STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING _____ B. WING _____	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY HEALTH AND REHABILITATION CENTER	3211 BISHOPS WAY LANE CHARLOTTE, NC 28215

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E 000	Initial Comments An unannounced Recertification survey was conducted on 12/03/19 through 12/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #18PM11.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Investigation survey was conducted from 12/03/19 through 12/06/19. There were seven complaint allegations investigated and they were all unsubstantiated. Event ID #18PM11.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		12/26/19

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

Electronically Signed | 12/29/2019

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F 623	Continued From page 1	F 623		

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the Ombudsman of hospital transfers for 2 of 2 residents (Resident #106 and #67) reviewed for hospitalization. Findings included:	F 623	1)Immediate notification to the ombudsman of resident #67 and resident #106's transfer to the hospital, with progress note charted in the resident's medical record of the notification. Completed on 12/26/2019 by the Director	

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F 623	Continued From page 3 1. Resident #106 admitted to the facility on 10/15/2019 and discharged from the facility to the hospital on 11/10/2019. She subsequently expired while at the hospital. Her diagnoses were inclusive of heart failure, pneumonia, and hypertension. Resident #106's discharge Minimum Data Set (MDS) dated 11/10/2019 revealed she had moderately impaired cognition for daily decision making. Review of Section A2100 (Discharge Status) revealed Resident #106 was discharged to an acute hospital. Review of Resident #106's SBAR (situation, background, assessment, recommendation- tool used to document a change in resident condition) revealed she was observed to have change in condition on 11/10/2019 by the nursing staff. Notification was provided to the Medical Doctor (MD), Emergency Management Services (EMS), and Resident #106's family. Review of Resident #106's electronic medical record, for the month of November 2019, revealed no documentation of notification being provided to the Ombudsman regarding the hospital transfer. An interview was completed with Social Worker #1 on 12/6/2019 at 1:10 PM. She was not aware notification needed to be made to the Ombudsman when a resident transferred to the hospital. An attempt was made to contact the Ombudsman on 12/6/2019 at 1:15 PM. She was not available for interview.	F 623	of Health Services. 2)Immediate notification to the ombudsman of discharges starting December 3rd, 2019 to present. Completed on 12/26/2019 by the Director of Health Services. 3)Report to be sent to the ombudsman of discharges from the facility, including discharges to the hospital, discharges to the community, and deaths. Report will be sent weekly X 1 month, then every two weeks X 1 month, and then monthly thereafter. Completed on 12/26/19 by the Director of Health Services, with ongoing reports sent by the social worker/designee. 4)Education provided to the social workers, admission's director, and assistant to the admission's director of ombudsman notification requirements. Completed on 12/6/2019 by the Director of Health Services. 5)Audit of discharge report to ensure the ombudsman has been notified of discharges. This audit will be completed by another social worker/designee who was not involved in sending the report originally to the ombudsman. Audit to be completed weekly X 1 month, then every two weeks X 1 month, and then monthly thereafter. Completed on 12/26/19 by the social worker. 6)Audits to be taken to quarterly Quality Assurance Performance Improvement meetings. Completed on 12/26/2019 by the Director of Health Services/Quality Assurance Performance Improvement team.	

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F 623	Continued From page 4	F 623		

An interview was completed with the Administrator on 12/6/2019 at 1:17 PM. The Administrator explained the facility had not previously informed the Ombudsman of hospital transfers. She verbalized the process moving forward would include notification to the Ombudsman on a monthly basis.

2. Resident #67's admission Minimum Data Set (MDS) dated 11/7/19 revealed she had moderately impaired cognition for daily decision making.

A review of Resident #67's medical record, a nursing note dated 11/26/19 at 12:33 PM revealed she had experienced increased shortness of breath. The nurse notified the medical provider and was given orders to treat Resident #67's condition. Resident #67 was transferred to the hospital for evaluation.

Resident #67 was readmitted to the facility on 11/29/19 with medical diagnoses inclusive of chronic obstructive pulmonary disease with acute exacerbation and heart failure.

During an interview with the Nurse Practitioner, NP#1, on 12/6/19 at 11:37 AM, she reported Resident #67 was initially treated in the facility due to a change in her condition with increased shortness of breath and worsening of heart failure and initially treated at the facility. NP #1 indicated Resident #67 was transferred to the hospital for cardiac consult.

