STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/12/19 through 11/15/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #492711.	E 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. §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	F 550		12/13/19

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

Electronically Signed | 12/02/2019

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F 550	Continued From page 1 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 observation, record review, and resident and staff interview, the facility failed to treat residents in a dignified manner as evidenced by failing to provide incontinence care when requested to Resident #64 resulting in her having to participate in Physical Therapy with pants wet from urination, missing 30 minutes of the annual Resident Council meeting, and causing her to feel embarrassed. The facility also failed to promote the dignity of residents by leaving Resident #110's meal tray on an open aired tray cart in the hall for a minimum of 20 minutes before assisting her with eating on 2 of 3 meal observations and failing to address Resident #12's complaints of difficulty sleeping caused by noises of yelling and banging from another resident. This failure to address Resident #12's complaints made him feel like no one was listening to his concerns. This was for 3 of 3 residents reviewed for dignity. The findings included: 1. Resident #64 was admitted to the facility on 7/25/18 with diagnoses that included bilateral post-traumatic osteoarthritis of knee, left and right knee contractures, and neuropathy.	F 550	F550: Resident Rights/Exercise of Rights Resident #64 was provided with incontinent care and was able to attend the Resident Council meeting. Resident #110 allegedly waited on her meal for more than 15 minutes to be served. If meal is served beyond 15 minutes from the time the tray arrives on the hall staff will reheat the food before serving the resident. Resident #12 has been moved to another room per resident request. All incontinent residents have the potential for the alleged deficient practice. Any dependent diners who choose to have meals in their rooms have the potential for alleged deficient practice. All residents have the potential for the alleged deficient practice regarding grievances. Staff Development Coordinator provided education on 11/29/19 on provision of incontinence care, timely delivery of resident meal trays for direct care staff which include; certified nursing assistants, licensed nursing staff, restorative staff, nurse managers, kitchen staff, and Guardian Angel team this education will	

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F 550	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 10/2/19 indicated Resident #64's cognition was intact. She had no behaviors and no rejection of care. Resident #64 was dependent on 2 or more for assistance with transfers and toileting and dependent on 1 for assistance with bed mobility and personal hygiene. She required the extensive assistance of 1 for dressing, she had functional limitations with range of motion on both sides of her lower extremities, and she utilized a wheelchair. Resident #64 was always incontinent of bladder and bowel. The active care plan for Resident #64 was reviewed on 11/14/19 and it included the focus area of assistance for all Activities of Daily Living (ADLs). This area was initiated on 7/11/19 and included, in part, the intervention of assistance with ADLs as needed. A nursing note dated 11/14/19 at 10:37 AM indicated Resident #64 returned to the facility from an appointment. An annual Resident Council meeting was conducted as part of the recertification survey on 11/14/19 at 2:30 PM. The Activity Director reported that Resident #64 would be late for the meeting as she was "waiting to be changed". At 2:55 PM on 11/14/19 Resident #64 entered the annual Resident Council meeting 25 minutes after the meeting began. On 11/14/19 at 3:25 PM following the annual Resident Council meeting an interview was conducted with Resident #64. Resident #64 stated that she was late for the meeting because	F 550	continue through 12/12/19. Staff Development Coordinator provided education on 11/29/ on facility grievance procedures for facility staff this education will continue through 12/12/19. An audit will be completed Director of Nursing or licensed nurse by 12/11/19 regarding residents with incontinence for signs of incontinence. An audit was will be completed Director of Nursing or licensed nurse by 12/11/19 on all dependent diners who eat in their rooms to determine how many meals are being served beyond 15 minutes from the time the tray arrived on the hall. Beginning 11/27/19 an audit was completed by Social Worker beginning for all interviewable residents on satisfaction with current roommate assignment. No residents stated a desire to change room assignments. Education was provided to direct care staff on 11/29/19 by Staff Development Coordinator (SDC) regarding timely incontinent care, with emphasis on ensuring residents with visible incontinence are changed immediately this education will continue through 12/12/19. Education was provided to direct care staff on 11/29/19 by Staff Development Coordinator (SDC) regarding timely delivery of meal trays and reheating meals if the tray sits on the carts for more than 15 minutes this education will continue through 12/12/19. Education provided to facility staff on 11/29/19 by SDC on Grievance procedures, with emphasis on reporting all grievances to social services this education will continue through 12/12/19.	

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F 550	Continued From page 3 she was waiting to receive incontinent care since she returned from an appointment this morning around 11:00 AM. The resident indicated that she knew what time it was because she had a digital clock on her phone that had the time on it. She reported that she told her assigned Nursing Assistant (NA), NA #5, that she needed to be changed several times and she said, "I know I will get to you". She went on to explain that she participated in Physical Therapy (PT) in her room that afternoon and the therapist saw that her pants were wet with urine. Resident #64 said that this interaction with the therapist as well as arriving to the Resident Council meeting late made her embarrassed. She further explained that she knew that all the residents in the meeting were aware that she was late because she needed to be changed. An interview was conducted with Resident #64's physical therapist on 11/15/19 at 8:35 AM. The therapist confirmed that she worked with Resident #64 in her room on the afternoon of 11/14/19 around 1:30 PM. She stated that she observed Resident #64's pants to be visibly wet with urine when she stood up from her wheelchair during the PT session. She reported that she was with Resident #64 for at least 30 minutes during that session. NA #5 was interviewed on 11/15/19 at 10:43 AM. NA #5 stated that she was assigned to Resident #64 on 11/14/19 from 11:00 AM to 3:00 PM. She reported that Resident #64 required assistance with incontinence care and she was able to let the staff know when she needed to be changed. She was asked if Resident #64 had requested assistance with incontinence care during her 11:00 AM to 3:00 PM shift on 11/14/19 and she	F 550	Beginning 11/23/2019 audits will be completed by Risk Manager (RM) to monitor timely tray distribution on alternating halls and alternating meals (to include weekends) three times weekly. Staff Development Coordinator to complete audits 3x per week on alternating halls to ask if residents are receiving incontinence care when needed. Social Worker to complete 10 resident interviews per week on alternating halls to ask if residents if they know how to report grievances and or if they have any unresolved grievances. The audits will be presented to the monthly QAPI by Risk Manager, Social Worker and Staff Development Coordinator for 3 months or until substantial compliance is achieved.	

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said the resident had not asked her for assistance until about 2:00 PM. NA #5 was asked if she had checked on Resident #64 prior to 2:00 PM to provide incontinence care and she revealed that she had not checked on the resident prior to 2:00 PM on 11/14/19. She explained that sometimes she asked Resident #64 if she needed to be changed and sometimes she just waited for the resident to tell her. She further explained that Resident #64 self-propelled her wheelchair throughout the facility and she was frequently outside so if she had not known where the resident was at then she wouldn't check to see if she needed changed. NA #5 stated that when she changed Resident #64 on the afternoon of 11/14/19 the resident's pants were wet with urine and she had to assist her with changing her pants.

An interview was conducted with the Director of Nursing (DON) on 11/15/19 at 1:25 PM. The DON reported that she expected all residents to be treated with dignity and respect. She further reported that she expected nursing staff to provide routine incontinence care to residents who required assistance.

2. Resident #110 was admitted to the facility on 6/26/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia.

A physician's order dated 9/9/19 indicated Resident #110 was to be assisted with all meals by staff.

The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired, she required the extensive assistance of 1 for eating,

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and she had significant weight loss.

A Registered Dietician (RD) note dated 11/12/19 indicated Resident #110's current weight was 140 pounds with 3.7% weight loss x 30 days, 13.6 % weight loss x 90 days, and 14.6% x 180 days. She required extensive assistance from staff with eating.

The active care plan for Resident #110 was reviewed on 11/12/19 and it included the focus area of nutritional risk (initiated on 9/17/19). The interventions included, in part, provide assistance during meals.

An observation was conducted of Resident #110 on 11/12/19 at 12:00 PM. She was in her room, eyes closed, and difficult to rouse. Resident #110 was not interviewable.

A continuous observation was conducted of the 100 hall during the lunch meal on 11/12/19 beginning at 12:20 PM. Resident #110's meal tray was observed with a lid covering the plate on an open-air cart on the 100 hall. All meal trays on the cart, with the exception of Resident #110's, were served to the residents within a 10-minute timeframe. Resident #110's meal tray remained on the open-air cart until 12:49 PM, 29 minutes after the meal tray was first observed on the hall. At 12:49 PM Nursing Assistant (NA) # 2 served the meal tray to Resident #110 and assisted her with eating.

