressure readings she provided for Resident #36 were the only readings documented for the resident. An interview with Nurse #3 on 12/19/18 at 2:18	F 760	DON and/or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	

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F 760	Continued From page 34 pm revealed residents blood pressures were checked weekly by the Nursing Assistants (NAs). She stated Resident #36 ' s blood pressure wasn ' t checked after she discovered the missing catapres patch. An interview with the Director of Nursing (DON) on 12/19/18 at 5:47 pm revealed it was her expectation that resident ' s medications were administered as ordered. The DON added she expected the medical record to contain the appropriate signatures when medications were administered.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		1/18/19

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F 761	Continued From page 35 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and interview with the consultant pharmacist the facility failed to store medication according to the manufacturer's instructions on 2 of 2 medication carts and 1 medication room. (Units 100 and 300) Findings included: Review of the manufacturer's instructions revealed: Unopened Insulin (Lantus, Novolog and Humalog) vials must be refrigerated. Once opened the vial must be discarded 28 days. Unopened Levemir vials must be stored in the refrigerator. Once opened Levemir must be discarded after 42 days. Observation on 12/17/18 at 4:50 PM of the medication storage of insulin from Unit 100 cart revealed: " (2) Novolog100U/ml vials were stored on the cart unopened and not refrigerated. " (2) vials of Novolog 100/ml were opened and there were no dates when opened. " Novolog 100U/ml vial was dated as opened on 11/2/18. . Observation on 12/17/18 at 5:15 PM of the medication storage of insulin from Unit 300 cart revealed: " Lantus was stored on the cart unopened and not refrigerated.	F 761	F761, Med Labeling and Storage How the corrective action was accomplished for those residents affected by the deficient practice. On 12-19-2018, the Surveyor removed 2 vials of Novolog that were unopened but stored without refrigeration in 100 hall medication cart. On 12-19-2018, the Surveyor removed 2 vials of open, undated vials of Novolog insulin in 100 hall medication cart. On 12-19-2018, the Surveyor removed a bottle of Novolog with open date of 11/2/2018. Medications were discarded per pharmacy policy by DON. On 12-19-2018, the Surveyor removed one unopened vial of Lantus, Levmir, and Humalog stored without refrigeration in 300 hall medication cart. Medications were discarded per pharmacy policy by DON. On 12-19-2018, the Surveyor removed a flocath that expired on 8/2012 from the medication storage area. The expired flocath was discarded by DON. How facility identified other residents potentially affected by the deficient practice. On 12-19-2018, the DON and LPN audited all medication carts and storage areas to ensure all medications were in date and stored according to the medication storage policy. Expired	

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F 761	Continued From page 36 " Levemir was unopened and stored in the medication cart without refrigeration. " Humalog was unopened and store in the medication cart without refrigeration Interview on 12/17/18 at 5:30 PM with Nurse #1 revealed she was unaware of why the insulin was stored in the cart unopened. There was a Flocath in the supply cabinet in the med storage room with the expiration date of 08/2012. Interview on 12/19/18 at 08:35 AM with the pharmacist indicated the policy opened f the facility was to refrigerate unopened insulin and Levemir and to date when insulins and Levemir. Interview on 12/19/18 at 9:07 AM with the Administrator, Director of Nurses (DON) and Pharmacy consultant was held. The DON expected unopened medications that required refrigeration be refrigerated. Once opened the vial should be dated and to follow manufactures instructions. The DON indicated she expected no expired medical supply be stored in the medication room.	F 761	supplies were discarded per policy. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-19-2018, an in-service was started by the DON on medication storage and removal of expired medications per facility policy for all licensed nurses, including agency, and no licensed nurses will be allowed to work after 1-18-2019 until in-service is completed. This in-service will be included with orientation for all newly hired licensed nursing staff and agency. How facility plans to monitor performance. The DON and/or designee will audit one medication cart and medication room weekly x 4 weeks and monthly for 2 months to ensure no expired medications are present, and medications are stored per pharmacy policy. The QA committee will monitor the results monthly for 3 months and determine the need for continued monitoring. The DON and/or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals	F 809		1/18/19

