STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD LIVING & REHAB CENTER	1624 HIGHLAND DRIVE WASHINGTON, NC 27889

(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
E 000	Initial Comments On 11/26/19 the facility was provided an amended 2567 report because example I of tag E0001 was deleted from the report by a State Agency Management review. Event ID# SUIH11.	E 000		
E 001 SS=D	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 establish a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan,	E 001	E001 failed to : " Establish an emergency plan that had been updated annually. " Address procedures with local,	11/29/19

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

Electronically Signed | 12/02/2019

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E 001	Continued From page 1 develop a process for cooperation and collaboration with local, tribal, regional, state and federal EP officials, develop a communication plan, develop subsistence for staff and patients, develop a means of tracking staff and patients, develop a method of sharing information and medical documentation, develop a means of sharing the EP plan with residents or responsible party (RP), put into place EP training and testing plans and document information in the EP regarding the emergency generator. The findings included: A review of the facility's Emergency Preparedness plan material on 11/07/19 revealed: A. The EP plan had not been established and had not been updated annually. B. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials. C. The EP plan did not address a communication plan. D. The EP plan did not address subsistence needs for staff and patients. E. The EP plan did not address procedures for tracking of staff and patients. F. The EP plan did not address policies and procedures for medical documents. G. The EP plan did not address a means of sharing the EP plan with residents or responsible	E 001	regional, state and federal EP Officials. " Address a communication plan " Address sustenance needs for staff and patients. " EP Did not address procedures for tracking of staff and patients " Address policies and procedures for medical documents " Address a means of sharing the EP plan with residents or responsible party. " Develop and put into place EP Training and testing plans. " Address location of emergency generator Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For those residents identified at risk the following corrective action has taken place: Administrator received training and review of all policies and procedures related to emergency preparedness on 11/26/2019 by the Regional director of Operations. Emergency plan in its entirety is reviewed and updated annually, last update review of 10/01/2019. On 11/26/2019 Administrator updated emergency plan to reflect regional, local, state and federal EP officials, communication plans, emergency menus for patients and staff, tracking procedures of staff and patients, policies for medical documents, means of sharing the information with residents and Responsible parties, individualized training and testing plans and the location of the emergency generator location. Administrator conducted in-service on	

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E 001	Continued From page 2 party (RP). H. The facility failed to develop and put into place EP training and testing plans. I. The EP plan lacked information regarding the emergency generator location. A review of the materials revealed the manual contained written policies and procedures but did not contain a written comprehensive EP Plan that met the federal requirements. There were two sections in the manual; one titled "Operational Policy and Procedure Manual for Long-Term Care Disaster and Emergency Response" by Med-Pass (last revised December 2014) and "Operational Policy and Procedure Manual for Long-Term Care" by Med-Pass (last revised December 2014). An interview was conducted with the Administrator on 11/07/19 at 3:18 PM. The Administrator stated that this was the only Emergency Preparedness manual he had, and he was unaware of the need to have a written individualized comprehensive emergency preparedness facility plan.	E 001	11/26/2019 and education to facility staff to the location of the facility policies and procedures related to emergency preparedness not limited but to include: Address procedures with local, regional, state and federal EP Officials, a communication plan, sustenance needs for staff and patients, procedures for tracking of staff and patients, policies and procedures for medical documents, sharing the EP plan with residents or responsible party, Training and testing plans and location of emergency generator. All staff present were in-serviced on 11/26/2019- 11/29/2019. All staff who did not attend will receive in-service education prior to return to work and newly hired staff will receive in-service education upon hire. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All Residents are at risk to be affected by this alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Facility administrator will conduct annual in-service education in accordance with Employee Education and Training Calendar at a minimum of annually. Administrator and maintenance director will review policies and procedures for annual updates prior to the annual in-service. Facility administrator will incorporate in-service attendance into the QAPI	

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E 001	Continued From page 3	E 001	program and HR director will report on each month. QAPI plan will be adjusted and re-evaluated monthly by the Administrator, to maintain substantial compliance with changes or modifications as they occur. Indicate dates when corrective action will be completed: 11/29/2019	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/04/19 through 11/07/19. Event ID# SUIH11. 3 of the 13 complaint allegations were substantiated resulting in deficiencies On 11/26/19 the facility was provided an amended 2567 report because example I of tag E0001 was deleted from the report by a State Agency Management review. Event ID# SUIH11.	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, 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.	F 550		11/29/19

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F 550	Continued From page 4 §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: Based on observations, resident and staff interviews, and record review the facility failed to maintain dignity by failing to knock on resident room doors or announce their presence before entering resident rooms for 1 of 3 residents observed for dignity (Resident #92). Findings included: Resident #92 was admitted to the facility on 4/04/18 with diagnoses which included heart failure, anxiety, and depression.	F 550	F 550 Regarding the alleged deficient practice of failure to knock on resident # 92 door or announce prior to entry, the Director of Nursing (DON) provided in service education on 11-26-19, for NA #1, regarding Resident Rights: Dignity and Respect, knocking on doors and announcing prior to entry into resident room. Current facility residents are at risk of the alleged deficient practice of failure to	

