STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	**2578 WEST FIFTH STREET GREENVILLE, NC 27834**

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E 000	Initial Comments An unannounced Recertification survey was conducted on 6/10/19 through 6/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KYU511.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID # KYU511. The survey team entered the facility on 06/10/19 to conduct a recerrification and complaint survey and exited on 06/13/19. Additional information was obtained on 07/1/19. Therefore, the exit date was changed to 07/1/19.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		7/12/19

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

Electronically Signed | 07/12/2019

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident representative interview, physician and staff interview the facility failed to have updated code status information available in the medical record for 1 of 32 residents (Resident #37) reviewed for advanced directives. The findings included: Resident #37 was re-admitted to the facility on 5/07/19 with diagnoses including urinary tract infection, kidney stone and chronic pain among others. Resident #37's medical record contained a yellow Do Not Resuscitate Order at the front of her chart with the effective date of 5/7/19 and box, checked	F 578	Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility executive director, the facility failed to verify the resident #37's code status upon return from the hospital and did not have updated paperwork signed by resident showing a discrepancy from hospital paperwork and previous information in resident's medical record. Immediate Actions On 6/13/19 all conflicting code status information removed from resident #37's chat and resident's code status was verified and proper paperwork was signed by resident and placed in the chart on 6/17/19.	

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F 578	Continued From page 2 no expiration, signed by the hospital physician. Resident #37's skilled nursing facility face sheet dated 5/7/19 indicated she was a Full Code. No "No Code Agreement" form between Resident #37 and the skilled nursing facility dated 5/7/19 was found in her record. Review of a 60-day nursing home note dated 5/9/19 written by Resident #37's skilled nursing facility attending physician indicated her code status was Do Not Resuscitate. No physician's Do Not Resuscitate Order for May 2019 was found in Resident #37's medical record. On 6/12/19 at 3:10 PM during an interview with Nurse #4 she indicted if she needed to know their code status she would check their face sheet. She further indicated Resident #37 had been sent out to the hospital that morning and was not available for interview. On 6/12/19 at 5:00 PM in an interview, the Director of Nursing (DON) indicated the yellow Do Not Resuscitate (DNR) form should have been removed from Resident #37's chart and shredded. She further indicated the DNR came from the hospital and was not valid in the skilled nursing facility. She went on to say that all residents admitted to the skilled nursing facility were Full Codes unless their attending physician in the facility wrote a DNR order. In a telephone interview on 6/13/19 at 11:54 AM Resident #37's skilled nursing facility attending physician indicated that to his knowledge	F 578	Identification of Others Facility Director of Nursing and Administrative staff completed 100% audit of resident charts for accurate code status'. Audit was completed on 6/13/19 and no other discrepancies in code statuses were noted. Systemic Changes On 7/12/2019 Facility Admissions Coordinator and Social Worker provided education by the Executive Director pertaining to all admission and readmission are required to have code status information signed and put on the resident's chart within 24 hours of admission or readmission. It will be the Admission Coordinator's responsibility to ensure this information is completed. Monitoring Process Facility Unit Manager or designee will review charts for new admissions and readmissions and records on 24 hr chart Audit tool. The tool will then be brought to the morning clinical meeting daily to verify correct information present. These reviews will be completed daily x5 days, weekly x4 weeks, and then monthly x3 months. Facility Social Worker will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 578	Continued From page 3 Resident #37 wished her code status to be Do Not Resuscitate. He further indicated the lack of a Do Not Resuscitate order in Resident#37's medical record was an oversight. He further indicated he would follow up with Resident #37 to correct the issue. On 06/13/19 at 12:58 PM interview with the DON (Director of Nursing) revealed residents are provided with a full admission paperwork packet each admission, including readmission after hospitalization, which includes advanced directive information and code status agreement form. The DON indicated that Resident #37 completed her own admission paperwork on 5/07/19 upon re-admission to the facility and provided copies of the paperwork. The DON further indicated that she was not able to locate documentation regarding discussion, current signed advanced directive information or a code status agreement form in Resident #37's medical record for the re-admission to the facility on 5/7/19. On 7/1/19 at 1:36 PM interview with her representative revealed Resident #37's wishes for code status were Do Not Resuscitate.	F 578		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		7/12/19