Review of Resident #67's electronic medical record revealed no documentation of notification being provided to the Ombudsman regarding the

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F 623	Continued From page 5 hospital transfer. An attempt was made to contact the Ombudsman on 12/6/2019 at 1:15 PM. She was not available for interview. On 12/06/19 at 12:32 PM during an interview with the Business Office Manager (BOM) stated once she confirmed a residents that were transferred to the hospital were admitted to the hospital, she contacted the social service staff at the facility who would notify the Ombudsman of a resident discharge to the hospital. An interview was completed with Social Worker #2 on 12/6/19 at 1:10 PM. SW #2 was not aware of why or who would notify the Ombudsman. She also was not aware written notification was required to the Ombudsman when a resident transferred to the hospital. On 12/06/19 at 01:17 PM, an interview was conducted with the Administrator. The Administrator reported at the time of Resident #67's transfer to the hospital, the facility had not been implemented a process to notify the Ombudsman and the resident's responsible party of a transfer to the hospital. The Administrator also reported the assistant to the Admission Director for the past three weeks had the responsibility to compile a list of emergency discharges and planned discharges on a monthly basis to notify the Ombudsman and resident's responsible party.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for	F 645		12/26/19

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F 645	Continued From page 6 individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.	F 645		

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F 645	Continued From page 7 (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to refer a resident with a diagnosis of paranoid schizophrenia for a Pre-admission Screening and Annual Review (PASARR) Level II screen on admission to the facility for 1 of 2 sampled residents reviewed for PASARR (Resident #60). The findings included: Resident #60 was admitted to the facility 1/28/19 with a PASARR Level 1 screen. Diagnoses on	F 645	1)Resident #60 immediately referred for level 2 PASARR screening. Completed on 12/4/2019 by the social worker. 2)Audit of all residents residing in the facility for possible need for PASARR level 2 screening. Completed on or before 12/26/2019 by the Director of Health Services and social worker. 3)Referrals sent in for PASARR level 2 screenings for those identified in building-wide audit. Completed on or before 12/26/2019 by the social workers.	

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F 645	Continued From page 8 admission included paranoid schizophrenia, among others. Resident #60's admission physician orders dated 1/28/19 and the January 2019 medication administration record revealed the following physician orders: ·Zyprexa, 15 milligrams (mg), an anti-psychotic medication used to treat paranoid schizophrenia ·Klonopin, 0.5 mg, used to treat panic attacks to calm the brain and nerves Resident #60's admission care plan revealed he received Klonopin and Zyprexa for schizophrenia. Interventions included the daily use of these medications with monitoring for any signs of adverse reactions. An admission minimum data set (MDS) assessment dated 2/4/19 revealed schizophrenia was indicated as a current diagnosis with daily use of an anti-psychotic. Section A 1500 of the MDS revealed Resident #60 had not been referred by the facility to the state for a Level II PASARR screen. An interview occurred on 12/05/19 at 3:41 PM with the Social Worker (SW). During the interview she stated that she completed section A 1500 of the admission MDS for Resident #60. The SW stated she was aware Resident #60 had a diagnosis of schizophrenia on admission and received an anti-psychotic medication daily. She further stated that she did not refer Resident #60 for a PASARR Level II screen because the family of Resident #60 advised that he had not exhibited any recent concerns related to the diagnosis. The Administrator was interviewed on 12/05/19 at	F 645	4)The admission's director and assistant to the admission's director, who are responsible for all admissions that come to the facility, will ensure that a level 1 PASARR is in the medical record from the receiving facility prior to admission. If a level 2 PASARR is warranted, the admission's director/assistant to the admission's director will ensure that a level 2 PASARR is completed prior to admission to the facility. Completed on 12/6/2019 by the admission's director/designee. 5)During the daily clinical meeting, and also during the completion of the first MDS assessment, diagnoses and medications will be reviewed to ensure that a level 2 PASARR is not warranted (as a second check to ensure a level 2 PASARR was not missed at admission). Completed on 12/6/2019 and ongoing by the interdisciplinary team. 6)The psychiatrist's progress notes will be reviewed after his monthly visits to see if any new diagnoses have been added that would warrant a referral for a level 2 PASARR. Diagnoses will also be reviewed during the quarterly care plan. Completed on 12/26/2019 by the interdisciplinary team. 7)Education provided to the social workers, admission's director, and assistant to the admission's director on the newly implemented PASARR process. Completed on 12/6/2019 by the Director of Health Services. 8)Audit of 50% of residents in the building for appropriate PASARR levels, performed weekly X 1 month, then every	