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F 550	Continued From page 5 Review of Resident #92's most recent quarterly Minimum Data Set (MDS) dated 10/15/19 revealed she was assessed as cognitively intact. An observation on 11/04/19 at 12:35 PM revealed that Nurse Aide (NA) #3 was observed to enter Resident #92's room without knocking or announcing her presence. An interview on 11/06/19 at 11:29 AM with Resident #92 revealed some of the staff knock on the door but she felt staff should always knock on the door even if it is open to make her aware they would like to enter her room. She further stated it bothered her if staff didn't knock on the door and enter her room without asking permission as they sometimes did. An interview with NA #3 on 11/04/19 at 12:39 AM indicated she was aware staff should always knock on the door or announce their presence before they entered a resident's room. She further stated she should have knocked before entering Resident #92's room but she had forgotten. NA #3 stated she knocks on doors when they are closed but doesn't always remember to knock on the door if it is open. An interview with the Director of Nursing on 11/04/19 at 12:48 PM revealed it was facility policy that staff knock on resident room doors even if they were open and that NA #3 should have knocked on Resident #92's door. An interview with the Administrator on 11/07/19 at 8:29 AM indicated he expected the staff to knock on the resident's doors.	F 550	knock on resident door or announce their presence before entering the residents room. The Administrator, DON, Staff Development Coordinator, Unit coordinator and /or Department supervisor will have provided in service education for current facility staff beginning on 11-25-19, regarding Resident Rights: Dignity and Respect, specifically knocking on doors. The Administrator ,DON, Staff Development Coordinator, Unit Coordinator and/or department Supervisor will provide in service education for current facility staff beginning on 11-25-19, regarding Resident Rights: Dignity and Respect, specifically knocking on doors. In service education, will be provided during new hire orientation. The Administrator, DON, ADON and SW will observe 15 resident rooms weekly for 4 weeks then 15 resident rooms monthly for 3 months to validate that staff members are knocking on resident doors prior to entering or announcing their presence prior to entering the residents room. The Administrator and/or the DON will review audits to identify patterns and/or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meeting for at least 3 months or until compliance is maintained.	
F 565	Resident/Family Group and Response	F 565		11/29/19

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F 565 SS=E	Continued From page 6 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with Resident Council	F 565	F 565	

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F 565	Continued From page 7 members and review of Resident Council minutes the facility failed to resolve concerns voiced by the Resident Council members during the previous 4 of 6 monthly meetings (May 2019, June 2019, July 2019, August 2019, September 2019 and October 2019). The findings included: Resident Council Meeting minutes from May 2019, June 2019, July 2019, August 2019, September 2019, and October 2019 were reviewed. A review of Resident Council minutes dated May 30, 2019 indicated residents voiced concerns regarding not receiving ice as requested with the social worker to follow-up. The Resident Council minutes from July 24, 2019 revealed residents voiced concerns regarding missing clothing with the social worker to follow-up. The Resident Council minutes from August 28, 2019 indicated residents expressed concerns related to missing items, not receiving water on 2nd and 3rd shifts and bed linens not being changed with the social worker to address. The Residents Council minutes from September 24, 2019 indicated missing items were voiced as a concern with the social worker to follow up. A grievance report dated 8/30/19 and labelled Resident Council revealed a concern regarding getting ice on 3-11 shift. No resolution had been completed on the grievance report. A grievance report dated 9/25/19 and labelled Resident Council revealed a concern regarding staff being loud on 3rd shift. No resolution had been completed on the grievance report.	F 565	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Administrator addressed Resident Council grievances from May 2019 through September 2019 on 11/22/19. The Activities Director (AD) presented the Resident Council President and the group a written letter of resolution on 11/27/19, regarding voiced concerns of not receiving ice, missing items and bed linens not being changed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the alleged deficient practice of the facility□s failure to resolve concerns voiced by the Resident council members. The Administrator completed an audit on 11/22/19, of the resident council minutes from May 2019 through November 2019, to validate that concerns voiced by the resident council group were resolved and a written letter of resolution was presented to the Resident council president and group on 11/27/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services (RCD) provided education on 11/26/19, to the Activity Director, Social Service	

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F 565	Continued From page 8 No additional grievance reports labelled Resident Council were located for review. An interview was conducted on 11/6/19 at 10:04 AM with the facility's resident council. There were ten residents present in the meeting. During the meeting residents expressed a concern with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation given as why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. The residents indicated none of their concerns had been addressed and the social worker never reported a resolution in the meetings (not receiving ice, missing items, noise on 3rd shift and not changing bed linens). Residents stated a staff member was present at Resident Council meetings and communicated their concerns to Administration. An interview was conducted with the Activities Director on 11/6/19 at 2:00 PM. She reported that she was present during the Resident Council meetings and took the minutes. She indicated the facility Social Worker was present during the meetings as well. The Activities Director stated it was her understanding the Social Worker would complete grievance forms after the Resident Council meetings. She indicated she was unsure of the process on resolution of grievances after the meetings. The Activities Director stated the social worker was no longer employed by the facility. The Director of Nursing (DON) stated during an interview on 11/7/19 at 2:44 PM that once a	F 565	director (SSD) and the Administrator regarding the facility grievance policy and procedure. The Activities Director (AD) will attend the Resident Council group during meetings and will document concerns voiced by the group on the facility Grievance form. The AD will give the Grievance form to the Administrator and the Administrator will assign the appropriate staff member to investigate and follow up regarding the concern within 5 days and present the investigation/resolution to the Activities Director (AD). The AD will log the grievance on the Resident Council Grievance Log. The (AD) will present the letter of resolution to the Resident Council President. The AD and Resident council president will present the resolution letter to the Resident Council Group at the next scheduled meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the Social Service Director (SSD) will review the Resident Council minutes and the Resident council grievance log monthly following the monthly resident council meeting to identify voiced concerns and validate that the concerns were documented on the facility Grievance form, the concerns were investigated and a resolution was obtained and presented to the Resident Council President in writing within 5 days of receiving the grievance and reviewed at the next scheduled Resident Council meeting for 3	

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F 565	Continued From page 9 grievance is completed by a resident or family member it is given to the social worker to log the grievance in the system for tracking. It is then given to the appropriate department for investigation and resolution. The grievance is given to the social worker who communicates the resolution to the resident or family member. The DON stated the social worker should have communicated the resolution of the grievance to the Resident Council.	F 565	months. The Administrator and/or the SSD will review the audit/monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the SSD will review the plan during the monthly QAPI meeting and the monitors will continue at the discretion of QAPI committee. Indicate dates when corrective action will be completed; November 29, 2019	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		11/29/19

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F 580	Continued From page 10 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, and record reviews, the facility failed to notify the resident's representative of a change in the condition of the resident's left foot for 1 of 1 residents (Resident # 4) . Findings included: Resident #4 was admitted to the facility on 4/4/2018 with the diagnoses which included chronic kidney disease and essential	F 580	F 580 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 4 RP was notified of wound status and general decline in overall health status on 9-27-19, 10-17-19 and 10-18-19 by the licensed nurse. He was invited to a care conference on 10-17-19	

