STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 11/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 An unannounced Recertification survey was conducted on 11/05/19 through 11/09/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VONC11.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Investigation survey was conducted from 11/05/19 through 11/09/19. Two of the 29 allegations were substantiated. Event ID #VONC11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to place a call light within reach for 1 of 3 residents reviewed for accommodation of needs (Resident #4). Findings included: Resident #4 was admitted to the facility on 6/11/2018. Her diagnosis included muscle weakness and foot drop. Resident #4's quarterly Minimum Data Set (MDS) dated 10/26/2019 revealed she had cognitive impairment and required extensive assistance with activities of daily living.	F 558	1) On 11/6/19, Maintenance switched resident #4's call light to a 'Pancake" shape to accommodate resident's needs. Also a clip was attached and call light placed within reach of the resident 2) On 11/7/19 a Quality Review was conducted by Management Team of current residents' call light to ensure clip in place and call lights were within residents reach. Issues identified were addressed. 3) Nurse Management will educate facility staff on reasonable accommodations of	12/7/19

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

Electronically Signed | 12/03/2019

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F 558	Continued From page 1 Resident #4 had a plan of care in place regarding alteration in musculoskeletal status related to contractures. The interventions were inclusive of ensuring her call light was within reach and respond promptly to all requests for assistance. An observation was made on 11/5/2019 at 9:43 AM of Resident #4. She was in bed resting and her call light was observed dangling beside the bed on the right side out of her reach. A follow up observation was made on 11/5/2019 at 11:39 AM and 3:06 PM of Resident #4. She was in bed and her call light continued to dangle bedside the bed on the right side out of her reach. An interview and observation was completed with Nurse Aide (NA) #2 on 11/5/2019 at 3:11 PM. NA #2 stated she was familiar with Resident #4. She stated the resident required assistance with bathing and dressing. NA #2 observed the call light dangling on the side of the bed. She verbalized Resident #4's call light should have been attached to her chest, so she could reach it. An observation was made on 11/7/2019 at 10:05 AM of Resident #4. She was in bed resting and her call light was on the floor. An interview and observation was completed with Unit Manager (UM) #1 on 11/7/2019 at 10:09 AM. UM #1 observed Resident #4's call light on the floor and not accessible to her. UM #1 verbalized "Resident #4's call light should not be on the floor". UM #1 explained Resident #4's call light should be within reach and accessible. She continued to explain the NA just completed care and should have made sure the call light was	F 558	needs related to call lights being within reach for residents by 12/9/19. The education will also be included in Orientation for new hires. During Mock Survey Rounds, the Interdisciplinary Team will make sure call lights are within reach for the residents. Also Licensed Nurses and Certified Nursing Assistants will check for placement during their rounds. 4) Interdisciplinary Team/ Designee through Mock Survey Rounds will observe residents to ensure call lights are within reach for residents three times per week for four weeks, then one time per week for two months and then one time monthly for three months to ensure compliance. The Director of Nursing will report on the result of the quality monitoring (Audits) to the Quality Assurance Performance Improvement Committee. The finding will be reviewed monthly by the Quality Assurance Improvement Committee and Audits updated if changes are needed based on finding. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 558	Continued From page 2 accessible prior to leaving the resident's room. UM #1 confirmed Resident #4 utilized her call light, as well as, hollered/ yelled out for staff assistance. An interview was completed with the Director of Nursing (DON) on 11/7/2019 at 1:22 PM. The DON explained staff should move the call bell along with the resident if they were in bed or in their chair. She continued to explain Resident #4 moved herself and at times threw the call light on the floor. The DON stated Resident #4 used her call light for staff assistance or would yell/ holler out for assistance. The DON verbalized Resident #4's call light should have been accessible to her. An interview was completed with the Administrator on 11/7/2019 at 3:48 PM. The Administrator verbalized he expected the resident's call lights to be accessible and within reach.	F 558		
F 641 SS=E	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 interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Preadmission Screening and Resident Review (PASRR) for 3 of 6 residents (Resident #14, #32, #23) reviewed for PASRR, Hospice services for 1 of 1 residents (Resident #24) that was terminally ill, and Range of Motion for 1 of 4 residents (Resident #5) reviewed for splinting devices.	F 641	1). On 11/8/19, Residents # 14, # 32, and # 23's Minimum Data Set (MDS) was updated to accurately reflect the residents MDS Assessment for Preadmission Screening and resident review (PASRR)by the MDS Nurse and Regional MDS nurse. On 11/7/19, resident # 24's MDS was updated to accurately reflect the residents	12/7/19

