STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 04/15/2019

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E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and update their Emergency Preparedness (EP) plan annually. The facility's EP plan failed to include information regarding the resident population to include residents at risk; facility subsistence, equipment and medical needs; a method for sharing information from the emergency plan with residents and their representative; provide and maintain documentation of annual staff training on the EP plan and conduct the required 2 annual	E 001	E001 Establishment of the Emergency Program (EP) No residents suffered any negative outcomes. All residents have the potential to be affected. On 5/24/19, the administrator updated the emergency preparedness (EP) plan. The update will be completed by 5/28/19.	5/28/19

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

Electronically Signed | 05/10/2019

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E 001	Continued From page 1 EP plan exercises. Findings Included: Review of the facility's Emergency Preparedness plan materials revealed: A. The EP plan signature page did not include any signatures or dates to reflect that it had been reviewed annually. B. The EP plan did not address the resident population including at risk residents and the type of services the facility could provide in an emergency. C. The EP plan did not address the subsistence, equipment or medical needs of the residents and staff during an emergency. D. The EP plan did not include a method for sharing information from the plan, that he facility had determined was appropriate, with the residents and their families or representatives. E. The EP plan did not include and / or document training for staff and volunteers annually. F. The EP plan testing exercises did not include a second full-scale exercise that was community or facility based and did not include a tabletop exercise with analysis. An interview with the Administrator on 4/12/19 at 10:30 am revealed she had started at the facility on 10/1/18 and had tried to work on some of the components of the EP plan. She acknowledged that the plan had not been reviewed and updated	E 001	By 5/28/19, the administrator will update the EP plan signature page to reflect that it was reviewed, signed, and dated annually. On 5/24/19, the administrator updated the EP plan to address the resident population including at risk residents and the type of services the facility could provide in an emergency. On 5/24/19, the administrator updated the EP plan to address subsistence, equipment or medical needs of the residents and staff during an emergency. By 5/28/19, the administrator will update the EP plan to include a method for sharing information for the plan that the facility had determined was appropriate, with the residents and their families or representative. By 5/28/19, the administrator will update the EP plan to include and/or document training for staff and volunteers annually. By 5/28/19, the administrator will update the EP plan to include testing exercises that include a second full-scale exercise that was community or facility based and includes a tabletop exercise with analysis. On 5/10/19, the regional vice president of operations provided education to the administrator regarding the requirement for an effective EP plan. The EP plan will be updated by 5/28/19 to reflect all CMS	

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E 001	Continued From page 2 annually. She stated it was her expectation that the requirements for the EP plan were met.	E 001	guidelines. To help reduce burn out and to accommodate insufficient staffing pending recruitment and call outs so that mistreatment/verbal abuse would not be experienced, the facility would initiate the emergency policy where employees who are needed to stay over during an emergency will be offered a bonus for extra shifts worked. Employees will also be offered paid sleep time and accommodations in the facility or other locations deemed necessary. The facility would solicit caregivers from sister facilities and also utilize any available care givers via agency. The updated EP plan will be reviewed quarterly for four (4) quarters by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure that the EP plan is implemented and EP exercises are completed per regulation.	
F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 06/11/19 to reflect the results of the Informal Dispute Resolution (IDR) process. The IDR process changed the scope and severity levels of F-550 from a G level to a D level, F-600 from a G level to a D level and F-725 was changed from a G level to an E level.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		5/28/19

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F 550	Continued From page 3	F 550		

self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

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F 550	Continued From page 4 Based on observations, resident and staff interviews the facility failed to provide incontinence care for residents that advised 2 different staff members that they were soiled and needed assistance. This resulted in the residents feeling ignored and angry. (Resident #134 and Resident #122). Finding included: 1. Resident #134 was admitted to the facility on 6/29/17 with diagnoses that included spinal stenosis, chronic pain syndrome, and right knee contracture. A review of Resident #134's most recent MDS (Minimum Data Set) coded as a quarterly assessment was dated 3/9/19. The MDS coded the resident as having no cognitive impairment. Resident #134 was coded functionally as needing extensive two-person assistance with toileting. The MDS also coded the resident as always incontinent of bladder and bowel. Under the vision section of the MDS, Resident #134 was coded as having adequate vision. A review of Resident #134's current care plan dated 3/7/19 revealed the resident was care planned for urinary incontinence related to physical immobility with the being the resident would be free from skin breakdown. Interventions included peri care after each incontinent episode. Resident #134 was also care planned for bowel incontinence with the goal being the resident would be clean, dry, and odor free. Interventions included containment and keeping resident clean after bowel movements.	F 550	On 5/10/19, 100% audit of all residents was completed by Administrative Nurses to assure all residents had been provided incontinent care timely to include during mealtime. Any concerns were immediately addressed by the administrative nurses to include providing incontinence care to residents. On 5/10/19, an 100% in-service with all licensed nurses and nursing assistants was initiated by the Director of Nursing (DON) and staff facilitator in regards to Dignity -Incontinence Care to include providing incontinent care during meal times. In-service was completed on 5/28/2019 In-service included: 1. Incontinent care will be provided following each incontinent episode to include during meal times 2. Steps to provide incontinent care during meal time for a resident in a private room 3. Steps to provide incontinent care during meal time for a resident in a semi-private room All newly hired licensed nurses and NAs will be in-serviced in regards to Dignity -Incontinence Care to include providing incontinent care during meal times during orientation by the Staff Facilitator. In-service to included: 1. Incontinent care will be provided following each incontinent episode to include during meal times 2. Steps to provide incontinent care during meal time for a resident in a private room 3. Steps to provide incontinent care during meal time for a resident in a	

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F 550	Continued From page 5 An interview was conducted on 4/7/19 at 5:35pm with Resident #134. She reported she had urinary incontinence in her brief and had called for assistance approximately 20 -30 minutes ago, but no one had come in yet. The call light was still on during the interview. During the interview, the resident rang for assistance and NA #13 arrived and told the resident she would try to find some help, but the supper trays were ready to be delivered to the residents. The resident reported she knew what time it was by asking the staff and her watch. An observation was made on 4/7/19 at 5:35 pm with Resident #134. NA #13 (Nursing Assistant) arrived in the resident's room and turned off the call bell and asked the resident what she needed. Resident #134 reported to NA #13 that she was wet and needed her brief changed. NA #13 reported it was time for the supper trays to be passed out, but she would see if she could get someone to help her. An interview was conducted on 4/7/19 at 6:30pm with Resident #134. The resident reported she was still wet and was waiting for someone to come and clean her and change her brief. She reported she ate her supper wet. During the interview, NA #13 came in to change Resident #134. The resident reported feelings of anger that no one helped her. On 4/9/19 at 12:30 pm an observation was made with Resident #134 by another surveyor. A strong, foul odor was noted on the resident. The resident refused to talk to the surveyor. An observation was made on 4/9/19 at 4:05 pm with Resident #134. The resident was lying in	F 550	semi-private room On 5/10/19, a 100% in-service was initiated by the staff facilitator with all licensed nurses, NAs, dietary staff, Dietary Manager, Therapy Manager, Therapy staff, Accounts Receivable, Accounts Payable, Social Worker, Housekeeping Supervisor, Housekeeping staff, Medical Records, Admissions Coordinator, Minimum Data Set Nurse, and Treatment nurse on Dignity □ Incontinence Care to include providing incontinent care. In-service was completed on 5/28/2019. All newly hired licensed nurses, NAs, dietary staff, dietary manager, therapy manager, therapy staff, accounts receivable, accounts payable, social worker, housekeeping supervisor, housekeeping staff, medical records, admissions coordinator, Minimum Data Set (MDS) Nurse, restorative nurse, and Treatment nurse will be in-serviced on the Dignity-Incontinence Care to include providing incontinent care during orientation by the Staff Facilitator. 25 % of all residents to include Resident #134 and Resident #122 will be observed by the DON or Designee for incontinent care to include meal times utilizing the Resident Care Audit Incontinent Care three times a week for eight weeks, then weekly for four weeks to ensure all residents to include Resident #134 and Resident #122 are offered incontinent prior to and/or during meals per facility protocol. Any staff who fail to provide incontinent care prior to and/or during mealtime will be immediately in-serviced	

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F 550	Continued From page 6 bed, moaning and groaning. Resident #134 had a strong, foul smelling odor noted on her. An interview was conducted on 4/9/19 at 4:05 pm with Resident #134. The resident reported she had stool on her and no one had come to change her since before lunch. She reported she had called for assistance and an aide came in and turned off the call bell and said she would be back but has not come back. Resident #134 reported she did not eat her lunch as the smell of her stool was so bad. She reported she was embarrassed and upset. She reported she didn't talk to the other surveyor because she was upset that she had stool on herself. During the interview, the resident's call light was on and NA #15 came in and turned off the call light and told the resident she would be right back with assistance. An observation was made on 4/9/19 at 4:20 pm of Resident #134. NA #15 and NA #14 arrived in the resident's room. The NAs were observed providing incontinence care to the resident. When the NAs pulled back the covers, Resident #134 had a large amount of dried stool on the incontinence pad, the bottom and top sheet, and gown. She also had dried stool on her right and left buttocks down to mid outer thighs, and under her fingernails. Her brief was full of stool. The NAs provided incontinence care. NA #14 cleansed the perineal area front to back and opened the labia to clean. NA #15 cleansed the rectal area, buttocks, and thighs with warm soap and water and rinsed and dried. NA #14 cleaned the resident's fingernails also. Resident #134's right buttock dressing to her pressure ulcer was soiled with stool and loose. Her buttocks were pink in color. NA #15 removed the soiled	F 550	by the staff facilitator or designee, on procedure for providing incontinent care to include incontinent care during mealtime. The DON will review and initial the Resident Care Audit Incontinent Care for completion 3 times a week for eight weeks, then weekly for four weeks to ensure all areas of concern are addressed. The Administrator will forward the results of Resident Care Audit Incontinent Care to the Quality Assurance (QA) Committee monthly for three months. The QA Committee will meet monthly for three months and review the Resident Care Audit Incontinent Care to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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dressing. Resident #134's gown and bed linens were also changed.

An interview was conducted with NA #14 on 4/9/19 at 6:55 pm. She reported her workload consisted of many two-person assistance residents. She reported it was difficult to give incontinence care as quickly as she should. She reported she started her shift at 3:00 pm and had not gotten to Resident #134's room until 4:20 pm when she was told the resident needed changing.

An interview was conducted with the Administrator on 4/11/19 at 6:00 pm. She reported it was her expectation that all residents who needed assistance with incontinence care not have to wait a long time to receive care.

2. Resident #122 was admitted to the facility on 3/14/19 with diagnoses that included muscle wasting and atrophy, chronic pain, and chronic respiratory failure.

A review of Resident #122's most recent MDS was coded as an admission assessment and dated 3/21/19. The resident was coded as having mild cognitive impairment. The MDS coded Resident #122's functional status as total care needing one-person assistance with toileting and bathing. The resident was coded as always incontinent of bladder and bowel. The resident's vision was coded as adequate.

A review of Resident #122's most current care plan dated 3/16/19 revealed the resident was care planned for incontinence care with interventions that included keep the resident clean and dry to prevention skin breakdown.

