STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 11/21/19 through 11/24/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OJP311.	E 000		
F 000	INITIAL COMMENTS A recert with complaint investigation survey was conducted from 11/21/19 through 11/24/19. 15 of the 15 complaint allegations were not substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		12/19/19

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

Electronically Signed | 12/18/2019

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F 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to complete an annual comprehensive MDS (minimum data set =	F 636	Resident number 2 has had an annual comprehensive assessment completed on 11/26/2019 with an ARD of 6/29/2019.	

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F 636	Continued From page 2 a tool used for resident assessment) assessment within 366 days for 1 of 23 residents (Resident #2) reviewed. The findings included: Resident #2 was admitted to the facility on 7/15/15 with diagnoses of, in part, ataxia, alzheimers, hypertension, hypothyroidism and depression. A quarterly MDS assessment dated 6/28/19 revealed Resident #2 had moderately impaired cognition, required extensive assistance of one person for mobility and was frequently incontinent of bladder. A record review revealed a quarterly MDS completed 3/29/19 and a quarterly assessment prior to that and was overdue for an annual comprehensive MDS assessment. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she started employment at the facility in August of 2019. She stated the MDS schedule was already made out when she started, so she just began following it. She stated they were working on a system to get the assessments and care plans up to date.	F 636	All resident have the potential to be affected by the deficient practice so the facility MDS department completed a 100% audit on all active residents to ensure no assessment have been missed. This audit was completed on 12/13/2019. The regional director of clinical services provided an in-service to the MDS Nurses on 12/18/2019 addressing the types and time frames for assessment completion. The MDS department and the DON will review all residents MDS schedules monthly to ensure that no assessments have been missed. The regional Clinical will audit 20% of census monthly times 3 months to ensure no missed assessments. The audits will be reviewed at the bi-weekly QA meeting and ongoing audits will be determined by the QA team.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 638	Resident number 6 had a quarterly	12/19/19

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F 638	Continued From page 3 facility failed to conduct a quarterly Minimum Data Set (MDS) assessment for 1 of 23 residents selected to be reviewed for Resident Assessments. (Resident #6). The Findings Included: Resident #6 was admitted to the facility on 7/17/19. A review of the Minimum Data Set (MDS) assessments for Resident #6 revealed the last assessment completed was an admission assessment completed on 7/24/19. No other MDS assessments had been completed since 7/24/19. An interview was conducted with the MDS Coordinator on 11/20/19 at 1:25 PM. During this interview, the MDS Coordinator stated she missed completing the quarterly assessment for Resident #6. She stated it was an oversight and should have been completed within three months after the admission assessment. During an interview with the Director of Nursing on 11/21/19 at 2:12 PM, she stated it was her expectation that quarterly MDS assessments are completed as required and scheduled.	F 638	assessment completed on 11/22/2019 with an ARD of 10/18/2019. All resident have the potential to be affected by the deficient practice so the facility MDS department completed a 100% audit on all active residents to ensure no assessment have been missed. This audit was completed on 12/13/2019. The regional director of clinical services provided an in-service to the MDS Nurses on 12/18/2019 addressing the types and time frames for assessment completion. The MDS department and the DON will review all residents MDS schedules monthly to ensure that no assessments have been missed. The regional Clinical will audit 20% of census monthly times 3 months to ensure no missed assessments. The audits will be reviewed at the bi-weekly QA meeting and ongoing audits will be determined by the QA team.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the	F 641	Resident number 20 had their MDS modified on 12/16/2019 to show the accurate coding of section N of the MDS.	12/19/19