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Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure

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F 623	Continued From page 6 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge to the resident's representative for a facility-initiated discharge for 4 of 4 residents reviewed for hospitalization (Resident #73, Resident #102, Resident #116, and Resident #118). The findings included: 1. Resident #73 was admitted to the facility on 2/14/19 with diagnoses that included gastroesophageal reflux disease. A nurse's note dated 3/11/19 written by Nurse #1 indicated Resident #73 was transferred to the hospital due to a rapid heart rate. The note indicated the family was notified of the transfer by phone. Resident #73's medical record revealed no information regarding the resident's responsible representative being provided with written notice of the resident's hospital transfer on 3/11/19. A nurse's note dated 3/17/19 revealed Resident #73 was readmitted to the facility from the hospital on 3/17/19. During an interview on 6/12/19 at 3:17 PM with Nurse #1 he stated when a resident was sent to	F 623	Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director, the facility failed to provide written notice of discharge to resident□s representative for facility initiated discharges due to facility staff not being aware that transfers to the hospital were considered facility initiated discharges. Immediate Actions Once determined, facility social worker provided in-service education by facility Executive Director stating that transfers to the hospital were considered facility initiated discharges and written notice of transfer must be given at the time of transfer. Education provided on 6/24/19. Identification of Others Due to the facility not being aware of transfers to the hospital being considered facility initiated discharges, all other residents sent to the hospital did not receive written notice of discharge. Systematic Changes New process put in place to send notice of transfer and bed hold policy to resident being transferred to the hospital. Facility Staff Development Coordinator provided 100% in-service provided to facility nurses to use of the new forms and the new	

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F 623	Continued From page 7 the hospital the paperwork sent included the face sheet, medication administration record and vital signs. He indicated there was no other paperwork sent. He indicated he notified the resident's family by phone of the hospital transfer. During an interview on 6/12/19 at 4:00 PM with the Admission Coordinator she stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 3/11/19. During an interview with the Administrator on 6/12/19 at 5:06 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers. 2. Resident #102 was admitted to the facility on 4/27/19 with diagnoses that included end stage renal disease. A nurse's note written by Nurse #2 dated 6/3/19 revealed Resident #102 was sent to the hospital due to chest pain. The note indicated the family was notified of the transfer by phone. Resident #102's medical record revealed no information regarding the resident's responsible representative being provided with written notice of the resident's hospital transfer on 6/3/19. A nurse's note dated 6/5/19 revealed Resident #102 was readmitted to the facility from the hospital on 6/5/19. During an interview on 6/12/19 at 4:00 PM with the Admission Coordinator she stated she did not send written notice of discharge to the resident or	F 623	process in order to have written notice delivered to residents and/or resident RPs at time of transfers. In-service education completed by 7/12/2019 and no nurse will be allowed to work after this date without receiving the education. Monitoring Process Facility Director of Nursing Services or designee will review all transfers for the previous day during the facility morning clinical meeting to ensure that documentation of notice of transfer was given and a copy remains at the facility and will be held by the facility Social Worker. This will be done daily x5 days, weekly x4 weeks, then monthly x3 months. Facility Director of Nursing Services will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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the resident's representative for the resident's hospital transfer on 6/3/19.

During an interview with the Administrator on 6/12/19 at 5:06 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.

During an interview with Nurse #2 on 6/13/19 at 7:52 AM she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the medication administration record and the physician's orders. She indicated no other paperwork was sent. Nurse #2 stated she contacted Resident #102's to inform them of the hospital transfer.

3. Resident #116 was admitted to the facility on 9/26/16 with diagnoses that included heart failure and diabetes mellitus.