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F 641	Continued From page 3 Findings included: 1. Resident #14 admitted to the facility on 3/4/2016. Her diagnoses included schizophrenia and major depressive disorder. Resident #14's annual MDS dated 2/24/2019 revealed severe cognitive impairment. Review of Section A1500- Preadmission Screening and Resident Review (PASRR) indicated Resident #14 did not have a mental illness and did not require a Level II PASRR to ensure appropriate placement in a long term care facility. Review of Resident #14's electronic medical record revealed a Level II PASRR issued on 3/30/2016. An interview was completed with the MDS Nurse on 11/7/2019 at 11:58 PM. The MDS Nurse explained she should look at the paperwork regarding PASRR, the current diagnoses list, and the medical record regarding PASRR level. The MDS Nurse further stated she should communicate and verify with Social Services to ensure coding was correct in Section A1500. She verbalized the coding was made in error and modification assessments would be completed to accurately reflect the residents current PASRR level. An interview was completed with the Administrator on 11/7/2019 at 3:41 PM. He stated the MDS assessment should be coded accurately related to PASRR. 2. Resident #32 admitted to the facility on 4/3/2019. Her diagnoses included schizophrenia	F 641	MDS Assessment for Hospice by the MDS Nurse. On 11/25/19, resident #5's MDS was updated to accurately reflect the residents MDS Assessment for Functional Limitation in Range of Motion in the Upper Extremity by the MDS nurse. 2). On 11/8/19, the Social Worker performed Quality Improvement monitoring of all residents to ensure accurate PASRR numbers in the medical record. On 11/8/19, the Regional MDS nurse performed Quality Improvement of all PASRR Level II resident's most recent comprehensive assessment to ensure accurate PASRR coding. On 11/7/19, the MDS nurse performed Quality Improvement of all Hospice residents to ensure accurate coding. On 11/25/19, the MDS nurse and Regional MDS nurse performed Quality Improvement on most recent assessment on all residents with Functional Limitation in Range of Motion to ensure accurate coding of range of motion. Issues identified were addressed. 3). On 11/8/19,the facility MDS nurse was re-educated by the regional MDS nurse on MDS coding accuracy for PASRR, Hospice and Functional Limitation in Range of Motion. On 11/27/19, the Interdisciplinary Team was re- educated by the Regional MDS nurse on resident PASRR determination.	

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F 641	Continued From page 4 and psychotic disorder. Resident #32's annual MDS dated 4/10/2019 revealed severe cognitive impairment. Review of Section A1500- Preadmission Screening and Resident Review (PASRR) indicated Resident #32 did not have a mental illness and did not require a Level II PASRR to ensure appropriate placement in a long term care facility. Review of Resident #32's electronic medical record revealed a Level II PASRR issued on 4/3/2019. An interview was completed with the MDS Nurse on 11/7/2019 at 11:58 PM. The MDS Nurse explained she should look at the paperwork regarding PASRR, the current diagnoses list, and the medical record regarding PASRR level. The MDS Nurse further stated she should communicate and verify with Social Services to ensure coding was correct in Section A1500. She verbalized the coding was made in error and modification assessments would be completed to accurately reflect the residents current PASRR level. An interview was completed with the Administrator on 11/7/2019 at 3:41 PM. He stated the MDS assessment should be coded accurately related to PASRR. 3. Resident #23 readmitted to the facility on 10/21/2019. His diagnoses included major depressive disorder. Resident #23's admission MDS dated 10/29/2019 revealed intact cognition. Review of Section A1500- Preadmission Screening and Resident	F 641	The Director of Nursing and/ or Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessments for accuracy of MDS Assessments- to include PASRR, Hospice and Functional Limitation in Range of Motion- on four random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 12/2/19. 4). The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee (QAPI). Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly. and quarterly at a minimum.	

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F 641	Continued From page 5	F 641		

Review (PASRR) indicated Resident #26 did not have a mental illness and did not require a Level II PASRR to ensure appropriate placement in a long term care facility.

Review of Resident #23's electronic medical record revealed a Level II PASRR issued on 4/24/2019.

An interview was completed with the MDS Nurse on 11/7/2019 at 11:58 PM. The MDS Nurse explained she should look at the paperwork regarding PASRR, the current diagnoses list, and the medical record regarding PASRR level. The MDS Nurse further stated she should communicate and verify with Social Services to ensure coding was correct in Section A1500. She verbalized the coding was made in error and modification assessments would be completed to accurately reflect the residents current PASRR level.