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F 580	Continued From page 11 hypertension. A review of a Minimum Data Set (MDS) dated 7/22/2019 revealed Resident #4 was mildly cognitively impaired and required extensive to total assistance with all aspects of activities of daily living. The care plan dated 7/25/2019, updated 8/23/2019 by Nurse #6, and revised on 10/18/2019 focused on a plan for a new wound on Resident #4's left lateral foot. The nurse's notes dated 8/19/2019 written by Nurse #6 revealed a new wound was found on the lateral surface of the Resident #4's left foot. Nurse #5 initiated the stage 3 facility wound protocol of a hydrogel and dry dressing. An interview with Nurse #6 on 11/6/2019 at 4:30 pm revealed she could not remember informing Resident #4's representative about the new wound that she found on the resident's left foot. She further stated she would like to believe that if she had called the representative she would have documented it in the record. Further review of the nurse's notes revealed no documentation of communication between the Nurse #6 and Resident #4's representative from 8/16/2019 until 9/27/2019 concerning the new wound to the resident's left foot. Nurse #6 called Resident #4's representative on 9/27/2019 and left a detailed message concerning the conditions of Resident #4's wound. During an interview with the resident's Representative on 11/06/2019 at 6:20 pm, he revealed no one from the facility had called him	F 580	and did not attend. Resident was admitted to the hospital and has not returned. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed on all residents with wounds on 11-15-19 by the wound nurse and DON. All residents RP□s were notified by 11-19-19 by either the Staff development coordinator (SDC) or Unit coordinator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All licensed nurses will be in-serviced by DON, SDC, DON, Unit coordiantor on MD and family notification with significant change in condition and on the documentation of the notification. Employees will be educated upon return to work and new employees will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; DON, Assistant Director of nursing, Unit coordinators will review new orders and incident reports to validate that resident Representative was notified 5 x week x 4weeks then weekly x 2 months. Indicate dates when corrective action will be completed; 12-18-19	

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F 580	Continued From page 12 about the wounds on Resident #4's left foot. The representative also stated when he went to visit the resident and saw the resident's left foot was wrapped in a bandageand that was when he discovered Resident #4 had a wound on his foot. The representative was unable to be specify exactly when he first noticed the dressing on Resident #4's foot and stated the early part of September 2019. The interview with the Director of Nursing (DON) on 11/7/2019 at 2:30 pm revealed the Nurse #6 stayed in close contact with Resident #4's representative and gave frequent updates concerning the resident's condition. The DON further stated Resident #4's representative should have been informed of the new wounds before 9/27/2019. An interview with the Administrator on 11/7/2019 at 3:00 pm revealed the nurses should have contacted Resident #4's representative concerning the new wound.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/29/19

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F 585	Continued From page 13	F 585		

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all

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information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 15 decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record reviews, the facility failed to resolve grievances for 3 of 3 residents (Resident #12, Resident #2 and Resident #63) reviewed for responses to grievances filed. Findings included: 1. Resident #12 was admitted to the facility on 3/17/2017 with diagnoses which included type 2 diabetes and anxiety disorder. The Minimum Data Set (MDS) dated 8/1/2019 revealed Resident #12 was cognitively intact and required total assistance for all activities of daily living. During an interview on 11/05/19 at 8:09 am Resident #12 revealed he had some clothes that had been missing for 2 months which included 4 colored t-shirts and 2 pairs of gray sweat pants. The resident also stated that he was informed by the Social Worker in September 2019 that the Administrator would replace the missing clothes. Resident #12 then stated he had not heard anything else about the replacement of his clothes. A review of a grievance report dated 9/18/2019 disclosed Resident #12 had communicated to the Social Worker that he was missing four shirts and two pairs of gray pants. An investigation on 9/23/2019 that was conducted by the Housekeeping Manager revealed one shirt was located and the Administrator was to replace 3 shirts and 2 pairs of sweat pants. Housekeeping	F 585	F 585 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) provided a written letter of resolution to Resident #12 on 11/7/19, regarding the grievance filed on 9/18/19 for missing clothing. The clothing was replaced by the facility on 11/7/19. The SSD provided a written letter of resolution to Resident # 2 on 11/18/19, regarding the grievance filed on 9/10/19, stating the resident had to wait an hour for care and the aid said she did not have time to care of her. The SSD provided a written letter of resolution to Resident #63 on 11/18/19, regarding the grievance filed on 10/19/19, regarding a staff members refusal to be assigned to her due to her size. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that voiced grievances have the potential to be affected by the alleged deficient practice of the failure to resolve grievances. The Administrator, Director of Nursing (DON) and SSD reviewed the Grievance log from September 1, 2019 through November 25, 2019 to validate that grievances have been resolved and the	

