| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345008 | A. BUILDING _____ B. WING _____ | 02/21/2019 |

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| COMPLETE CARE AT MYERS PARK | 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 |

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| E 000 | Initial Comments<br><br>A recertification survey was conducted 2/18/19 - 2/21/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID: H4YV11. | E 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have | F 565 | | 3/21/19 |

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

Electronically Signed | 03/15/2019

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| F 565 | Continued From page 1<br>family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, review of Resident Council Minutes, and review of Food Committee Minutes, the facility failed to resolve 3 repeated department concerns for housekeeping, dietary, and nursing voiced during 4 Resident Council meetings (November 2018, December 2018, January 2019, and February 2019).<br><br>The findings included:<br><br>Review of Resident Council Minutes and Food Committee Minutes from 4 consecutive Resident Council meetings revealed the following repeated resident concerns:<br>November 2018 - Housekeeping - personal clothing items not returned, poor customer service; Dietary - poor customer service; cold foods; not enough choices on the selective menu.<br><br>Housekeeping department responded that personal items would be located and returned and customer service re-education would be provided. Dietary department responded that the selective menu was sufficient and would remain the same, customer service re-education would be provided and the department would start using warming trays again.<br><br>December 2018 - Housekeeping - personal clothing items not returned and poor customer service. Dietary - poor customer service, food cold at dinner, menu items not available, and not enough choices on the selective menu. | F 565 | A special Resident Council Meeting was held March 15, 2019. Residents in attendance with new or unresolved missing items were addressed through the facility grievance process. The facility□s missing items/personal belongings policy and procedure was also discussed. The policy was also disseminated to residents not in attendance and sent to families and responsible parties. To address nursing and dietary concerns, staff customer service expectations, which included call bell response, and the quality and compliance with resident meals were also discussed. The alternative menu was reviewed to evaluate satisfaction and compliance. The facility administrator also provided his contact number to attending residents in the event of dissatisfaction with facility staff. The administrator□s contact number is also available at all nursing stations. The process leading to the deficient practice has been identified as insufficient resident satisfaction<br><br>To help ensure an acceptable plan of correction, facility staff will be educated on customer service expectations, which include, but are not limited to the resident missing items/personal belongings policy and procedure, call bell response, and meal service expectations on. | |

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| F 565 | Continued From page 2<br><br>Housekeeping department responded that personal items would be located and returned and customer service re-education would be provided. There was no documented response from the dietary department.<br><br>January 10, 2019 - Housekeeping - personal clothing items not returned. Dietary - poor customer service, foods on the selective menu not available, food overcooked/undercooked, condiments not provided, bread molded, and cold foods. Nursing - extended wait time for call light response and poor customer service.<br><br>Housekeeping department responded that personal items would be located and returned. Dietary department responded that a new selective menu would start on 1/11/19. Nursing department responded that customer service re-education would be provided.<br><br>February 2019 - Nursing - extended wait time for call light response. Dietary - food undercooked.<br><br>Follow up to the February 7, 2019 Resident Council Meeting was unavailable for review.<br><br>A lunch meal dining observation occurred on 2/18/19 from 12 PM - 1 PM. Review of the posted menu revealed Italian blend vegetables and garlic bread would be served. Observation during the lunch meal revealed residents did not receive Italian blend vegetables or garlic bread.<br><br>An interview on 2/18/19 at 1:38 PM with the dining services director (DSD) revealed she was aware that the garlic bread needed to be prepared and stated, "The cook just forgot to | F 565 | To help ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, call bell response, and resident meal compliance audits will be conducted by the facility administrator, dietary manager, unit nurse managers and designees starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times weekly for 4 weeks. Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter. Resident council meeting minutes will also be reviewed to evaluate improvement or needed adjustments.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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| F 565 | Continued From page 3 | F 565 | | |

make it and put it on the line, it was an honest mistake." A follow up interview with the DSD occurred on 2/21/19 at 11:56 AM and revealed the Italian blend vegetables were not served for lunch on 2/18/19 because the box of vegetables received from the vendor was labeled "Italian blend vegetables", but the box actually contained sliced carrots. The DSD stated this had occurred before with the same vendor and that each time she notified the vendor.

An interview on 2/18/19 at 1:47 PM with dietary staff #1 revealed she had a lot of tasks to complete for the lunch meal that day and that she just missed preparing some items. She stated "I forgot to do it, my mistake."

During a Resident Council meeting held on 2/20/19 at 2:30 PM, 6 residents expressed that they were still missing personal clothing items for several months that had been mentioned during previous Resident Council meetings. During this meeting 10 of 12 residents expressed that hot foods were still served cold, pasta and beef served at lunch on 2/20/19 was overcooked, main and selective menu items were not always available and customer service in the dietary department was still poor. The residents also expressed extended wait time for call light response and dissatisfaction with customer service during nursing care.

An interview was conducted on 2/21/19 at 10:04 AM with the Housekeeping Director (HD). He stated he assumed his role about a month ago and was made aware of resident concerns expressed during Resident Council regarding not receiving personal clothing items. The HD stated he was in the process of developing a system to

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| F 565 | Continued From page 4<br>ensure residents received their personal clothing back timely. He stated he was not aware that residents were still missing personal items from several months ago.<br><br>An interview on 2/21/19 at 10:39 AM with both the Administrator and Director of Nursing (DON) revealed they were aware of resident concerns related to housekeeping, nursing and dietary departments. The Administrator stated that he turned over staff in the housekeeping department for those who were not meeting the standards. He expressed he was not aware that residents were still missing personal items. The Administrator and DON both expressed that the dietary department would need to be more consistent in following the menus. The DON stated that staff in the nursing department were continuously re-educated to answer call lights and communicate a response to get needs met. Documentation was provided for review regarding nursing customer service re-education in August 2018, December 2018 and January 2019. | F 565 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified | F 636 | | 3/21/19 |