An interview was completed with the Administrator on 11/7/2019 at 3:41 PM. He stated the MDS assessment should be coded accurately related to PASRR.

4. Resident #24 readmitted to the facility on 8/1/2018. Her diagnoses were inclusive of vascular dementia with behavior disturbance, and deaf non-speaking.

A Hospice contract dated 9/4/2018 certified Resident #24 was admitted under the care and services of Hospice for end of life.

Review of the annual MDS dated 9/11/2019 revealed Resident #24 had severe cognitive impairment. Review of Section O0100K- Special

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F 641	Continued From page 6	F 641		

Treatments and Programs was coded as Resident #24 not receiving Hospice services.

An interview was completed with the MDS Nurse on 11/7/2019 at 11:07 AM. The MDS Nurse stated she was aware Resident #24 was on Hospice and should have been coded as receiving those services. She further verbalized the coding was an oversight and she would correct the assessment.

An interview was completed with the Administrator on 11/7/2019 at 3:41 PM. He stated he would expect for the MDS assessment to be coded accurately to reflect the resident's status/ condition.

5. Resident #5 was readmitted to the facility on 04/27/19 with diagnoses which included cerebral infarction and hemiplegia affecting left non-dominant side.

Resident #5's admission Minimum Data Set (MDS) dated 05/04/19 revealed short term and long-term memory problems. The MDS indicated there were no functional limitations in Resident #5's range of motion which interfered with daily functions or placed Resident #5 at risk for injury.

Resident #5's most recent quarterly MDS dated 08/01/19 revealed an assessment of severely impaired cognition. The MDS indicated there were no functional limitations in Resident #5's range of motion which interfered with daily functions or placed Resident #5 at risk for injury.

Resident #5's Functional Maintenance Program dated 08/01/19 revealed direction for daily passive range of motion of the left arm to

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F 641	Continued From page 7 increase joint flexibility for tolerance with elbow and wrist/hand splints. Resident #5's care plan dated 08/07/19 revealed interventions for an alteration in musculo-skeletal status related to contractures included use of supportive devices as recommended. Observations on 11/05/19 at 11:51 AM and 3:08 PM, on 11/06/19 at 8:50 AM and 2:04 PM and on 11/07/19 at 9:26 AM, 10:26 AM and at 12:01 PM revealed Resident #5's left elbow and hand were contracted without splint use. Interview with the MDS Coordinator on 11/08/19 at 10:48 AM revealed Resident #5's left upper extremity impairment was not coded since Resident #5 would not regain use of the left arm. The MDS Coordinator reported contracture management for pain of risk of pressure injury was not considered. Interview with the Administrator on 11/08/19 at 11:02 AM revealed Resident #5's MDS should be accurate.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		12/7/19

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F 688	Continued From page 8 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to apply a left elbow splint as ordered for 1 of 4 sampled residents who required splints for contracture management (Resident #5). The findings included: Resident #5 was readmitted to the facility on 04/27/19 with diagnoses which included cerebral infarction and hemiplegia affecting left non-dominant side. Resident #5's most recent quarterly MDS dated 08/01/19 revealed an assessment of severely impaired cognition. The MDS indicated there were no functional limitations in Resident #5's range of motion which interfered with daily functions or placed Resident #5 at risk for injury. Resident #5's Functional Maintenance Program dated 08/01/19 revealed direction for daily passive range of motion of the left arm to increase joint flexibility for tolerance with elbow and wrist/hand splints. Resident #5's care plan dated 08/07/19 revealed interventions for an alteration in musculo-skeletal status related to contractures included use of	F 688	1) On 11/6/19 physician notified and new order received to discontinue left elbow splint and to continue Active Range of Motion (AROM)/ Passive Range of Motion (PROM) exercises to prevent further contractures, use pillows and hand rolls for support for resident #5. 2) On 11/7/19, a Quality Review was conducted by Nurse Management of current residents with orders for splints to ensure they are being applied per physician orders. Issues identified were addressed. 3) Nurse Management will educate nursing staff to include licensed nurses, certified nursing assistants, and therapy department on splints application to ensure residents with orders for splints are applied per physician orders and to notify nurse manager immediately if splint not available. The education will be completed by 12/9/19. The education will also include in Orientation of new hires. Therapy will communicate to licensed nurse residents referred to restorative nursing for splint application. Licensed Nurse will transcribe order to treatment	