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F 585	Continued From page 16 was to make sure Resident #12's name was in the clothes. No resolution had been completed on the grievance report. During an interview with the Administrator on 11/7/2019 at 10:04 am, he revealed Resident #12's clothes had not been replaced because he had forgot about replacing the shirts and pants until it came up during the survey. The Administrator also stated the grievance report concerning the missing clothes should have been followed up earlier. He further stated the missing shirts and pants had been replaced the morning of 11/7/2019. An interview with the Director of Nursing on 11/7/2019 at 2:41 pm revealed Resident #12 should have received a letter with the resolution for his grievance concerning the missing shirts and pants. She also stated the letter would have normally been presented to the resident by the Social Worker. 2. Resident #2 was admitted to the facility on 11/5/18 with diagnoses that included muscle weakness and anxiety disorder. The Minimum Data Set (MDS) assessment dated 7/20/19, a quarterly assessment revealed Resident #2 was cognitively intact and required assistance for all activities of daily living. During an interview with Resident #2 she stated she had complained about a nurse aide not assisting her with care for one hour in September 2019 to the Director of Nursing (DON). She reported she received no information regarding the resolution of her complaint. A review of a grievance report dated 9/10/19	F 585	person that voiced the grievance has received a written notice of resolution. There were 40 grievances identified where the person had not been given a written resolution. The SSD provided a written resolution by 11/26/19, to the 40 people that were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services provided education on 11/26/19, for the Administrator, DON, SSD and the Activities Director, regarding the facility Grievance policy and process for investigating and providing written notice of resolution to the person that voiced the grievance within 5 days of receiving the grievance. When a grievance is voiced, the grievance is written on the facility grievance form and given to the SSD. The SSD or the Administrator will log the grievance and give to the Administrator to assign to the appropriate staff member for investigation and resolution. The assigned staff member will complete the investigation within 5 days and will document on the grievance form. The grievance form will be returned to the SSD or Administrator to provide a written letter of resolution to the person that voiced the concern. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 585	Continued From page 17 indicated Resident #2 had communicated to the DON that she waited one hour for assistance with care and was told by the nurse aide that she didn't have time to help her. An investigation on 9/13/19 revealed the nurse aide denied the resident waited one hour for care. This was corroborated by a second nurse aide and a nurse who were working on the hall that day. No resolution had been completed on the grievance report. The DON stated during an interview on 11/7/19 at 2:44 PM that once a grievance is completed by a resident or family member it is given to the social worker to log the grievance in the system for tracking. It is then given to the appropriate department for investigation and resolution. The grievance is given to the social worker who communicates the resolution to the resident or family member. The DON stated the social worker should have communicated the resolution of the grievance to Resident #2. 3. Resident #63 was admitted to the facility on 7/25/18. Her diagnoses included obesity, diabetic foot ulcer and hypertension. The quarterly Minimum Data Set dated 10/1/19 revealed Resident #63 was cognitively intact. She had no behaviors or rejection of care. Resident #63's care plan revised on 8/5/19 revealed she had self-care performance deficit related to impaired mobility. For transfers she could stand and pivot from bed to wheelchair with one staff assist but required a mechanical lift to transfer from wheelchair back to bed and needed 2 staff assist. On 11/4/19 at 1:00 PM Resident #63 stated she	F 585	The Administrator and/or the DON will review the grievance log 5x week for 4 weeks then 3 x week for 2 months, to validate that the investigations are complete and written letter of resolution has been provided to the person that voiced the grievance within 5 days of receipt of the grievance. The Administrator and/or the DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the DON will review the plan during the monthly QAPI and the audits/monitors will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; November 29, 2019	

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F 585	Continued From page 18 had discussed various grievances with the Director of Nursing (DON). She stated the DON did not provide any information back to her about her grievances. On 11/7/19 at 8:45 AM Resident #63 stated she had reported numerous things to the DON but had not received any feedback from anyone about the grievances she had reported. A review of the grievance reports revealed a grievance dated 10/19/19 from Resident #63 about a staff member who refused to be assigned to the resident due to her size. The grievance had a resolution written in by the DON but the section of the grievance report for Investigation results and resolution reported were not completed. The form was signed by the DON on 10/23/19. On 11/7/19 at 2:39 PM the DON stated once a grievance was completed it was sent back to the social worker (SW) who was responsible for sending a letter to the person who filed the grievance. She added the SW who would have complete the grievance response in October 2019 was no longer working at the facility and a new SW just started in the position a week ago.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and	F 641	F 641 Address how corrective action will be	11/29/19

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F 641	Continued From page 19 Annual Resident Review (PASARR) for 2 of 3 residents reviewed PASARR coding accuracy (Residents #33 and #102). Findings included: 1.Resident #33 was admitted to the facility on 4/03/19 with reentry on 4/22/19 with diagnoses which included manic depression and renal failure. The resident's medical record contained a renewed PASARR Level II Determination Notification dated 11/01/19 with expiration date 1/30/20. A review of the admission Minimum Data Set (MDS) assessment dated 4/29/19 indicated Resident #33 was not coded for Level II Preadmission Screening and Resident Review (PASARR) to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 11/06/19 at 10:01 AM an interview was conducted with MDS Nurse #1 who stated the MDS assessment for Resident #33 dated 4/29/19 was incorrect and should have reflected his PASARR Level II status. She further stated she would submit a modification for the admission MDS assessment immediately. On 11/07/19 at 8:21 AM an interview was conducted with the Administrator who stated that the MDS assessment should have been coded	F 641	accomplished for those residents found to have been affected by the deficient practice; The MDS nurse completed a modified MDS assessment for Resident #33 on 11/6/19, to include coding of PASARR Level II. The MDS nurse submitted the modified MDS assessment to the CMS on 11/6/19. The MDS nurse completed a modified MDS assessment for Resident #102 on 11/6/19, to include coding of PASARR Level II. The MDS nurse submitted the modified MDS assessment to CMS on 11/6/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents with a PASARR Level II has the potential to be affected by the alleged deficient practice of the facility□s failure to accurately code on the MDS assessment. The Admission coordinator, Social Service Director (SSD) and the MDS nurses completed an audit on 11/6/19, of current facility residents to identify residents with a PASARR Level II, and validate that the MDS is coded accurately to reflect the PASARR Level II. There were a total of 18 residents with PASARR Level II, and 9 of those were coded inaccurate on the MDS assessment. The MDS nurses modified assessments for the 9 residents that were identified, on 11/6/19 and submitted to CMS by 11/8/19, to reflect accurate coding of the PASARR Level II on the MDS	

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F 641	Continued From page 20 correctly. 2. Resident #102 was admitted to the facility on 2/12/15 with reentry on 9/27/19 with diagnoses which included schizophrenia and traumatic brain injury. The resident's medical record contained a PASARR Level II Determination Notification made on 11/10/16 with no end date. The annual Minimum Data Set (MDS) assessment dated 10/03/19 indicated Resident #102 was not coded for Level II Preadmission Screening and Resident Review (PASARR) to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 11/06/19 at 10:01 AM an interview was conducted with MDS Nurse #1 who stated the MDS assessment for Resident #33 dated 4/29/19 was incorrect and should have reflected his PASARR Level II status. She further stated she would submit a modification for the admission MDS assessment immediately. On 11/07/19 at 8:21 AM an interview was conducted with the Administrator who stated that the MDS assessment should have been coded correctly.	F 641	assessment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services (RCD) provided education on 11/5/19 to the SSD, Admission Coordinator and the MDS nurses regarding accurate coding of the PASARR Level II on the MDS assessment. The Admission coordinator (AC) and/or the SSD will identify residents with PASARR Level II upon admission to the facility. The AC and/or the SSD will maintain a list of residents with PASARR Level II and the expiration dates. The SSD and/or the MDS coordinators will validate PASARR Level II prior to coding the MDS assessment. The MDS nurses will validate accurate coding of PASARR Level II prior to locking the MDS assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) or the Assistant Director of Nursing (ADON) will monitor coding of PASARR Level II on the MDS assessment for residents identified with PASARR Level II 5 x week for 4 weeks then weekly for 2 months, prior to the MDS assessment being locked, to validate that the MDS assessment was coding accurately to reflect PASARR Level II for the identified residents.	