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| F 636 | Continued From page 5 | F 636 | | |

by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission,

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| F 636 | Continued From page 6<br>excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, family member and staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to: vision for 1 of 1 sampled residents with vision impairment; urinary incontinence/indwelling urinary catheter for 1 of 2 sampled residents with an indwelling urinary catheter (Residents #42).<br><br>The findings included:<br><br>1. Resident #42 was admitted to the facility on 02/06/09 with diagnoses which included dementia and diabetes mellitus.<br><br>a) Review of Resident #42's significant change Minimum Data Set (MDS) dated 12/31/18 revealed an assessment of severely impaired cognition. The MDS indicated Resident #42 had moderately impaired vision. The MDS triggered the Visual Function Care Area Assessment (CAA).<br><br>Review of Resident #42's Visual Function CAA dated 01/02/19 revealed no documentation of findings with a description of the problem, contributing factors, and risk related to impaired vision. There was no documentation of input from Resident #42's family representative. There | F 636 | Resident #42 assessment was updated to reflect the correct visual status. Resident #42 Care Area Assessment was also updated to reflect the resident□s current condition and status.<br><br>All residents with visual impairments and indwelling catheters assessments have been updated to reflect their current conditions and status.<br><br>To help ensure the deficient practice does not reoccur, the facility□s Interdisciplinary Care Plan Team will be educated on accurate completion of residents□ comprehensive and care assessments. All assessments will be reviewed by the Director of Nursing or designee prior to submission.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.

Observation on 02/18/19 at 10:05 AM revealed Resident #42's left eye socket did not contain an eye. Resident #42's right eye followed movement.

Interview on 02/18/19 at 10:08 AM with Resident #42's family member revealed Resident #42 used a prosthesis until several years ago. Resident #42's family member explained maintenance of vision in the remaining eye was a priority since Resident #42 enjoyed watching television.

Interview with the MDS Coordinator on 02/21/19 at 9:08 AM revealed Resident #42's Visual function CAA should contain specific information. The MDS coordinator could not provide a reason for the lack of documented descriptions, contributing factors, risk factors and analysis of findings.

Interview with the Director of Nursing (DON) on 02/21/19 at 9:49 AM revealed she expected the MDS Coordinator to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.

b) Review of Resident #42's significant change Minimum Data Set (MDS) dated 12/31/18 revealed an assessment of severely impaired cognition. The MDS indicated Resident #42 used an indwelling urinary catheter. The MDS triggered the Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA).

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| F 636 | Continued From page 8<br><br>Review of Resident #42's Urinary Incontinence CAA dated 01/02/19 revealed no documentation of findings with a description of the problem, contributing factors, and risk related to an indwelling urinary catheter. There was no documentation of input from Resident #42's family representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.<br><br>Observation on 02/19/19 at 2:57 PM revealed Resident #42 had an indwelling urinary catheter. Resident #42's catheter tubing and bad contained clear, yellow urine.<br><br>Interview with the MDS Coordinator on 02/21/19 at 9:08 AM revealed Resident #42's Urinary Incontinence/Indwelling Catheter CAA should contain specific information. The MDS coordinator could not provide a reason for the lack of documented descriptions, contributing factors, risk factors and analysis of findings.<br><br>Interview with the Director of Nursing (DON) on 02/21/19 at 9:49 AM revealed she expected the MDS Coordinator to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings. | F 636 | | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status. | F 641 | | 3/21/19 |

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| F 641 | Continued From page 9<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, a resident interview (Resident #25), staff interview and medical record review, the facility failed to accurately assess 2 Minimum Data Set (MDS) assessments for cognitive patterns (Residents #12 and #62) for 2 of 3 sampled residents reviewed for communication and 2 MDS assessments regarding the use of restraints (Residents #12 and #25) for 2 of 2 sampled residents reviewed for restraints.<br><br>The findings included:<br><br>1. Resident #12 was admitted to the facility on 7/4/14. Diagnoses included, in part, chronic post-traumatic stress disorder and anxiety.<br><br>A care plan revised 11/20/18 identified Resident #12 could not speak or understand English as well as her primary language, Spanish. Interventions included to use a communication board and a translator as needed.<br><br>Review of section C, Cognitive Patterns, for a quarterly MDS dated 11/20/18 assessed Resident #12 with a score of 00 out of 15 during a Brief Interview for Mental Status (BIMS), an assessment of cognition. Review of section P, Physical Restraints, revealed Resident #12 was assessed with the use of a physical restraint, bed rails used less than daily.<br><br>During an interview on 2/19/19 at 11:01 AM nurse aide #2 (NA #2) revealed Resident #12's primary language was Spanish, she understood some English and staff also used a communication board to communicate with the Resident. NA #2 | F 641 | Residents #12 and #62 were reassessed using their dominant language. The resident□s assessments and have been updated. Residents #12 and #25 assessments were corrected and updated to reflect no usage of restraints<br><br>Assessments for residents with language barriers were reviewed and updated as needed. Currently, there are no other residents with restraints, therefore no other residents were affected.<br><br>To help ensure the deficient practice does not reoccur, the facility□s Interdisciplinary Care Plan Team will be educated on accurate completion of residents□ comprehensive and care assessments. All assessments will be reviewed by the Director of Nursing or designee prior to submission.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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stated Resident #12 did not get out of bed unassisted and required staff assistance and the use of a mechanical device for transfers.

During an interview on 2/20/19 at 10:52 AM, Nurse #1 stated the primary language for Resident #12 was Spanish, but she also understood some English.