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F 688	Continued From page 9 supportive devices as recommended. Resident #5's occupational therapy summary dated 08/22/19 directed use of a left upper extremity orthotic (elbow/hand) for left upper extremity contracture management. A nurse practitioner's order dated 10/14/19 revealed direction for application of an elbow splint to Resident #5's left arm each morning with removal at bedtime. Resident #5's October 2019 Treatment Administration Record (TAR) revealed documentation of daily splint application from 10/01/19 to 10/24/19. Resident #5's November 2019 TAR revealed documentation of daily splint application from 11/01/19 to 11/05/19. Observations on 11/05/19 at 11:51 AM and 3:08 PM revealed Resident #5 in bed. Resident #5 did not have an elbow splint on his left arm. Observations on 11/06/19 at 8:50 AM and 2:04 PM revealed Resident #5 in bed. Resident #5 did not have an elbow splint on his left arm. Observations on 11/07/19 at 9:26 AM, 10:26 AM, and 12:01 PM revealed Resident #5 in bed. Resident #5 did not have an elbow splint on his left arm. Interview with Nurse Aide (NA) #1 on 11/07/19 at 12:08 PM revealed Resident #5 did not use a splint on the left arm. NA #1 reported she cared for Resident #5 since his transfer from another unit several weeks ago and was not aware of a splint.	F 688	record and update the resident's Kardex. The Certified Nursing Assistants will utilize the Kardex to know which residents need splints applied. Certified Nursing Assistants will be responsible for applying the splints. 4) Nurse Managements will conduct random audits to ensure splints are being applied per physician order Three times a week for four weeks, then one time a week for two months and then one time monthly for Three months to ensure Accuracy. The Director of Nursing will report on the results of the quality monitoring (Audits) to the Quality Assurance Performance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 688	Continued From page 10 During an interview with Medication Aide (MA) #1 on 11/07/19 at 12:12 PM, MA #1 reported Resident #5 should wear an elbow splint on the left arm. MA #1 was unable to locate Resident #5's elbow splint. Interview with the Occupational Therapist Assistant on 11/07/19 at 12:16 PM revealed Resident #5 received a discharge to restorative nursing for left elbow splint application on 08/22/19. Interview with the Director of Nursing (DON) on 11/07/19 at 12:28 PM revealed Resident #5's splint became unable to apply after a laundry mishap on 11/01/19. The DON reported Resident #5 should have received left arm positioning with pillows and a rolled cloth in the left hand when the splint became unavailable. A second interview with the DON occurred on 11/07/19 at 1:14 pm. The DON provided a vendor order for Resident #5's elbow splint replacement dated 11/07/19. The DON also provided a physician's telephone order dated 11/07/19 for discontinuance of the elbow splint and use of pillows and handrolls for support.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		12/7/19

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F 690	Continued From page 11 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain an indwelling urinary catheter's tubing and bag below the bladder for 1 of 3 sampled residents who used an indwelling urinary catheter (Resident #5). The findings included: Resident #5 was readmitted to the facility on 04/27/19 with diagnoses which included cerebral infarction, stage 4 pressure ulcer, hydronephrosis	F 690	1) Resident #5's indwelling urinary catheter tubing and bag were repositioned below the bladder. Physician notified and new order received on 11/6/19 to change full collection bag to leg bag. 2) On 11/6/19 a Quality Review was conducted by Nurse Management of current residents with indwelling urinary catheter to ensure indwelling urinary	

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	345473	A. BUILDING _____ B. WING _____	C 11/09/2019