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F 550	Continued From page 8 An interview was conducted with Resident #122 on 4/11/19 at 10:20 am. Resident #122 reported she had called for incontinence care this morning before breakfast and no one had come in to change her yet. She reported NA #16 came in with her breakfast tray and she told her she was wet, but the aides were handing out the breakfast trays and NA #16 said she would be back but had not seen her. Resident #122's sister was present during the interview and corroborated the resident's story. The resident reported feeling "ignored" when no staff came back in to assist her. An observation was made on 4/11/19 at 10:55 am of Resident #122. NA #16 arrived in the resident's room and performed incontinence care and bathed Resident #122. NA #16 used proper technique and cleansed with warm water and soap, rinsed, and dried the resident. It was observed that the resident's brief was wet and had stool in it. Resident #122 had dried stool on her buttocks. Her buttocks were pink and the dressing on her sacral area was loose and soiled with stool. A clean brief was applied to the resident. An interview was conducted with NA #16 on 4/11/19 at 11:10 am. She was unable to state why she did not come back into the room for 2 hours to, provide care to Resident #122. An interview was conducted with the Administrator on 4/11/19 at 6:00 pm. She reported it was her expectation that all residents who needed assistance with incontinence care not have to wait a long time to receive care.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		5/28/19

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F 561	Continued From page 9 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to get an alert and oriented resident out of bed according to her choice for 1 of 3 residents reviewed for choices. (Resident #47) Findings included:	F 561	Resident #47 no longer resides in the facility. On 5/9/19, a 100% questionnaire of all alert and oriented residents was completed by the Social Worker (SW) in regards to resident preferences. The assigned hall nurse, unit managers and/or	

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F 561	Continued From page 10 Resident #47 was admitted to the facility on 8/1/2016 with diagnoses that included diabetes mellitus, and acute respiratory failure with hypoxia. A review of Resident # 47's care plan dated 1/21/2019 revealed she needed extensive assistance for transferring from one position to the other by two people with a lift. She also required two people assist with baths and showers. A review of "Resident #47's care guide dated 1/21/2019 indicated she like to be up by 10:30 am and assist to activities of choice (on hold). It also revealed she required three or more people with a lift for bed mobility." A review of Resident # 47 ' s most recent minimum data set assessment dated 1/31/2019 revealed she was assessed as cognitively intact. She had no behaviors of rejection of care. She was assessed to require extensive assistance of three people with bed mobility and transfers. During an interview with Resident #47 on 4/7/19 at 3:30 pm, she revealed she did not get up during the week because the facility was always short of staff. Resident #47 stated there were days she didn't get out of bed until lunch time. Resident #47 indicated she would love to be up for breakfast. She would like to eat sitting up in her wheel chair. Resident #47 indicated she had told the Administrator and Director of Nurses this information many times and the response she received was they were short staffed every day. "Resident #47 indicated she was so sick and tired of being told they were short of staff she didn't know what to do. Resident #47 stated sometimes	F 561	MDS nurse updated all resident care plan/care guide for any new or changes in resident preference identified during the audit. The questionnaires were completed 5/28/2019. A 100% in-service for all licensed nurses and nursing assistants (NAs), including agency staff, was initiated on 5/8/19 by the Staff Facilitator in regards to resident preferences to include waking/sleep hours, showers and meal time preferences to include: (1) Residents have the right to make choices about aspects of life in the facility that are significant to the resident. This includes but is not limited to (a) Choosing bath or shower preference (b) Wake/sleep times preference (c) Meal preferences to include being up in chair for meals (d) Activity preferences (e) Religious preferences. (2) Staff should notify DON when a resident voices a new preference so the facility can attempt to accommodate the preference (3) MDS/Nurses must update care plan/care guide for all new or changes in resident preferences. (4) Staff must attempt to honor resident preferences to include shower, wake/sleep times, mealtime preferences to include being up in chair for meals and activity preferences and notify DON if preference cannot be honored for any reason. In-service will be completed by 5/28/19. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation.	

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F 561	Continued From page 11 there was only one Nurse and one Nursing Assistant for all of us on this hall. Resident #47 indicated because of my size I need three staff to help me get up and this is why I wait so long." An observation of Resident #47 on April 8, 2019 at 9:15 am revealed she was in bed. The resident stated she was waiting on staff to get her up. An observation of Resident #47 on April 8, 2019 at 10:30 am revealed she was still in bed. An Interview with Nurse Aide #4 on April 8, 2019 at 10:45 am indicated she was still waiting for another aide to assist her with Resident #47. She stated they needed three or more staff to help get this resident up and stated they were always short of staff. "NA# 4 indicated that both the Administrator and Director of Nurses knew the facility had struggles with having staff on the hall to provide care for the resident. NA#4 indicated that she felt that the head of the facility does not care about the safety of the residents if that was true we would have more staff on the shifts." An observation of Resident #47 on 4/8/19 at 11:30 am revealed she was up in her wheel chair being transported to the Resident Council Meeting. An observation of Resident # 47 on 4/9/19 at 9:00 am revealed she was in bed waiting for staff to get her. Resident #47 indicated the NA reported they were short of staff today. An interview with Nurse Aide # 5 on April 9, 2019 revealed she has worked there since November 2019. NA #5 stated the workload for this hall was very hard because all of the resident were very	F 561	10% of all alert and oriented residents will be audited by the social workers weekly for four weeks then monthly for one month utilizing the Resident Preference Audit Tool to ensure resident preferences are being honored to include but not limited to meal time preferences and being up in chair for meals. All areas of concern will be immediately addressed by the social workers, unit managers and/or Mininum Data Set (MDS) nurse during the audit to include re-education of staff and updating resident preferences as indicated. The Director of Nursing (DON) will initial the Resident Care ADL/Preference Audit Tool for completion and to assure all areas of concern were addressed weekly for four weeks then monthly for one month. The DON will forward the results of the Resident Preference Audit Tool to the Quality Assurance (QA) Committee monthly for two months. The QA Committee will meet monthly for two months and review the Resident Preference Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 561	Continued From page 12 demanding for care and it was hard if you were the only NA on the hall for hours at a time. The NA stated that Resident #47 had to wait a long time because she needed help with this resident. The NA stated that the Nurses on the hall and the Director of Nurses were aware of this but we are short staffed 90% of the time. The Social Worker was not available to be interviewed during this survey. During an interview with the Administrator on Thursday April 11, 2019 at 6:15pm, she indicated her expectation was for each resident's choices to be honored daily.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		5/28/19

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F 584	Continued From page 13 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interviews the facility failed to (1) maintain walls in residents' rooms to prevent areas of exposed plaster for 4 of 16 rooms (rooms 301, 305, 404, 407), (2) maintain ceilings in residents' rooms where the popcorn ceiling was coming off and leakage for 3 of 16 rooms (rooms 204, 209 and 219), (3) repair/replace over the bed light fixtures for 2 of 16 rooms (rooms 301 and 323), (4) repair or replace broken items in residents' rooms for 5 of 16 rooms (rooms 130, 203, 209, 301 and 323). Findings included: 1a. Room 301 was observed on 4-7-19 at 3:30pm. The wall behind the bed was noted to have paint chipped off exposing the plaster	F 584	Beginning on 5/10/19, the maintenance director and maintenance assistant conducted an initial audit of the facility for safe/clean/comfortable/homelike environment. The following areas of concern were noted 1. Areas of exposed plaster in rooms, 2. Ceilings and leakage, 3. Repair and replace over the bed light fixtures, 4. Repair and replace broken items in resident's rooms. The initial audit was completed by 5/21/19. On 05/10/19, the administrator provided proactive in servicing for the maintenance director and the maintenance assistant. The in service covered safe/clean/comfortable/homelike environment. The in service was completed by 05/10/19.	

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F 584	Continued From page 14 underneath. Room 301 was observed again on 4-11-19 at 2:35pm and revealed the wall behind the bed had missing paint exposing the plaster underneath. The area was noted to be approximately 2 feet by 3 feet. 1b. Room 305 was observed on 4-7-19 at 4:38pm. The wall behind the resident's bed had 4 holes. Room 305 was observed again on 4-11-19 at 2:45pm. The wall behind the resident's head board was noted to have 4 holes creating the shape of a box. 1c. Room 404 was observed on 4-8-19 at 9:54am. The wall behind the resident's bed was noted to have gouges leaving plaster exposed. Room 404 was observed again on 4-11-19 at 2:48pm revealing approximately 2 feet by 3 feet gouges in the wall behind the resident's head board exposing the plaster. 1d. Room 407 was observed on 4-8-19 at 12:58pm. The wall behind the resident's head board was noted to have paint chipped off exposing the plaster. Room 407 was observed again on 4-11-19 at 2:52pm. The wall behind the resident's head board had approximately a 2 foot by 3-foot area where the paint had been chipped off exposing the plaster underneath. During an interview with the maintenance manager on 4-11-19 at 2:53pm, the maintenance	F 584	Beginning on 5/10/19, the administrator, staff facilitator and/or designee proactively in serviced facility staff on recognizing the need for repairs and how to report it. The facility utilizes verbal communication and/or the electronic TELS system to report and prioritize needed repairs to promote a safe/clean/comfortable/homelike environment. The in service will be completed by 5/28/19. On 4/11/19, the maintenance director began ordering and/or purchasing supplies/equipment to repair rooms 130,203,204,209,219,301,305,323,404, and 407. From 4/11/19-5/24/19 the maintenance director continued ordering and/or purchasing supplies/equipment to address ongoing maintenance requests. On 4/12/19, the maintenance director and maintenance assistant began repairs of resident rooms. Repairs of resident rooms will continue on an ongoing basis to ensure a safe/clean/comfortable/homelike environment. Specifically, corrective actions will be completed for the identified resident rooms (130,203,204,209,219,301,305,323,404,407) by 5/24/19. The administrator, the maintenance director or designee will review status of repair/work orders in Interdisciplinary Team (IDT) meeting and as needed. The administrator, maintenance director, maintenance assistant and/or corporate representative will complete Quality Improvement Monitoring of facility for safe/clean/comfortable/homelike	

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F 584	Continued From page 15 manager stated the facility had blue head board bumpers that were placed over the top of the head board to prevent the bed from scraping against the wall. He also stated he had put them on all the beds but "they keep disappearing and I don't know what happens to them." 2a. Room 204 was observed on 4-7-19 at 5:05pm. The bathroom ceiling was noted to be stained brown above the toilet and the popcorn ceiling was noted to be peeled away and loose around the sprinkler head. Room 204 was observed again on 4-11-19 at 2:27pm. An area on the ceiling was approximately 2 inches by 3 inches. It was brown in color and the popcorn ceiling was peeled away and loose around the sprinkler head. 2b. Room 209 was observed on 4-8-19 at 8:24am and revealed the popcorn ceiling had chipped away in the bathroom above the mirror. Room 209 was observed again on 4-11-19 at 2:30pm. A 6 by 3-inch area of the popcorn ceiling had been chipped away. 2c. Room 219 was observed on 4-8-19 at 8:51am. The ceiling above the closet appeared to have water damage from a leak. Room 219 was observed again on 4-11-19 at 2:33pm. The ceiling above the closet was discolored, and the plaster was patchy and bumpy. The area was approximately 2.5 feet by 2.5 feet. During an interview with the maintenance manager, he stated he had been the only	F 584	environment. The monitoring will be completed on five percent (5%) of resident rooms five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for four (4) weeks. The maintenance director or maintenance assistant will present the Quality Improvement Monitoring results and trends to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor the results of the Quality Improvement Monitoring for three (3) months. The committee will make recommendations regarding need for continued monitoring.	