A nurse's note dated 5/1/19 written by Nurse #4 revealed Resident #116 was sent to the hospital due to an altered level of consciousness. The note indicated the family was notified of the transfer via phone.

Resident #116's medical record revealed no information regarding the resident's responsible representative being provided with written notice of the resident's hospital transfer on 5/1/19.

A nurse's note dated 6/10/10 revealed Resident #116 was readmitted to the facility from the hospital on 5/5/19.

During an interview on 6/12/19 at 4:00 PM with the Admission Coordinator she stated she did not

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send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 5/1/19.

During an interview with the Administrator on 6/12/19 at 5:06 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.

During an interview on 6/13/19 at 8:22 AM Nurse #4 stated when a resident was sent to the hospital the paperwork sent included the medication administration record, code status, and face sheet. She indicated no other paperwork was sent. Nurse #4 stated she notified Resident #116's family of her emergent hospital transfer.

4. Resident #118 was admitted to the facility on 03/12/19 with diagnoses including end-stage renal
disease and dialysis dependence among others.

Review of a Speech Therapy note written by Speech Therapist #1 dated 3/20/19 at 2:04 pm indicated Resident #118's representative wanted Resident #118 sent to the emergency room and was working with the DON (Director of Nursing) to have her transferred.

A nurse's note dated 03/20/19 at 2:27 PM written by Nurse #3 revealed 911 was called and Resident #118 was sent to the hospital due to an abnormal abdominal scan. The note further indicated her representative was present at her bedside.

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Further review of resident #118's medical record revealed she did not return to the facility.

Review of the resident's hospital discharge summary dated 03/26/19 revealed the resident would be discharged from the hospital to a new skilled nursing facility per the request of the resident's family.

On 06/12/19 at 2:01 PM in an interview the DON indicated Resident #118 was admitted to the facility for a 21 day short stay rehabilitation. She further indicated she did not know why Resident #118 did not return to the facility.

An interview on 3/20/19 at 2:04pm with Speech Therapist #1 revealed that she was planning to work with Resident #118 on 03/20/19 and had just taken her for a session when Resident #118's representative approached her and said she wanted Resident #118 transferred to the hospital. Speech Therapist #1 further indicated it was her understanding Resident #118's representative felt Resident #118's stomach issues were not being addressed and she was working with the DON to get Resident #118 transferred to the hospital.

Resident #118's medical record revealed no information regarding Resident #118's representative being provided with written notice of the resident's hospital transfer on 03/20/19.

During an interview on 06/12/19 at 2:17 PM Nurse #3 indicated Resident #118 and her representative were aware of the reason for transfer to the hospital on 03/20/19. She further indicated she did not send written notice of discharge with Resident #118 on 03/20/19 as it was her understanding the Admissions

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F 623	Continued From page 11 Coordinator was responsible for providing the written notice to the resident or resident's representative. During an interview on 06/12/19 at 4:00 PM with the Admission Coordinator she stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 03/20/19. During an interview with the Administrator on 06/12/19 at 5:06 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers. On 6/24/19 two attempts to contact Resident #118's family regarding her discharge from the facility were unsuccessful. On 06/25/19 at 11:09 AM an interview with the Admissions Coordinator revealed that Resident #118's family chose not to have her to return to the facility.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		7/12/19