A second meal observation was conducted of the 100 hall during the dinner meal on 11/12/19 at 5:10 PM. Resident #110's meal tray arrived on the open-air cart and was served to her within 10 minutes with staff assistance provided for eating.

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A third meal observation was conducted of the 100 hall during the dinner meal on 11/13/19 at 5:10 PM. Resident #110's meal tray was observed with a lid covering the plate on an open-air cart on the 100 hall. All meal trays on the cart, with the exception of Resident #110's, were served to the residents within a 10-minute timeframe. Resident #110's meal tray remained on the open-air cart until 5:30 PM, 20 minutes after the meal tray was first observed on the hall. At 5:30 PM an NA served the meal tray and assisted Resident #110 with eating.

An interview was conducted with NA #2 on 11/14/19 at 11:00 AM. She stated that she began working at the facility in June and she was frequently assigned to Resident #110. NA #2 recalled working with Resident #110 on 11/12/19 and acknowledged that it took close to 30 minutes for her meal tray to be served to her. She revealed that this was a normal occurrence for Resident #110's meal tray to sit on the open-air cart for greater than 20 minutes prior to being served to her. She explained that the NA assignment for the section of the facility where Resident #110 resided included a long hall and short hall on the 100-hall unit and encompassed more residents than some of the other assignments. She stated that she believed this was why it took so long for Resident #110's meal tray to be served and for her to be assisted with eating. When NA #2 was asked if Resident #110's food was still warm when served to her she said, "probably not" indicating that the resident was unable to make her needs known so she had not asked the resident if the food was warm enough. NA #2 explained that since the resident had already waited so long to get her

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food that she hadn't wanted her to have to wait longer for her to go reheat the food.

The Dietary Manager (DM) was interviewed on 11/14/19 at 1:41 PM. He reported he began working as the DM about 5 weeks ago. The observations of Resident #110's meal tray sitting on the open-air cart for 29 minutes prior to be served during lunch on 11/12/19 and for 20 minutes during dinner on 11/13/19 were reviewed with the DM. The DM stated that it was not acceptable for a meal tray to sit on the open-air tray cart for that long without being reheated prior to being served to the resident. He explained that they had some closed metal tray carts at the facility, and he was in the process of ordering coverings for the open-air tray carts to help keep the meals warm for a longer period of time.

An interview was conducted with the Director of Nursing (DON) on 11/15/19 at 1:25 PM. The DON reported that she expected all residents, regardless of their cognitive status, to be treated in a dignified manner. The observations of Resident #110's meal tray sitting on the open-air cart for 29 minutes prior to be served during lunch on 11/12/19 and for 20 minutes during dinner on 11/13/19 were reviewed with the DON. She indicated that if a cognitively impaired resident's meal tray had been sitting on an open-air tray cart for an extended period of time prior to being served that she expected staff to reheat the food prior to serving the meal to the resident. The DON stated that recently the facility had an increase in the number of residents who required assistance with eating which may have contributed to the delay in Resident #110's meal being served and eating assistance being provided.

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3. Resident #12 was admitted to the facility on 7/31/19 with diagnosis of cerebral vascular accident.

His care plan dated 8/1/19 documented goals and interventions for cardiac disease and assistance with activities of daily living.

The 14-day Minimum Data Set documentation revealed Resident #12 had an intact cognition. The resident required assistance of 1 staff for activities of daily living and the resident was always continent. The active diagnoses were cerebral vascular accident, muscle weakness, and unspecified abnormalities of gait.

On 11/12/19 at 12:17 pm Resident #12 was interviewed who stated his roommate (Resident #25) informed him "I hate you" when the resident asked the roommate to be quiet at night (during sleeping hours). The resident commented that he did not like his roommate ' s response. The resident complained that the resident was sleeping in his wheel chair at the nurses station all day and up at night getting up to the bathroom every hour. The roommate had not used the call light but called out for staff, yelling in the middle of the night. The resident stated he was kept awake and not getting enough sleep. The roommate also yelled and banged on the bathroom door while the resident used the bathroom (did not wait until the resident was finished), and the resident did not like this. The resident commented that he had informed the staff of his concerns and the staff would enter his room each night in response to the roommate ' s yelling and they were aware. The resident stated "this (roommate ' s behavior) keeps happening

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and no one has done anything."

An observation of Resident #12 during interview 11/12/19 at 12:17 am revealed he looked tired by his blinking eyes, yawning, and facial expression. The resident also commented he was tired.

Nurse #1 was interviewed on 11/13/19 at 9:30 am who stated she was familiar with Resident #12. Nurse #1 indicated she was informed by the resident and night staff "regularly" that the resident ' s roommate (Resident #25) had kept him up at night.

An observation was done of Resident #12 ' s roommate in his wheel chair at the nurses' station sleeping during this interview (11/13/19 at 9:30 am).

Resident #12 had additional information to add during interview on 11/13/19 at 10:25 am. The resident shared that his wife had asked staff for another room so he (the resident) could sleep at night. The resident ' s roommate had used foul language and stated "I hate you" which the resident does not like. The resident commented "it happened again last night."

Additional observation of Resident #12 during interview on 11/13/19 revealed he continued to appear tired by his blinking eyes, yawning, and facial expression.

An interview was conducted on 11/13/19 at 12:20 pm of Nursing Assistant #1 (NA) who was regularly assigned to the resident and stated she was aware that Resident #12 complained his roommate kept him up at night, banged on the bathroom door and hollered aggressively. NA #1

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stated this had been going on for a quiet a while, months. NA #1 stated that the roommate slept after breakfast and was provided activities in the afternoon instead of going back to bed to keep him awake during the day. NA #1 stated that she had informed the assigned nurse (Nurse #1) on more than one occasion.

On 11/13/19 at 2:50 pm an interview was conducted with Social Work (SW) #1 and #2 who both stated that they were not aware or been informed that resident #12 was unable to sleep because of loud yelling, behavior and verbal aggression from the resident ' s roommate. They were also not aware of the roommate ' s banging on the bathroom door and yelling when the resident was using the bathroom and statements such as "I hate you" and use of curse words. SW #1 stated she was not informed by the resident's spouse that there was a request for room change. SW #2 stated that she was informed today that the resident had concerns regarding his roommates yelling and was offered another room that was not by the window. The resident requested to be placed on the waiting list for another room with the bed by the window. Both SWs stated that nursing had not informed them of the complaints and a grievance was not initiated.

A review of Resident #12 ' s SW notes since the resident's admission (7/31/19) revealed they were notified by nursing on 11/13/19 and documented the resident's concern of his roommate ' s behaviors and inability to sleep. A room change was offered today and was declined; request was made to be placed on a waiting list for a room with a bed by the window.

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On 11/14/19 at 2:30 pm an interview was conducted with Nurse #1 who stated that Resident #12 complained to her on more than one occasion that his roommate was yelling at night and the resident was up at night (not able to sleep). Nurse #1 stated she asked psychiatry to address the roommate ' s yelling at night due to insomnia (last month). Nurse #1 indicated she did not inform SW of the resident's complaints or offer/consider writing a grievance because the resident did not ask for one.

The Director of Nursing (DON) was interviewed on 11/14/19 at 2:49 pm who was not aware of Resident #12 ' s complaints. The DON stated she expected resident complaints to be reported to SW for follow through with the grievance process. The DON commented she would start education with nursing staff to complete a grievance when the resident complains of something significant to them.