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F 584	Continued From page 16	F 584		

maintenance worker for the facility for over a year. He also stated the facility had hired another maintenance worker 3 months ago and that they have been working on repainting the residents' rooms.

3a. Room 301 was observed on 4-7-19 at 4:21pm. The light fixture above the resident's bed was noted to be loose from the wall.

Room 301 was observed again on 4-11-19 at 2:35pm. The left corner of the light fixture was loose from the wall causing the light fixture to have a downward slant.

3b. Room 323 was observed on 4-7-19 at 6:06pm. The plastic cover on the light fixture above the resident's bed was noted to be broken.

Room 323 was observed again on 4-11-19 at 2:45pm and revealed the plastic cover on the light fixture was broken preventing the plastic cover to lock into place and exposing the florescent bulb.

The maintenance manager was interviewed on 4-11-19 at 2:45pm. The maintenance manager stated he was not aware of the issues with the light fixtures. He stated the nursing assistants, or the nurses needed to inform him of issues verbally or by the facility's computer system and he denied that he had been informed of the light fixtures needing to be fixed. The maintenance manager stated he would have his assistant fix room 301 "immediately" but that he would have to check if he had a replacement cover for room 323.

4a. Room 130 was observed on 4-8-19 at 9:19am. The resident's shelf had fallen off the

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F 584	Continued From page 17	F 584		

wall and the resident stated it had happened shortly after his admission to the facility.

Room 130 was observed again on 4-11-19 at 2:23pm and revealed the shelf was laying on the floor propped against the wall at the foot of the resident's bed partially blocking access to the left side of the bed.

4b. Room 203 was observed on 4-7-19 at 4:53pm and revealed the window screen frame was bent.

Room 203 was observed again on 4-11-19 at 2:25pm. The window screen frame was unable to be secured in the window due to the frame being bent allowing insects into her room when she had the window open.

4c. Room 209 was observed on 4-8-19 at 8:24am. The metal toilet paper holder was noted to be broken.

Room 209 was observed again on 4-11-19 at 2:30pm and revealed the metal toilet paper holder was missing one side of the holder causing the holder to be non-operational.

4d. Room 301 was observed on 4-7-19 at 3:30pm. The electrical outlet covering was noted to be loose from the wall.

Room 301 was observed again on 4-11-19 at 2:35pm revealing the cover to the electrical outlet located behind the head board of the resident's bed was loose from the wall.

4e. Room 323 was observed on 4-7-19 at 6:06pm. Blinds that covered the window were broken.

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F 584	Continued From page 18 Room 323 was observed again on 4-11-19 at 2:45pm and revealed the window blind had several broken slats on the left side of the blind. The resident stated the blind was "like that when I moved in here." During an interview with the maintenance manager on 4-11-19 at 2:45pm, he stated the nursing assistants, or the nurse should verbally or through the computer system inform him of issues in the residents' rooms. The maintenance manager denied that he had been informed of the issues. He also stated he would talk with his assistant and begin working on the issues. The Administrator was interviewed on 4-11-19 at 5:30pm. The Administrator stated the maintenance director had been the only maintenance personnel in the facility for over a year and expected the environmental issues to improve since the facility had hired another maintenance worker 3 months ago.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		5/28/19

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F 600	Continued From page 19 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family, nurse practitioner and staff interviews the facility failed to prevent physical and verbal abuse for 1 of 7 residents review for abuse (Resident #129). During the provision of care, a staff member was heard and observed yelling at a resident to stand up even though the resident was assessed to not have the ability to stand without staff assistance. The resident grabbed the staff member to prevent falling and the staff member responded by shaking the resident. Following the incident, the resident complained of increased pain. Pain medication was changed from as needed to routine administration. Finding included: Resident #129 was admitted to the facility on 2/27/18. Resident #129 had diagnoses including osteomyelitis of vertebra, chronic pain due to trauma, vitreous hemorrhage, retinal detachment, blindness and diabetes. A review of Minimum Date Set (MDS) dated 10/13/18 revealed in section J Pain Management revealed Resident #129 was on pain medication PRN(as needed)and he rarely has pain and on the Pain scale his score was 3. A Minimum Data Set (MDS) dated 1/13/2019 revealed Resident #129 was cognitively intact and impaired vision. He required extensive assistance for transfer with the assistance from two people for toilet use, he was total dependent	F 600	On 4/9/19 at 10 am, Resident #129 reported he had an incident where Resident #129 felt that Nurse #10 had abused him. On 4/8/19, the administrator was informed of Resident #129s allegation of abuse and immediately took corrective action. The administrators actions included: On 4/9/9, the administrator removed Nurse #10 from working at the facility during the investigation of abuse. On 4/9/19, the administrative nurses performed skin audits on residents who are not interviewable to identify any residents with signs/symptoms of abuse. The audit identified no additional residents with signs of abuse. On 4/9/19, the social worker (SW) completed resident abuse questionnaires with interviewable residents. The questionnaires revealed no further allegations of abuse. On 4/8/19, the regional vice president (RVP) proactively educated the administrator and director of nursing on abuse prevention in the facility and recognizing potential allegations of abuse. On 4/8/19, the administrator directed the administrative nurses to initiate proactive education for all staff including contracted staff. The re-education covered: Abuse and neglect. In-service will be completed by 5/28/19. A Registered Nurse Consultant offered	

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F 600	Continued From page 20 on staff with one person physical assist. For balance during transition and walking, he was coded as not steady and only able to stabilize with staff assistance. Resident #129 was able to make his needs known to staff. The assessment indicated Resident #129 had no behavior or mood issues. An interview with Nurse Aide #9 on April 10, 2019 at 4pm revealed Resident #129 was able to make his needs know to staff and was able to assist with his care and treatment. The NA indicated that he could roll from side to side if you told him what he needed to do. The NA #9 indicated she wouldn't provide care to him standing up and the resident was blind. Interview with Resident #129 on 4/8/19 at 10am revealed on 1/6/19 he had an incident where he felt that Nurse #10 had abused him. Resident #129 revealed that on that day the facility was short of staff. Nurse #10 and Nurse #51 worked as Nursing Assistants (NAs). Resident #129 indicated that Nurse #10 came in to change him and asked him to stand up during the care. He explained he almost fell because she asked him to stand. Resident #129 indicated during this incident she got upset with him and shook him so hard that his head and neck have not been the same since. He indicated that this information was reported to the Administrator and Nurse #10. Resident #129 stated he has had pain "like crazy" since the incident and he took pain medication daily. During this interview Resident #129 indicated he report this information to the Nurse Practitioner and his pain medication were increased. During a second interview with Resident #129 on 4/9/2019 at 9am, the resident revealed that during the incident Nurse #10 asked	F 600	Culture and Sensitivity training with Administrative staff on 5/7/19. On 5/21/19 Nurse #10 was educated one on one by the Facility Consultant in regards to (1) Abuse and Neglect Policy (2) Combative Residents and (3) Safe Handling Policy. On 5/21/19 resident #129 was educated by the Social Worker in regards to Abuse and Neglect to include (1) what is abuse? (2) Types of abuse (3) Reporting abuse immediately and (4) who to report abuse to -Unit Manager, Social Worker, Administrator, Nurse Supervisor. On 5/21/19 a resident council meeting was held by the Activity Director and Social Worker to discuss Abuse and Neglect to include (1) what is abuse? (2) Types of abuse (3) reporting abuse immediately and (4) who to report abuse to. Any alert and oriented resident who did not attend the resident council meeting will be in-serviced one on one by the Social Worker. In-service will be completed by 5/28/19. Starting on 5/28/19, the Social Worker (SW) will do weekly rounds asking all interviewable residents if staff are being good to the residents. The weekly rounds will be completed for three (3) months. Starting on 5/28/19, the administrative unit nurses and/or assigned nurse will monitor direct care of two (2) residents each shift, to include all shifts and weekends, once weekly for eight (8) weeks, then monthly x four (4) weeks. The audit results will be taken to the QAPI meeting monthly for discussion and further recommendations Starting on 5/22/19 the Administrator will	

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F 600	Continued From page 21 him to stand up so she could change him and during that process he felt like he was going to fall and he reached out to grab something to prevent his fall. Resident #129 indicated that he informed Nurse #10 that nursing staff do not check him standing up. Resident #129 indicated he did not realize what he was grabbing, Resident #129 said he just did not want to fall. Resident #129 said Nurse #10 shook him so hard for touching her he fell to his bed. Review of a nurses note dated 1/6/2019 at 5:30pm stated "resident grabbed my right breast and shirt pulled me to him and swung at me with his right hand while yelling he knew the catheter was in his prostate and I could go .... myself." This note was written by Nurse #10. Phone interview on 4/10/19 at 10:47 am with Nurse #10 revealed she worked as a Nursing Assistant (NA) on 1/6/19. She came in about 3:30 pm. Resident #129's call light was on and she answered it. The Nurse #10 explained the resident wanted to get up into his wheelchair to go to the dining room for supper. The resident was sitting on the side of his bed and she placed his wheelchair to the left of him. Nurse #10 stated the resident needed assistance from one person for transfer and when she started to assist him to stand and get into his wheelchair the resident stated his catheter tubing was stuck behind him. She explained she checked the tubing and it was not stuck anywhere. Nurse #10 indicated she told the resident that the tubing was not stuck and he started yelling at her with profanity. The resident then took his left arm and grabbed her shirt and chest. Resident #129 attempted to swing at her with his right arm, but never did strike her. She was able to remove his left hand from her shirt and placed it on his leg. She stated the resident	F 600	meet weekly with nurse #10 x 4 weeks to identify any concerns related to resident interactions for the purpose of ensuring the facility to include nurse #10 honors resident's rights and preferences. In-service updates and audit results will be taken to the QAPI meeting monthly for three (3) months for discussion and recommendations. The administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Findings of the investigation is the allegation was unsubstantiated.	

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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never stood. He remained seated on the side of the bed the entire time. Nurse #10 explained the resident's nurse (Nurse #15) came into the room at that time and told the resident he shouldn't speak to her like that. Nurse #10 stated she left the room when Nurse #15 came in. Nurse #10 believed she documented the resident's behaviors in the medical record. She stated later in the shift, the resident's sister came to the facility and the resident apologized to Nurse #10. On 1/7/19 (Monday) Nurse #10 was told that the resident had reported that she had been physically abusive towards him. The Administrator, Social Worker, resident and his son had a meeting and according to Nurse #10, the resident denied that the incident ever happened. Nurse #10 was called down to the meeting and the resident apologized to her. Nurse #10 explained she wasn't aware of any physical injuries to the resident after the incident.

An interview with Nurse #51 on 4/9/19 at 2:30pm revealed that she was working on the unit on 1/6/19 and heard a loud commotion from Resident #129's room. Nurse #51 stated she opened the door to the room and Nurse #10 yelled for her to get out of the room. Nurse #51 stated Nurse #10 used profanity when she yelled this to her and to Resident #129. Nurse #51 report this incident to the Administrator. Nurse #51 indicated she had to write a statement about what happened during the event and the statement was returned to her to rewrite it, because of how it was written.