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F 637	Continued From page 12 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to perform a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for hospice care (Resident #51). Findings included: Resident #51 was admitted to the facility on 9/21/18 with diagnoses that included chronic obstructive pulmonary disease and anemia. Review of Resident #51's most recent MDS assessment dated 4/25/19 coded as a quarterly assessment revealed he was assessed as significantly cognitively impaired. Resident #51 had no moods or behaviors. The MDS indicated at the time of the assessment Resident #51 was not receiving hospice services. A physician order dated 5/9/19 revealed an order for an evaluation for hospice services. A nurse's note dated 5/10/19 for Resident #51 revealed hospice services began on 5/10/19. Review of Resident 51's MDS assessments revealed a significant change assessment was not completed since 5/10/19 when the resident began receiving hospice services. During an interview conducted with MDS Nurse #2 on 6/13/19 at 11:11 AM she stated she was unsure why a significant change assessment was not completed for Resident #51. She indicated Resident #51's annual assessment is due 7/4/19.	F 637	Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director, the facility staff (MDS Coordinator) did not follow the expectation of performing a significant change assessment on resident #51 at the time they were viewed for hospice care. Immediate Actions Once aware of the issue, a significant change assessment was completed and submitted by the MDS Coordinator for resident #51 on 6/13/19 for hospice care. Identification of Others The facility MDS coordinators audited 100% of hospice resident□s medical records to ensure that significant change assessments were completed appropriately. This audit was completed on 7/8/19 and the result were documented with any discrepancies noted and corrected at that time. Systematic changes On 7/12/19 the facility MDS staff were provided in-service education by facility Executive Director in regards to the need for significant change assessments and what constitutes a need for a significant change assessment, being reviewed or started on hospice care. Hospice resident will be discussed in the facility morning clinical meeting to include when resident begin to be followed by hospice and when they stop receiving hospice care. At this time the MDS coordinators	

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F 637	Continued From page 13 An interview was conducted with the Administrator on 6/13/19 at 11:32 AM who stated MDS assessments should be done within the required time frames.	F 637	will acknowledge that they are aware of the need for a significant change assessment and if the assessment is completed. This is to be recorded in the notes for this meeting. Monitoring process The facility Director of Nursing Services or designee will review clinical meeting notes to ensure that and residents identified to need significant change assessments during the meeting have had completed assessments. These reviews will be documented on the Significant Change monitoring tool and any identified uncompleted assessments will be addressed with the MDS Coordinators at that time. These reviews will be conducted weekly x4 weeks and monthly x3 months. Facility Director of Nursing Services will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		7/12/19

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F 640	Continued From page 14	F 640		

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,

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F 640	Continued From page 15 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment to the Centers for Medicare and Medicaid Services (CMS) system within the required timeframe for 1 of 21 residents reviewed for transmission of MDS assessments (Resident #1). The findings included: Resident #1 was admitted to the facility on 1/28/19 with diagnoses including chronic obstructive pulmonary disease and diabetes mellitus. Review of Resident #1's MDS assessments revealed a completed discharge assessment dated 2/25/19 that had not been transmitted to CMS as of 6/13/19. An interview was conducted with MDS Nurse #2 on 6/13/19 at 11:11 AM who stated Resident #1 was admitted to the facility on 1/28/19. She stated she was unsure why the resident's discharge assessment dated 2/25/19 was not transmitted to CMS as of 6/13/19. An interview was conducted with the Administrator on 6/13/19 at 11:32 AM who indicated assessments should be submitted in compliance with the MDS manual.	F 640	Root Cause Analysis Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not follow RAI guidelines on transmitting the Minimum Data Set (MDS) to the CMS system. Immediate Action The assessment for Resident #1 was completed and submitted on 6/13/19. Identification of Others An audit of transmitted assessments for the past 90 days was completed by the MDS Coordinators by 7/12/19. Any areas of non-compliance will be modified and re-submitted per RAI guidelines. Systematic Changes Education will be provided to the MDS Coordinators by 7/12/19 by the facility Executive Director on timely transmitting of the MDS assessments to the CMS system. The facility Executive Director will have a weekly meeting with the MDS team to review assessments and ensure they are transmitted timely. Monitoring Process Effective 7/12/19, the facility Executive Director will audit all completed MDS assessments weekly for timely transmission weekly x4 weeks then a sample of assessments monthly for x2 months. These audits will be recorded and kept by the ED for review. Facility Executive Director will report all	