On 11/15/19 at 12:05 pm an interview was conducted with the Physician who was familiar with and responsible for Resident #12. The physician stated that he had been informed of the resident's roommate behavior escalation and that the resident has had behaviors for a long time. The physician commented he was informed several weeks ago, about mid October, that there was an altercation between residents, Resident #12 and his roommate, where the roommate was banging on the bathroom door and yelling. The Physician was informed that the resident was very upset about the incident. The Physician stated that he would expect staff to bring to the team (DON) resident to resident interaction (yelling at night and banging on the bathroom door and yelling while the roommate was in the

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 550	Continued From page 12 bathroom) where there was a concern.	F 550		
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. §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	F 585		12/13/19

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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 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

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F 585	Continued From page 14 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 decision. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview of the resident, staff and Physician, the facility failed to follow the grievance policy for 1 of 1 sampled resident (Resident #12). Findings included: The facility Grievances/Complaints, Recording and Investigating policy dated 4/2017 documented that "All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Upon receiving a greivance and complaint report, the Grievance Officer will begin an investigation into the allegations." Resident #12 was admitted to the facility on 7/31/19 with diagnosis of cerebral vascular accident. His care plan dated 8/1/19 documented goals and	F 585	F585: Grievances Resident #12 has been moved to another room per resident request. All residents have the potential for the alleged deficient practice regarding grievances. The Staff Development Coordinator conducted education on 11/29/19 and on facility grievance procedures for facility staff, with emphasis on reporting all resident concerns or grievances to their supervisor or the social worker to ensure follow up this education will continue through 12/12/19. All new hires will receive education upon hire during orientation. An audit was completed by Social Worker on 11/27/19 for all interviewable residents on satisfaction with current roommate assignment. No other residents had	

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F 585	Continued From page 15 interventions for cardiac disease and assistance with activities of daily living. The 14-day Minimum Data Set documentation revealed the resident had an intact cognition. The resident required assistance of 1 staff for activities of daily living and the resident was always continent. The active diagnose were cerebral vascular accident, muscle weakness, and unspecified abnormalities of gait. On 11/12/19 at 12:17 pm Resident #12 was interviewed who stated his roommate (Resident #25) informed him "I hate you" when the resident asked the roommate to be quiet at night (during sleeping hours). The resident commented that he did not like his roommate ' s response. The resident complained that the resident was sleeping in his wheel chair at the nurses station all day and up at night getting up to the bathroom every hour. The roommate had not used the call light but called out for staff, yelling in the middle of the night. The resident stated he was kept awake and not getting enough sleep. The roommate also yelled and banged on the bathroom door while the resident used the bathroom (did not wait until the resident was finished), and the resident did not like this. The resident commented that he had informed the staff of his concerns and the staff would enter his room each night in response to the roommate ' s yelling and they were aware. The resident stated "this (roommate ' s behavior) keeps happening and no one has done anything." Nurse #1 was interviewed on 11/13/19 at 9:30 am who stated she was familiar with Resident #12. Nurse #1 indicated she was informed by the resident and night staff "regularly" that the	F 585	complaints about current roommates or wanted a room change. Social Worker will complete 10 random resident interviews per week on alternating halls to ask residents if they know how to report grievances and or if they have any unresolved grievances starting 11/27/19. The audits will be presented to the monthly QAPI by the Social Worker for 3 months or until substantial compliance is achieved.	

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resident ' s roommate (Resident #25) had kept him up at night.

Resident #12 had additional information to add during interview on 11/13/19 at 10:25 am. The resident shared that his wife had asked staff for another room so he (the resident) can sleep at night. The resident ' s roommate had used foul language and stated "I hate you" which the resident does not like. The resident commented "it happened again last night."

An interview was conducted on 11/13/19 at 12:20 pm Nursing Assistant #1 (NA) who was regularly assigned to the resident and stated she was aware that Resident #12 complained his roommate kept him up at night, banged on the bathroom door and hollered aggressively. NA #1 stated this had been going on for a quiet a while, months. NA #1 stated that she had informed the assigned nurse (Nurse #1) on more than one occasion.

On 11/13/19 at 2:50 pm an interview was conducted with Social Work (SW) #1 and #2 who both stated that they were not aware or been informed that resident #12 was unable to sleep because of loud yelling, behavior and verbal aggression from the resident ' s roommate. They were also not aware of the roommate ' s banging on the bathroom door and yelling when the resident was using the bathroom and statements such as "I hate you" and use of curse words. SW #1 stated she was not informed by the resident's spouse that there was a request for room change. SW #2 stated that she was informed today that the resident had concerns regarding his roommates yelling and was offered another room that was not at the window. The

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resident requested to be placed on the waiting list for another room with the bed by the window. Both SWs stated that nursing had not informed them of the complaints and a grievance was not initiated. (SW are the Grievance Officers).

A review of Resident #12 ' s SW notes since the resident's admission (7/31/19) revealed they were notified by nursing on 11/13/19 and documented the resident's concern of his roommate ' s behaviors and inability to sleep. A room change was offered today and was declined; request was made to be placed on a waiting list for a room with a bed by the window.

On 11/14/19 at 2:30 pm an interview was conducted with Nurse #1 who stated that Resident #12 complained to her on more than one occasion that his roommate was yelling at night and the resident was up at night (not able to sleep). Nurse #1 stated she asked for psychiatry to address the roommate ' s yelling at night due to insomnia (last month). Nurse #1 indicated she did not inform SW of the resident's complaints or offer/consider writing a grievance because the resident did not ask for one.

The Director of Nursing (DON) was interviewed on 11/14/19 at 2:49 pm who was not aware of Resident #12 ' s complaints. The DON stated she expected resident complaints to be reported to SW for follow through with the grievance process. The DON commented she would start education with nursing staff to complete a grievance when the resident complains of something significant to them.

On 11/15/19 at 12:05 pm an interview was conducted with the Physician who was familiar

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F 585	Continued From page 18 with and responsible for Resident #12. The physician stated that he had been informed of the resident's roommate behavior escalation and that the resident has had behaviors for a long time. The physician commented he was informed several weeks ago, about mid October, that there was an altercation between residents, Resident #12 and his roommate, where the roommate was banging on the bathroom door and yelling. The Physician was informed that the resident was very upset about the incident. The Physician stated that he would expect staff to bring to the team (DON) resident to resident interaction (yelling at night and banging on the bathroom door and yelling while the roommate was in the bathroom) where there was a concern.	F 585		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) for a resident with two or more areas of	F 637	F637: Comprehensive Assessment after Significant Change Resident #114 Significant Change in	12/13/19

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F 637	Continued From page 19 decline (Activities of Daily Living, continence and pressure ulcer) for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #114). The findings included: Resident #114 was originally admitted to the facility on 6/11/19 with diagnoses that included a history of a stroke, compression fracture of the lumbar vertebrae, diabetes and heart failure. The Admission MDS assessment dated 6/18/19 indicated Resident #114 was cognitively intact and required supervision for eating, limited assistance for bed mobility, transfers and dressing, extensive assistance with toileting and hygiene and was dependent on staff for bathing. The assessment further indicated Resident #114 was continent of bowel and bladder and had no pressure ulcers. On 8/6/19 Resident #114 was discharged to the hospital and was readmitted on 8/13/19 with a new diagnosis of pneumonia and deep tissue injury noted to the left great toe and right heel. A review of the Wound Evaluation and Management Summary dated 8/21/19 revealed Resident #114 had unstageable Deep Tissue Injury to his right heel and left big toe for a duration of 9 days. Review of the Wound Evaluation and Management Summary dated 8/28/19 revealed the Deep Tissue Injury to Resident #114's right heel was resolved. A review of the Wound Evaluation and Management Summary dated 10/2/19 revealed	F 637	Status Assessment (SCSA) completed and transmitted on 11/27/2019 by MDS Coordinator. MDS Coordinator reset assessment date for Resident #114 upon discovery of significant change and completed new assessment for Resident # 114 of assessment reference date of 11/20/2019, completed on 11/26/2019 and transmitted on 11/27/2019. An audit of current residents with prior Omnibus Budget Reconciliation Act (OBRA) assessment completed and an acute care admission the last quarter reviewed for SCSA by MDS Coordinator, with no other SCSA identified. On 12/2/2019 MDS Coordinator began weekly audit of all residents for start of therapy, new skin issues or other significant changes identified to ensure capture of SCSA for all residents. On 12/2/2019 MDS coordinator began weekly interdisciplinary team, including but not limited to; MDS Coordinator, Director of Nursing and/or Unit Coordinator, Social Worker, Dietician and/or Dietary Manager, License Therapist, review of assessment schedule which entails identifying any significant change for residents 3 weeks prior to assessment reference date, 2 weeks prior to assessment date and 1 week prior to assessment date and review of residents readmitted to facility at the following clinical meeting. Education provided to Care Plan Team by Regional Minimum Data Set (MDS) Nurse on 11/22/2019 related to the Resident Assessment Instrument (RAI)Guidelines	