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F 809	Continued From page 37 §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to offer bedtime snacks to 5 of 6 residents reviewed for bedtime snacks (Resident #21, Resident #37, Resident #47, Resident #51 and Resident #55). Finding included: 1. During an interview on December 17, 2018 at 2:30 pm Resident #21 indicated that bedtime snacks had not been provided for him at night. During an observation on Tuesday December 18, 2018 from 7:00 pm until 9:05 pm no one was observed passing out or offering snacks to Resident #21 or any other residents on the 300 hall.	F 809	F809, Snacks at Bedtime How the corrective action was accomplished for those residents affected by the deficient practice. Resident #21 was offered a bedtime snack and accepted on 12-20-2018. Resident #37 was offered a bedtime snack and accepted on 12-20-2018. Resident # 47 was offered a bedtime snack and accepted on 12-20-2018. Resident # 51 was offered a bedtime snack and accepted on 12-20-2018. Resident #55 was offered a bedtime snack and accepted on 12-20-2018. How facility identified other residents potentially affected by the deficient	

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During a second interview on December 18, 2018 at 9:03 pm Resident #21 indicated that he did not get a snack on Monday night nor had anyone asked him tonight if he wanted a snack. Resident #21 stated he had only been offered a nighttime snack approximately 3 times in the 3 months he had been at the facility.

During an interview with Nursing Assistant (NA) #100 on December 18, 2018 at 9:15 pm revealed that snacks were passed out between 8pm and 9pm. NA #100 added "do you see anything, the kitchen had not delivered snacks tonight."

During an interview with the Dietary Manager on 12/19/2018 at 10:34 am revealed that snacks were provided three times a day, including bedtime snacks for residents. He stated the snacks offered included ½ sandwiches, sugar free cookies, assorted cookies, crackers, juice and milk. The DM explained they stocked these items in a cart and cooler that was sent out to nursing to distribute. He stated they didn ' t have any residents that received labeled snacks. He stated he expected the nursing staff to pass out the snacks to the residents.

During an interview with the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed that her expectation was that every resident in the facility be offered a bedtime snack.

During an interview with the Administrator on December 20, 2018 at 2:45 pm revealed he expected staff to offer bedtime snacks every night for any resident who wanted a snack per regulation.

2. During an interview on December 17, 2018 at

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practice.
From 12-21-2018 to 12-28-2018, the Assistant DON completed interviews with interviewable residents to ensure residents are pleased with their snacks, and any concerns were addressed and resolved immediately by the Assistant DON. By 1-18-2019, the Social Worker audited the last 60 days of concerns with the focus of snacks, and there were no grievances related to snacks.

Identified the measures or systemic changes taken to ensure deficient practice will not recur.
All licensed nurses, and CNAs will be in-serviced by 1-18-2019 by the DON and/or designee on offering residents snacks including bedtime snacks, and no licensed nurse or CNA will be allowed to work after that date until in-service is complete. This in-service was added to the orientation for all newly hired licensed nurses and CNAs.

How facility plans to monitor performance.
The DON and/or designee will audit 10 residents weekly for 4 weeks and monthly x 2 months to ensure residents are offered bedtime snacks. The QA committee will review the results monthly for 3 months and determine the need for continued monitoring. The DON and/or designee will present the findings to the QA committee for further oversight.

The title of the person responsible for implementing the acceptable plan of correction.