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F 640	Continued From page 16	F 640	findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
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 observation, staff and interviews, and record review the facility failed to accurately code the Minimum Data Set (MDS) assessments for activities of daily living (Resident #56) and wanderguard (Resident #24) for 2 of 2 residents reviewed for MDS accuracy. Findings included: 1. Resident #56 was admitted to the facility on 6/23/2016 with diagnoses which included anoxia brain damage, contracture of left elbow and right wrist, and respiratory failure. Resident #56's MDS dated 4/26/2019 revealed the resident required extensive assistance with bed mobility, transfers, bathing, toilet use, dressing, personal hygiene and eating. It further revealed Resident #56 was severely cognitive impaired. The care plan dated 2/3/2019 revealed a plan	F 641	Root Cause Analysis Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not accurately portray resident condition on the MDS assessment for ADLs and wonder guards due to incomplete record reviews. Immediate Actions Assessment for resident #56 dated 4/26/2019 was modified/corrected by the MDS Coordinator on 6/13/2019 to indicate the proper assistance level for ADLs. Assessment for resident #24 dated 4/26/2019 was modified/corrected by the MDS Coordinator on 6/13/2019 to indicate the presence of a wander guard. Identification of Others An audit of MDS assessments for the last recent assessment will be completed by the MDS coordinator by 7/12/2019 validating accuracy of ADL assistance and	7/12/19

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F 641	Continued From page 17 that focused on Resident #56 required total assistance with activities of daily living (adls) related to a diagnosis with a goal to have his needs met daily. An observation on 6/10/2019 at 11:00 am revealed Resident #56 resting in bed with eyes open. He was positioned on his left side with his knees drawn up to his chest, and had both hands closed tightly with braces on both wrists. Resident# 24 responded to verbal stimulation by blinking his eyes. There was a feeding machine infusing nutrients in his Percutaneous Endoscopic Gastrostomy tube (peg tube) and oxygen connected to a mask that covered his tracheostomy site. An interview with the MDS nurse on 6/12/2019 at 1:35 pm revealed there was no documentation in the nurse's note that indicated Resident #56 was total care for adls. She also stated that she had modified the MDS to correctly show Resident #56 as being total care for all adls. The interview with the Director of Nursing (DON) and the Nurse Consultant on 6/13/2019 at 5:10 pm revealed the MDS should have been coded as totally dependent for all care. The DON stated Resident #56 had been unable to do anything for himself since she had been working at the facility. She further stated the MDS should have been coded correctly. 2. Resident #24 was admitted to the facility on 10/19/15 with diagnoses that included dementia. Review of a physician's order dated 10/14/18	F 641	presence of wander guard. Any assessments found to be incorrect will be corrected and resubmitted at this time. Systematic Changes Education will be provided to the MDS Coordinators by 7/12/2019 by the facility Executive Director pertaining to accuracy of assessments. Monitoring Process Effective 7/12/2019, the facility Executive Director will audit a sample of completed MDS assessments weekly x4 weeks then a sample of assessment monthly x2 months to ensure coding accuracy. These audits will be recorded and kept by the ED for review. Facility Executive Director will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 641	Continued From page 18 ordered the use of a wander alarm. Review of Resident #24's care plan dated 1/11/19 indicated a wander alarm was used daily. Review of Resident #24's MDS assessment dated 4/26/19, coded as a quarterly assessment specified no wander alarms were used during the 7-day look back period. Review of Resident #24's medication administration record for April 2019 revealed the wander alarm battery was checked nightly. An interview was conducted with MDS Nurse #2 on 6/13/19 at 11:14 AM who stated she was instructed by her facility MDS consultant wander alarms were not to be coded on MDS assessments. During an interview with the Administrator on 6/13/19 at 11:32 he stated it is his expectation that MDS assessments are coded accurately.	F 641		
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.	F 657		7/12/19