During an interview with Nurse #15 on April 10, 2019, he indicated he was the House Supervisor for the evening of January 6, 2019. Nurse #15 indicated all the nursing assistants for the 100

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hall called out on the 3-11 shift. Nurse #51 inquired about staffing for the evening. Nurse #15 indicated Nurse #10 was called and arrived to work approximately 30 minutes later. Nurse #15 indicated he saw Nurse #10 enter into Resident #129's room, the room was one door down from the Nurses' station. Nurse #15 indicated he heard and recognized Nurse #10 telling Resident #129 to "GET UP". Nurse #15 heard Resident #129 say, "WAIT A MINUTE, THEY HELP ME UP, I'M BLIND and I CAN'T STAND MYSELF. YOU'RE GOING TO HAVE TO HELP ME!" Nurse #15 then heard Nurse #10 yelling, "YOU CAN STAND UP". Nurse #15 indicated that he opened the door to Resident #129's room. Resident #129 was observed at the foot of his bed and both Nurse #10 and Resident #129 were yelling at one another. Nurse #15 indicated he saw Nurse #10 rapidly lean into Resident #129's face and yell at him. Resident #129 also was in her face and Nurse #10 drew back and balled her hand. Nurse #15 indicated that this happened fast and he immediately placed himself between the two individuals. As Nurse # 10 left the room she kept exchanging words with Resident #129. Once Nurse #10 left the room, Nurse #15 went up to Resident #129 who was crying hysterically and asked him what had happened. He could barely get the words out and he said, "I'm scared of her, please don't let her come back in here. Resident #129 indicated he was asleep and she barged in here and started yelling and cursing at me telling me to stand up. Resident #129 indicated that he told her he can't stand by myself." He indicated that he need assistance. Resident #129 continued, "I can't see, and she yanked my arm and dragged me up and I began to fall and reached out to catch myself and I must have grabbed her. Nurse #10 hit me in my arm and I

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fell back to the bed. Nurse #15 indicated that Resident #129 also said, "I was sitting up and I couldn't see anything. I then felt both her arms on my shoulders and Nurse #10 starting shaking me hard." Nurse #10 was strong, too, and I can't defend myself anymore." Nurse #15 indicated he was able to help deescalate Resident #129. Nurse #15 also indicated he was able to make Resident #129 feel safe for that evening. Resident #129 indicated to Nurse #15, he was sorry for what happened and thanked Nurse #15 for helping him. Nurse #15 asked Nurse #10 what happened? Nurse #10 indicated that Resident #129 grabbed her breast. Nurse #15 indicated that he asked Nurse #10 not to return to Resident #129's room for the remainder of the night. Nurse #15 indicated that he assessed Resident #129. Resident #129 had no visible injuries. Nurse #15 reported he had increase in pain with his neck and headache since that incident. Nurse #15 indicated that this incident was reported to the Administrator.

During an interview with the Administrator on 4/8/19 at 5pm she revealed this incident was brought to her attention during the morning/stand up meeting on 1/7/19. She stated when the incident was reported to her the Nurse #10 was removed from the floor and placed in the office. She explained she went and interviewed Resident #129 and he told her that the incident never happened.

A follow-up interview with Resident #129 on 4/8/19 at 5:40 pm revealed he had not told the Administrator that the incident never happened. He confirmed the details provided from his initial interview.

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An interview with the family member for Resident #129 on 4/9/19 at 2pm revealed he received a call on 1/6/19 (unsure of the time) from the resident who stated the Nurse #10 shook and hurt him. Resident #129 told him that Nurse #10 put her hands on him and shook him. The family member indicated he was out of town and asked his aunt to go out to the facility and see what was going on with Resident #129. The family member stated he had a meeting with the facility on 1/9/19. He added Nurse #10 and Resident #129 apologized to each other. The family member stated Resident #129 has had increased complaints of pain to his head, neck and eyes since the incident with Nurse #10.

A review of progress note dated 1/11/19 "Resident asked for pain medication for neck hurting and was given, Will continue to monitor.

A review of Minimum Date Set (MDS) dated 1/13/19 revealed in section J Pain Management revealed Resident #129 was on pain medication PRN(as needed)and he frequently had pain and on the Pain scale his score was 5.
A review of progress note dated 1/14/19, revealed that "Resident #129 asked to see Nurse Practitioner Note indicated that "Upon entering room he complained of pain extrending from back to neck to top of head. He reports severe pain behind right eye. Resident reports that the headache and eye pain intensified when a staff member shock him as she was helping with ADL care and he felt as if he was falling and he reached out and accidently grabbed staffed member breast, he reports he could not see since he is visually impaired and was just trying to prevent himself from falling. Since then, he has had headache that won't go away and his right

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eye vision has was worsened. Resident states he went for ophthalmology follow-up appointment on Friday (January 11, 2019) and the ophalmologist asked if he had falled recently as there has been a change in vision work up and resident states ophthalmologist said something has "folded over' and there is nothing more he can do." Diagnoses and assessment: headaches around the eyes, decreased vision in both eyes, and neck pain. Plain: Schedule pain medication q 8 hours. To have a MRI due to acute complaint, headache, eye pain, neck pain, history of retinal detachment."

A review of progress note dated 1/17/19 this was follow-up to headache and eye pain. Resident still complaints of headache from neck to back of head occipital region. Blurred vision and right eye pain.

A review of progress note dated 1/21/19 noted Resident asked for pain medication at 5am due to neck pain, Resident level of pain was 5 on the pain scale, medication given and was effective.

A review of progress note dated 1/31/19 note Resident refused restorative ambulation program today due to having a bad headache. Nurse notified.

An interview on 4/10/19 at 11:42 am with the Nurse Practitioner (NP) who provided care for Resident #129 revealed the resident had requested to be seen due to increased neck pain, headache and change in vision. She stated the resident reported to her that a staff member had come in to change him and they had him stand up. When he stood up he felt like he was going to fall, and he reached out in front of him

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F 600	Continued From page 27 and grabbed onto the staff member to stabilize him and prevent him from falling. The resident told her that when he did this the staff member started shaking him. The NP explained the incident. The NP explained she changed his pain medication from as needed to a routine dose because of his increase complaints of pain following the incident.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow the abuse policy with the requirement to report abuse allegations within 2 hours of notification of the allegation and a 5 working day investigation report to the State Survey within the required timeframes for 3 of 3 residents. (Resident #129, Resident #135 and Resident #53) The finding included: Administrative Policies (Revision 03/10/2017)	F 607	On 4/8/19, the administrator reported an initial allegation of abuse for Resident #129 to the appropriate state agency. On 4/15/2019, the administrator submitted an investigation report for Resident #129 to the appropriate state agency. On 4/9/19, the administrator reported an initial allegation report of abuse for Resident #135 to the appropriate state agency. On 4/9/19, the administrator submitted an investigation report for Resident #135 to the appropriate state agency.	5/28/19

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F 607	Continued From page 28 Reporting / Response: o The Administrator is responsible to ensure that incidents, as indicated, are reported to the appropriate local/state/federal agencies, including the Nurse Aide Registry. The Administrator will ensure that the appropriate state agencies are notified according to federal and state regulations as follows. The Administrator will ensure for all allegations that involves abuse or results in serious bodily injury, the Division of Health Service Regulation, Health Care Personnel Section, and Adult Protective Services are notified immediately but no later than 2 hours after the allegation is received and determination of alleged abuse is made. A written report must be sent to Health Service Regulation, Health Care Personnel Section, within five working days of the date the facility becomes aware of the alleged incident. A. During an interview with Resident #129 on April 7, 2019 at 4:30pm he revealed he reported an allegation of staff abuse on January 5, 2019. Resident #129 indicated he was shook by a staff member so hard that he fell on his bed. Resident #129 indicated that he reported this information to a male nurse. During an interview with the Male Nurse on 4/9/2019 at 11am he confirmed that he reported this allegation of abuse to the Administrator (designated abuse coordinator) on January 6, 2019. During an interview with the Administrator on 4/9/2019 at 11:35am she indicated she was aware of this abuse allegation on January 7, 2019. Review of the facility	F 607	On 4/9/19, the administrator reported and allegation of abuse for Resident # 53 to the appropriate state agency. On 4/9/19, the administrator submitted an investigation for Resident #53 to the appropriate state agency. On 5/10/19, 100% audit of all resident reportable events for 30 days was initiated by the facility consultant to ensure all investigative folders are complete to include a 24 hour report and 5 day report with written summary of investigation with proof of fax confirmation, police report when applicable, statements from staff and other documentation as indicated. All areas of concern will be immediately addressed by the administrator to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and completion of investigation. Audit will be completed by On 5/10/19, 100% audit of all grievance/concern forms for 30 days was initiated by the facility consultant to ensure that any allegations of abuse/neglect were reported in a timely manner. All areas of concern will be immediately addressed by the Administrator to include faxing 24 hour/5 day report and obtaining confirmation of fax completion and completion of investigation. On 5/10/2019, 100% questionnaire of all alert and oriented residents was initiated by the social workers in regards to abuse and neglect. All areas of concern will be immediately addressed by the Administrator to include faxing initial investigation and investigation reports and	

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F 607	Continued From page 29 reported abuse allegations revealed no 5- day investigation was done. Review of this report revealed the allegation was faxed to the state agency on 4/9/2019 at 3:41pm. B. During an interview on 4/8/19 at 5:25pm with Resident #135's family member they reported the staff and the transportation scheduler hit resident's head on head board on 3/15/19. The FM indicated that he believed the staff member did this intentionally. The FM reported the staff said, "I didn't know we were so strong" He reported he talked to the administrator the next day and asked if an incident report had been done and was told "I don't know". FM indicated during this interview that he reported this information to the Administrator on 3/16/2019 after a conservation he had with Administrator indicating that he felt that his wife had been abused by staff. The FM indicated this was done intentionally. Review of the facility reported abuse allegations revealed no 5 -day investigation was done. During an interview with the Administrator on 4/9/2019 at 11:35am she indicated she was aware of this abuse allegation on 3/16/2019. Review of this report revealed the allegation that the FM stated that resident was abused was faxed to the state on 4/9/2019 at 12:55pm. C. During an interview on April 8, 2019 at 12:30pm with Resident #53 he reported he was talking to a staff member about getting a cell phone and the staff kept interrupting him during their conversation. He reported he was speaking loudly because he didn't hear well, and the staff member started yelling at him. The staff member threatened to call police and throw the resident out of the facility. The staff physically grabbed his	F 607	obtaining confirmation of fax completion and completion of investigation. The questionnaire will be completed 5/12/2019. 5/10/2019, a 100% in-service was completed by the Facility Nurse Consultant with the Administrator, DON, Social Worker in regards to Reporting Abuse and Neglect to include: The facility must initiate an investigative folder for all required state reportable events to include but is not limited to the following: 1. Completion of an initial report, within two hours of the notification of an allegation. The initial report should be faxed to state upon completion and the facility must retain fax confirmation records as proof report was faxed per state requirements 2. Completion of an investigation report, with summary of investigation. 5 day report, summary of investigation and supporting documents should faxed to state upon completion and the facility must retain fax confirmation records as proof report was faxed per state requirements 3. Statements from staff or witnesses 4. In-services related to event 5. Police report if indicated 6. All other documents as related to the investigation If at any time the facility is unable to fax the Initial allegation or investigation report or have issues with fax being received by state, the facility must continue to attempt to fax reports daily until completed and show proof of each attempt. If the facility	

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F 607	Continued From page 30 chair and backed him out of the room. Resident #53 indicated that he reported this information to the Administrator on 3/24/2019. Resident #53 indicated that the Administrator did not believe him. Review of the facility reported abuse allegations revealed no 5- day investigation was done. During an interview with the Administrator on 4/9/2019 at 11:35am she indicated she was aware of this abuse allegation on 3/24/2019, but the Resident was discharged from the Facility. Review of this report revealed the allegation was faxed to the state agency on 4/9/2019 at 1:57pm. An interview with the Administrator on 4/11/20119 at 6:30pm revealed her expectation of the regulations of abuse that the report had to be sent within 2 hours of the allegation.	F 607	is unsure if report was received, the Administrator should contact DHHS to confirm and document the call in the investigative folder. 100% of all alert and oriented residents will be audited by the social workers utilizing the Resident Abuse/Neglect Audit Tool weekly for four weeks then monthly for one month to ensure all allegations reported to the state. All areas of concern will be immediately addressed by the Administrator to include faxing initial allegation and investigation report and obtaining confirmation of fax completion and/or completion of investigation The Administrator, Staff Development Coordinator (SDC) or designee will review and initial the Resident Abuse/Neglect Audit Tool weekly for four weeks then monthly for one month to assure all areas of concern have been addressed. The Administrator, SDC or designee will forward Resident Abuse/Neglect Audit Tool to the Quality Assurance (QA) committee monthly for three months to determine trends and/or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 641	On 04/11/19, Resident #72 was correctly	5/28/19

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record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the provision of an antipsychotic medication for 1 of 5 residents reviewed for Mood/Behavior (Resident #72) and to reflect the use of a wander guard for 1 of 2 residents reviewed for Unsafe Wandering/Elopement (Resident #140).