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F 809	Continued From page 39 2:30 pm Resident #37 indicated that bedtime snacks were not offered at night. During an observation on Tuesday December 18, 2018 at 7:00 pm until 9:05 pm no one was observed offering snacks to Resident #371 or any other resident on the 100 hall. During a second interview on December 18, 2018 at 9:07 pm with Resident #37 she indicated that she never received a snack at night and no one had offered her anything tonight. During an interview with Nursing Assistant (NA) #100 on December 18, 2018 at 9:15 pm revealed that snacks were passed out between 8pm and 9pm. NA #100 added "do you see anything, the kitchen had not delivered snacks tonight." During an interview with the Dietary Manager on 12/19/2018 at 10:34 am revealed that snacks were provided three times a day, including bedtime snacks for residents. He stated the snacks offered included ½ sandwiches, sugar free cookies, assorted cookies, crackers, juice and milk. The DM explained they stocked these items in a cart and cooler that was sent out to nursing to distribute. He stated they didn ' t have any residents that received labeled snacks. He stated he expected the nursing staff to pass out the snacks to the residents. During an interview with the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed that her expectation was that every resident in the facility be offered a bedtime snack. During an interview with the Administrator on December 20, 2018 at 2:45 pm revealed he	F 809	The DON is responsible for implementing the plan of correction.	

F 809 Continued From page 40 F 809

expected staff to offer bedtime snacks every night for any resident who wanted a snack per regulation.

3. During an interview on December 17, 2018 at 2:30 pm Resident #55 indicated that bedtime snacks were not offered at night.

During an observation on Tuesday December 18, 2018 at 7:00 pm until 9:06 pm no one was observed passing out or offering snacks to Resident #55 or any other resident on the 100 hall.

During a second interview on December 18, 2018 at 9:07 pm Resident #55 indicated that she never got snacks at night. Resident #55 revealed that no one had offered her a snack tonight.

During an interview with Nursing Assistant (NA) #100 on December 18, 2018 at 9:15 pm revealed that snacks were passed out between 8pm and 9pm. NA #100 added "do you see anything, the kitchen had not delivered snacks tonight."

During an interview with the Dietary Manager on 12/19/2018 at 10:34 am revealed that snacks were provided three times a day, including bedtime snacks for residents. He stated the snacks offered included ½ sandwiches, sugar free cookies, assorted cookies, crackers, juice and milk. The DM explained they stocked these items in a cart and cooler that was sent out to nursing to distribute. He stated they didn ' t have any residents that received labeled snacks. He stated he expected the nursing staff to pass out the snacks to the residents.

During an interview with the Director of Nurses

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(DON) on December 20, 2018 at 2:30 pm revealed that her expectation was that every resident in the facility be offered a bedtime snack.

During an interview with the Administrator on December 20, 2018 at 2:45 pm revealed he expected staff to offer bedtime snacks every night for any resident who wanted a snack per regulation.

4. During an interview on December 17, 2018 at 2:30 pm Resident #51 indicated that bedtime snacks were not offered at night.

During an observation on Tuesday December 18, 2018 at 7:00 pm until 9:05 pm no one was observed passing out or offering snacks to Resident #51 or any other resident on the 100 hall.

During a second interview on December 18, 2018 at 9:09 pm Resident #51 indicated that she never got snacks at night and no one had offered her anything tonight.

During an interview with Nursing Assistant (NA) #100 on December 18, 2018 at 9:15 pm revealed that snacks were passed out between 8pm and 9pm. NA #100 added "do you see anything, the kitchen had not delivered snacks tonight."

During an interview with the Dietary Manager on 12/19/2018 at 10:34 am revealed that snacks were provided three times a day, including bedtime snacks for residents. He stated the snacks offered included ½ sandwiches, sugar free cookies, assorted cookies, crackers, juice and milk. The DM explained they stocked these items in a cart and cooler that was sent out to

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F 809	Continued From page 42	F 809		

nursing to distribute. He stated they didn ' t have any residents that received labeled snacks. He stated he expected the nursing staff to pass out the snacks to the residents.

During an interview with the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed that her expectation was that every resident in the facility be offered a bedtime snack.

During an interview with the Administrator on December 20, 2018 at 2:45 pm revealed he expected staff to offer bedtime snacks every night for any resident who wanted a snack per regulation.

5. During an interview with Resident #47 on December 18, 2018 at 9:11 pm revealed she would love to have a snack sometimes but the staff were very busy during this shift. Resident #47 indicated she had not been offered a snack tonight and because she was diabetic sometimes she needed a little something to eat round this time.