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F 657	Continued From page 19 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to update the care plan to reflect a pressure ulcer had healed for 1 (Resident #78) of 22 care plans reviewed. The findings included: Resident #78 was admitted to the facility 8/13/18 with diagnoses including end stage renal disease, hypertension and cardiovascular accident. Resident #78's Wound Assessment Forms revealed the resident's left heel pressure wound was resolved on 1/3/19. Resident #78's Minimum Data Set (MDS) assessment a discharge assessment dated 2/6/19 indicated at Resident #78 had unhealed pressure ulcer(s). Resident #78's quarterly minimum data set (MDS) dated 5/12/19 revealed she was	F 657	Root Cause Analysis Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not update resident #78□s care plan for a healed pressure ulcer due to an incomplete record review. Immediate Action Resident #78□s care plan was updated to no longer contain a pressure ulcer on 6/13/2019. Identification of Others An updated report of residents that had pressure ulcer was given to the MDS coordinators and a100% audit of all care plans conducted by the MDS coordinator to ensure that residents that had pressure ulcer had them appropriately addressed on their care plans and those that did not have pressure ulcers did not have them addressed on their care plans. This audit is to be completed with care plans	

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F 657	Continued From page 20 cognitively intact and required limited to extensive assistance with activities of daily living. The MDS specified the resident did not have any unhealed pressure ulcers. A review of the care plan updated on 6/9/19 by MDS nurse #1 revealed Resident #78 had a stage III pressure ulcer on her left heal. During an interview with Resident #78 on 6/13/19 at 9:03 AM she stated she no longer had a pressure ulcer. During an interview with the wound nurse #1 on 6/13/19 at 3:00 PM she reported the pressure ulcer on the left heel of Resident #78 was no longer there and it had healed but she did not know the date it was healed. During an interview with MDS nurse #1 on 6/13/19 at 5:19 PM she stated she was the one who signed the resident's 6/9/19 wound care plan as being reviewed and to be continued. She stated the wound care plan should have been resolved.	F 657	updated by 7/12/2019. Systematic Changes The facility MDS Coordinators were provided in-service education by facility Executive Director on 7/12/19 on the necessity of obtaining accurate information regarding residents and updating their care plans accordingly to reflect their current condition. The facility clinical staff will discuss wound healing a progress weekly and the MDS Coordinator will be present or will receive current information from wound care nurse and will update the resident□s care plan as necessary at this time. Monitoring Process The facility Director of Nursing services or designee will review the care plans of all residents discussed in the clinical meeting as it pertains to wounds to ensure they are accurately updated as necessary. These reviews will be recorded and retained and will be conducted weekly x4 weeks and monthly x2 months. Facility Director of Nursing Services will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		7/12/19

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F 761	Continued From page 21 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to remove expired biologicals from the medication room refrigerator (300/400 hall) and failed to remove an expired stock medication from the medication storage room (500 hall) for 2 of 2 medication storage rooms reviewed for medication storage. Finding included: 1. An observation of the 500-hall medication room and refrigerator was conducted on 6/11/2019 at 11:51 am with Nurse #2. The observation revealed a bottle of calcium 500 mg with the	F 761	Root Cause Analysis Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director, the facility staff failed to identify four unopened containers of medications in medication preparation rooms at two nurses stations during routine medication audits. Immediate Action All identified expired medication removed from storage room and disposed of on 6/11/2019 Identification of Others An 100% audit of all medication	