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F 645	Continued From page 9 4:56 PM. The interview revealed that she was aware that a resident with a diagnosis of schizophrenia should be referred for a PASARR Level II screen. She further stated that the facility did not refer Resident #60 for a PASARR Level II after admission because he was admitted with a PASARR Level I number after a hospitalization where he was screened. She also stated that he was in another skilled nursing facility prior to being admitted to the facility and she thought that he would have been referred while a resident there. The Administrator further stated after admission to the facility the referral just did not occur.	F 645	2 weeks X 1 month, then monthly X 3 months, then quarterly thereafter. Completed on 12/26/2019 by the Director of Health Services with future audits completed by the social worker/designee. 9)Audits to be taken to quarterly Quality Assurance Performance Improvement meetings. Completed on 12/26/2019 by the Quality Assurance Performance Improvement team.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/1/20

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F 657	Continued From page 10 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to invite a resident/resident representative to a care plan meeting scheduled by the facility for 1 of 2 residents reviewed for invitation to care plan meeting (Resident #99). The findings included: Resident #99 was admitted to the facility on 1/29/19 with diagnoses inclusive of speech and language deficits following cerebral infarction, right and left shoulder muscle wasting and atrophy. Resident #99's last quarterly Minimum Data Set (MDS) dated 11/18/19 revealed she was cognitively intact. Resident #99's care plan was last updated and revised on 11/18/19. The facility could not find evidence that Resident #99 or her family member was invited to attend her care plan meeting. The facility's receptionist was newly employed, and the previous receptionist was unavailable for interview. A review of a nursing note dated 11/20/19 at 1:38 PM, the nurse documented Resident #99 was discharged from Hospice. Resident #99 had a new order for palliative care consult.	F 657	1)Invitation of resident #99 for a care plan meeting. Completed on 12/26/2019 by the MDS nurse. 2)Care plan letter invitations that are sent to resident representatives will be photocopied and scanned into the medical record to help effectively track invitations that are sent. A copy of the care plan invitation letter will also be given to the resident, if inclusion in the care plan is practicable (i.e. alert, oriented). Completed on 12/11/2019 by the social workers, MDS nurses, and receptionist. 3)Documentation will be included in the medical record regarding attendance and care plan needs of the resident. Completed on 12/11/2019 and ongoing by the interdisciplinary team. 4)Care plans will be held even in the event that a resident and/or representative has declined participation. Completed on 12/11/2019 by the social workers and MDS nurses. 5)Education provided to the receptionists, MDS nurses, and social workers surrounding new care plan invitation process. Completed on or before 1/1/2020 by the Director of Health Services and Administrative Assistant. 6)Audit performed of 25% of short term care residents and 25% of long term care	

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F 657	Continued From page 11 During an interview with Resident #99 on 12/3/19 at 10:12 AM, she stated was not sure if her family member was informed of her last care plan meeting. Resident #99 reported that she does not understand palliative care and desired to be invited to and participate in her care plan meetings. On 12/6/19 at 12:40 PM, an interview was conducted with Social Worker (SW) #2. The SW reported that Resident #99 and a family member had attended the 72-hour care plan meeting. She also indicated Resident #99's family member had attended the care plan meeting with Hospice on 5/30/19. The SW stated she was unsure if Resident #99 was invited to all her care plan meetings. An interview on 12/6/19 at 1:30 PM with Director of Nursing (DON), she reviewed the process of the invitation to care plan meetings. The DON reported MDS staff inform the facility's receptionist of upcoming care plan meetings scheduled for residents. The receptionist was responsible for notification to the resident/responsible party/family member by letter. An email sent to the social service staff indicated who will participate in the care plan meeting in person or by conference call. The DON stated Resident #99 deferred during the period of her decline in health and most likely the interdisciplinary team deferred to the nephew for notification. The DON stated in completing Resident #99's quarterly assessment, the staff should have included Resident #99 in the invitation to her care plan meeting. The Administrator was interviewed on 12/6/19 at	F 657	residents to ensure proper invitation of residents/resident representatives to care plan meetings has occurred, and that proper documentation is in the medical record of attendance and/or refusal. Audits performed monthly X 3 months, then quarterly thereafter. Completed on 12/11/2019 by the MDS nurses and social workers. 7)Audits to be taken to quarterly Quality Assurance Performance Improvement meetings. Completed on 12/26/2019 by the Quality Assurance Performance Improvement team.	