During an observation on Tuesday December 18, 2018 at 7:00 pm until 9:05 pm no one was observed passing out or offering snacks to Resident #47 or any other resident on the 100 hall.

During an interview with Nursing Assistant (NA) #100 on December 18, 2018 at 9:15 pm revealed that snacks were passed out between 8pm and 9pm. NA #100 added "do you see anything, the kitchen had not delivered snacks tonight."

During an interview with the Dietary Manager on 12/19/2018 at 10:34 am revealed that snacks

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F 809	Continued From page 43 were provided three times a day, including bedtime snacks for residents. He stated the snacks offered included ½ sandwiches, sugar free cookies, assorted cookies, crackers, juice and milk. The DM explained they stocked these items in a cart and cooler that was sent out to nursing to distribute. He stated they didn ' t have any residents that received labeled snacks. He stated he expected the nursing staff to pass out the snacks to the residents. During an interview with the Director of Nurses (DON) on December 20, 2018 at 2:30 pm revealed that her expectation was that every resident in the facility be offered a bedtime snack. During an interview with the Administrator on December 20, 2018 at 2:45 pm revealed he expected staff to offer bedtime snacks every night for any resident who wanted a snack per regulation.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		1/18/19

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F 812	Continued From page 44 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain kitchen equipment in a sanitary, safe operating condition and failed to allow service / cookware to air dry before being stored. This was evident in 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 12/17/18 from 9:30 am through 10:00 am with the Dietary Manager (DM) revealed the following: a. The interior of the ice machine had a reddish-brown buildup of a slimy substance. b. Three (3) half size deep steam table pans were stacked together wet on a shelf designated for clean, ready to use pots and pans. c. Eleven (11) meal trays were stacked together wet on a cart near the steam table for lunch service. d. A 3-compartment storage bin that contained new single-use plastic lids for cups and bowls had sticky yellowish-brown substances and food particles in the bottom of the bins. e. Six (6) steam table lids that were being used to cover food on the steam table were noted to have a build-up of food on the tops and handles. f. The bottom convection oven had a string tied to keep the oven doors closed. The oven was in use. g. A ceiling vent located above the dish machine	F 812	F812, Sanitary Kitchen Equipment How the corrective action was accomplished for those residents affected by the deficient practice. On 12-18-2018, the title cleaned the ice machine in the kitchen which removed the reddish brown substance. On 12-18-2018, the Dietary Manager re-washed the three half size deep steam table pans noted to be wet and stuck together on a shelf designated for ready-to-use clean pots and pans. They were then allowed to air dry correctly before use. On 12-18-2018, the Dietary Manager rewashed the 11 meal trays that were stacked together wet near the steam table. They were allowed to air dry correctly before use. On 12-18-2018, the Dietary Manager cleaned the storage bin that contained the new single use plastic lids for cups and bowls. This cleaning removed the yellowish-brown substance and food particles in bin bottoms. The single use lids were discarded prior to cleaning. On 12-18-2018, the Dietary Manager removed and cleaned the six steam table lids that were being used to cover food on the steam table with a buildup of food on the trays and handles. The steam table lids were then cleaned and dried prior to next use. On 12-18-2018, the	