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F 641	Continued From page 21	F 641	The DON or the ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or the ADON will review the plan during monthly QAPI and the monitors will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; November 29, 2019	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		11/29/19

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F 655	Continued From page 22 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to formulate a baseline care plan for 2 of 2 residents reviewed for baseline care plans (Resident # 109 and Resident # 210). The findings included: 1. Resident #109 was admitted to the facility on 8/2/19 with diagnoses that included anemia and hypertension. Resident #109 ' s admission Minimum Data Set (MDS) dated 8/16/19 coded her cognitively intact, requiring limited assistance for most activities of daily and having the expectation to be discharged to the community. Resident #109 was discharged home on 8/30/19	F 655	F 655 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 109 was discharged from the facility on 8-30-19. Resident #210 discharged on 11-6-19 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed on 11-26-19 by MDS of all residents admitted 11-1-19 -11-25-19. All residents had a baseline care-plan completed.	

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	345228	A. BUILDING _____ B. WING _____	C 11/07/2019

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F 655	Continued From page 23 and a review of closed records revealed the facility failed to complete a baseline care plan. An interview was completed with MDS Nurse #1 on 11/7/19 at 1:54 PMwho stated she initiated Resident #109 ' s baseline care plan but each discipline is responsible for completing their own section. She stated the social worker should have completed her section and ensured it was signed by the resident or resident representative. She reported the social worker is no longer employed at the facility. During an interview with the Administrator on 11/7/19 at 3:07 PM he stated the social worker should have completed her section of the baseline care plan and ensured it was signed by Resident #109. 2. Resident #210 was admitted to the facility on 8/2/19 with diagnoses that included anemia and hypertension. Resident #210 ' s admission Minimum Data Set (MDS) dated 8/16/19 coded her cognitively intact, requiring limited assistance for most activities of daily and having the expectation to be discharged to the community. Resident #210 discharged on 11/7/19 and attempts to reach her were unsuccessful. A review of Resident #210 ' s medical revealed the facility failed to complete a baseline care plan. An interview was completed with MDS Nurse #1 on 11/7/19 at 1:54 PM who stated she initiated Resident #210 ' s baseline care plan but each discipline is responsible for completing their own section. She stated the social work section was	F 655	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; MDS, SW and Admissions Coordinator were in-serviced by DON on the baseline care plan process and ensuring that all sections are completed by the appropriate department. This in-servicing was completed on 11-14-19 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; DON, ADon, and or Unit coordinator will audit all new admissions 5 x week x 12 weeks then 3 x week x 4 weeks to ensure baseline care plan is completed. Indicate dates when corrective action will be completed; 11-29-19	

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F 655	Continued From page 24 not completed as the social worker was no longer employed by the facility. MDS Nurse #1 further stated no one ensured the resident signed the baseline care plan. During an interview with the Administrator on 11/7/19 at 3:07 PM he stated a new social worker has been hired and will be instructed to complete her section of the baseline care plan and ensure it is signed by the resident.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		11/29/19

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F 657	Continued From page 25 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record reviews, the facility failed to have a care conference for 1 of 1 residents (Resident # 88) reviewed for care plans. Findings included: Resident # 88 was admitted to the facility on 6/7/2019 with diagnoses which included sepsis, atrial fibrillation, and Type 2 diabetes. A review of a quarterly Minimum Data Set (MDS) dated 9/11/2019 revealed Resident # 88 was moderately cognitively impaired and required extensive assistance with activities of daily living (ADL). During an interview with Resident # 88 on 11/5/2019 at 1:00 pm, the resident revealed he had not been invited to a care conference since his admission and did not know what a care conference was. The record review revealed no documentation a care conference had taken place. An interview with the Social Worker (SW) on 11/6/2019 at 8:32 am, revealed the Social Worker was responsible for initiating contact with the resident and the resident's representative to invite both parties to the care conference. The SW further stated that she could not find any documentation that Resident # 88 or the resident's representative had been contacted about a care conference.	F 657	F 657 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) contacted Resident #88 and the emergency contact on 11/15/19 to invite them to a care plan conference scheduled for 11/21/19. The emergency contact declined to attend and did not want to reschedule or attend via phone. Resident #88 declined to attend the care plan conference and did not voice any concerns or questions related to his plan of care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents are at risk to be affected by the alleged deficient practice of failing to have a care conference to review the residents care plan. The MDS nurses completed an audit on 11/11/19, to identify when the last care conference was held for each resident. There were 27 residents identified that had not had a care conference held within the last quarter of their MDS assessment. The SSD notified via letter and/or phone call for the 27 residents and/or the Resident representative (RP) on 11/15/19, to invite/schedule a care conference.	