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	345544	A. BUILDING _____ B. WING _____	C 12/06/2019

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F 657	Continued From page 12 1:33 PM. The Administrator stated residents who were improving in their health should be invited to be active in their care and attend care plan meetings. She also indicated the residents who were declining in their health, staff should defer to health care proxy and extend an invitation to the resident's care plan meeting.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide an on-going activity program which met the individual interests and needs to enhance the quality of life for 2 of 3 sampled residents (Resident #87 and Resident #99). The findings included: 1. Resident #87 was admitted to the facility on 11/15/17 with diagnoses inclusive of essential hypertension, other abnormalities of gait and mobility, and Alzheimer's disease with late onset. Review of Resident #87's annual Minimum Data	F 679	1)Residents #87 and #99's preferences reviewed with resident and/or family to ensure information is up-to-date and accurate, and that they are indeed inclusive and representative of their current preferences. Completed on or before 1/1/2020 by the Life Enrichment Coordinator/designee. 2)Invitation and inclusion of activities that align with resident #87 and resident #99's preferences, with documentation supporting the invitation and/or participation. Completed on or before 1/1/2020, and ongoing, by the Life Enrichment team and interdisciplinary	1/2/20

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F 679	Continued From page 13 Set (MDS) dated 11/12/19 indicated he had severe cognitive impairment and was rarely/never understood. A family interview was conducted for Daily and Activity Preferences and revealed he enjoyed listening to music, attending religious services, group activities, being around pets and going outside in good weather were all very important to him. Review of Resident #87's care plan updated and revised on 11/12/19 included a focus area for activities of daily living self-care performance deficit related to confusion, dementia, and fatigue. His care plan also included a focus area related to activities that identified he was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. The goals for Resident #87 focus areas were to maintain current level of function in mobility, ADL and maintain involvement in cognitive stimulation, social activities as desired respectively. Review of Resident #87's care plan revised on 11/12/19 included: Activities of daily living self-care performance deficit. Goals included: to maintain involvement in cognitive stimulation, social activities as desired. Interventions included: dependent on staff for meeting emotional, intellectual, physical and social needs, and needs lots of encouragement to participate. A review of the facility's December 2019 activities calendar for the unit where Resident #87 resided included opportunities for group activities during the day and one on one visits twice a week by the activities staff. An observation on 12/3/19 at 10:48 AM revealed Resident #87 was in his room, sitting up in bed	F 679	team. 3)Audit of all residents' documentation related to activity participation currently residing in the facility to ensure opportunities are being offered/created related to the resident's individual preferences and/or plan of care. Completed on or before 1/2/2020 by the Director of Health Services and Life Enrichment Coordinator. 4)Any identified resident in above audit with lack of documentation to support inclusion of preferences in their daily plan of care will be offered opportunities to support their preferences. Completed on or before 1/2/2020 by the Life Enrichment team and interdisciplinary team. 5)New process implemented to audit documentation for participation and/or opportunities created to support preferences in order to identify any residents that may be lacking documentation. New process also implemented to capture participation when outside vendors provide activities. Completed on 1/2/2020 by the Life Enrichment Coordinator/designee. 6)Education provided to the Life Enrichment team and nursing team on reviewing resident preferences and creating opportunities to support those preferences and to document when those opportunities occur. Education also provided to the Life Enrichment team on the new documentation process for outside vendors. Completed on or before 1/2/2020 by the Director of Health Services and Assistant Director of Nursing.	

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F 679	Continued From page 14 with his eyes open. No music was on and the television was turned off. A group of residents were observed at this same time in the living area with a television turned on for viewing. On 12/3/19 at 03:09 PM, an observation was made of Resident #87 lying on his back with his eyes open wearing a hospital gown. A group of residents in wheelchairs were observed at this time in an activity facilitated by the activity director in the living area where Resident #87 resided. An interview was conducted on 12/5/19 at 3:12 PM with Nurse Aide (NA) #1. She reported the second shift (3:00 PM - 11:30 PM) nurse aides routine was to assist Resident #87 getting dressed to go to the dining room for dinner every evening. NA #1 reported that she had not observed the television and music on in Resident #87's room. An interview with the Activity Director (AD) was conducted on 12/05/19 at 12:18 PM. The AD stated daily activities were provided and the residents' participation was noted. The AD was not able to verify that Resident #87 had participated in any activities during the month of December On 12/06/19 at 11:27 AM, Resident #87 was observed awake and in bed wearing his personal clothes. A group of residents were observed at this time watching a movie in the larger activity room in the facility. During an interview with the Administrator on 12/06/19 at 1:35 PM, she stated the team should create opportunities for residents to be a part of activities in a group and/or their preferences.	F 679	7)Audit of all residents currently residing in the building to ensure documentation supports that opportunities are being offered/created related to resident's preferences. Residents identified in documentation audit that are lacking opportunities/invitation for engagement will be invited to activities and/or opportunities will be created to foster those preferences. Audit completed weekly X 1 month, then twice monthly ongoing. Completed on or before 1/2/2020 by the Life Enrichment Coordinator/designee. 8)Above audits to be taken to quarterly Quality Assurance Performance Improvement meetings for discussion and review. Completed on 12/26/2019 by the Quality Assurance Performance Improvement team.	