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F 812	Continued From page 45 was noted with a heavy build-up of rust. An interview with the DM on 12/17/18 at 10:00 am revealed the steam table pans and the meal trays should have been allowed to air dry before being stored. He stated the ice machine was cleaned by maintenance, but the dietary staff should clean the ice machine as spills occur. He stated the 3-compartment storage bin for disposable lids should be clean. The DM added the steam table lids should have been cleaned after the breakfast meal and prior to putting any food for the lunch meal on the steam table. He explained a service request had been submitted to maintenance to repair the convection oven door. An interview on 12/19/18 at 5:59 pm with the Administrator revealed it was his expectation that facility policies were followed for equipment storage and kitchen maintenance.	F 812	Maintenance Director repaired the bottom convection oven doors. This resolved the issue of using a string to close. On 12-18-2018, the Maintenance Director repaired the vent located above the dish machine, removing the rust. How facility identified other residents potentially affected by the deficient practice. On 12-18-2018, the Maintenance Director audited all ice machines. On 12-18-2018, the Dietary Manager audited all half deep steam table pans, and meal trays to ensure all were clean and dry when stored. On 12-18-2018, that Dietary Manager audited all storage bins in the kitchen to ensure clean with no debris or substances. On 12-18-2018, the Dietary Manager audited all steam table lids to ensure they were clean prior to and during meal service. On 12-18-2018, the Maintenance Director audited all vents in the kitchen ceiling for rust. No further issues were noted in the follow up checks. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-24-2018, the Dietary Manager in-serviced all dietary staff on ice machine cleaning, appropriate storage of dishes, pans, appropriate drying of pans, dishes, and trays, cleaning of bins, cleaning of steam table lids, cleaning of vents. This in-service was completed by 1-18-2019, and no dietary staff will be allowed to work after that date until in-service is complete. This in-service will be part of the	

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F 812	Continued From page 46	F 812	orientation process for all newly hired dietary employees. How facility plans to monitor performance. The Dietary Manager and/or designee will randomly audit pan, dish, tray storage, kitchen bins, ovens for safe functioning, kitchen vents weekly x 4 weeks and monthly x 2 months to ensure kitchen equipment is in a sanitary, safe operating condition including allowing service/cookware to air dry before stored. The QA committee will monitor the results monthly for 3 months and determine the need for continued monitoring. The Dietary manager and/or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The Dietary Manager is responsible for implementing the plan of correction.	
F 867 SS=E	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 record reviews and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented	F 867	F867, QAPI Committee How the corrective action was	1/18/19

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F 867	Continued From page 47 procedures and monitor interventions that the committee put into place following the 2/14/18 annual recertification survey and 6/22/18 compliant investigation. This was for 5 recited deficiencies in the areas of Accuracy of Assessments (F641), Care Plan Timing and Revision (F657), Developing and Implementing Comprehensive Care Plans (F656), Residents Free of Significant Medication Errors (760), and OAPI/QAA Improvement activities (F867). Findings include: 1. F641 Accuracy of Assessments: Based on record review and interviews with staff, the facility failed to accurately code the MDS (Minimum Data Set) in 1 of 5 residents reviewed for immunizations (Resident #130). During the recertification survey dated 2/14/18, the facility was cited for F641 for failing to accurately code the MDS on 2 out of 5 residents (Resident #36 and Resident #48) reviewed for special treatments or pressure ulcers. 2. F657 Care Plan Timing and Revision: Based on record review, staff interviews, resident interviews and observation, the facility failed to revise resident care plans to accurately reflect a resident's decline in their abilities to perform their activities of daily living (ADL. This was evident for 2 of 6 residents (Resident #41 and Resident #44) reviewed for ADL care. During the recertification survey dated 2/14/18, the facility was cited for F657 for failing to update the resident's care plan to reflect how the resident transferred for 1 of 5 residents reviewed for activities of daily living (Resident #20). 3. F656 Developing and Implementing the Comprehensive Care Plans: Based on record review, staff interviews and resident interviews, the facility failed to develop a care plan for 3 of 15 residents (Resident #41, Resident #8 and	F 867	accomplished for those residents affected by the deficient practice. On 1-18-2019, the Regional VP in-serviced the Administrator on QAPI including implementation of procedures and the monitoring of interventions. On 1-16-2019, the Administrator in-serviced the interdisciplinary team on QAPI including implementation of procedures and the monitoring of interventions. Facility has now implemented training during orientation, and proactive training related to repeat deficient practices in areas of F-641 accuracy of assessment, F-657- care plan timing and revision, F-656 development of care plan and implementation of care plan intervention, F-760 free from significant mediation errors, and F-867 quality assurance performance improvement. How facility identified other residents potentially affected by the deficient practice. On 1-16-2019, the QA Committee held a meeting to review the purpose and function of the QA committee and review on-going compliance issues. This meeting was conducted by the Administrator. Committee Members trained include DON, Social Worker, Activity Director, Therapy representative, Medical Director, and Treatment Nurse. These committee members will attend QA Committee Meetings on an ongoing basis and additional team members will be assigned as appropriate. Identified the measures or systemic	