The findings included:

1. Resident #72 was admitted to the facility on 2/24/17. Her cumulative diagnoses included schizophrenia, Alzheimer ' s disease, anxiety and depression.

A review of Resident #72 ' s physician orders for February 2019 included an order for 50 milligrams (mg) quetiapine (an antipsychotic medication) to be given by mouth twice daily (initiated on 9/10/18). A physician ' s order was also initiated on 2/8/19 for 5 mg / 1 milliliter (ml) haloperidol (an antipsychotic) to be given as 2 mg injected intramuscularly every 8 hours as needed (PRN) for agitation or anxiety for 7 days. The February 2019 physician orders did not include a medication order for insulin.

A review of Resident #72 ' s February 2019 Medication Administration Record revealed the prescribed quetiapine was administered routinely as ordered. Additionally, one dose of haloperidol was administered to the resident on 2/8/19 and one dose was administered on 2/12/19.

A review of Resident #72 ' s annual Minimum Data Set (MDS) assessment dated 2/13/19 was completed. The MDS revealed the resident was assessed by staff to have moderately impaired

changed on the Minimum Data Set (MDS) to reflect that the resident received antipsychotic medication.

On 04/11/19, Resident #140 was correctly changed on the MDS to reflect that the resident had a wander guard.

On 05/08/19, 100% audit of all residents receiving antipsychotic medication and with wander guards was conducted to include Resident #72 and Resident #140 by the Director of Nursing (DON) to ensure that the coding was accurate. Any concerns were immediately corrected by the DON to include modifying the MDS assessment to reflect that residents receiving antipsychotic medications and residents with wander guards are coded correctly.

On 05/08/19, an in-service was initiated by the director of nursing (DON) for all MDS nurses to ensure residents receiving antipsychotic medications and residents with wander guards are coded correctly. The in-service was completed on 5/08/19.

Starting on 5/13/19 the unit manager nurses or designee will review 100% of all residents receiving antipsychotics and all residents with a wander guard will be reviewed to ensure that coding on MDS is accurate weekly for 4 weeks, then monthly for 2 months, utilizing the MDS Coding Accuracy Audit Tool to ensure all coding for residents receiving antipsychotic medications and residents

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F 641	Continued From page 32 cognitive skills for daily decision making. Section E of the MDS indicated the resident exhibited behavioral symptoms not directed towards others on 1-3 days during the 7-day look back period. The behaviors were reported to place the resident at significant risk for physical illness or injury and to significantly interfere with the resident ' s participation in activities or social interactions. Section N of the MDS assessment indicated the resident received two injections and reported two insulin injections were ordered and administered during the 7-day look back period. The assessment noted Resident #72 received an antipsychotic medication 7 out of 7 days and an antipsychotic medication was administered on a routine basis only. An interview was conducted on 4/11/19 at 11:45 AM MDS Nurse #2. During the interview, the nurse reviewed Section N on Resident #72's most recent MDS assessment dated 2/13/19. When asked about the coding of the injections reported on the MDS, the nurse stated she would need to review the resident's chart. An interview was conducted on 4/11/19 at 12:00 PM with MDS Nurse #1. During the interview, the MDS Nurse #1 reported Section N of the MDS assessment for Resident #72 should have been coded to indicate the resident received two injections of haloperidol rather than insulin during the 7-day look back period. The nurse stated, "That was an error." She also reported the MDS assessment should have noted the resident received an antipsychotic medication both on a routine and PRN basis during the 7-day look back period. An interview was conducted on 4/11/19 at 2:10	F 641	with a wander guard are coded correctly. Any areas of concern identified during the review will immediately be addressed to include accurately coding residents receiving antipsychotic medications and residents with a wander guard by the unit manager or designee. The DON will present the findings of the MDS Coding Accuracy Audit Tool to the Quality Assurance (QA) committee monthly for 3 months. The QA Committee will meet monthly for 3 months and review the MDS Coding Accuracy Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	

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F 641	Continued From page 33	F 641		

PM with the facility's Administrator. During the interview, the Administrator reported her expectation was that the residents' MDS assessments would be as accurate as possible.

2. Resident #140 was admitted to the facility on 2/12/19. His cumulative diagnoses included cerebral infarction (stroke) and dementia with behavioral disturbance.

Review of the facility ' s February 2019 Transmitter Testing Log for Resident #140 revealed a wander guard was tested for this resident each day from 2/12/19 through 2/28/19.

A review of Resident #140's care plan included the following area of focus:
--Problematic manner in which resident acts characterized by ineffective coping: Wandering and/or at risk for unsupervised exits from facility related to a new environment, wants to get home to wife (initiated 2/13/19; revised 2/13/19). The care plan interventions included, in part: Check daily to ensure resident has an alarm bracelet on and that it is functioning properly (initiated 2/13/19).

A review of Resident #140's admission Minimum Data Set (MDS) assessment dated 2/19/19 revealed the resident had moderately impaired cognitive skills for daily decision making. Section E of the MDS indicated the resident wandered on 4-6 days out of 7 days. Section P of the MDS assessment reported a wander/elopement alarm was not used for this resident.

An interview was conducted on 4/11/19 at 10:11 AM with Nurse #16. Nurse #16 was the hall nurse assigned to care for Resident #140. During

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F 641	Continued From page 34 the interview, the nurse was asked if this resident had a wander guard in place. The nurse reported she was not sure. At the time of the interview, Resident #140 was sitting in the common area. The nurse was observed as she verified a wander guard was placed on his left ankle. An interview was conducted on 4/11/19 at 12:00 PM with MDS Nurse #1. During the interview, the MDS nurse reported Resident #140 did have a wander guard in place during the 7-day look back period for his admission MDS (dated 2/19/19). She stated, "I missed that...it was a coding error." An interview was conducted on 4/11/19 at 2:10 PM with the facility's Administrator. During the interview, the Administrator reported her expectation was that the residents' MDS assessments would be as accurate as possible.	F 641		
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	F 656		5/28/19

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F 656	Continued From page 35 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 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 observation, staff interview and record review the facility failed to develop a comprehensive care plan that addressed wandering behaviors. This was evident in 1 of 2 sampled residents reviewed for wandering behaviors. (Resident #107). The facility failed to develop a care plan that addressed range of motion for Resident #397 in 1 of 1 residents reviewed for hand contractures. Findings included: 1. Resident #107 was initially admitted to the facility on 3/8/19 with cumulative diagnoses which	F 656	On 4/11/19, the Minimum Data Set (MDS) nurse updated Resident #107 care plan to include wandering behaviors. On 5/9/19, the MDS nurse updated Resident #397 care plan to include range of motion. On 5/9/19, 100% audit of all residents at risk for wandering was completed by the director of nursing (DON) and/or designee to ensure that all residents with wandering behaviors have a comprehensive care plan that addresses wandering behaviors. All areas of concern were immediately	

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F 656	Continued From page 36 included dementia and congestive heart failure. Record review revealed on 3/8/19, a wander risk assessment was completed with a score of 15. A score of 5 or greater deemed the resident at risk for wandering. Review of the Minimum Data Set (MDS) 14 day assessment dated 3/22/19 coded the resident with moderate impaired cognition, fluctuation in disorganized thinking and 4-5 days of wandering behavior. Review of the nurses' progress notes revealed: On 4/5/19 at 3:25 PM resident wandering around the unit into and out of other resident rooms. Attempted to remove items from other resident rooms. On 4/7/19 (? Time) resident into and out of resident rooms. Review of the written care plans dated 2/16/19 revealed no written care plan that addressed Resident #107's wandering behavior. Observation on 04/07/19 at 4:58 PM revealed Resident #107 was wearing a wander guard type leg bracelet on the right ankle. Interview on 04/11/19 at 11:34 AM with Resource Nurse #1 revealed Resident #107 becomes confused, ambulated in the hallways a lot and very easily redirected. Interview on 04/11/19 at 12:58 PM with MDS Coordinator #1 who stated she just missed the development of the written care plan that addressed Resident #107 for wandering	F 656	addressed by the DON and/or designee and the MDS nurse to include updating the care plan for wandering behavior. Audit was completed on 5/10/19. On 5/9/19, 100% audit of all residents with hand contractures was completed by the DON and/or designee to ensure that all residents with hand contractures have a comprehensive care plan that addresses range of motion. All areas of concern were immediately addressed by the DON and/or designee and the MDS nurse to include updating the care plan for range of motion. Audit was completed on 5/10/19. On 5/10/19, 100% in-service was initiated by the corporate nurse consultant and the administrator with all members of the interdisciplinary care plan team to include but not limited to the dietary manager, Minimum Data Set (MDS) nurses, social services director, admissions coordinator, activities director, restorative nurses and unit managers) on the requirements for completing a comprehensive care plan for each resident to include, but not limited to residents with wandering behaviors and residents with contractures. An audit will be completed of 10% of all resident□s at risk for wandering to include resident #107 by the DON and/or designee utilizing the Care Plan Audit Tool weekly for four weeks and then monthly for one month to ensure all residents at risk for wandering have a comprehensive care plan that includes wandering behaviors and interventions for wandering behaviors. All areas of concerns will be immediately addressed by the DON and/or designee and the MDS nurse to	