On 2/20/19 at 11:15 AM, NA #3 was observed to assist Resident #12 with grooming while in bed. NA #3 communicated with Resident #12 using non-verbal cues and spoke to her in English and Spanish. Resident #12 responded to non-verbal cues when encouraged to use a 1/4 hand rail for bed mobility. Resident #12 spoke to NA #3 in Spanish. NA #3 stated Resident #12 did not get out of bed unassisted and required total staff assistance and the use of a mechanical device for transfers.

During an interview on 2/20/19 at 3:59 PM, the MDS Coordinator stated she completed section P, Physical Restraints for the quarterly MDS dated 11/20/18. The MDS Coordinator stated she should not have assessed Resident #12 with the use a restraint because the side rails were used by Resident #12 to reposition in bed and the Resident could not get out of bed without staff assistance.

During an interview on 02/20/19 at 4:16 PM, the social worker (SW) stated she completed section C, Cognitive Patterns, during the quarterly MDS dated 11/20/18 by asking Resident #12 the questions in English. She confirmed that Spanish was the primary language for Resident #12 and that if she had completed the BIMS section by asking the questions in Spanish or by using a

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| F 641 | Continued From page 11 | F 641 | | |

communication board, it was possible that the Resident's score could have been different.

An interview on 2/20/19 at 5:29 PM with the Director of Nursing revealed she expected staff who completed the MDS to interview residents in their primary language using an interpreter or a translation tool if needed and for staff to visually assess a resident's ability to use the side rail to determine if it met the definition of restraint.

During a follow up interview with the SW on 2/21/19 at 2:00 PM, she stated that she had just conducted a BIMS for Resident #12 with a staff member who spoke Spanish and the Resident scored 05 of 15 for the cognitive assessment.

2. Resident #25 was admitted to the facility 6/15/15. Diagnoses included, in part, glaucoma, dementia and generalized muscle weakness.

Review of section P, Physical Restraints for a quarterly MDS dated 12/6/18 revealed Resident #25 was assessed with the use of a physical restraint, bed rails used less than daily. The MDS also assessed him with intact cognition.

A care plan revised 12/28/18 identified Resident #25 had range of motion limitations and used SR for assistance with positioning. Interventions included the assistance of SR for bed mobility.

Resident #25 was observed on 2/20/19 at 10:18 AM in his room seated on his bed applying shoes to his feet. Bilateral 1/4 SR were raised on his bed. Resident #25 was observed to use the right 1/4 SR for bed mobility and to transfer independently to his wheel chair. Resident #25 stated that the SR helped him with his transfers

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and did not prevent him from getting in/out of bed.

During an interview on 2/20/19 at 3:59 PM, the MDS Coordinator stated she completed section P, Physical Restraints for the quarterly MDS dated 12/6/18. The MDS Coordinator stated she should not have assessed Resident #25 with the use a restraint because the SR were used by Resident #25 to reposition in bed and for transfers in/out of bed.

An interview on 2/20/19 at 5:29 PM with the Director of Nursing revealed she expected staff who completed the MDS to visually assess a resident's ability to use the SR to determine if it met the definition of restraint.

3. Resident #62 was admitted to the facility on 1/7/15. Diagnoses included, in part, mood affective disorder, major depressive disorder with psychotic symptoms and dementia with behaviors.

A care plan revised 12/10/18 identified Resident #62 could not speak or understand English as well as her primary language, Spanish. Interventions included to use a communication board and a translator as needed.

An annual Minimum Data Set (MDS) dated 12/10/18 assessed Resident #62 with a score of 00 out of 15 during a Brief Interview for Mental Status (BIMS), an assessment of cognition.

Resident #62 was observed on 2/20/19 at 10:56 AM seated in her wheel chair in the TV area and on 2/20/19 at 12:40 PM seated in her wheel chair in the dining room. Staff were observed to

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| F 641 | Continued From page 13<br>communicate to Resident #62 with non-verbal cues and verbal cues in Spanish. Resident #62 was observed to follow verbal commands communicated to her in Spanish and non-verbal cues.<br><br>An interview with nurse aide #1 (NA #1) occurred on 2/20/19 at 12:42 PM and revealed Resident #62 spoke Spanish and understood some English.<br><br>An interview on 2/20/19 at 4:14 PM with the social worker (SW) revealed she completed Resident #62's BIMS section of the annual MDS dated 12/10/18 by asking the questions in English. She confirmed that Spanish was the primary language for Resident #62 and that if she had completed the BIMS section by asking the questions in Spanish, it was possible that the Resident's score could have been different.<br><br>An interview on 2/20/19 at 5:29 PM with the Director of Nursing revealed she expected staff who completed the MDS to interview residents in their primary language using an interpreter or a translation tool if needed.<br><br>The SW was observed on 2/21/19 at 2:00 PM to conduct a BIMS for Resident #62 with a staff member who spoke Spanish. Resident #62 was observed to communicate in Spanish. The SW stated the Residents BIMS resulted in a score of 03 out of 15 during the interview. | F 641 | | |
| F 644 SS=E | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the | F 644 | | 3/21/19 |

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| F 644 | Continued From page 14<br>pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to refer residents with intellectual disability or a mental health diagnosis on admission for a Preadmission Screening and Resident Review (PASRR) Level II screening for 3 of 3 residents reviewed for PASRR (Residents #12, # 52 and Resident #85)<br><br>Findings included:<br><br>1. Resident #12 was admitted to the facility on 7/4/14. Diganoses included, in part, unspecified intellectual disabilities due to a traumatic brain injury.<br><br>Review of section A 1500, Preadmission Screening and Resident Review (PASRR), of an annual Minimum Data Set (MDS) dated 8/20/18 indicated Resident #12 had not been referred for | F 644 | PASARR review requests have been submitted for Residents #12, #52, and #85.<br><br>All other residents with intellectual disabilities or mental health diagnosis have been reviewed to determine if a PASARR review is needed. All needed reviews have been submitted.<br><br>To help ensure the deficient practice does not reoccur, the facility□s Interdisciplinary Care Plan Team will be educated on the requirements of PASARR review requests and the PASARR submission process. Qualifying resident assessments will be reviewed for necessity of PASARR review request by the Director of Nursing.<br><br>Findings will be reviewed weekly. Results | |