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F 867	Continued From page 48 Resident #36) who had a diagnosis of dementia and/or were receiving psychotropic mediations. During the recertification survey dated 2/14/18, the facility failed to develop and implement a comprehensive care plan on 1 out of 1 resident (Resident #36) who was on dialysis to monitor the graft access site and remove the dressing to the site nightly. 4. Residents Free of Significant Medication Errors: Based on observation, record review and staff interviews, the facility failed to administer a blood pressure medication as ordered by the physician. This was evident for 1 of 5 residents reviewed for unnecessary mediations (Resident #36). During the complaint survey dated 6/22/18, the facility failed to administer scheduled medications to 3 out of 4 residents (Resident #3 and Resident #9) that were to receive 5:00pm medications on 6/19/18. During the recertification survey dated 2/14/18, 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 3/17/17 recertification survey. During the current annual recertification survey dated 12/21/18, the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 2/14/18 annual recertification survey. An interview was conducted with the administrator and the corporate nurse consultant on 12/20/18 at 2:20pm. The Administrator reported he is the QAA committee leader and the committee consists of the director of nursing, the staff development coordinator, MDS (Minimum Data Set) nurse, admissions coordinator, dietary	F 867	changes taken to ensure deficient practice will not recur. On 1-18-2019, the Regional VP in-serviced the administrator related to the appropriate functioning of the QA Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641, F657, F656, F760, and F867. On 1-16-2019, the administrator in-serviced the department heads related to the appropriate functioning of the QA Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641, F657, F656, F760, and F867. The QA Committee will continue to identify other areas of quality concern through the QA review process. The QA Committee will meet monthly to identify issues related to quality assessment and quality assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F641, F657, F656, and F760. How facility plans to monitor performance. The QAPI Committee, including the Medical Director, will continue to meet monthly and review QA report information, review trends and corrective actions, validate progress in correction of deficient practices, or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions.	

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F 867	Continued From page 49 manager, social worker, activities director, and the maintenance director. The Administrator reported there had been recent management changes and the committee met monthly and discussed any significant changes at the morning meetings. He reported it was his expectation that the facility not have any repeat deficiencies.	F 867	The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the plan of correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		1/18/19

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F 880	Continued From page 50 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection control	F 880	F880, Infection Control	

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F 880	Continued From page 51 program that established a surveillance plan which identified, tracked and monitored infections. This was evident in 3 of 3 monthly surveillance data reviewed (October 2018 to December 2018). Findings included: A review of the facility's Infection Control Surveillance Policy dated 9/2014 revealed in part that the facility should monitor residents who showed signs and symptoms of an infection and a designated staff member would initiate the "Infection Control Surveillance" form. The facility's Infection Control Surveillance Protocol revealed in part that a designated nurse should; initiate the "Infection Control Surveillance" form, implement infection control precautions as needed, notify the attending physician, notify the resident's representative, document presence or absence of symptoms, document response to antibiotics if ordered, document complaints from the resident related to the infection, analysis of the data should be entered on a "Monthly Infection Log" for tracking purposes. During a review of the facility's records for infection control, there was no documentation of the implementation for identifying, tracking and monitoring infections. An interview with the Director of Nursing occurred on 12-19-18 at 11:00am. The Director of Nursing stated she had not seen an infection control policy or protocols but produced a "Resident infection log" that she had been using since 12-4-18 to try and track infections and antibiotics however the "log" was incomplete and did not	F 880	How the corrective action was accomplished for those residents affected by the deficient practice. On 12-24-2018, the DON developed and implemented an infection control program that established a surveillance plan that identified, tracked, and monitored infections. How facility identified other residents potentially affected by the deficient practice. On 1-9-2019, the Assistant DON reviewed all residents on antibiotics for the month of December 2018. Any areas of concern were addressed in QAPI with the Medical Director. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-27-2018, the facility consultant provided education to the DON on developing an infection control program that will identify, track, and monitor infections based on the policy and procedure. This in-service will be part of the orientation for any new infection control practioner in the facility. How facility plans to monitor performance. The DON and/or designee will audit 10 residents weekly to ensure if a resident is on antibiotic, the resident has been identified and is being tracked and monitored through the infection control program. The QA committee will monitor the results monthly for 3 months and determine the need for continued	