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F 657	Continued From page 26 During an interview with MDS Nurse #1 on 10/7/2019 at 9:28 am, MDS Nurse #1 stated the MDS department would give the SW a calendar of the conferences that needed to be scheduled and the SW would contact the representative and resident to schedule the care conference. The MDS Nurse #1 further stated the schedule would be returned to the MDS department with the conference dates on it. MDS Nurse #1 stated Resident # 88 had not had a care conference since his admission. She also stated that she did not know how the conference was missed. An interview with the Administrator on 10/7/2019 at 3:00 pm revealed the SW should have sent an invitation letter to the resident's representative for the care conference and Resident # 88 should have also been invited to attend the meeting.	F 657	Conferences were completed for the 27 identified residents by 11/21/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services (RCD) completed education on 11/26/19, for the SSD, MDS nurses, Director of Nursing and the Assistant Director of Nursing regarding the process for inviting and conducting the care conference. The MDS nurses will provide a calendar to the SSD and the DON, of upcoming MDS assessments. The SSD or the MDS nurse will provide/mail a written and/or verbal invitation to the resident and/or the RP. The resident and/or the RP will have the opportunity to request date/time change and ability to attend via phone. The Interdisciplinary team will complete the Multidisciplinary Care Conference form, summarizing the residents plan of care. The plan of care will be discussed with the resident and/or the RP and they will be asked to sign the Multidisciplinary Care conference form or documentation will support that the resident and/or RP declined to attend. The signed form will be placed in the residents hard chart. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON or the ADON will monitor/audit care conference invite letters weekly for 3	

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F 657	Continued From page 27	F 657	months, then bi weekly for 3 months, to validate that residents and/or RP were invited to the care conference. The DON or the ADON will monitor/audit Multidisciplinary Care Conference forms weekly for 3 months, then bi weekly for 3 months to validate that conferences were held and resident and/or RP signed the form if attended, or documentation to support resident and/or RP declined to attend. The DON or the ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or the ADON will review the plan during monthly QAPI and will continue monitors at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; November 29, 2019	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		11/29/19

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F 661	Continued From page 28 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 1 closed records reviewed for a planned discharge (Resident # 109). The findings included: Resident #109 was admitted to the facility on 8/2/19 with diagnoses that included anemia and hypertension. Resident #109's admission Minimum Data Set dated 8/16/19 coded him cognitively intact, requiring limited assistance for most activities of daily and having the expectation to be discharged to the community. Resident #109 was discharged home on 8/30/19 and a review of closed records revealed the facility failed to complete a recapitulation of Resident #109's stay in the facility.	F 661	F 661 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #109 has been discharged from the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that plan to discharge are at risk for the alleged deficient practice of failure to complete a recapitulation of stay for a planned discharge. Address what measures will be put into	

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F 661	Continued From page 29 During an interview with the Social Worker on 11/7/19 at 2:20 PM she stated she was recently hired and it is her role to ensure home health and durable medical equipment were ordered for residents, if needed, prior to discharge. She stated she was not familiar with the discharge planning paperwork completion. An interview was conducted with the Assistant Director of Nursing who discharged Resident #109 on 11/7/19 at 12:07 PM stated she had no knowledge of discharge recapitulation of stay. An interview was conducted with the Administrator on 11/7/19 at 3:03 PM who indicated all sections of Resident #109's discharge summary should have been completed prior to his discharge.	F 661	place or systemic changes made to ensure that the deficient practice will not recur; In service with the IDT team was held on 11-19-19. The discharge process was reviewed. SW will imitate the IDT discharge planning tool to be completed by the team. On day of discharge the nurse and/or SW will print the form, review with resident and/or family, review the medication list and have them sign a copy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; DON/ Assistant Director of Nursing will audit 100% of discharge charts 5 x week x 4 weeks then 3 x week x 4 weeks then q month to validate that the D/C planning tool was complete and reviewed with the resident/family. Indicate dates when corrective action will be completed; 11-29-19	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide nail care for 1 of 2 residents (Resident #5) reviewed who were	F 677	F 677 Address how corrective action will be	11/29/19

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F 677	Continued From page 30 dependent on staff for assistance with activities of daily living. The findings included: Resident #5 was admitted to the facility on 3/20/17. Her diagnoses included vascular dementia and heart failure. A review of the quarterly minimum data set (MDS) dated 7/22/19 revealed she was severely cognitively impaired. She had no behaviors or rejection of care. Resident #5 required extensive assistance with activities of daily living (ADLs) including eating. She was totally dependent on staff for bathing. The care plan for resident #5 initiated on 9/15/17 (no revision date observed) revealed she had ADL self-care performance deficit related to disease process. The care plan stated she required staff assistance to complete ADL tasks daily. The interventions included Resident #5 required total assistance by one staff with bating/showering daily and as needed. An observation of Resident #5 on 11/4/19 at 4:19 PM revealed her fingernails on both hands had brown debris under the nails. On 11/6/19 at 11:48 AM Nursing Assistant (NA) #4 stated she was the care giver for Resident #5 today. NA #4 said she had given the resident a bath this morning. An observation of Resident #5's fingernails revealed the fingernails on both hands continued to have brown debris under the nails on both hands. The fingernail on the right ring finger was	F 677	accomplished for those residents found to have been affected by the deficient practice; Residents nails were cleaned and trimmed by Nurse #5 on 11-6-19. Resident #5□s nails will be cleaned as needed and will be checked by the licensed nurse at least weekly. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit of all resident□s fingernails was completed by licensed nurses on 11-19-19. Nail care was provided at the time by the licensed nurse and/or CNA to any resident that needed nail and/or agreed to have nail care. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All nursing staff was in-serviced on providing ADL care- specifically providing nail care with bath or shower. Employees will be educated upon return to work. New employees will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Licensed nurse will complete an audit on nail care of the residents on their hall 1 x week x 4 weeks, then bi weekly x 4 weeks, then monthly. DON/ADON will do weekly audits to	

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F 677	Continued From page 31 ¾ to 1 inch long. On 11/6/19 at 12:14 PM NA #4 stated she gave Resident #5 a bath that morning. She stated as part of the bath she would use the wash cloth to clean under the fingernails. Upon viewing Resident #5's fingernails she stated the fingernails were dirty and needed to be clipped. She did not respond when questioned why the fingernails were not cleaned during the bath this morning. On 11/6/19 at 12:15 PM Nurse #1 observed Resident #5's fingernails. She reported the fingernails should have been cleaned and clipped because the fingernails on both hands were dirty and needed to be clipped. On 11/7/19 at 11:24 PM Nurse #5 said Resident #5 had never refused care but did not like to have her nails trimmed. Nurse #5 stated when she was the cart nurse for that hall she would clean and clip resident #5's fingernails weekly. Nurse #5 stated she clipped Resident #5's fingernails yesterday. She stated nail care should have been completed during the resident's bath. On 11/7/19 at 12:05 PM the Director of nursing stated the NA was responsible to provide nail care as part of the resident's bath.	F 677	identify patterns and/or trends and will adjust plan as needed to maintain compliance. Plan will be reviewed in the monthly QAPI meeting for at least 3 months or until compliance is maintained. Indicate dates when corrective action will be completed; 11-29-19	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-	F 685		11/29/19