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| F 644 | Continued From page 15<br>evaluation of a Level 2 PASARR screen to have a serious mental illness or mental retardation or related condition.<br><br>A care plan revised 12/28/18 identified Resident #12 had impaired neurological and communication status due to a traumatic head injury resulting in intellectual disabilities.<br><br>An interview with the MDS Coordinator on 2/20/19 at 3:59 PM revealed she completed section A 1500, PASRR of the annual MDS dated 8/20/18 for Resident #12. The MDS Coordinator stated that Resident #12 currently had a Level 1 PASRR and had not been referred for evaluation of a Level 2 PASRR status. The MDS Coordinator further stated that if residents did not meet certain criteria for a Level 2 PASRR screen, a referreal was not made.<br><br>The Director of Nursing stated in an interview on 2/20/19 at 5:29 PM that she expected staff who completed the PASRR section of the MDS to make Level 2 PASRR referrals as indicated.<br><br>2. Resident #52 was admitted to the facility on 9/25/18 with medical diagnoses inclusive of Psychosis, unspecified.<br><br>Review of the admission Minimum Data Set (MDS) dated 10/2/18 and the quarterly assessment dated 1/2/19 revealed a diagnosis of psychotic disorder. Review of section A 1500, Preadmission Screening and Resident Review (PASRR), of the admission Minimum Data Set (MDS) dated 10/2/18 indicated Resident #52 had not been referred for evaluation of a Level 2 PASRR screen to have a serious mental illness or mental retardation or related condition. | F 644 | will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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During an interview with a nursing unit manager, Nurse #3, on 2/21/19 at 1:32 PM, she reported Resident #52 had an antianxiety medication added to his regimen on 1/21/19 due to his combativeness with other residents. The nurse reported Resident #52 had displayed sexually inappropriate behaviors as well.

During an interview with the Nurse Practitioner (NP) on 2/21/19 at 1:05 PM, she reported Resident #52 was referred for psychiatry consult on 2/12/19 due to irritability and combativeness with care. The NP reported Resident #52's medication regimen including psychotropic, antianxiety and mood stabilizer were not decreasing behaviors.

During an interview with the Social Worker (SW), she reported MDS identified residents with mental health diagnosis and she would receive information from the MDS coordinator regarding the need to refer for Level II screening. The SW stated she was involved in daily staff meetings that include discussions of residents with behavioral concerns. The SW stated she was aware Resident # 52 had ordered a consult with psychiatry due to behaviors related to increased agitation, verbally abusive and combativeness. The SW identified an understanding of referrals for Level II screening but stated there had been no discussion regarding a Level II PASRR referral for Resident #52.

During an interview with the Director of Nursing (DON) on 2/20/19 at 5:29 PM, she stated her expectation of staff who completed the PASRR section of the MDS to make a Level II referral for screening as indicated by an intellectual disability

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and a mental health diagnosis.

3. Resident #85 was readmitted to the facility on 1/9/19 with medical diagnoses inclusive of Schizophrenia, unspecified.

Review of the admission minimum data set (MDS) dated 7/11/18 and the quarterly assessment dated 1/16/19 revealed a diagnosis of schizophrenia, unspecified. Review of section A 1500, Preadmission Screening and Resident Review (PASRR), of an admission Minimum Data Set (MDS) dated 7/11/18 indicated Resident #85 had not been referred for evaluation of a Level 2 PASRR screen to have a serious mental illness or mental retardation or related condition.

Resident #85's care plan revealed a focus area for behaviors related combativeness, anxiety and aggressiveness and refusing care.

During an interview on 2/21/19 at 2:01 PM with Nurse #2, the nurse reported Resident #85's behaviors of combativeness and physical aggression were present on admission and have continued with antianxiety and psychotropic medications added to her regimen.

During an interview with the Nurse Practitioner (NP) on 2/21/19 at 1:05 PM, she reported Resident #85 was receiving services by psychiatry to identify medications to manage behaviors displayed on admission and since readmission to the facility. The NP stated she was not aware of what additional services could be offered with a PASRR Level II screening.

During an interview with the Social Worker (SW), she reported MDS identified residents with mental

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| F 644 | Continued From page 18<br>health diagnosis and she would receive information from the MDS coordinator regarding the need to refer for Level II screening. The SW stated was involved in daily staff meetings that include discussions of residents with behavioral concerns. The SW stated she was aware Resident # 85 had become more agitated and had displayed more odd behaviors such as throwing herself on the floor and barricading the door to her room. The SW identified an understanding of referrals for Level II screenings but stated there had been no discussion regarding a level II PASRR referral for Resident #85.<br><br>During an interview with the Director of Nursing (DON) on 2/20/19 at 5:29 PM, she stated her expectation of staff who completed the PASRR section of the MDS to make a Level II referral for screening as indicated by an intellectual disability and a mental health diagnosis. | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 3/21/19 |

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| F 656 | Continued From page 19<br>required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document 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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review the facility failed to develop a care plan regarding provision of an on-going activity program which met the individual interests and needs to enhance the quality of life for 1 of 3 sampled cognitively impaired residents (Resident #63) and place non-skid footwear as indicated by the care plan for 1 of 3 residents reviewed for falls/accidents (Resident #64).<br><br>The findings included: | F 656 | Resident #63 care plan was updated to reflect person centered care preferences and activities. Resident #64 was provided non-skid socks.<br><br>Residents requiring non-skid socks were assessed for proper use. Vulnerable residents were assessed to ensure person centered activities and preferences were care planned and provided. | |