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F 880	Continued From page 52 have the required elements of Infection Control Surveillance. She also denied that there had been any known outbreaks of infections since she was hired in November 2018. During an interview with the Administrator and Director of Nursing on 12-20-18 at 11:33am the Administrator stated the facility had not implemented or established an Infection Control Surveillance program and the facility did not have a designated Infection control person or a staff member that was Certified in Infection Control. An interview with the Administrator and Director of Nursing occurred on 12-20-18 at 2:35pm. The Director of Nursing stated she expected someone in the facility to attend the North Carolina "SPICE" program to become Certified in Infection Control and that infections were monitored and supervised daily and as appropriate care would be coordinated with the facility's Medical Director.	F 880	monitoring. The DON and/or designee will present the findings to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection control program that established an antibiotic	F 881	F881, Antibiotic Stewardship Program How the corrective action was	1/18/19

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F 881	Continued From page 53 stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage and duration of use of antibiotics. This was evident in 3 of 3 monthly surveillance data reviewed (October 2018 to December 2018). Findings included: During a review of the Infection Control Policy it was noted there was no policy or protocols for an Antibiotic Stewardship Program, however, there was documentation explaining monitoring procedures for antibiotic use. An interview with the Director of Nursing occurred on 12-19-18 at 11:00am. She stated she was unaware and had not heard that there should be an antibiotic stewardship program. The Director of Nursing also stated she had not seen an infection control policy or protocols but was able to produce a "Resident infection log" that she had been using since 12-4-18 to try and track infections and antibiotics however the "log" was incomplete and did not have the required elements for monitoring antibiotic use. During an interview with the Administrator and Director of Nursing on 12-20-18 at 11:33am the Administrator stated the facility did not have an antibiotic stewardship program or a staff member that was Certified in Infection Control. An interview with the Administrator and Director of Nursing occurred on 12-20-18 at 2:35pm. The Director of Nursing stated she expected someone in the facility to attend the North Carolina "SPICE" program to become Certified in Infection Control and that antibiotic use was monitored and	F 881	accomplished for those residents affected by the deficient practice. On 1-16-2019, the DON, Assistant DON, and Medical Director developed an infection control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of indication, dosage, and duration of use of antibiotics. How facility identified other residents potentially affected by the deficient practice. On 1-9-2019 the Assistant DON reviewed all residents on antibiotics for the month of December 2018 using the written definitions of infections (McGeer's criteria) to analyze appropriate antibiotic use including prescribing, indication, dosage, and duration. This review also includes review of nursing and physician documentation of indication for use. Identified the measures or systemic changes taken to ensure deficient practice will not recur. On 12-27-2018, the facility consultant provided education to the DON on developing an infection control program that established antibiotic stewardship with written protocols on antibiotic prescribing, documentation of indication, dosage, and duration of use. This in-service will be part of the orientation for any new infection control practioner in the facility. How facility plans to monitor performance. The DON and/or designee will audit 10	

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F 881	Continued From page 54 supervised daily and as appropriate care would be coordinated with the facility's Medical Director.	F 881	residents weekly to ensure if residents are on antibiotic, they have been identified and are being tracked and monitored through the infection control program to include antibiotic stewardship. The QA committee will monitor the results monthly for 3 months and determine the need for continued monitoring. The DON and/or designee will present findings and recommendations to the QA committee for further oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the plan of correction.	