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F 761	Continued From page 22 expiration date of 4/19/2019 in a paper box on top of a cart. An interview with Nurse #2 on 6/11/2019 at 12:00 pm revealed she checked the medications daily and weekly for expired medications. She further stated she had checked the medications the day before and she did not know how she missed seeing the expired bottle of calcium. An interview with the Director of Nursing (DON) and the Nurse Consultant was conducted on 6/12/2019 at 5:10 pm. The DON revealed the nurses should have checked the medications for expirations dates and returned the medications to the pharmacy. 2. An observation of the 300/400 medication storage room was conducted on 6/11/2019 at 12:17 pm with Nurse #3. The observation of the refrigerator revealed three unopened boxes of influenza vaccine with the expiration dates of 5/2019. An interview with Nurse #3 on 6/11/2019 at 12:30 pm revealed the nurse would look through the medication cabinets and carts for expired medications weekly, all expired medication would be removed, and the name of the medication written down. The nurse further stated the medications were placed in the gray tote and sent back to the pharmacy. An interview with the Director of Nursing (DON) and the Nurse Consultant was conducted on 6/12/2019 at 5:10 pm. The DON revealed the nurses should have checked the medications for expirations dates and returned the medications to the pharmacy.	F 761	preparation rooms conducted by the facility Unit Managers completed 6/12/2019 to ensure there were no other expired medications present. Systematic Changes Unit managers received in-service education from the facility's Director of Nursing Services on 6/14/2019 to check medication preparation weekly and each manager is to be assigned a room to audit. Results of these audits will be recorded and kept by the Director of Nursing Services for review. Monitoring Process Medication preparation room audits will be conducted weekly ongoing. Facility Director of Nursing Services will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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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 observations and staff interviews the facility failed to maintain the dish machine sanitizer at the correct strength and failed to maintain the wash temperature at 120 degrees or higher during 2 of 2 dish machine observations. The findings included: An observation on 6/10/19 at 9:45 AM revealed 2 dietary staff members were using the kitchen's dish machine to wash the breakfast dishes. According to the machine's specifications on a label on the front of the dish machine, it was a low temperature machine and used chlorine for sanitizing. The label revealed the dish machine should have 50 parts per million (PPM) of chlorine. The Certified Dietary Manager (CDM)	F 812	Root Cause Analysis Due to root cause analysis by the facility administrative staff and Executive Director the facility could not maintain dish sanitizer on 6/10/19 and appropriate water temperature on 6/13/19 due to malfunctions will the dish machine. Immediate Action Dish machine evaluated by Maintenance Director and Dish Machine chemical dispenser company on 6/10/2019 and Chlorine content for sanitizer was at appropriate level. Dish machine reevaluated by Maintenance Director and a local boiler repair company on 6/13/2019 for water	7/12/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 24 used a test strip to check the chlorine content of the dish machine's water. The chlorine test strip did not change colors to register the presence of any chlorine in the dish machine's water. The Certified Dietary Manager (CDM) was interviewed on 6/10/19 at 9:45 AM. The CDM stated she did not know why the chlorine was not working. She stated the chlorine test was completed daily by the kitchen staff. She added the dish machine should have a rinse temperature of 120 degrees Fahrenheit and register 50 ppm chlorine on the test strip. She was observed to check the container of chlorine and said there was chlorine in the container so she did not know why it was not registering. She said they needed to hand wash and hand sanitize the dishes until she could get the maintenance man to check the machine. During an additional observation of the dish machine on 6/13/19 at 9:03 AM the dietary staff were observed washing the breakfast dishes in the dish machine. The wash temperature registered 116 degrees Fahrenheit (F) during 3 separate wash cycles. An observation of the manufacturer tag located on the machine revealed the minimum acceptable wash temperature was 120 degrees Fahrenheit (F). The CDM was present during the observation on 6/13/19 at 9:03 AM. The CDM stated she was not sure why the temperature was not reaching 120 degrees F. She added the thermometer was just replaced yesterday because the previous one was hit and possibly broken. The CDM said she would contact the maintenance man and the machine's chemical provider company to determine the cause of the low wash	F 812	temperature and boiler was adjusted so temperature will maintain at 120 degrees for the dish machine. Systemic Changes Dietary staff will check and monitor sanitizer and water temperature prior and during each use and if any abnormalities are noted they are to be reported to facility Dietary Manager and Maintenance Department for correcting. Monitoring Process Facility Dietary Manager or designee will review temperature and sanitation logs and temperature logs to ensure the dish machine remains in compliance with the appropriate levels of both. Starting 7/12/2019 these reviews will be conducted weekly x 4 weeks then monthly x2 months. Facility Dietary Manager will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 812	Continued From page 25 temperature. She added in the meantime she would use only disposable ware for serving food to the residents.	F 812		