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| F 656 | Continued From page 20<br><br>1. Resident #63 was admitted to the facility on 01/11/18 with diagnoses which included seizures and anoxic brain injury.<br><br>Review of Resident #63's annual Minimum Data Set (MDS) dated 01/08/19 revealed an assessment of short term and long-term memory loss. Staff assessment of activity preferences included listening to music and doing things with groups of people. The Activity Care Area Assessment did not trigger.<br><br>Review of Resident #63's care plan dated 12/31/18 revealed no documentation regarding activity interventions. The care plan documented impaired communication which listed interventions initiated on 01/13/18 of: "call my name or gently touch my arm or hand to help me maintain awareness of the activity going on around me and encourage me to maintain eye contact with staff, volunteers during 1:1 activities."<br><br>This tag is cross-referenced to 483.24 F 679 Quality of Life: Based on observations, staff interviews, and record review the facility failed to provide an on-going activity program which met the individual interests and needs to enhance the quality of life for 1 of 3 sampled cognitively impaired residents (Resident #63).<br><br>Interview with the activity director on 02/21/19 at 8:57 AM revealed Resident #63's care plan did not include specific, individualized interventions for activities. The activity director reported Resident #63 received sensory stimulation which included listening to music.<br><br>Interview with the Director of Nursing on 02/21/19 | F 656 | To help ensure the deficient practice does not reoccur, the facility□s care staff will be educated on resident care interventions. Care staff will also be educated on following resident care plans to help ensure person centered activities and preferences are provided.<br><br>To help ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, weekly audits will include monitoring of identified vulnerable residents to ensure person centered activities and preferences are provided.<br><br>Audits will be conducted by the Activities Director, and Unit Nurse Managers or designees starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times weekly for 4 weeks. Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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at 2:16 PM revealed Resident #63's care plan should be individualized and contain interventions for an on-going activity program.

2. Resident #64 was readmitted to the facility on 11/12/18 with medical diagnoses inclusive of Alzheimer's disease unspecified and hypertension.

A review of the significant change Minimum Data Set (MDS) dated 11/18/19 revealed Resident #64 was not steady on her feet and required two-person assistance for transfer. Resident #64 was noted to use a wheelchair for mobility.

A review of Resident #64's care plan dated 1/21/19 revealed a focus area identifying at risk for falls with an intervention to wear non-skid footwear to prevent slipping. The care plan also identified Resident #64 had multiple falls with the most recent fall due to standing/walking on 10/17/18.

An observation on 2/18/19 at 2:44 PM revealed Resident #64 was sitting in a wheelchair in the common area on the unit wearing regular socks.

An observation on 2/20/19 at 10:20 AM revealed Resident #64 was sitting in a wheelchair and propelling herself with her feet in the hall on the unit. Resident #64 was wearing regular socks at the time.

An interview with Nurse #3 on 2/20/19 at 10:24 AM revealed Resident #64 was to wear non-skid footwear as an intervention due to her risk for falling. Nurse #3 stated Resident #64 had removed her socks and shoes and had attempted to get up from the wheelchair and walk on her

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own in the past. Nurse #3 reported the nursing staff and nurse aides should refer to the Kardex, a medical information system, for instructions of individualized care for each resident after receiving their assignment.

During an interview on 2/20/19 at 10:34 AM with NA #9 who cared for Resident #64 on 2/20/19 during the first shift (7:00 AM - 3:00PM) revealed Resident #64 was unsteady on her feet and would get up from a sitting position and walk on her own. NA #9 reported she monitored Resident #64 by making sure she was visible in a common area. NA #9 stated Resident #64 should wear non-skid footwear to prevent her from slipping. NA #9 stated Resident #64 was dressed by the night shift (11:00pm - 7:00am) nurse aide. NA #9 stated she overlooked Resident #64 was not wearing non-skid footwear.

During an interview on 2/20/19 at 4:30 PM, NA #10 reported she had placed the T.E.D. hose (antiembolism stockings) and regular socks when she dressed Resident # 64 on the morning of 2/20/19. NA #10 stated she was aware Resident #64 had a history of falling. NA #10 stated she had forgotten to place the non-skid footwear on Resident #64.

An interview with the Director of Nursing (DON) on 2/20/19 at 3:27 PM revealed her expectation was for nurse managers to communicate to nurse aides changes in the residents' care plan and update the nurse aides' monitoring sheet and the individual Kardex for the residents. The DON stated she expected the nurse aides to utilize and follow the Kardex to provide individualized care for the residents.

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| F 657 | Continued From page 23 | F 657 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record review the facility failed revise a care plan regarding leg swelling for 1 of 2 residents with required application thrombo-embolic deterrent (TED) hose (Resident #84).<br><br>The findings included: | F 657 | Resident #84 order for the use of thrombo-embolic deterrent hose was clarified to reflect proper usage.<br><br>All other residents with thrombo-embolic deterrent hose orders were reviewed and updated to reflect measurable outcomes. | 3/21/19 |