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F 685	Continued From page 32 §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to arrange transportation for an eye appointment for 1 of 1 residents reviewed for vision (Resident #63). The findings included: Resident #63 was admitted to the facility on 7/25/18. Her diagnoses included morbid obesity, diabetic foot ulcer and hypertension. A review of the nursing notes revealed a note dated 7/25/19 by Nurse #1 which read she was aware of orders from the doctor and an appointment was scheduled with the local eye doctor on 8/7/19. A note by Nurse #4 dated 8/7/19 revealed Resident #63 returned from the (eye) appointment and was scheduled for a return appointment on 10/9/19. The quarterly Minimum Data Set dated 10/1/19 revealed Resident #63 was cognitively intact. She had adequate vision and did not use corrective lenses. She required limited assistance of 2 people for transfers. She was not steady for surface to surface transfers but was able to	F 685	F 685 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Method of transportation has been secured for resident number #63. Resident has eye appointments scheduled for 12-2-19, and 1-23-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All current facility residents with special transportation needs are @ risk for the alleged deficient practice. Currently there are no other residents with special transportation needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON provided in- service to all unit coordinators on appointment scheduling and arrangement of transportation. A list of appointments that need to be	

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F 685	Continued From page 33 stabilize with staff assistance. She had range of motion impairment on one side of her lower extremity. She had no behaviors or rejection of care. Resident #63's care plan revised on 8/5/19 revealed she had self-care performance deficit related to impaired mobility. For transfers she could stand and pivot from bed to wheelchair with one staff assist but required a mechanical lift to transfer from wheelchair back to bed and needed 2 staff assist. The care plan did not address vision or eye care. The 10/15/19 note by Nurse #4 stated the resident returned from eye appointment. "Need to evaluate retina, waiting for resident to be in wheelchair before proceeding." A review of the consult note dated 10/15/19 from the eye appointment read "Findings: Consider cataract sx (surgery) Need to evaluate retina. Waiting for patient to be in wheelchair before procedure." An observation on 11/5/19 at 2:20 PM revealed Resident #63 was seated in a wheelchair outside her room door. She had her head down reading a book. She was wearing 2 pairs of glasses at the same time. During an interview on 11/5/19 at 2:20 PM Resident #63 stated her vision had decreased so much in the past 2 months she could not see so she was trying to accomplish reading by wearing 2 pairs of reading glasses at the same time. During an interview on 11/7/19 at 8:15 AM Resident #63 stated her vision had changed significantly in the last 2-3 months due to not	F 685	scheduled will be kept in the front of the appointment book, and date and time of appointment will be listed. Appointment book will be brought to the morning meeting 5 days a week to discuss. In servicing was initiated on 11-26-19. In servicing, will include unit coordinators as they return to work and will be included in orientation for U/C that are new to the role. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; DON/Administrator / ADON will audit the appointment list to ensure all appointments have been scheduled and attended 5 x week x 4 weeks , then 3 x week x 4 weeks then 1 x week. DON/Administrator will review audits to identify patterns or trends and adjust plan as needed to maintain compliance. Plan will be reviewed in monthly QAPI meeting for at least 3 months or until compliance is maintained. Indicate dates when corrective action will be completed; 11-29-19	

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	345228	A. BUILDING _____ B. WING _____	C 11/07/2019

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F 685	Continued From page 34	F 685		

receiving an injection in her eye because she needed a test prior to getting another injection. She was seeing an eye doctor in another city but was unable to continue there because the contracted transportation company did not have the ability to accommodate the wide wheelchair she was using because it would not fit into the van. She stated the facility measured their facility van's lift width and her wheelchair would not fit into their van. She reported the solution was to transport her by stretcher with the other contracted transport company who provided stretcher transportation. Resident #63 continued to report the facility did assist with an eye appointment locally but again she had to be transported by stretcher. She stated during the eye appointment she was informed she needed to complete an eye test which required her to be sitting upright and able to fit at the examination equipment but the stretcher would not fit for the eye test to be completed. She stated without that particular eye test she was no able to receive the injections into her eye which were required for her vision to stabilize. She also stated she was unable to visualize her husband ' s face yesterday when he visited but she knew it was him based on the sound of his footsteps as he entered the dining area where she was. Resident #63 then stated she had her own personal wheelchair which was smaller than the facility wheelchair she was currently using. The resident said she only sat in her personal wheelchair one time for a few minutes to demonstrate to the facility she could sit in it. She said Nurse #1 told her the wheelchair was too tight for her to sit in it.

On 11/7/19 at 1:50 pm Nurse #1 stated the facility had a facility van and had 2 contracted van companies, one for wheelchair transport and the

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F 685	Continued From page 35 other for stretcher transport. Nurse #1 said they do not have a van that will accommodate the large wheelchair the facility provided for Resident #63. She added Resident #63 had a wheelchair she used at home but it would not fit into the facility van. Nurse #1 reported she observed Resident #63 sitting in her personal wheelchair and noted the wheelchair was too small for the resident. She said she had only seen the resident in her personal wheelchair one time. Nurse #1 was aware Resident #63 needed to be in a wheelchair for a test she needed at the eye doctor. She stated the eye doctor was a local doctor. On 11/7/19 at 2:45 PM the Director of Nursing (DON) stated she was aware Resident #63 requested to go to the eye doctor and she would have go by wheelchair and the wheelchair she was using did not fit into the facility van or in the contracted van transport company's van. The DON stated Resident #63 brought in her personal wheelchair to try. She stated she thought the personal wheelchair did fit onto the van but the resident did not fit into the wheelchair. The DON said she thought the Administrator had called other transport companies to request a bariatric wheelchair transport but he had no luck.	F 685		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident council and	F 745	F 745	11/29/19