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F 656	Continued From page 37 behavior. Interview on 4/11/19 at 2:10 PM the Administrator stated she expected the care plans to be accurate and in "real time (referring to reflecting resident's current needs)". 2. Resident #397 was admitted to the facility on 10/4/18 with diagnoses that included persistent vegetative state, anoxic brain damage, and intracranial injury. A review of Resident #397's most recent MDS (Minimum Data Set) coded as a quarterly assessment and dated 1/11/19 revealed the resident was cognitively impaired. Active diagnoses included Aphasia, respiratory failure, persistent vegetative state, anoxic brain damage, and intracranial injury. The MDS section for restorative nursing program regarding splint or brace assistance was blank. Resident #397's functional status revealed that the resident had limitation in range of motion upper extremity (shoulder, elbow, wrist, hand) with impairment on both sides. A review of Resident #397's current care plan dated 1/29/19 revealed the resident was not care planned for limitation in range of motion or contractures. An observation was made on 4/8/19 at 1:00 pm of Resident #397. It was observed that Resident #397 had contractures of both hands. An interview was conducted with MDS #1 on 4/11/19 at 1:10 pm. She reported it was her responsibility to develop and implement care plans to include all care areas pertinent to the residents. She reported she should have care	F 656	include updating care plan and retraining of staff as indicated. The DON will review and initial the Care Plan Audit Tool weekly for four weeks and then monthly for one to ensure any areas of concern have been addressed. An audit will be completed of 10% of all residents with hand contractures to include resident #397 by the DON and/or designee utilizing the Care Plan Audit Tool weekly for four weeks and then monthly for one month to ensure all residents with hand contractures have a comprehensive care plan that includes range of motion and interventions to prevent further contractures. All areas of concern will be immediately addressed by the DON and/or designee and the MDS nurse to include updating care plan and retraining of staff as indicated. The DON will review and initial the Care Plan Audit Tool weekly for four weeks and then monthly for 1 month to ensure any areas of concern have been addressed. The DON and/or designee will forward the results of the Comprehensive Care Plan Audit Tool to the Quality Assurance Committee monthly for two months. The Quality Assurance Committee will meet monthly for two months and review the Comprehensive Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100%	

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F 656	Continued From page 38 planned range of motion on Resident #397's care plan. An interview was conducted with the Administrator on 4/11/19 at 6:00 pm. She reported it was the responsibility of the MDS nurses to develop and implement individualized and complete care plans for each resident. She reported it was her expectation that every resident would have individualized, and complete care plans developed and implemented.	F 656	audits, in-services, and monitoring related to the plan of correction.	
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	F 657		5/28/19

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F 657	Continued From page 39 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record reviews, the facility failed to review and revise the care plan to accurately reflect the eating assistance required for 1 of 9 residents reviewed for Nutrition (Resident #60); and, failed to address the use of anticoagulant, antidepressant, and antianxiety medications for 1 of 6 residents reviewed for Unnecessary Medications (Resident #82). The findings included: 1. Resident #60 was admitted on 5/19/17 with re-entry to the facility on 7/23/17. Her cumulative diagnoses included non-Alzheimer ' s dementia, Parkinson ' s disease, and dysphagia. A review of Resident #60 ' s most recent Minimum Data Set (MDS) assessment dated 2/8/19 was completed. The MDS revealed the resident had severely impaired cognitive skills for daily decision making. Section G of the MDS indicated the resident required extensive assistance for bed mobility, transfers, walking in room, locomotion on the unit and dressing. She was reported to be totally dependent on staff for eating, toileting, and personal hygiene. A review of the facility ' s electronic records for the eating assistance provided to Resident #60 ' s from the 7-day look back period for the 2/8/19 MDS (2/2/19 - 2/8/19) was reviewed. Documentation on the electronic records indicated Resident #60 was totally dependent on	F 657	On 4/11/19, Resident #60 care plan was reviewed and revised by the facility Minimum Data Set (MDS) nurse to reflect the eating assistance required for the resident. On 4/9/19, Resident #82 care plan was reviewed and revised by the facility MDS nurse to reflect the use of anticoagulant, antidepressant and antianxiety medications. On 5/9/19, a 100% audit of all residents that require assistance with eating to include Resident #60 and residents that use anticoagulant, antidepressant and antianxiety medications to include Resident #82, was conducted by the director of nursing (DON), staff facilitator, activity director, and facility social workers 0to ensure that all areas of the care plan reflect the resident□s individual needs The audit was completed on 5/10/19. Any concerns were immediately addressed by the DON, staff facilitator, activity director and facility social worker to include updating the care plan to reflect residents that require assistance with eating and residents that use anticoagulant, antidepressant, and antianxiety medications. On 5/8/19, an in-service was initiated by the staff facilitator with all nurses in regards to Updating and Revising Care Plans that includes but is not limited to reviewing and revising the care plan for	

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F 657	Continued From page 40 staff for eating all meals recorded during this period of time. The dates in the paragraph below are confusing. A review of Resident #60 ' s current comprehensive care plan included the following areas of focus: --Requires assistance/potential to restore or maintain maximum function of self-sufficiency for eating related to cognitive deficit; poor attention span (initiated 6/1/17; revised on 6/5/17). The goals for this area of focus included: "Resident will feed self 75 % (percent) of each meal daily with prompting from staff by next review" (initiated on 6/1/17; revised on 4/1/19); Will maintain adequate nutrition through next review (initiated 6/5/17; revised on 4/1/19). The care plan interventions for this area of focus included the following, in part: --Staff to set up tray for resident each meal (initiated 6/1/17); --Assist resident with eating if resident needs assistance (initiated 6/1/17; revised 6/1/17); --Eating: provide intermittent encouragement and physical assist (initiated 6/1/17). A review of Resident #60 ' s electronic medical record included a Dietary note dated 4/1/19. The note reported the resident ' s eating ability as "Total assistance." An observation was conducted on 4/7/19 at 6:00 PM of the evening meal on Resident #60 ' s hall. Resident #60 was observed to be fed by staff. The resident did not attempt to eat or drink by herself during the observation. A mealtime observation was conducted of Resident #60 on 4/9/19 at 12:24 PM. The	F 657	each resident change, including residents that require assistance with eating and residents that use anticoagulant, antidepressant and antianxiety medications. The in-service will be completed by 00/00/00. All newly hired nurses will be in-serviced by the staff facilitator on Updating and Revising Care Plans during orientation. An audit will be completed of 10% of all resident□s care plans, including care plan for Resident #60, Resident #82, residents that require assistance with eating and residents that use anticoagulant, antidepressant and antianxiety medications by the DON and/or designee utilizing the Care Plan Audit Tool weekly for four weeks, then monthly for 1 month to ensure that the care plan is revised and updated for the resident to reflect changes in assistance required for eating and/or care plan is revised and updated to reflect medications. All areas of concern will be immediately addressed by the DON and/or designee to include revising and updating the care plan and retraining of staff as indicated. The DON will review and initial the Care Plan Audit Tool weekly for four weeks and then monthly for one month to ensure any areas of concern have been addressed. The DON will forward the results of the Care Plan Audit Tool monthly for two months. The Quality Assurance (QA) committee will meet monthly and review the Care Plan Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring for two	

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resident was observed to be fed by staff. The resident did not attempt to eat or drink by herself during the observation.

An observation was conducted on 4/10/19 at 12:30 PM during mealtime on Resident #60 ' s hall. Resident #60 was observed to be fed by staff. The resident did not attempt to eat or drink by herself during the observation.

An interview was conducted on 4/11/19 at 11:35 AM with MDS Nurse #2. During the interview, the nurse reviewed Resident #60's care plan related to her need for eating assistance. She also reviewed the 2/8/19 MDS assessment which indicated the resident was totally dependent on staff for eating. When asked about the discrepancy between the information coded on the most recent MDS and the current care plan, Nurse #2 stated, "You're probably correct, it needs to be updated." Upon further inquiry as to whether the resident ' s care plan provided an accurate picture of the resident and her eating abilities, the MDS nurse stated the care plan, "Needed to be re-worded."

An interview was conducted on 4/11/19 at 12:00 PM with MDS Nurse #1. During the interview, the MDS nurse reported she had reviewed Resident #60 ' s care plan with regards to her need for assistance with eating. MDS Nurse #1 stated the resident ' s care plan should say, "Pretty much total assist with everything (including eating) at this time." The MDS nurse reported Resident #60 had declined since the care plan was last revised two years ago.

An interview was conducted with the Administrator on 4/11/19 at 6:00 PM. During the

months.

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interview, the Administrator reported it was the responsibility of the MDS nurses to update care plans for the residents. She reported it was her expectation that all care plans were updated when there were any changes in the residents ' care areas.

2. Resident #82 was admitted to the facility on 11/29/18 with diagnoses that included paraplegia, neurogenic bladder, and pain syndrome.

A review of Resident #82's most recent MDS (Minimum Data Set) assessment coded as a quarterly assessment was dated 2/18/19. Resident #82 was coded as cognitively intact. Active diagnoses included neurogenic bladder, paraplegia, anxiety, depression, and chronic pain syndrome. Resident #82's medication look back period revealed the resident received antianxiety medications 7 out of 7 days, antidepressant medications 7 out of 7 days, anticoagulant medication 7 out of 7 days, antibiotics 3 out of 7 days, and opioids 7 out of 7 days.

A review of Resident #82's current care plan dated 3/21/19 revealed the resident was not care planned for anticoagulant medications, antidepressant medications, and antianxiety medications.
A review of Resident #82's February 2019 Medication Administration Record revealed the resident received Xanax 1 mg (milligram) twice daily for anxiety, Zoloft 50 mg daily for depression, and Eliquis 2.5 mg twice daily as anticoagulant.

An interview was conducted on 4/8/19 at 12:02

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F 657	Continued From page 43 pm with MDS #2 nurse. She reported it was her responsibility to update and implement all residents care plans based on the MDS assessments. After reviewing the 2/18/19 MDS assessment and care plan for Resident #82, MDS #2 reported she overlooked care planning the anticoagulants, antianxiety, and antidepressant medications. An interview was conducted with the Administrator on 4/11/19 at 6:00 pm. She reported it was the responsibility of the MDS nurses to update care plans for the residents. She reported it was her expectation that all care plans were updated when there were any changes in the resident's care areas.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review nd staff interview the facility failed to thoroughly cleanse Resident #39's perineal area after a urinary incontinence episode. The facility failed to apply a protective barrier cream to the skin of Resident #39. This was evident in 1 of 5 residents reviewed for activities of daily living. Findings included: Resident #39 was readmitted to the facility on 10/23/16 with cumulative diagnoses which included dementia and tardive dyskinesia.	F 677	On 4/10/19, Resident #39 was provided perineal care utilizing appropriate technique by the assigned nursing assistant. On 4/10/19, the unit manager in-serviced Nursing Assistant #10 (NA) in regards to Perineal Care to include providing incontinent care in a front to back manner. With return demonstration by the unit manager. On 05/10/19, a 100% Resident Care Audit of Incontinent Care to include NA #10 and Resident #39, was initiated by the	5/28/19