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F 637	Continued From page 20 the left big toe was a Stage 3 pressure ulcer (sores that have broken completely through the top two layers of the skin and into the fatty tissue below). A quarterly MDS assessment dated 10/22/19 revealed Resident #114 remained cognitively intact. He required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene and was dependent on a staff member for bathing. The assessment also indicated Resident #114 was always incontinent of bowel and bladder and had a stage 3 pressure ulcer. On 11/12/19 at 11:15am Resident #114 was interviewed. He stated he required very little assistance with bed mobility, transfers and dressing prior to his hospitalization in August 2019, but after his hospitalization he was readmitted with pressure areas to his right heel and left big toe, had become more incontinent and required more assistance from staff for personal care tasks. An interview occurred with Nurse Aide #4 (NA) on 11/14/19 at 2:20pm. She stated before Resident #114 went to the hospital he required supervision to limited assistance with most of his Activities of Daily Living (ADL's) and was continent of bowel and bladder. When he returned from the hospital in August 2019, he had a sore on his foot, required more assistance with ADL's as well as incontinence care. On 11/14/19 at 4:20pm MDS Nurse #1 was interviewed. She stated it was an oversight not to complete a significant change assessment due to the increased need for assistance with bed mobility, transfers and dressing, the change with	F 637	for SCSA requirements when a resident's condition changes from his/her baseline as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments. New hires responsible for scheduling and setting assessment reference dates will be trained by Regional MDS Nurse during orientation period. Interdisciplinary team including but not limited to; MDS Coordinator, Director of Nursing and/or Unit Coordinator, Social Worker, Dietician and/or Dietary Manager, License Therapist, will review resident with readmission or change in status for a significant change for either major improvement or decline during the standard clinical meeting, decision to proceed with SCSA will be determined up to 14 days and SCSA completed within 14 days after decision of SCSA. The MDS Coordinator or Licensed Nurse will complete a weekly audit of up to 5 residents with observations of SCSA and SCSA scheduled for 3 months. The MDS Coordinator will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and recommendations. The findings will be reported to QAPI for 3 months. Trends will be noted, and the plan of correction will be modified as needed based on trend.	

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F 637	Continued From page 21 incontinence and the new area of a pressure ulcer when the quarterly MDS was completed on 10/22/19. In an interview with the Director of Nursing on 11/15/19 at 1:30pm she indicated it was her expectation for the MDS Nurse to complete a significant change in status MDS assessment as required in the regulation, 14 days after 2 or more changes in the MDS areas were determined.	F 637		
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 interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of life expectancy and active diagnoses for 1 of 1 residents reviewed for hospice care (Resident #110). The findings included: 1. Resident #110 was admitted to the facility on 6/26/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia, failure to thrive, and right femur fracture. 1a. The medical record indicated Resident #110 was admitted to hospice services on 10/10/19. The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired. She was	F 641	F641: Accuracy of Assessments Resident #110 assessment was corrected on 11/14/2019 to reflect the end of life and active diagnosis by MDS Coordinator and transmitted and accepted on 11/19/2019. All residents receiving hospice services have the potential to be affected. An audit was conducted on 11/27/2019 by the Director of Nursing for each hospice resident to determine if their assessments were accurate and no inaccuracies were discovered. MDS nurses were educated by the Regional MDS Nurse on 11/22/19 regarding proper coding of life expectancy and active diagnosis on the MDS. New hires responsible for scheduling and setting assessment reference dates will be trained by Regional MDS Nurse during orientation period.	12/13/19

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F 641	Continued From page 22 coded with hospice services but was not coded with a life expectancy of less than 6 months. An interview was conducted with MDS Nurse #1 on 11/14/19 at 10:10 AM. The 10/19/19 MDS for Resident #110 that indicated she was receiving hospice services but did not have a life expectancy of less than 6 months was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed she coded the sections of this MDS assessment related to hospice services and life expectancy for Resident #110. She revealed she was unaware of the Resident Assessment Instrument (RAI) instructions that indicated a life expectancy of less than 6 months was to be coded if the resident was receiving hospice services. During an interview with the Director of Nursing on 11/15/19 at 1:25 PM she stated she expected the MDS to be coded accurately. 1b. A Nurse Practitioner note dated 10/7/19 indicated Resident #110 had a right femur fracture. The significant change Minimum Data Set (MDS) assessment dated 10/19/9 indicated Resident #110's cognition was severely impaired. Resident #110's femur fracture was not included as an active diagnosis. An interview was conducted with MDS Nurse #1 on 11/14/19 at 10:10 AM. The 10/19/19 MDS for Resident #110 that had not included an active diagnosis of a femur fracture was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed she coded the active diagnoses section of this MDS assessment for Resident #110. She revealed this	F 641	DON/License Nurse will conduct MDS audits to hospice services and validate life expectancy and up to 5 residents of active diagnosis are coded in the MDS weekly. Director of Nursing will present audits to the Quality Assurance Performance Improvement monthly times 3 months for review. Trends will be noted, and the plan of correction will be modified as needed based on trend.	

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F 641	Continued From page 23 was an error and that the active diagnoses on this 10/19/19 MDS should have included Resident #110's femur fracture as an active diagnosis. During an interview with the Director of Nursing on 11/15/19 at 1:25 PM she stated she expected the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		12/13/19

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 656	Continued From page 24 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a comprehensive care plan for the use of an antipsychotic medications (Resident #79), the use of an anticoagulant (Resident #125) and long-term antibiotic use (Resident #17). The facility also failed to implement the care plan for nutrition (Resident #110). This was for 4 of 28 sampled residents. The findings included: 1. Resident #79 was admitted on 7/6/15 with cumulative diagnoses of Dementia and Traumatic Brain Injury (TBI). Review of Resident #79's quarterly Minimum Data Set (MDS) dated 10/8/19 indicated moderate cognitive impairment and he exhibited no behaviors. He was coded for taking an antipsychotic medication for 7 of 7 days of the look back period. Review of Resident #79's November 2019 Physician orders read Seroquel (antipsychotic) 37.5 milligrams (mg) every night.	F 656	F656: Develop/Implement Comprehensive Care Plans •Resident #79's care plan has been updated to reflect resident the use of antipsychotic medication by MDS Coordinator on 11/14/2019. •Resident # 125 is discharged from the facility with return not anticipated. •Resident #17 s care plan has been updated to reflect resident the use of prophylactic antibiotic medication by MDS Coordinator on 11/14/2019. •Resident #110's care plan reviewed with dietary and primary nursing staff of implementation of current supplemental interventions by MDS Coordinator on 11/14/2019. All residents have the potential for the alleged deficient practice. An audit on all residents was conducted on 11/14/19 by the Director of Nursing and License Nurse to verify comprehensive care plans are in place for residents receiving antipsychotic medications, anticoagulants, long-term	

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F 656	Continued From page 25 Review of Resident #79's November 2019 Medication Administration Record (MAR) read he was receiving Seroquel nightly as ordered. Review of Resident #79's comprehensive care plan last revised on 11/12/19 did not include a care plan for the use of an antipsychotic medication. In an interview on 11/14/19 at 10:10 AM, MDS Nurse #1 stated she started at the facility one year ago and for 8 months, she was the only person doing MDS's and care plans. MDS Nurse #1 stated the facility hired MDS Nurse #2 in August 2019. In another interview on 11/14 at 4:25 PM, MDS Nurse #1 stated she thought she completed a care plan for Resident #79's antipsychotic medication but apparently she did not. She stated it was an oversight and should be care planned. In an interview on 11/15/19 at 1:20 PM, the Director of Nursing (DON) stated it was her expectation that Resident #79's antipsychotic medication be care planned. 2. Resident #125 was admitted on 10/23/19 a diagnosis of a right femur fracture. Resident #125's 5-day admission Minimum Data Set (MDS) dated 10/27/19 indicated moderate cognitive impairment and he exhibited no behaviors. He was coded for having received his anticoagulant medication 4 of the 7 look back days. Review of Resident #125s November 2019	F 656	antibiotics as well as nutritional supplements. This audit identified 2 residents on antibiotics and care plans were updated by 11/14/2019 and all residents on antipsychotic medications had up to date care plans. MDS nurses and Registered Dietician were educated by the Regional MDS Nurse on 11/22/19 regarding developing/implementing comprehensive care plans. Dietary Staff who place supplements on the tray educated on tray card system and accuracy beginning 11/26/2019. New hires responsible for scheduling and setting assessment reference dates will be trained by Regional MDS Nurse during orientation period. Monthly review of antipsychotic medication orders will be completed by Facility Pharmacy Consultant to identify residents with these orders and will provide report to facility within 72 hours of completion. DON or License Nurse will conduct MDS audits to validate comprehensive care plans are in place for residents receiving antipsychotic medications, anticoagulants, long-term antibiotics as well as nutritional supplements weekly. Observational audit of supplements provided as ordered will be completed by Risk Manager beginning 11/23/19 3x weekly for 3 months. Facility Pharmacy Consultant will present audit findings to QAPI monthly and MDS will update all comprehensive care plans for accuracy based on results. Director of Nursing audits of comprehensive care plans will be presented to Quality Assurance	