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| F 657 | Continued From page 24<br><br>Resident #84 was admitted to the facility on 01/16/19 with diagnoses which included dementia and osteoarthritis.<br><br>Review of Resident #84's admission Minimum Data Set (MDS) dated 01/23/19 revealed an assessment of severely impaired cognition. The MDS indicated Resident #84 required the extensive assistance of one person with dressing.<br><br>Review of a nurse practitioner note dated 01/23/19 revealed Resident #84's legs were swollen. The nurse practitioner documented 1 plus edema on both legs.<br><br>Review of a nurse practitioner order dated 01/23/19 revealed direction for TED hose application each morning with removal at bedtime.<br><br>Review of Resident #84's care plan dated 01/26/19 revealed there was no documentation of interventions to address Resident #84's leg swelling. There was no documentation of TED hose application.<br><br>Observation on 02/19/19 at 9:01 AM, 9:45 AM and at 2:32 PM revealed Resident #84 seated in a wheel chair. Resident #84 wore ankle socks and shoes. Resident #84's ankles and feet were slightly swollen.<br><br>Interview on 2/20/19 at 10:05 AM with Nurse #2 revealed Resident #84 required daily TED hose application.<br><br>Interview on 02/21/19 at 1:01 PM with the MDS Coordinator revealed Resident #84's care plan | F 657 | To help ensure the deficient practice does not reoccur, licensed staff will be educated on the proper use of thrombo-embolic deterrent hose based on each resident□s written order. Residents with orders for thrombo-embolic deterrent hose will be assessed for need and use based on residents□ orders.<br><br>Audits will be conducted by each unit□s Nurse Manager or designee starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times weekly for 4 weeks. Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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| F 657 | Continued From page 25<br>should include interventions to address leg swelling. The MDS Coordinator explained the unit nurses reviewed the care plan when changes occurred between the scheduled quarterly review.<br><br>Interview with Nurse #3, unit manager, at 2:08 PM on 02/21/19 revealed the unit nurses did not update or revise resident care plans.<br><br>Interview with the Director of Nursing (DON) at 2:11 PM on 02/21/19 revealed Resident #84's care plan should include interventions to address leg swelling. The DON explained either the MDS Coordinator or unit nurses could update and revise the care plan. | F 657 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review the facility failed to provide an on-going activity program which met the individual interests and needs to enhance the quality of life for 1 of 3 sampled cognitively impaired residents (Resident #63). | F 679 | Resident #63 care plan was updated to reflect person centered care preferences and activities.<br><br>Vulnerable residents were assessed to ensure person centered activities and preferences were care planned and | 3/21/19 |

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| F 679 | Continued From page 26<br>The findings included:<br><br>Resident #63 was admitted to the facility on 01/11/18 with diagnoses which included seizures and anoxic brain injury.<br><br>Review of Resident #63's annual Minimum Data Set (MDS) dated 01/08/19 revealed an assessment of short term and long-term memory loss. Staff assessment of activity preferences included listening to music and doing things with groups of people. The Activity Care Area Assessment did not trigger.<br><br>Review of Resident #63's care plan dated 12/31/18 revealed no documentation regarding activity interventions. The care plan documented impaired communication which listed interventions initiated on 01/13/18 of: "call my name or gently touch my arm or hand to help me maintain awareness of the activity going on around me and encourage me to maintain eye contact with staff, volunteers during 1:1 activities."<br><br>Observation on 02/18/19 at 10:39 AM and at 11:19 AM revealed Resident #63 in bed. Resident #63 was alert, nonverbal and both eyes followed movement. A music player on the bedside table was off.<br><br>Observation on 02/18/19 at 12:25 PM revealed Resident #63 asleep in bed.<br><br>Observation on 02/18/19 at 2:30 PM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.<br><br>Observation on 02/19/19 at 8:51 AM revealed Resident #63 asleep in bed. | F 679 | provided.<br><br>To help ensure the deficient practice does not reoccur, care staff will be educated on resident care plans to ensure person centered activities and preferences are provided.<br><br>To help ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, weekly audits will include monitoring of identified vulnerable residents to ensure person centered activities and preferences are provided. Audits will be conducted by the Activities Director or designees starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times weekly for 4 weeks. Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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| F 679 | Continued From page 27 | F 679 | | |

Observation on 02/19/19 at 10:29 AM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Observation on 02/19/19 at 2:58 PM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Observation on 02/19/19 at 3:39 PM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Observation on 02/19/19 at 3:55 PM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Observation on 02/20/19 at 9:16 AM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Interview with Nurse Aide (NA) #6 on 02/20/19 at 10:59 AM revealed Resident #63 required a lift for transfer and did not get out of bed every day.

Interview with NA #7 on 02/20/19 at 11:00 AM revealed Resident #63 enjoyed music. NA #7 reported Resident #63 smiled when music is played in the dining room.

Observation on 02/20/19 at 11:59 AM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Observation on 02/20/19 at 2:53 PM revealed Resident #63 awake and alert in bed. A music player on the bedside table was off.

Interview with NA #3 on 02/20/19 at 3:07 PM

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| F 679 | Continued From page 28 | F 679 | | |

revealed Resident #63 enjoyed rhythm and blues, hip hop and popular music. NA #3 explained Resident #63 would smile and move to the music when the bedside music player was on. NA #3 reported she thought the activity department turned the music on and the nurse aides would turn it on occasionally.

Interview with NA #8 on 02/20/19 at 3:15 PM revealed Resident #63 smiled when music played. NA #8 reported Resident #63 liked a specific popular singer and had the singer's tape in the music player. NA #8 explained Resident #63's family member or the activity department turned on the music.

Interview with Nurse #5, agency nurse, on 02/21/19 at 8:48 AM revealed she was not familiar with Resident #63's usual activities.

Interview with Nurse #4 on 02/21/19 at 8:48 AM revealed the full-time charge nurse, Nurse #6, who usually worked on Resident #63's hall was on leave. Nurse #4 reported Nurse #6 usually turned on Resident #63's music.

Interview with the activity director on 02/21/19 at 8:57 AM revealed Resident #63 received one to one visits 4 to 6 times a week. The activity director explained the visits included listening to music. The activity director reported any staff member could turn on the music player for Resident #63 to enjoy. The activity director explained Nurse #6, the full-time charge nurse, turned the music on.