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(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 677	Continued From page 44 Record review of the quarterly Minimum Data Set (MDS) dated 1/26/19 coded Resident #39 as having moderately impaired cognition, total dependence of 2 staff for bathing, extensive assistive of 2 staff for toileting and incontinent of bowel and bladder. Review of the care plan goal and interventions last revised on 5/31/17 with a target date of 4/14/19 for review included that included incontinence and perineal care after each incontinent episodes or toileting and application of a protective barrier cream. Observation of perineal care on 4/10/19 at 2:38 PM performed by Resource Nurse (RN) #2 and Nursing Assistant (NA) #10 was conducted. The resident's brief was removed, and the resident had begun to experience an episode of urinary incontinence. The urine had wet the fitted sheet and under pad. NA #10 cleansed Resident #39's groin with a pre-moistened wipe but did not open the resident's legs to cleanse her perineal area. Resident # 39 was repositioned on her left side and her buttocks and rectal areas were cleansed. A clean brief was then placed on the resident. No protective barrier cream was applied. Interview on 04/10/19 at 2:55 PM with NA #10 who stated Resident # 39 was not agitated today like usual. NA #10 further stated, "I am not sure why I did not open her legs to do incontinent care." Interview on 04/10/19 at 3:13 PM with Resource Nurse #2 stated resident was not agitated today during incontinence care and her expectation was Resident # 39's perineal area be cleansed during incontinence care. Resource Nurse #2 indicated	F 677	staff facilitator, and the unit managers with all nurses and NAs that provide direct patient care to ensure staff are utilizing appropriate technique when providing perineal care. All areas of concern were immediately addressed by the staff facilitator and the unit managers to include retraining of staff. Resident care audits will be completed by 5/28/19. On 5/10/19, a 100% in-service was initiated by the staff facilitator with all nurses and NAs including NA #10 in regards to Perineal Care to include: 1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area 4. Wash perineal area with soap and water or peri-care products a. For the female resident: cleanse the labia with strokes from top to bottom then rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean gloves before continuing care 8. Apply clean brief/clothes 9. Make resident comfortable In-service will be completed by 5/28/19. All newly hired nurses and NAs will be in-serviced by the staff facilitator during orientation. 10% Resident Care Audits of incontinent care will be completed by the staff facilitator and unit manager nurses and NAs to include the NA #10 and Resident #39 utilizing the Resident Care Audit	

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F 677	Continued From page 45 protective barrier cream was not applied because the resident's skin was intact.	F 677	Tool-Incontinent Care to ensure staff are utilizing appropriate technique when providing perineal care weekly for eight weeks, then monthly for one month. The Director of Nursing (DON) will review and initial the Resident Care Audit Tool-Incontinent Care weekly for eight weeks then monthly for one month to ensure all areas of concern were addressed. The DON will forward the results of the Resident Care Audit Tool-Incontinent Care to the Quality Assurance (QA) Committee monthly for three months. The QA Committee will meet monthly for three months and review the Resident Care Audit Tool-Incontinent Care audit results to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		5/28/19

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F 688	Continued From page 46 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide restorative range of motion to prevent further contractures to 1 out of 1 residents (Resident #397) with hand contractures. Findings include: Resident #397 was admitted to the facility on 10/4/18 with diagnoses that included persistent vegetative state, anoxic brain damage, and intracranial injury. A review of Resident #397's most recent MDS (Minimum Data Set) coded as a quarterly assessment and dated 1/11/19 revealed the resident was cognitively impaired. Active diagnoses included Aphasia, respiratory failure, persistent vegetative state, anoxic brain damage, and intracranial injury. The MDS section for restorative nursing program regarding splint or brace assistance was blank. Resident #397's functional status revealed that the resident had limitation in range of motion upper extremity (shoulder, elbow, wrist, hand) with impairment on both sides. A review of Resident #397's current care plan dated 1/29/19 revealed the resident was not care planned for limitation in range of motion or contractures. An observation was made on 4/8/19 at 1:00 pm of	F 688	F688 On 4/10/19, a therapy referral was placed by the Minimum Data Set (MDS) nurse for Resident #397 to evaluate/treat hand contractures. On 4/12/19, therapy was initiated and bilateral hand splints and elbow extension splint were ordered for Resident #397. On 5/8/19, a 100% audit of all residents to include Resident #397 was initiated by the restorative nurse to identify any resident with contractures or risk for contractures. A therapy referral will be immediately initiated by the restorative nurse for any identified concerns during the audit. Audit will be completed by 5/9/19. On 5/8/19, a 100% audit of resident progress notes to include resident #397 for the past 30 days was initiated by the restorative nurse to identify any resident with decreased mobility and/or risk for contractures. All areas of concern will be immediately addressed by the restorative nurse to include initiating a therapy referral, assessment of the resident, and notification of MD/RR. The audit will be completed by 5/9/19. On 5/8/19, a 100% staff questionnaire	

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F 688	Continued From page 47 Resident #397. It was observed that Resident #397 had contractures of both hands with no splints noted on hands. An observation was made on 4/9/19 at 5:30 pm of Resident #397. The resident's hands were noted to be contracted into fists with no splint or apparatus noted in hands. No odor was noted and nails trimmed. An observation was made on 4/10/19 at 10:00 am of Resident #397. It was observed that the resident's hands were contracted into fists with no splint or restorative device in place. An interview was conducted on 4/10/19 at 11:42 am with the Rehab Manager. She reported that when Resident #397 was admitted to the facility, his diagnoses were adult failure to thrive and vegetable state. She reported a therapy referral was not ordered. She reported this resident had not been referred to therapy. An interview was conducted on 4/10/19 at 12:40 pm with Nurse #13. She reported that if a resident had contractures, then the staff would apply splints and if the resident did not have splints, rolled washcloths would be applied. She reported she had never seen Resident #397 with splints or rolled washcloths in his hands. An observation was made on 4/10/19 at 4:30 pm of Resident #397 lying in bed with hands contracted into fists with no splint or restorative device noted in hands. An interview was conducted on 4/10/19 at 7:55 pm with Resource Nurse #2. She reported that any resident that was admitted to the facility with	F 688	was initiated by the restorative nurse and/or staff facilitator with all nurses, therapy director, therapy staff and nursing assistants in regards to resident with contractures or at risk for contractures to include: (1) Do you know of any resident who has a decrease or decline in mobility? (2) If yes, who and who did you report it too? (3) Do you know of any resident who has contractures? (4) If yes, who and who did you report it too? (5) Do you know of any resident with contractures that does use splints? (6) If yes, who? All areas of concern will be immediately addressed by the restorative nurse to include therapy referral as indicated and obtaining appropriate mobility equipment. Questionnaires will be completed by 5/28/19. On 5/8/19, a 100% in-service was initiated by the staff facilitator and/or restorative nurse with all nurses, therapy director, therapy staff and nursing assistants in regards to residents with contractures or at risk for contractures to include: (1) All residents admitted with decreased mobility, contractures or at risk for contractures must be referred to therapy by nursing staff for further evaluation and treatment to maintain or improve mobility or Range of Motion and prevent contractures (2) If a resident has a decline in mobility to include decrease in range of motion, the nurse must notify the physician, place therapy referral as indicated and update the resident representative. (3) If a resident is receiving restorative therapy, the nurse	

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F 688	Continued From page 48 contractures would have rolled washcloths or splints put in their hands. She reported the staff would do range of motion with residents or the resident would be referred to restorative nursing or therapy. The Resource Nurse #2 reported Resident #397's family does range of motion when they visited. She reported she thought staff should be performing range of motion but could not produce any documentation of staff performing range of motion or if any rolled washcloths were put in the resident's contracted hands. She reported Resident #397 had not received any therapy. An interview was conducted on 4/10/19 at 8:00 pm with NA (Nursing Assistant) #14. She reported no one had told her anything about splints or range of motion for Resident #397. An interview with the Administer was conducted on 4/11/19 at 6:00 pm. She reported it was her expectation that any resident with contractures would receive a therapy referral for range of motion and/or splints.	F 688	must ensure therapy is completed by the restorative aide as ordered/recommended with documentation in the electronic record. (4) Splints must be applied per plan of care and skin checks completed by nursing staff (5) If a resident has decreased mobility of the hands and does not have an order for splints, nursing staff should place hand rolls to prevent contractures. The in-service will be completed by 5/28/19. All newly hired nurses, therapy director, therapy staff and nursing assistants will be in-serviced during orientation by the staff facilitator in regards to residents with contractures or at risk for contractures. A 10% audit of all residents to include Resident #397 will be completed by the restorative nurse utilizing the Mobility Audit Tool weekly for eight (8) weeks, then monthly for one (1) month to ensure all residents with decreased mobility, contractures or at risk for contractures to include Resident #397 has been assessed, therapy referral placed when indicated and preventative measures initiated. Any areas of identified concern will be immediately addressed by the restorative nurse during the audit to include assessment of resident, therapy referrals as indicated, obtaining appropriate mobility equipment and education of staff. The director of nursing (DON) will initial the Mobility Audit Tool weekly for eight (8) weeks, then monthly for one (1) month to ensure all areas of concern were addressed.	

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F 688	Continued From page 49	F 688	The restorative nurse will ensure that 10% of all nurses, therapy staff and nursing assistants will complete the Staff Mobility Questionnaire weekly for eight (8) weeks, then monthly for one (1) month to identify any residents with decreased mobility, contractures or risk for contractures. All areas of concern will be immediately addressed by the restorative nurse. The DON will initial the Staff Mobility Questionnaire weekly for eight (8) weeks, then monthly for one (1) month to ensure all areas of concern were addressed. The administrator will forward the results of the Mobility Audit Tool and the Staff Mobility Questionnaire to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will meet monthly for three (3) months and review the Mobility Audit Tool and the Staff Mobility Questionnaire to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		5/28/19

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F 725	Continued From page 50 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide sufficient nursing staffing to provide incontinence care for 2 of 7 dependent residents who alerted two different staff members that they were soiled and needed assistance. (Resident #134, and Resident #122). The facility failed to honor Resident #47 choice to be out of bed daily in 1 of 3 resident reviewed for choices. The facility failed to prevent physical and verbal abuse to Resident #129 in 1 of 7 residents reviewed for abuse. Findings Included: This tag was cross-referred to F 550 Based on observations, resident and staff	F 725	F725 On 4/9/19, the nursing assistant (NA) assisted Resident #47 out of bed. On 4/10/2019, the NA assisted Resident # 134 and Resident # 122 with activities of daily living (ADL). On 4/10/19, the administrator reviewed the daily staff sheet and determined there was sufficient staffing to meet resident needs. The administrator and designees encouraged the NAs to ask for assistance as needed. By 4/10/19, the administrator began offering shift bonuses for NAs, licensed practical nurses (LPN), and registered	

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F 725	Continued From page 51 interviews the facility failed to provide timely incontinence care for residents that advised 2 different staff members that they were soiled and needed assistance. This resulted in the residents feeling ignored and angry. (Resident #134 and Resident #122). F 561 Based on observations, staff and resident interviews, and record review the facility failed to get an alert and oriented resident out of bed according to her choice for 1 of 3 residents reviewed for choices (Resident #47). F600 Based on record reviews, resident, family, nurse practitioner and staff interviews, the facility failed to prevent physical and verbal abuse for 1 of 7 residents reviewed for abuse (Resident #129). During the provision of care, a staff member was heard and observed yelling at a resident to stand up even though the resident was assessed to not have the ability to stand without staff assistance. The resident grabbed the staff member to prevent falling and the staff member responded by shaking the resident. Following the incident, the resident complained of increased pain. Pain medication was changed from as needed to routine administration. An interview with Nurse #51 on 4/10/19 at 2:30pm revealed that the facility was short of staff on the weekdays and weekends. Nurse #51 indicated she had observed only one NA assigned per hall and had reported this information to Administrator on many occasions. Nurse #51 also revealed an incident were one resident was left on her bed pan for over 4 hours. An interview with Nurse #28 on 4/11/19 at 12:30pm revealed he felt that the facility was	F 725	nurses (RN). The administrator also began offering sign-on bonuses. The administrator verified that online recruitment posting was still active. On 4/10/19, the administrator verified the facility had current contracts with staffing agencies. On 5/12/19 the administrator will in-service the director of nursing, and scheduler on staffing expectations including ensuring the schedule is reviewed for adequate staffing patterns. The in-service was completed by 5/12/19. In an effort to reduce burnout in staff to avoid care not being provided and the yelling and inappropriate response by staff the facility will monitor and/or limit the amount of shift pickups by staff, offer rest days if staff show signs of burnout, rounding and speaking with residents about their care, continue to hire new employees, continue to advertise for new staff via various mediums (such as NC Works, indeed, and the chamber of commerce), and to use consistent agency to make sure that employees get a repose from work and residents have consistent staff as well. The DON, scheduler and/or the administrator will audit the daily staffing for 8 weeks. This will be documented on the F725 Monitoring Tool. The administrator will present the findings and trends of the F725 Monitoring Tool to	