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F 679	Continued From page 15	F 679		

2. Resident #99 was admitted to the facility on 1/29/19 with diagnoses inclusive of speech and language deficits following cerebral infarction, right and left muscle wasting and atrophy.

Review of Resident #99's Minimum Data Set (MDS), the last quarterly assessment dated 11/18/19 revealed she was cognitively intact. On the annual assessment dated 2/22/19, Resident #99 reported she identified that she enjoyed attending religious services, being around pets and keeping up with the news. The Activity Care Area Assessment did not trigger on Resident #99's annual assessment.

Review of Resident #99's care plan updated and revised with the last quarterly MDS assessment did not include a focus area and goals for activities.

An interview with Resident #99 on 12/3/19 at 10:05 AM was conducted. She reported the activity staff did not come into her room for one on one activities, however, she did have interest in exploring one on one activities.

During an interview with the Activities Director (AD) on 12/5/19 at 12:28 PM, the AD was unable to identify any activities Resident #99 had participated in related to worship services or one on one activities in her room. The AD reported that she had not attended a care plan meeting for Resident #99 in the past six months.

A second interview was conducted with Resident #99 regarding her interest in activities on 12/6/19 at 11:30 AM. She stated she was familiar with pet therapy and recalls seeing the dogs the prior

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F 679	Continued From page 16 week. Resident #99 expressed a desire to attend worship service, however, she has not attended since admission. Resident #99 also stated she would like to get out of bed more and receive communion in her room as she had in the past. During an interview with the Administrator on 12/6/19 at 1:35 PM, she stated the team should create opportunities for residents to be a part of activities in a group and/or their preferences.	F 679		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		12/26/19

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F 732	Continued From page 17 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post accurate resident census and nurse staffing information for the facility in an area visible to residents and visitors for 3 out of 4 days during the recertification survey conducted 12/3/2019 through 12/6/2019. Findings included: An observation was completed on 12/3/2019 at 8:58 AM of posted facility census and nurse staffing. The observation revealed the posting was dated 12/1/2019. An observation on 12/4/2019 at 9:35 AM revealed posted facility census and nurse staffing was dated for 12/1/2019. An observation on 12/5/2019 at 9:20 AM revealed posted facility census and nurse staffing was dated for 12/1/2019. An interview was completed on 12/5/19 at 2:45 PM with an Agency Employee (temporary staffing coordinator) who stated she was responsible for daily staffing assignments for the facility. She	F 732	1)Daily staffing reviewed with information posted immediately to reflect the most current staffing/census. Completed on 12/5/2019 by the Director of Nursing. 2)Review of daily staffing posting process with the RN supervisors. Completed on or before 12/10/2019 by the Director of Nursing. 3)Initiation of a revised daily staffing form. Completed on or before 12/10/2019 by the Director of Nursing. 4)Education with all RN nursing supervisors, receptionists, and staffing coordinator. Completed on or before 12/17/2019 by the Director of Nursing. 5)The front desk receptionist will review daily staffing posting each morning to ensure correct date is posted. If the information is not correct, the receptionist will contact the staffing coordinator or the RN supervisor for document to be corrected. Completed on 12/5/2019 by the Director of Nursing. 10)Random audit of 10 days each month to ensure appropriate staffing posted is in place. Audits results will be taken to the	

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F 732	Continued From page 18 also stated her responsibility did not include posting the facility census and nurse staffing daily. An interview was conducted on 12/6/19 at 11:50 AM with Day Shift Nursing Supervisor #1. She reported nursing supervisors were responsible for posting the facility census and nursing staffing daily in the absence of the staffing coordinator. On 12/6/19 at 2:24 PM, Day Shift Nursing Supervisor #2 was interviewed regarding the responsibility of posting the facility census and nurse staffing. She reported she was scheduled on the day shift as nursing supervisor on December 3, 2019 - December 5, 2019. She stated an assumption was made by her, the temporary staffing coordinator was responsible for the daily posting of the facility census and nurse staffing daily. On 12/5/19 at 2:45 PM, the Director of Nursing (DON), she reported the full-time staffing coordinator was on medical leave and the day shift (7:00 AM - 3:30 PM) nursing supervisors were responsible for posting the facility census and nurse staffing daily. The DON reported the day shift nurse supervisors were informed of the need to post the census and nurse staffing daily to inform family members and visitors of the number of nurses and residents in the building.	F 732	quarterly Quality Assurance Performance Improvement meetings. Completed on 12/26/2019 by the Director of Nursing/designee.	