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F 745	Continued From page 36 staff interviews the facility failed to provide assistance to residents to help them vote in a municipal election held 11/5/19. The findings included: The resident council minutes dated 10/31/19 revealed resident council members were instructed assistance with voting was the responsibility of the residents ' family members. An interview was conducted on 11/6/19 at 10:04 AM with the facility's resident council. There were ten residents present in the meeting. During the meeting residents expressed a concern related to the provision for residents to vote in elections. The residents stated that they were informed that any assistance needed with the voting process would have to be the responsibility of their family members. They stated that some residents do not have family members who are able to assist them with voting. Resident #23 stated during the Resident Council meeting on 11/6/19 at 10:04 AM that she did not feel it was fair that people who did not have involved family members to assist with the voting process were unable to exercise their right to vote. Resident #57 reported on 11/6/19 at 10:05 AM during the Resident Council meeting that she had a family member that provided with her an absentee ballot in the 11/5/19 election. She further stated the facility used to provide assistance with voting and staff from the Board of Elections would come to assist with the process. An interview was conducted with the Activity	F 745	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Activities Director and the Administrator attended the Resident Council meeting on 11/22/19, and informed the residents in attendance that the facility will assist residents with voting. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that need assistance with voting have the potential to be affected by the alleged deficient practice of failure to assist residents with voting. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services provided education on 11/26/19, for the Activities Director, Social Service Director, Administrator and Director of Nursing regarding facility responsibility to assist residents with voting. The Activities Director or Social Service director will identify facility residents that may need assistance with voting prior to the election date. The Activities Director or Social Service Director will provide absentee ballots and assist residents as needed with voting in upcoming elections. Indicate how the facility plans to monitor	

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F 745	Continued From page 37 Director on 11/6/19 at who stated she had informed the residents that assistance with the voting process such as transportation to the polls or with obtaining absentee ballot process was the responsibility of the family members of the residents. She reported she was given this instruction from the prior Activities Assistant. An interview was conducted with the Administrator on 11/7/19 at 3:03 PM who indicated it is the responsibility of the facility to make provisions for residents to be able to vote in elections. He further indicated he was unaware that residents were given this information and would ensure provisions were made for residents to vote in future elections.	F 745	its performance to make sure that solutions are sustained; The Administrator or Director of Nursing will monitor the list of residents identified as needing assistance with voting and will validate that absentee ballots are available and the resident receives the assistance as needed to vote in the upcoming election. There is no current election underway in the county, state or US, that would affect our current residents. Completion of this monitor will be discussed during monthly QAPI through the next election date. Indicate dates when corrective action will be completed; November 29, 2019	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification of 12/07/18. This was for one recited deficiency that was originally cited in December 2018 on an annual recertification and complaint survey and subsequently cited	F 867	F 867 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) contacted Resident #88 and the emergency contact on 11/15/19 to invite	11/29/19

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F 867	Continued From page 38 again during the facility's current recertification and complaint survey of 11/07/19. The recited deficiency was in the area of care plan timing and revision. The continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referenced to: F-657 Care Plan Timing and Revision: Based on resident and staff interviews, and record reviews, the facility failed to have a care conference for 1 of 1 resident (Resident # 88) reviewed for care plans. During the facility's 12/07/18 annual recertification and complaint survey the facility was cited for failing to invite residents and responsible parties to participate in care plan meetings for 1 of 1 sampled residents (Resident #64) reviewed for care plan participation. During an interview with the Administrator on 11/07/19 at 4:42 PM, he stated the facility should have continued performing the QAA audits for a longer period of time after being cited for tag F-657 during the facility's 12/07/18 survey.	F 867	them to a care plan conference scheduled for 11/21/19. The emergency contact declined to attend and did not want to reschedule or attend via phone. Resident #88 declined to attend the care plan conference and did not voice any concerns or questions related to his plan of care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents are at risk to be affected by the alleged deficient practice of failing to have a care conference to review the residents care plan and failure to maintain an effective QAPI plan. The MDS nurses completed an audit on 11/11/19, to identify when the last care conference was held for each resident. There were 27 residents identified that had not had a care conference held within the last quarter of their MDS assessment. The SSD notified via letter and/or phone call for the 27 residents and/or the Resident representative (RP) on 11/15/19, to invite/schedule a care conference. Conferences were completed for the 27 identified residents by 11/21/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services provided in service education on 11/26/19, for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS	

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F 867	Continued From page 39	F 867	coordinators, Social Worker, Activities Director and Infection Control Nurse, regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The Regional Director of Clinical Services (RCD) completed education on 11/26/19, for the SSD, MDS nurses, Director of Nursing and the Assistant Director of Nursing regarding the process for inviting and conducting the care conference. The MDS nurses will provide a calendar to the SSD and the DON, of upcoming MDS assessments. The SSD or the MDS nurse will provide/mail a written and/or verbal invitation to the resident and/or the RP. The resident and/or the RP will have the opportunity to request date/time change and ability to attend via phone. The Interdisciplinary team will complete the Multidisciplinary Care Conference form, summarizing the residents plan of care. The plan of care will be discussed with the resident and/or the RP and they will be asked to sign the Multidisciplinary Care conference form or documentation will support that the resident and/or RP declined to attend. The signed form will be placed in the residents hard chart. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON or the ADON will monitor/audit care conference invite letters weekly for 3 months, then bi weekly for 3 months, to validate that residents and/or RP were invited to the care conference.	

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F 867	Continued From page 40	F 867	The DON or the ADON will monitor/audit Multidisciplinary Care Conference forms weekly for 3 months, then bi weekly for 3 months to validate that conferences were held and resident and/or RP signed the form if attended, or documentation to support resident and/or RP declined to attend. The DON or the ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the DON will review the plan during monthly QAPI and will continue monitors at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; November 29, 2019	