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F 656	Continued From page 26 Physician orders read Enoxaparin (anticoagulant) 40 milligrams (mg) subcutaneously every day with a start date of 10/23/19. Review of Resident #125's November 2019 Medication Administration Record (MAR) read he was receiving the Enoxaparin injection daily as ordered. Review of Resident #125's comprehensive care plan last revised on 11/08/19 did not include a care plan for the use of an anticoagulant medication. In an interview on 11/14/19 at 10:10 AM, MDS Nurse #1 stated she started at the facility one year ago and for 8 months, she was the only person doing MDS's and care plans. MDS Nurse #1 stated the facility hired MDS Nurse #2 in August 2019. In another interview on 11/14 at 4:25 PM, MDS Nurse #1 stated she thought she completed a care plan for Resident #125's anticoagulant medication but apparently she did not. She stated it was an oversight and should be care planned. In an interview on 11/15/19 at 1:20 PM, the Director of Nursing (DON) stated it was her expectation that Resident #125's anticoagulant medication be care planned. 3. Resident #17 was admitted to the facility on 8/4/17 with diagnoses that included dementia. A physician's order for Resident #17 dated 7/30/19 indicated Methenamine Hippurate	F 656	Performance Improvement monthly times 3 months for review. Trends will be noted, and the plan of correction will be modified as needed based on trend.	

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(antibiotic medication) 1 gram (gm) daily for Urinary Tract Infection (UTI) prophylaxis. There was no stop date for this order.

A hard copy print out of email correspondence dated 8/2/19 between the Staff Development Coordinator (SDC) and the Associate Director for the state's infection control and epidemiology program indicated the usage of Methenamine Hippurate for UTI prophylaxis for Resident #17 was reviewed. The Associate Director wrote that she believed Methenamine Hippurate would not fall under the purview of the facility's antibiotic stewardship program as this medication was used to prevent or control UTIs and stop the growth of bacteria but was not used to treat active infections.

The 8/9/19 significant change Minimum Data Set (MDS) assessment indicated Resident #17's cognition was severely impaired. She received an antibiotic on 7 of 7 days and had no active infections.

Resident #34's active physician's orders were reviewed on 11/13/19 and revealed the 7/30/19 physician's order for Methenamine Hippurate remained an active order.

A review of Resident #17's active comprehensive care plan on 11/13/19 revealed no information related to the long-term use of a prophylactic antibiotic.

An interview was conducted with the SDC on 11/13/19 at 3:30 PM. She stated she was responsible for the facility's infection control program and monitoring antibiotic use. The 8/2/19 email related to the use of Methenamine

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Hippurate for Resident #17 was reviewed with the SDC. She confirmed she initiated this correspondence with the Associate Director of the state's infection control and epidemiology program to ensure this medication's usage was in accordance with the facility's antibiotic stewardship program.

During an interview with MDS Nurse #1 on 11/14/19 at 10:10 AM the use of a long-term prophylactic antibiotic for Resident #17 was reviewed. The care plan for Resident #17 that included no information related to the use of a long-term prophylactic antibiotic was reviewed. MDS Nurse #1 stated that a care plan should be in place for Resident #17's prophylactic antibiotic usage. She reported that she thought there was a care plan in place in the past, but the facility was in the process of switching to a new care plan system and she thought this focus area may have been missed when the most recent care plan for Resident #17 was created.

An interview was conducted with the Director of Nursing on 11/15/19 at 1:25 PM. She stated that she expected a care plan to be in place to address the long-term use of a prophylactic antibiotic for Resident #17.

4. Resident #110 was admitted to the facility on 6/26/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia.

A physician's order dated 9/24/19 indicated mighty shake (nutritional supplement) twice daily with lunch and dinner for Resident #110 related poor appetite.

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The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired, she required the extensive assistance of 1 for eating, and she had significant weight loss.

The active care plan for Resident #110 was reviewed on 11/12/19 and it included the focus area of nutritional risk (initiated on 9/17/19). One of the interventions for this focus area was the provision of nutritional supplements as ordered. This intervention specified that mighty shake twice daily was one of Resident #110's ordered nutritional supplements.

A meal observation was conducted of Resident #110 at lunch on 11/12/19 at 12:49 PM. Resident #110 was in her room and Nursing Assistant (NA) #2 served her meal tray and began to provide her assistance with eating. The dietary tray card was viewed, and it indicated a mighty shake was to be included on the tray. There was no mighty shake observed on Resident #110's meal tray.

A meal observation was conducted on 11/13/19 at 5:30 PM. Resident #110 was in her room and NA #3 served her meal tray and began to provide her assistance with eating. The dietary tray card was viewed, and it indicated a mighty shake was to be included on the tray. There was no mighty shake observed on Resident #110's meal tray.

NA #3 was interviewed on 11/13/19 at 5:33 PM. She confirmed Resident #110 had a mighty shake on her dietary tray card, but no mighty shake on her tray. She indicated that she had not noticed the mighty shake was missing, but she would go and obtain one from the kitchen.

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F 656	Continued From page 30 An interview was conducted with NA #2 on 11/14/19 at 11:00 AM. She stated that she began working at the facility in June and she was frequently assigned to Resident #110. NA #2 recalled working with Resident #110 on 11/12/19 and assisting her with eating her lunch. She confirmed the mighty shake was not on Resident #110's meal tray for lunch on 11/12/19 and she had not obtained the mighty shake from the kitchen. She admitted that it happened frequently that the mighty shake was not on Resident #110's meal tray. NA #2 revealed that she had not wanted to get anyone in trouble, so she hadn't reported this issue to anyone. The Dietary Manager (DM) was interviewed on 11/14/19 at 1:41 PM. He reported he began working as the DM about 5 weeks ago. The observation of Resident #110's mighty shake not being served on her meal tray for the lunch meal on 11/12/19 and the dinner meal on 11/13/19 were reviewed with the DM. The DM stated that there were multiple new staff working in the kitchen and he believed this was why this error occurred. An interview was conducted with the Director of Nursing on 11/15/19 at 1:25 PM. She stated that she expected care plan interventions to be consistently implemented and for nutritional supplements to be provided as ordered.	F 656		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 675		12/13/19

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F 675	Continued From page 31 residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview of the resident, staff and Physician, the facility failed to provide an environment that enhanced the resident ' s quality of life for 1 of 5 sampled residents (Resident #12). Findings included: Resident #12 was admitted to the facility on 7/31/19 with the diagnosis of cerebral vascular accident. His active care plan dated 8/1/19 documented goals and interventions for cardiac disease and assistance with activities of daily living. The 14-day Minimum Data Set documentation revealed Resident #12 had an intact cognition. The resident required assistance of 1 staff for activities of daily living and the resident was always continent. The active diagnoses were cerebral vascular accident, muscle weakness, and unspecified abnormalities of gait. On 11/12/19 at 12:17 pm Resident #12 was interviewed who stated his roommate (Resident #25) informed him "I hate you" when the resident asked the roommate to be quiet at night (during sleeping hours). The resident commented that he did not like his roommate ' s response. The resident complained that the resident was	F 675	F675: Quality of Life Resident #12 has been moved to another room per resident request. All residents have the potential for the alleged deficient practice regarding grievances. Staff Development Coordinator began in-service education on 11/29/19 on facility grievance procedures for facility staff. On 11/27/19 an audit was completed by Social Worker for all interviewable residents on satisfaction with current roommate assignment. No other residents had complaints about current roommates or wanted a room change. Staff Development Coordinator provided education on 11/29/19 on facility grievance procedures for facility staff this education will continue through 12/12/19.All new hires will receive education upon hire during orientation regarding reporting resident roommate complaints. Social Services will conduct 10 random audits weekly, interviewing residents to determine roommate satisfaction starting 11/27/19. Audits will be presented by the Social Services Director to Quality Assurance	

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sleeping in his wheel chair at the nurses station all day and up at night getting up to the bathroom every hour. The roommate had not used the call light but called out for staff, yelling in the middle of the night. The resident stated he was kept awake and not getting enough sleep. The roommate also yelled and banged on the bathroom door while the resident used the bathroom (did not wait until the resident was finished), and the resident did not like this. The resident commented that he had informed the staff of his concerns and the staff would enter his room each night in response to the roommate ' s yelling and they were aware. The resident stated "this (roommate ' s behavior) keeps happening and no one has done anything."