Interview with the Director of Nursing (DON) on 02/21/19 at 9:41 AM revealed Resident #63's music should be turned on every day. The DON

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| F 679 | Continued From page 29<br>reported nursing staff or activity staff could turn on the music. | F 679 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and physician interviews, and record review the facility failed to apply thrombo-embolic deterrent (TED) hose for 1 of 2 residents with required application of TED hose (Resident #84).<br><br>The findings included:<br><br>Resident #84 was admitted to the facility on 01/16/19 with diagnoses which included dementia and osteoarthritis.<br><br>Review of Resident #84's admission Minimum Data Set (MDS) dated 01/23/19 revealed an assessment of severely impaired cognition. The MDS indicated Resident #84 required the extensive assistance of one person with dressing.<br><br>Review of a nurse practitioner note dated 01/23/19 revealed Resident #84's legs were swollen. The nurse practitioner documented 1 plus edema on both legs. | F 684 | Resident #84 order for the use of thrombo-embolic deterrent hose was clarified to reflect proper usage.<br><br>All other residents with thrombo-embolic deterrent hose orders were reviewed and updated to reflect measurable outcomes.<br><br>To help ensure the deficient practice does not reoccur, licensed staff will be educated on the proper use of thrombo-embolic deterrent hose based on each resident□s written order. Residents with orders for thrombo-embolic deterrent hose will be assessed for need and use based on residents□ orders.<br><br>Audits will be conducted by each unit□s Nurse Manager or designee starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times weekly for 4 weeks. | 3/21/19 |

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| F 684 | Continued From page 30<br><br>Review of a nurse practitioner order dated 01/23/19 revealed direction for TED hose application each morning with removal at bedtime.<br><br>Review of the Resident #84's electronic Medical Administration Record (eMAR) revealed documentation of TED hose application from 01/24/19 to 02/19/19 at 9:00 AM.<br><br>Observation on 02/19/19 at 9:01 AM revealed Resident #84 seated in a wheel chair. Resident #84 wore ankle socks and shoes. Resident #84's ankles and feet were slightly swollen.<br><br>Observation on 02/19/19 at 9:45 AM revealed Resident #84 seated in a wheel chair. Resident #84 wore ankle socks and shoes. Resident #84's ankles and feet were slightly swollen.<br><br>Observation on 02/19/19 at 2:32 PM revealed Resident #84 asleep in a wheel chair. Resident #84 wore ankle socks and shoes. Resident #84's ankles and feet were slightly swollen.<br><br>Interview with Nurse Aide (NA) #4 at 2:36 PM on 2/19/19 at 2:36 PM revealed Resident #84 required physical assistance with dressing.<br><br>Interview with NA #5 on 02/19/19 at 2:44 PM revealed Resident #84 required physical assistance with dressing. NA #5 reported Resident #84 received all care required and did not require special stockings.<br><br>Observation on 02/20/19 at 9:50 AM revealed Resident #84 received emergency transportation to the emergency room. TED hose hung on a | F 684 | Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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| F 684 | Continued From page 31<br>towel bar in Resident #84's bathroom.<br><br>Interview on 02/20/19 at 10:05 AM with Nurse #2 revealed she documented application of Resident #84's TED hose on 02/19/19 but relied on nurse aides to apply the hose. Nurse #2 reported she did not notice the absence of Resident #84's TED hose. Nurse #2 could not provide a reason for documentation of TED hose application on 02/19/19.<br><br>Interview with Nurse #3, unit manager, at 10:11 AM on 02/20/19 revealed staff should apply Resident #84 TED hose each morning. Nurse #3 explained the nurse should check and document TED hose application.<br><br>Interview with the Director of Nursing (DON) at 10:25 AM on 2/20/19 revealed she expected Resident #84 to receive TED hose application as ordered.<br><br>Interview with Resident #84's physician at 10:25 AM on 2/20/19 revealed he expected TED hose to be applied as ordered. | F 684 | | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed<br>CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed; | F 803 | | 3/21/19 |

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| F 803 | Continued From page 32<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on 5 residents observed during dining (Resident #45, #60, #66, #29 and #74), 10 of 12 residents (Residents #2, #5, #27, #41, #45, #54, #61, #67, #71, and #81) who attended a Resident Council Meeting, staff interviews and record review, the facility failed to follow the menu and serve two food items (garlic bread and Italian mixed vegetables) during a lunch meal for 1 of 3 observed meals.<br><br>The findings included:<br><br>1. Review of the facility's lunch meal menu revealed residents were to receive spaghetti and meatballs with tomato sauce, Italian blend vegetables, garlic bread and white cake on 02/18/19.<br><br>Observation at 12:45 PM on 02/18/19 revealed residents who dined in the second floor dining room received spaghetti with meat sauce, sliced | F 803 | The facility current menu cycle has been reviewed for accuracy. The facility dietary manager has reviewed all current stock to ensure current menu items are available.<br><br>To help ensure the deficient practice does not reoccur, dietary staff will be educated on ensuring listed menu items are available for the proposed meal served. Dietary staff will also be educated on ensuring resident meal tickets accurately reflect items served prior to receipt by residents.<br><br>Audits will be conducted by the facility dietary manager or designee to ensure menu items are available and served as indicated on the daily menu. Audits will be conducted starting on February 25, 2019 thru March 20, 2019. Then weekly audits will begin March 18, 2019 for 5 times | |