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F 725	Continued From page 52 short staffed, and this has been reported many times. Nurse #28 indicated they continued to work short of staff daily. Nurse #28 stated he was the only Nurse on the hall today. An interview with NA #9 on 4/11/19 at 4pm revealed she been working at the facility for 4 months. NA #9 revealed that during the 3pm-11pm shift she had anywhere from 20 to 26 residents during the day. She stated this week had been great because she only had about 10 to 12 residents and this was workable for her. NA indicated it was very hard to provide great care for residents if there was on 1 NA to 20 residents or more. She added the residents had suffered daily because of the staffing shortage in the facility. NA #9 also revealed the Administrator and the DON were aware of this situation. NA #9 indicated she had worked double shifts because of the staffing issues with this building. NA #9 indicated she loved her job and just wanted to have extra help. An interview with the Administrator 4/12/19 at 12:09 pm revealed it was her expectation to provide sufficient staff to meet the needs of the residents.	F 725	the Quality Assurance and Performance Improvement (QAPI) committee monthly for three (3) months for further recommendations.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		5/28/19

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F 757	Continued From page 53 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and nurse practitioner interviews, the facility failed to discontinue Lasix administered once daily to Resident #101 after she was evaluated in the Emergency Department (ED) for dehydration and a physician's order was received to change the medication to be given on an as needed (PRN) basis. This was evident for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #101 was admitted to the facility on 02/02/2019 with cumulative diagnoses which included Alzheimer's disease and hypertension. Review of the physician orders included Lasix 20 milligrams (mg) by mouth (po) daily with a start date of 2/2/19. Lasix is a drug used to remove excessive fluid from the body. Review of the Medication Administration Record (MAR) revealed the drug was scheduled to be administered at 9 AM daily.	F 757	On 5/10/19, the administrative nurses audited all resident medication administration records for as-needed diuretics. Any as needed diuretic 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. Beginning 5/12/19, the Staff development coordinator (SDC) will initiate an in-service with licensed nurses, incusing agency, on as-needed diuretic medication duration. This in-service should end on 5/28/19 This in-service will be part of the orientation for new licensed nursing staff,	

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F 757	Continued From page 54 Review of the progress notes revealed: On 3/12/19 at 3:57PM Resident #101 was transferred to hospital emergency room from the facility. On 3/13/19 Resident #101 returned to the facility at 3:15 PM with cumulative diagnoses which included dehydration, sinus tachycardia and treated with intravenous fluids. Review of the ED hospital discharge after visit summary form revealed: " The primary diagnoses were dehydration, heart failure and sinus tachycardia. " Under section for "instructions" How you take Lasix "has changed." "Review your updated medication list below." Review of the medication list noted below included a change of when to take and reasons to take Lasix. " Under Section Discharge Medication List "continue these medications which has changed" Lasix 20 mg. Take 1 tablet (20 mg total) by mouth daily prn for swelling or other edema. " Under the section "continue these medications which have not changed" did not include Lasix 20 mg daily to be continued. Review of the physician orders revealed a verbal order dated 3/13/19 for Lasix 20 mg daily prn for swelling or other edema. Review of the March and April MAR revealed Lasix 20 mg po daily prn for swelling and other edema was transcribed onto the record. The previous order for daily Lasix 20 mg at 9 AM had not been discontinued on the MAR. Unsuccessful attempts were made to contact Nurse #28 (who obtained the verbal order and transcribed the order onto the MAR). Review of the MAR revealed Resident #101 was administered Lasix 20 mg po daily at 9 AM from 3/14/19 until 4/10/19. Progress notes revealed from 3/14/19 until	F 757	including agency. 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.	

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F 757	Continued From page 55	F 757		

4/10/19 there were no assessments that Resident #101 had swelling or any type of edema.
Interview and record review on 4/11/19 at 1:25 PM with Nurse #12 (nurse who was assigned to Resident #101 frequently) initialed he administered Lasix 20 mg po at 9 AM on 3/19, 22-26, 28/19 and 4/4/19 and 4/7/19. Nurse #12 stated the daily routine dose of Lasix should have been discontinued (D/C).

Interview on 4/11/19 at 2:10 PM with the Administrator stated an expectation that the Lasix should have been discontinued but administering the drug caused no harm.
Interview and record review of the hospital discharge summary on 4/11/19 at 2:30 PM with the Nurse Practitioner (NP) in the presence of the Administrator was completed. The NP stated even though the Lasix was given, no harm came to Resident #101. When an inquiry was made about the D/C of the routine Lasix dosage she indicated the discharge summary did not state the word "discontinue"
Interview on 4/11/19 at 5:18 PM with Nurse #13 who stated she initialed the administration of Lasix 20 mg on 3/30/19 and 4/5/19 because " I depended on the person who transcribes it on the MAR because I am unable to check every medication with the physician orders. "
Record review revealed the facility used two (2) different nurse agency staff. Nurse #20 (who administered Lasix 40 mg po on 3/16/19) worked for Nurse Agency #1. Attempts to contact Nurse #20 were unsuccessful.
Interview via the phone on 4/15/19 at 8:19 AM with Nurse #11 (who initialed the administration of the daily routine Lasix 20 mg po on 3/27/19 and 4/3/19) stated she could not recall Resident #101 or the administration of any medication to the

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F 757	Continued From page 56 resident. Attempts to interview staff who administered the daily Lasix on 3/17, 18, 21, 29/19 and 4/1, 4/2, 4/6, 4/8. 4/9/19 were unsuccessful.	F 757		
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 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 discard food that was expired, date food that was open and failed to allow dishware to air dry before being stacked and placed on the tray line for use. This was evident in 1 of 1 kitchen observations. Findings included: An observation of the kitchen was completed on	F 812	On 4/7/2019, the dietary staff discarded all items that were not properly dated or labeled. This task was completed on 4/17/19. On 4/7/19, the dietary staff removed from service all items that were wet nesting. The items were washed again and placed on a drying rack to dry completely before use. This task was completed on 4/17/19. On 4/25/19, the dietary manager initiated	5/28/19

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F 812	Continued From page 57 4-7-19 at 3:45pm with the weekend dietary supervisor revealed the following: 1. 96 plastic rectangle bowls were stacked together wet and placed on the tray line ready for use. 2. 1 - 5-pound tub of peanut butter was noted to be open without an open or expiration date. 3. 1 - 2-pound bag of hush puppies was noted to be open without an open date or expiration date. 4. 40 assorted 4-ounce containers of yogurt were noted to have an expiration date of 3-12-19. The case the yogurt came in had an open date of 4-6-19 and there were approximately 20 yogurts missing from the case. The supervisor was noted to discard the yogurt. During an interview with the weekend dietary supervisor on 4-7-19 at 4:00pm, She stated she was unaware the bowls on the tray line were wet and they were to be used during the dinner meal service. She also stated she was not sure why the peanut butter and hush puppies were not dated "I only work the weekends and did not know the items were not dated." The supervisor stated the kitchen staff had provided the yogurts to residents on 4-6-19 and 4-7-19 but did not know what residents or which meal. The Dietary Manager was interviewed on 4-7-19 at 4:30pm. The Dietary Manager stated she was unaware of the issues in the kitchen and expected food that had been opened to have an open and expiration date, dishware to be stacked dry and expired food discarded.	F 812	proactive in servicing to the dietary staff. The in service included the requirement to 1. Discard food that is expired, 2. Date food that is opened, 3. Allow dishware to air dry before being stacked and placed on the tray line for use. The in service was completed on 5/21/19. By 4/25/19, the dietary manager or designee began completing audits utilizing the Dietary Audit Tool. The tool will ensure 1. Discard food that is expired, 2. Date food that is opened, 3. Allow dishware to air dry before being stacked and placed on the tray line for use. The Dietary Audit Tool will be completed five (5) days a week for four (4) weeks then two (2) days a week for eight (8) weeks. The corrective action will be completed in three (3) months. The dietary manager or designee will present the Dietary Audit Tool results and trends to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor the results of the Dietary Audit Tool for three (3) months. The committee will make recommendations regarding the need for continued monitoring.	
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		5/28/19

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F 814	Continued From page 58 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep the dumpster doors closed and maintain the area surrounding the dumpster free from trash and debris. This was evident in 2 of 2 dumpsters. Findings included: During an observation of the dumpster area on 4-9-19 at 2:20pm with the Assistant Dietary Manager, the dumpster area was noted to have a trash dumpster #1 and a card board dumpster #2. Dumpster #1 was noted to have plastic gloves, pieces of paper and cardboard around the base of the dumpster and dumpster #1's doors were not closed. Dumpster #2 was noted to have a broken compressor, a broken plastic cart, 2 broken wheelchairs and 2 broken decorative metal pieces on the ground and dumpster #2's lid was not closed. The Assistant Dietary Manager was interviewed on 4-9-19 at 2:20pm. The Assistant Dietary Manager stated when a member of the kitchen staff empty's the trash they are supposed to pick up any trash around the dumpster and make sure the doors are closed. She also stated the larger items in the dumpster area belonged to maintenance and she was not aware of who or when large items are removed. An interview with the maintenance manager occurred on 4-9-19 at 2:30pm. The maintenance manager stated he was aware of the items in the dumpster area and that he had a gentleman he	F 814	On 4/12/19, maintenance staff properly closed the dumpster door and removed trash and debris from the surrounding dumpster area. The initial audit was completed on 4/12/19. On 4/25/19, the dietary manager provided proactive in servicing to the dietary, housekeeping, and maintenance department staff. The proactive in servicing included the requirement to ensure clutter and debris are not housed at dumpster. The in-service was completed by 5/21/19. Beginning on 4/12/19, the dietary manager or designee will complete audits utilizing the Dumpster Audit Tool. The tool will ensure 1. Dumpster doors are closed tightly, 2. There is no excess debris, trash or equipment stored around the dumpster, 3. Any corrective action taken. Corrective actions will be immediately addressed by the auditor. The Dumpster Audit Tool will be completed five (5) days a week for four weeks, then three (3) times a week for eight weeks. The corrective action will be completed in three (3) months. The dietary manager or designee will present the Dumpster Audit Tool results and trends to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor the results of the Dumpster Audit Tool for three (3) months. The committee will make recommendations regarding the	

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F 814	Continued From page 59 called to come and remove large items. He stated he did not have a specific schedule of when he called the gentleman, but he would call him today (4-9-19) to have the items removed. The dumpster area was observed on 4-11-19 at 3:40pm and revealed the broken plastic cart and the 2 decorative metal pieces remained at dumpster #2. The maintenance manager was not available for a second interview. The Administrator was interviewed on 4-11-19 at 5:30pm. The Administrator stated she did not know why the other large items were not removed but she would speak with the maintenance manager when he returned to have the items removed. She also stated she expected the dumpster area to remain free of trash and debris.	F 814	need for continued monitoring.	