Nurse #1 was interviewed on 11/13/19 at 9:30 am who stated she was familiar with Resident #12. Nurse #1 indicated she was informed by the resident and night staff "regularly" that the resident ' s roommate (Resident #25) had kept him up at night.

Resident #12 had additional information to add during interview on 11/13/19 at 10:25 am. The resident shared that his wife had asked staff for another room so he (the resident) could sleep at night. The resident ' s roommate had used foul language and stated "I hate you" which the resident does not like. The resident commented "it happened again last night."

An interview was conducted on 11/13/19 at 12:20 pm with Nursing Assistant #1 (NA) who was regularly assigned to the resident and stated she was aware that Resident #12 complained his roommate kept him up at night, banged on the bathroom door and hollered aggressively. NA #1

Performance Improvement monthly times 3 months.

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had observed the roommate banging on the bathroom door and hollering and intervened. NA #1 stated this had been going on for a quiet a while, months. NA #1 commented that she had informed the assigned nurse (Nurse #1) on more than one occasion.

On 11/13/19 at 2:50 pm an interview was conducted with Social Work (SW) #1 and #2 who both stated that they were not aware or been informed that resident #12 was unable to sleep because of loud yelling, behavior and verbal aggression from the resident ' s roommate. They were also not aware of the roommate ' s banging on the bathroom door and yelling when the resident was using the bathroom and statements such as "I hate you" and use of curse words. SW #1 stated she was not informed by the resident's spouse that there was a request for room change. SW #2 stated that she was informed today that the resident had concerns regarding his roommates yelling and was offered another room that was not by the window. The resident requested to be placed on the waiting list for another room with the bed by the window. Both SWs stated that nursing had not informed them of the complaints and a grievance was not initiated.

A review of Resident #12 ' s SW notes since the resident's admission (7/31/19) revealed they were notified by nursing on 11/13/19 and documented the resident's concern of his roommate ' s behaviors and inability to sleep. A room change was offered today and was declined; request was made to be placed on a waiting list for a room with a bed by the window.

On 11/14/19 at 2:30 pm an interview was

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conducted with Nurse #1 who stated that Resident #12 complained to her on more than one occasion that his roommate was yelling at night and the resident was up at night (not able to sleep). Nurse #1 stated she asked psychiatry to address the roommate ' s yelling at night due to insomnia (last month). Nurse #1 indicated she did not inform SW of the resident's complaints or offer/consider writing a grievance because the resident did not ask for one.

The Director of Nursing (DON) was interviewed on 11/14/19 at 2:49 pm who was not aware of Resident #12 ' s complaints. The DON stated she expected resident complaints to be reported to SW for follow through with the grievance process. The DON commented she would start education with nursing staff to complete a grievance when the resident complained of something significant to them.

On 11/15/19 at 12:05 pm an interview was conducted with the Physician who was familiar with and responsible for Resident #12. The physician stated that he had been informed of the resident's roommate behavior escalation and that the resident has had behaviors for a long time. The physician commented he was informed several weeks ago, about mid October, that there was an altercation between residents, Resident #12 and the roommate, where the roommate was banging on the bathroom door and yelling. The Physician was informed that the resident was very upset about the incident. The Physician stated that he would expect staff to bring to the team (DON) resident to resident interaction (yelling at night and banging on the bathroom door and yelling while the roommate was in the bathroom) where there was a concern.

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff and Registered Dietician, the facility failed to provide nutritional supplements as ordered on 2 of 3 dining observations for 1 of 7 residents reviewed for nutrition (Resident #110). The findings included: Resident #110 was admitted to the facility on 6/26/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia. A physician's order dated 9/24/19 indicated mighty shake (nutritional supplement) twice daily	F 692	F692: Nutrition/Hydration Status Maintenance Resident #110 tray card was updated on 11/26/2019 to move nutritional supplements from preferences to physician nourishment of tray card. All residents receiving nutritional supplements have the potential for the alleged deficient practice. An audit was conducted by the Registered Dietician on 11/26/19 tray cards for residents receiving nutritional supplements tray cards were updated to show nutritional supplements under the supplement section of the tray	12/13/19

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F 692	Continued From page 36 with lunch and dinner for Resident #110 related to poor appetite. The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired, she required the extensive assistance of 1 for eating, and she had significant weight loss. A Registered Dietician (RD) note dated 11/12/19 indicated Resident #110's current weight was 140 pounds with 3.7% weight loss x 30 days, 13.6 % weight loss x 90 days, and 14.6% x 180 days. She required extensive assistance from staff with eating and her nutritional supplements included mighty shakes twice daily. The active care plan for Resident #110 was reviewed on 11/12/19 and it included the focus area of nutritional risk (initiated on 9/17/19). One of the interventions for this focus area was the provision of nutritional supplements as ordered. This intervention specified that mighty shake twice daily was one of Resident #110's ordered nutritional supplements. A meal observation was conducted of Resident #110 at lunch on 11/12/19 at 12:49 PM. Resident #110 was in her room and Nursing Assistant (NA) #2 served her meal tray and began to provide her assistance with eating. The dietary tray card was viewed, and it indicated a mighty shake was to be included on the tray. There was no mighty shake observed on Resident #110's meal tray. A second meal observation was conducted of Resident #110 at the dinner meal on 11/12/19 at 5:20 PM. Resident #110 was in her room and her meal was provided as ordered.	F 692	card. All supplement orders were correct and tray cards now reflect supplement in nourishment section. The Registered Dietician updated the tray card system on 11/26/19 and educated by the Certified Dietary Manager (CDM) regarding entering nutritional supplements under physician orders in the tray card system on 11/26/19. All resident tray cards were reviewed by the CDM and updated as needed. Nursing staff will be educated by Registered Dietician beginning 11/26/19 on reading the tray tickets to ensure the supplement was provided, and if it was not, to notify the kitchen and get the supplement. All new nursing hires will receive education upon hire during orientation regarding reading of meal tickets to ensure supplements are included on meal tray as ordered. The Registered Dietician and or the CDM will all audit new admissions weekly and random resident tray cards on all meals to include weekends, who receive nutritional supplements 3 times per week. Audits will be presented to Quality Assurance Performance Improvement by the Registered Dietician monthly times 3 months or until substantial compliance is achieved.	

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A third meal observation was conducted on 11/13/19 at 5:30 PM. Resident #110 was in her room and NA #3 served her meal tray and began to provide her assistance with eating. The dietary tray card was viewed, and it indicated a mighty shake was to be included on the tray. There was no mighty shake observed on Resident #110's meal tray.

NA #3 was interviewed on 11/13/19 at 5:33 PM. She confirmed Resident #110 had a mighty shake on her dietary tray card, but no mighty shake on her tray. She indicated that she had not noticed the mighty shake was missing, but she would go and obtain one from the kitchen.

An interview was conducted with NA #2 on 11/14/19 at 11:00 AM. She stated that she began working at the facility in June and she was frequently assigned to Resident #110. NA #2 recalled working with Resident #110 on 11/12/19 and assisting her with eating her lunch. She confirmed the mighty shake was not on Resident #110's meal tray for lunch on 11/12/19 and she had not obtained the mighty shake from the kitchen. She admitted that it happened frequently that the mighty shake was not on Resident #110's meal tray as ordered. NA #2 revealed that she had not wanted to get anyone in trouble, so she hadn't reported this issue to anyone. She stated that Resident #110 seemed to prefer sweet foods and she had the best intake of items such as ice cream and the mighty shake when she received it. NA #2 reported that Resident #110 had received her ice cream on 11/12/19 on her lunch tray and she ate most of the ice cream.