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| F 803 | Continued From page 33<br>carrots and white cake. Residents did not receive a slice of garlic bread and Italian mixed vegetables.<br><br>Review of Resident #45's quarterly Minimum Data Set (MDS) dated 12/21/18 revealed an assessment of intact cognition. Interview with Resident #45 on 02/18/19 at 12:46 PM revealed he would like to have garlic bread with the meal.<br><br>Review of Resident #60's annual MDS dated 01/08/19 revealed an assessment of intact cognition. Interview with Resident #60 on 02/18/19 at 12:51 PM revealed he would like to receive garlic bread.<br><br>Review of Resident #66's annual MDS dated 01/08/19 revealed an assessment of moderately impaired cognition. Interview with Resident #66 on 02/18/19 at 12:55 PM revealed he preferred a green vegetable with the meal and would like to have a slice of garlic bread.<br><br>Interview with the dining services director (DSD) on 02/21/19 at 11:56 AM revealed the omission of the garlic bread was an oversight. The DSD explained the cook thought the DSD made the garlic bread which did not occur. The DSD reported the Italian blend vegetables were not served due to incorrect labeling by the manufacturer. The DSD explained when the box labeled Italian mixed vegetables was opened, the box contained sliced carrots.<br><br>Interview with the Administrator at 11:02 AM on 02/21/19 revealed menu items listed on the menu should be served.<br><br>2a. Resident #29 was admitted to the facility on | F 803 | weekly for 4 weeks. Thereafter, audits will be completed 3 times weekly for 4 weeks, and twice weekly for 4 weeks thereafter.<br><br>Findings will be reviewed weekly. Results will be discussed and addressed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting. | |

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8/25/18. Review of a quarterly Minimum Data Set dated 12/7/18 revealed Resident #29 had clear speech, was able to be understood/understand others, her cognition was moderately impaired and she required oversight, cueing and encouragement with meals.

A lunch meal dining observation occurred on 2/18/19 from 12 PM - 1 PM. Review of the posted menu revealed Italian blend vegetables and garlic bread would be served. Resident #29 was observed during the lunch meal. The observation revealed Resident #29 did not receive Italian blend vegetables or garlic bread as per the tray card on her lunch tray. Resident #29 confirmed she did not receive the the items selected on her menu.

An interview on 2/18/19 at 1:38 PM with the dining services director (DSD) revealed she was aware that the garlic bread needed to be prepared and stated, "The cook just forgot to make it and put it on the line, it was an honest mistake." A follow up interview with the DSD occurred on 2/21/19 at 11:56 AM and revealed the Italian blend vegetables were not served for lunch on 2/18/19 because the box of vegetables received from the vendor was labeled "Italian blend vegetables", but the box actually contained sliced carrots. The DSD stated this had occurred before with the same vendor and that each time she notified the vendor.

An interview on 2/18/19 at 1:47 PM with dietary staff #1 revealed she had a lot of tasks to complete for the lunch meal that day and that she just missed preparing some items. She stated "I forgot to do it, my mistake."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345008 | A. BUILDING _____ B. WING _____ | 02/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT MYERS PARK | 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 |

| (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 803 | Continued From page 35 | F 803 | | |

2b. Resident #74 was re-admitted to the facility on 1/4/19. Review of a significant change Minimum Data Set dated 1/11/19 revealed Resident #74 had clear speech, was able to be understood/understand others, his cognition was intact and he ate independently after set up.

A lunch meal dining observation occurred on 2/18/19 from 12 PM - 1 PM. Review of the posted menu revealed Italian blend vegetables and garlic bread would be served. Resident #74 was observed during the lunch meal. The observation revealed Resident #74 did not receive Italian blend vegetables or garlic bread as per the menu. Resident #74 stated "I like garlic bread, I wish they would serve what's on the menu."

An interview on 2/18/19 at 1:38 PM with the dining services director (DSD) revealed she was aware that the garlic bread needed to be prepared and stated, "The cook just forgot to make it and put it on the line, it was an honest mistake." A follow up interview with the DSD occurred on 2/21/19 at 11:56 AM and revealed the Italian blend vegetables were not served for lunch on 2/18/19 because the box of vegetables received from the vendor was labeled "Italian blend vegetables", but the box actually contained sliced carrots. The DSD stated this had occurred before with the same vendor and that each time she notified the vendor.

An interview on 2/18/19 at 1:47 PM with dietary staff #1 revealed she had a lot of tasks to complete for the lunch meal that day and that she just missed preparing some items. She stated "I forgot to do it, my mistake."

2c. A lunch meal dining observation occurred on

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|---|---|---|---|
| | 345008 | A. BUILDING _____ B. WING _____ | 02/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 803 | Continued From page 36 | F 803 | | |

2/18/19 from 12 PM - 1 PM. Review of the posted menu revealed Italian blend vegetables and garlic bread would be served. Observation during the lunch meal revealed residents did not receive Italian blend vegetables or garlic bread.

An interview on 2/18/19 at 1:38 PM with the dining services director (DSD) revealed she was aware that the garlic bread needed to be prepared and stated, "The cook just forgot to make it and put it on the line, it was an honest mistake." A follow up interview with the DSD occurred on 2/21/19 at 11:56 AM and revealed the Italian blend vegetables were not served for lunch on 2/18/19 because the box of vegetables received from the vendor was labeled "Italian blend vegetables", but the box actually contained sliced carrots. The DSD stated this had occurred before with the same vendor and that each time she notified the vendor.

An interview on 2/18/19 at 1:47 PM with dietary staff #1 revealed she had a lot of tasks to complete for the lunch meal that day and that she just missed preparing some items. She stated "I forgot to do it, my mistake."

During a Resident Council meeting held on 2/20/19 at 2:30 PM, 10 of 12 residents (Residents #2, #5, #27, #41, #45, #54, #61, #67, #71, and #81) expressed that main and selective menu items were not always available and that at times the posted menu was not followed. The residents expressed that at lunch on 2/18/19 they did not receive garlic bread or the vegetable that was posted on the menu that day.

An interview on 2/21/19 at 10:39 AM with both the Administrator and Director of Nursing (DON)

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|---|---|---|---|
| | 345008 | A. BUILDING _____ B. WING _____ | 02/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT MYERS PARK | 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 |

| (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 803 | Continued From page 37<br>revealed they were aware of resident concerns related to the dietary department. The Administrator and DON both expressed that the dietary department would need to be more consistent in following the menus. | F 803 | | |