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F 690	Continued From page 12 with renal and ureteral obstruction and hemiplegia affecting left non-dominant side. Resident #5's most recent Minimum Data Set (MDS) dated 08/01/19 revealed an assessment of severely impaired cognition. The MDS indicated use of an indwelling urinary catheter. Resident #5's care plan dated 08/07/19 revealed interventions for indwelling urinary catheter use included direction to position the catheter bag and tubing below the level of the bladder. Observations on 11/05/19 at 11:51 AM and 3:08 PM revealed Resident #5 supine in bed. Resident #5's indwelling urinary catheter bag was attached to left 1/3 side rail and at chest level, approximately 6 inches above the bladder. Observations on 11/06/19 at 8:50 AM and 2:04 PM revealed Resident #5 supine in bed. Resident #5's indwelling urinary catheter bag was attached to left 1/3 side rail and at chest level, approximately 6 inches above the bladder. Interview with Nurse Aide (NA) #1 on 11/06/19 at 2:06 PM revealed she did not notice Resident #5's indwelling urinary catheter tubing and bag placement. NA #1 immediately placed the catheter tubing and bag on Resident #5's bed frame below the bladder. Interview with Medication Aide (MA) #1 on 11/07/19 at 12:03 PM revealed she did not notice Resident #5's indwelling urinary catheter placement above the bladder when she administered medications on 11/06/19. An interview was conducted on 11/08/19 at 9:39	F 690	catheter tubing and bag are positioned below the bladder. Issues identified were addressed. 3) Director of Nursing and Nurse Management will educate Licenses Nurses and Certified Nursing Assistants on Indwelling Urinary Catheter placement by 12/9/19. Licensed Nurses and Certified Nursing Assistants will complete rounds throughout their schedule shift to observe for proper placement of indwelling urinary catheters. 4) Nurse Management will conduct random audits to observe residents with Indwelling Urinary Catheters for proper placement below the bladder three time a week for four weeks, then one time a week for two months and then one time monthly for three months to ensure accuracy. The Director of Nursing will report on the result of the quality monitoring (Audits) to the Quality Assurance Performance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 690	Continued From page 13 AM with Unit Manager #1. Unit Manager #1 reported Resident #5's indwelling urinary catheter tubing and bag should be placed below bladder lever. UM #1 reported staff should check for correct placement each time Resident #5 received care. Interview with the Director of Nursing (DON) on 11/08/19 at 12:28 PM revealed Resident #5's indwelling urinary catheter tubing and bag should be placed below the bladder. The DON reported staff training occurred on 11/07/19 to prevent recurrence of placement above the bladder.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		12/7/19

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F 732	Continued From page 14 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post accurate nurse staffing information for the facility in an area visible to residents and visitors for 1 out of 5 days during the recertification survey conducted 11/5/2019 through 11/9/2019. Findings included: An observation was completed on 11/5/2019 at 8:48 AM of posted nurse staffing. The observation revealed posted nurse staffing dated for 10/28/2019. An interview was completed with the Restorative Aide (RA), who also served as the Scheduler, on 11/5/2019 at 11:36 AM. She stated the Receptionist was responsible for updating the nurse staffing sheet and posting the nurse staffing sheet daily. The RA was not aware the nurse staffing sheet posted upon entry to the facility was dated for 10/28/2019 and not the current date of 11/5/2019. The RA was not	F 732	1) Staff posting immediately corrected on 11/5/19 to reflect accurate nurse staffing information for the facility. 2) Nurse Management and Scheduler completed audit of staff posting for the past 30 days on 11/ 30/19 to reconcile staff posting to on-shift. Issues identified were addressed. 3) Regional Director of Clinical Services educated Executive Director, Director of Nursing, Nurse Managers and Scheduler on staff posting on 12/2/19. Scheduler will be responsible for ensuring staffing is posted during the weekdays, on the weekends, Manager on Duty will be responsible for staffing being posted. The Scheduler will reconcile staff posting sheets to On-Shift to ensure accuracy. 4) Director of Nursing, Executive Director, or designee will audit nurse staff posting	

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F 732	Continued From page 15 certain as to why the nurse staffing sheet was not posted. An interview was completed on 11/5/2019 at 3:55 PM with the Receptionist. She revealed she and the RA were responsible for ensuring the nurse staffing sheet was completed and posted. The Receptionist stated she was aware the nurse staffing sheet was dated for 10/28/2019 and was not up to date. The Receptionist continued to verbalize she was waiting on the current schedules to complete the nurse staffing sheet and once she received them, she would update the posting. She explained the normal process would be for her to receive the updated schedule and complete the nurse staffing sheet and post the information first thing in the mornings. An interview was completed with the Director of Nursing (DON) on 11/7/2019 at 9:19 AM. The DON stated the process would be for the Receptionist and the RA to reconcile the nurse staffing sheet with current information and for the nurse staffing sheet to be posted daily. An interview was completed with the Administrator on 11/7/2019 at 4:04 PM. He stated the Receptionist should post the nurse staffing sheet daily with accurate information.	F 732	to ensure accurate nursing staff information is posted three times a week for four weeks, then one time a week for two months and then one time monthly for three months to ensure proper posting. The Director of Nursing will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The finding will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	