The Dietary Manager (DM) was interviewed on

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F 692	Continued From page 38 11/14/19 at 1:41 PM. He reported he began working as the DM about 5 weeks ago. The observation of Resident #110's mighty shake not being served on her meal tray for the lunch meal on 11/12/19 and the dinner meal on 11/13/19 were reviewed with the DM. The DM stated that there were multiple new staff working in the kitchen and he believed this was why this error occurred. During an interview with the RD on 11/14/19 at 1:43 PM she stated that she expected nutritional supplements to be provided as ordered to support the nutritional needs of the residents. An interview was conducted with the Director of Nursing on 11/15/19 at 1:25 PM. She stated that she expected nutritional supplements to be consistently provided as ordered.	F 692		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		12/13/19

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F 756	Continued From page 39 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview of the staff and Pharmacy Consultant, the Pharmacist failed to identify and address the need for an abnormal involuntary movement scale (AIMS) assessment for 2 of 3 sampled residents on antipsychotic medication (Residents #25 and #34). Findings included: 1. Resident #25 was admitted to the facility on 12/1/17 with diagnoses of insomnia and schizoaffective disorder. Documentation of the most recent AIMS assessment for the resident was dated 3/16/18. Resident #25 had a physician order for Seroquel	F 756	F756: Drug Regimen Review, Report Irregular, Act on Residents #25 and #34 were immediately assessed on November 14th, 2019 with Abnormal Involuntary Movement Scale, (AIMS) completed and added to their charts during survey. There were no abnormal findings. 100% audit of residents on antipsychotic medications completed on November 14th, 2019 during survey by Unit Managers. There were no abnormal findings. On this day, all residents were assessed, AIMS were updated accordingly, and placed in their charts. Effective November 14th, 2019,	

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F 756	Continued From page 40 XR 400 milligrams twice a day dated 3/22/18. The care plan dated 6/17/19 had goals and interventions for antipsychotic medication documented. A review of the resident ' s quarterly Minimum Data Set (MDS) dated 9/2/19 revealed clear speech, was understood, and understands. The resident was severely cognitively impaired. The resident required extensive assistance of one staff for dressing and toileting and limited assistance with personal hygiene. Transfer, standing and turning required supervision. The active diagnoses were schizophrenia and insomnia. There were 7 days of antipsychotic, antianxiety, and antidepressant medication administered. On 11/14/19 at 5:00 pm an interview was conducted with the Director of Nursing (DON) who stated the AIMS evaluation was scheduled with the quarterly MDS by the Unit Coordinator. The last AIMS assessment for the resident documented in the medical record was 3/16/18. The DON indicated she checked with the Pharmacist who informed her that he had not checked for an AIMS evaluation with psychotropic medication administration. The Pharmacy Consultant was interviewed in person on 11/14/19 at 5:10 pm who stated he had looked for the AIMS assessment during his monthly pharmacy review, which should be done about every 6 months, but had not informed staff when one was not identified in the resident's medical record. Unit Manager #1 who was assigned to Halls 300	F 756	Pharmacy consultant added AIMS monitoring to his antipsychotic medications report that will be reviewed monthly during QAPI meeting. On November 15th, 2019, education was provided by the Director of Nursing (DON) to all Unit Managers, clinical supervisors, and Pharmacy Consultant on facility policy regarding quarterly antipsychotic medication monitoring and documentation. Effective December 1st, 2019, Risk Manager (RM) or Director of Nursing (DON) will conduct monthly audits for all residents receiving antipsychotic medication to ensure AIMS is completed quarterly. Effective December 1st, 2019, audit results will be brought to QAPI by the Director of Nurses x 3 months, with further monitoring to be decided by the QAPI committee if thresholds are not met.	

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and 400 (Resident #25) was interviewed on 11/15/19 at 1:00 pm regarding the AIMS assessment schedule for residents who received psychotropic medication. Unit Manager #1 stated that she scheduled the assessment with the quarterly MDS and the assigned nurse was responsible to complete the AIMS assessment. She commented the AIMS assessment had not been scheduled for staff to complete and this would be corrected.
2. Resident #34 was admitted to the facility on 8/6/15 with diagnoses that included dementia, anxiety, and psychotic disorder.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for 12/26/18 for Resident #34 with a score of 0 (no involuntary movements identified).

A physician's order for Resident #34 dated 3/13/19 indicated ABH gel, a combination gel of Ativan (antianxiety medication) 0.5 milligrams (mg)/Benadryl (antihistamine medication) 25 mg/Haldol (antipsychotic medication) 1 mg, apply contents of 1 milliliter (ml) syringe to skin twice a day.

The quarterly Minimum Data Set (MDS) assessment dated 9/9/19 indicated Resident #34's cognition was severely impaired, and she received antipsychotic medication and antianxiety medication on 7 of 7 days during the MDS look back period.

A review of Resident #34's current physician's orders on 11/14/19 indicated the 3/13/19 order for ABH gel twice daily remained an active order.

A review of the hard copy and electronic medical

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record from 12/27/18 through 11/14/19 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #34 since 12/26/18.

There was no evidence in Resident #34's medical record of the Pharmacy Consultant identifying and addressing that an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #34 since 12/26/18.

During an interview with the Director of Nursing (DON) on 11/14/19 at 5:00 PM she stated that the facility's normal process was to complete AIMS assessments quarterly for residents on antipsychotic medication. She indicated the AIMS assessments were done when the quarterly and annual MDS assessments were completed. The DON reported that the AIMS assessments were completed by hand and were placed in the hard copy medical record. She indicated the Unit Coordinators were responsible for ensuring the AIMS assessments were completed.

An interview with MDS Nurse #2 on 11/14/19 at 5:25 PM revealed confirmation that there was no AIMS assessment
or any other involuntary movement assessment completed for Resident #34 since 12/26/18. She stated she reviewed the hard copy and electronic medical record for Resident #34.

Unit Coordinator (UC) #2 was interviewed on 11/15/19 at 8:46 AM. She stated that the facility's normal process was for AIMS assessments were completed quarterly, and the timeframes coordinated with the MDS assessments. She reported that she was responsible for ensuring the AIMS assessments

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were completed every 3 months either by herself or by one of the floor nurses for all residents on her unit who were on antipsychotic medication. Resident #34's medical record that revealed an AIMS assessment was not completed for Resident #34 from 12/27/18 through 11/14/19 was reviewed with UC #2. She revealed that this was an oversight and that routine AIMS assessments should have been completed every 3 months for Resident #34 due to her use of ABH gel which included the antipsychotic medication Haldol.

An interview was conducted with the Pharmacy Consultant on 11/14/19 at 5:15 PM. He stated that his expectation for the completion of AIMS assessments was on initiation of an antipsychotic medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessments for antipsychotic medication due to the potential side effects of the medications. Resident #34's most recent AIMS completed on 12/26/18 was reviewed with the Pharmacy Consultant. Resident #34's physician's orders that indicated ABH gel had been in use since 3/13/19 was reviewed with the Pharmacy Consultant. He revealed he had not identified that an AIMS assessment was not completed since 12/26/18 for Resident #34. He additionally revealed that he had not routinely checked for AIMS assessments during his monthly drug regimen reviews. The Pharmacy Consultant acknowledged that his expectation would have been for an AIMS assessment to be completed a minimum of every 6 months for Resident #34 due to her use of ABH gel which included the antipsychotic medication Haldol.

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F 756	Continued From page 44 During a follow up interview with the DON on 11/15/19 at 1:25 PM she stated that she expected the Pharmacy Consultant to routinely check for AIMS assessments for residents on antipsychotic medication during his monthly drug regimen reviews and to complete a pharmacy recommendation for an updated AIMS if an assessment was due.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		12/13/19

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F 758	Continued From page 45 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff and Pharmacy Consultant, the facility failed to complete the abnormal involuntary movement scale (AIMS) assessment for 2 of 3 sampled residents on antipsychotic medication (Residents #25 and #34). Findings included: 1. Resident #25 was admitted to the facility on 12/1/17 with diagnoses of insomnia and schizoaffective disorder. Documentation of the most recent AIMS assessment for the resident was dated 3/16/18. Resident #25 had a physician order for Seroquel XR 400 milligrams twice a day dated 3/22/18.	F 758	F758: Free from Unnecessary Psychotropic Meds/PRN use Residents #25 and #34 were immediately assessed on November 14th, 2019 with AIMS completed and added to their charts during survey. There were no abnormal findings. 100% audit of residents on antipsychotic medications completed on November 14th, 2019 during survey by Unit Managers. There were no abnormal findings. On this day, all residents were assessed, AIMS were updated accordingly, and placed in their charts. Effective November 14th, 2019, Pharmacy consultant added AIMS monitoring to his antipsychotic	

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F 758	Continued From page 46 The care plan dated 6/17/19 had goals and interventions for antipsychotic medication. A review of the resident ' s quarterly Minimum Data Set (MDS) dated 9/2/19 revealed clear speech, was understood, and understands. The resident was severely cognitively impaired. The resident required extensive assistance of one staff for dressing and toileting and limited assistance with personal hygiene. Transfer, standing and turning required supervision. The active diagnoses were schizophrenia and insomnia. There were 7 days of antipsychotic, antianxiety, and antidepressant medication administered. On 11/14/19 at 5:00 pm an interview was conducted with the Director of Nursing (DON) who stated the AIMS evaluation was scheduled with the quarterly MDS by the Unit Coordinator. The last AIMS for the resident documented in the medical record was 3/16/18. The DON indicated she checked with the Pharmacist who informed her that he had not checked for an AIMS evaluation with psychotropic medication administration. The Pharmacy Consultant was interviewed in person on 11/14/19 at 5:10 pm who stated he had looked for the AIMS assessment, which should be done about every 6 months, but had not informed staff when one was not identified in the resident's medical record during the monthly pharmacy review. Unit Manager #1 who was assigned to Halls 300 and 400 (Resident #25) was interviewed on 11/15/19 at 1:00 pm regarding the AIMS assessment schedule for residents who received	F 758	medications report that will be reviewed monthly during QAPI meeting. On November 15th, 2019, education was provided by the Director of Nursing (DON) to all Unit Managers, clinical supervisors, and Pharmacy Consultant on facility policy regarding quarterly antipsychotic medication monitoring and documentation. All new nurse hires will receive education upon hire during orientation regarding AIMS. Effective December 1st, 2019, Risk Manager (RM) or Director of Nursing (DON) will conduct monthly audits for all residents receiving antipsychotic medication to ensure AIMS is completed quarterly. Effective December 1st, 2019, audit results will be brought to QAPI by the Director of Nurses x 3 months, with further monitoring to be decided by the QAPI committee if thresholds are not met.	

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psychotropic medication. Unit Manager #1 stated that she scheduled the assessment with the quarterly MDS and the assigned nurse was responsible to complete the AIMS assessment. She commented the AIMS assessment had not been scheduled for staff to complete and this would be corrected.

2. Resident #34 was admitted to the facility on 8/6/15 with diagnoses that included dementia, anxiety, and psychotic disorder.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for 12/26/18 for Resident #34 with a score of 0 (no involuntary movements identified).

A physician's order for Resident #34 dated 3/13/19 indicated ABH gel, a combination gel of Ativan (antianxiety medication) 0.5 milligrams (mg)/Benadryl (antihistamine medication) 25 mg/Haldol (antipsychotic medication) 1 mg, apply contents of 1 milliliter (ml) syringe to skin twice a day.

The quarterly Minimum Data Set (MDS) assessment dated 9/9/19 indicated Resident #34's cognition was severely impaired, and she received antipsychotic medication and antianxiety medication on 7 of 7 days during the MDS look back period.

A review of Resident #34's current physician's orders on 11/14/19 indicated the 3/13/19 order for ABH gel twice daily remained an active order.

A review of the hard copy and electronic medical record from 12/27/18 through 11/14/19 revealed an AIMS assessment or any other involuntary

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movement assessment had not been completed for Resident #34 since 12/26/18.

During an interview with the Director of Nursing (DON) on 11/14/19 at 5:00 PM she stated that the facility's normal process was to complete AIMS assessments quarterly for residents on antipsychotic medication. She indicated the AIMS assessments were done when the quarterly and annual MDS assessments were completed. The DON reported that the AIMS assessments were completed by hand and were placed in the hard copy medical record. She indicated the Unit Coordinators were responsible for ensuring the AIMS assessments were completed.

An interview with MDS Nurse #2 on 11/14/19 at 5:25 PM revealed confirmation that there was no AIMS assessment
or any other involuntary movement assessment completed for Resident #34 since 12/26/18. She stated she reviewed the hard copy and electronic medical record for Resident #34.

Unit Coordinator (UC) #2 was interviewed on 11/15/19 at 8:46 AM. She stated that the facility's normal process was for AIMS assessments to be completed quarterly, and the timeframes coordinated with the MDS assessments. She reported that she was responsible for ensuring the AIMS assessments were completed every 3 months either by herself or by one of the floor nurses for all residents on her unit who were on antipsychotic medication. Resident #34's medical record that revealed an AIMS assessment was not completed for Resident #34 from 12/27/18 through 11/14/19 was reviewed with UC #2. She revealed that this was an oversight and that routine AIMS

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F 758	Continued From page 49 assessments should have been completed every 3 months for Resident #34 due to her use of ABH gel which contained the antipsychotic medication Haldol. An interview was conducted with the Pharmacy Consultant on 11/14/19 at 5:15 PM. He stated that his expectation for the completion of AIMS assessments was on initiation of an antipsychotic medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessments for antipsychotic medication due to the potential side effects of the medications. During a follow up interview with the DON on 11/15/19 at 1:25 PM she stated that she expected AIMS assessments to be completed every 3 months and for the Unit Coordinators to ensure that these assessments were in the medical record.	F 758		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an	F 849		12/13/19

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LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services

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provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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F 849	Continued From page 52 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 849		

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F 849	Continued From page 53 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain the hospice provider's plan of care for 1 of 1 residents reviewed for hospice care (Resident #110). The findings included: Resident #110 was admitted to the facility on 6/26/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia and failure to thrive. A physician's order dated 10/10/19 indicated Resident #110 was admitted to hospice services.	F 849	F849: Hospice Services Resident #110 Hospice Plan of Care was received and place in resident chart on 11/14/19. All residents receiving hospice services have the potential to be affected. An audit was conducted on 11/26/19 by the Medical Records Coordinator for each hospice resident to determine if their hospice plan of care was in the chart and residents receiving hospice services plan of care were on chart. Care Plan Team was educated by Regional MDS Nurse on 11/22/19	

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F 849	Continued From page 54 The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired, and she was receiving hospice services. A review of the hard copy medical record and the electronic medical record on 11/13/19 revealed there was no plan of care from the hospice provider in Resident #110's medical record. An interview was conducted with the Director of Nursing (DON) on 11/14/19 at 9:47 AM. She reported that the facility Social Workers (SWs) were the designated staff who coordinated care with the hospice providers. The DON reviewed Resident #110's medical record and confirmed the hospice provider's plan of care was not in the record. She stated she was going to have Medical Records staff obtain this document. SW #1 and SW #2 were interviewed on 11/14/19 at 10:20 AM. Both SWs reported that the hospice provider normally put all of their documentation in the hard copy medical record themselves. They stated that they had not reviewed the records of residents on hospice services to ensure all required documentation was obtained from the hospice providers. On 11/14/19 at 10:36 AM the hospice provider's plan of care for Resident #110 was received by fax at the facility. This plan of care was for the certification period of 10/10/19 through 1/7/20. During a follow up interview with the DON on 11/15/19 at 1:25 PM she stated she expected the hospice provider's plan of care to be in the facility's medical record.	F 849	regarding comprehensive documentation for residents receiving Hospice services. Hospice providers will be educated by 12/11/2019 by Social Worker related to providing care plans to facility on development and review quarterly and as needed. Social Worker will audit charts for residents within 72 hours of initiation of Hospice Services to ensure care plan is in place. New hires responsible for scheduling and setting assessment reference dates will be trained by Regional MDS Nurse during orientation period. Care plans will be reviewed during care plan meeting per the MDS scheduled with invitation extended to Hospice providers. MDS Coordinator and Social Worker will conduct chart audits to validate hospice plan of care inclusion weekly. Audits from both MDS Coordinator and Social Worker will be presented to Quality Assurance Performance Improvement monthly times 3 months by the MDS Coordinator for review. Trends will be noted, and the plan of correction will be modified as needed based on trend.	

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