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F 641	Continued From page 4 areas of medications received for 5 of 23 (Resident #'s 20, 73, 105, 109 and 106) residents reviewed and functional status for 1 of 1 residents (Resident #64) reviewed for nutrition. The findings included: 1. Resident #20 was admitted to the facility on 3/7/16 with a diagnosis of hypertension. A quarterly MDS assessment dated 8/23/19 revealed Resident #20 had an active diagnosis of hypertension. The MDS did not refect Resident #20 had received a diuretic during the assessment look back period. A record review revealed a physician ' s order dated 11/2/16 for Lasix 20 milligrams daily. The Medication Administration Record (MAR) for August 2019 revealed Resident #20 had received Lasix 20 milligrams 7 times during the assessment look back period. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she completed the medication section of the MDS by looking at the physician orders. She stated she must have missed the diuretic for Resident #20. 2. Resident #73 was admitted to the facility on 4/11/09. Her diagnoses included, in part, atrial fibrillation and anxiety. A quarterly MDS assessment dated 10/11/19 revealed Resident #73 had active diagnoses of anxiety and atrial fibrillation. The MDS did not reflect Resident #73 had received an anticoagulant medication or an antianxiety medication.	F 641	This modification has been transmitted to the state on 12/16/2019. Resident number 73 had their MDS modified on 12/16/2019 to show the accurate coding of section N of the MDS. This modification has been transmitted to the state on 12/16/2019. Resident number 105 had their MDS modified on 12/16/19 to show the accurate coding of section N of the MDS. This modification has been transmitted to the state on 12/16/19. Resident number 106 had their MDS modified on 12/16/19 to show the accurate coding of section N of the MDS. This modification has been transmitted to the state on 12/16/19. Resident number 64 had their MDS modified on 12/16/19 to show the accurate coding of section G of the MDS. This modification was transmitted to the state on 12/16/19. Resident number 109 had their MDS modified on 12/16/19 to show the accurate coding of section N of the MDS. This modification was transmitted to the state on 12/16/19. All resident have the potential to be affected by the deficient practice so the facility MDS department completed a 100% audit on all active residents most recent MDS to ensure that sections G and N of the MDS were accurate. This audit was completed on 12/16/19. The regional director of clinical services provided an in-service to the MDS Nurses on 12/18/2019 addressing accurate coding of	

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F 641	Continued From page 5 A record review revealed a physician ' s order for buspar 22.5 milligrams by mouth twice a day ordered on 3/25/19 and a physician ' s order for Eliquis 2.5 milligrams by mouth twice a day ordered 11/2/16. Resident #73 ' s MAR for October 2019 indicated she had received buspar 22.5 milligrams twice a day and Eliquis 2.5 milligrams twice a day each day during the look back period. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she completed the medication section of the MDS by looking at the physician orders. She stated she did not catch that Resident #73 was taking an anticoagulant or an antianxiety medication. 3. Resident # 105 was admitted to the facility on 1/29/18 with diagnoses that included, in part, lewy body dementia and Parkinson ' s disease. A review of the physician ' s orders revealed Celexa 20 milligrams daily for lewy body dementia. Resident #105 was not prescribed an antianxiety medication. An annual MDS dated 11/1/19 revealed Resident #105 had active diagnoses of dementia. The MDS did not indicate Resident was taking an antidepressant. Instead, Resident #105 ' s MDS indicated she had received an antianxiety medication. A review of the MAR for October and November 2019 indicated Resident #73 received celexa 20 milligrams daily for 7 out of 7 days of the look back period.	F 641	sections G and N of the MDS. The Regional Director of Clinical Services will conduct an audit of 20% of MDS completed weekly to ensure accurate coding of Sections N and G. Results of the audits will be reviewed at the Monthly QA meeting and further audits will be at the direction of the QA Team.	

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F 641	Continued From page 6	F 641		

An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she must have coded the antianxiety instead of the antidepressant.

4. Resident #106 was admitted to the facility on 10/25/19 with diagnoses that included, in part, cerebrovascular disease and dysphagia following cerebral infarction.

The November 2019 Medication Administration Record (MAR) indicated Resident #106 was not ordered an anti-coagulant medication nor had he received an anti-coagulant medication.

The admission MDS assessment dated 11/1/19 revealed Resident #106 received an anti-coagulant medication four of seven days during the look back period.

On 11/21/19 at 9:39 AM an interview was completed with MDS Nurse #1. She said when she coded medications on section N of the MDS they were coded per drug classification and not how they were used. She indicated the resident received Brilinta, 90 milligrams, twice a day. MDS Nurse #1 stated she coded the medication as an anti-coagulant but when she researched the classification of the medication during the interview she discovered it was an anti-platelet medication. She acknowledged she should have coded a zero under the anti-coagulant section.
5. Resident #64 was admitted to the facility on 7/28/15 with diagnoses that included, in part, profound intellectual disabilities, aphasia, hypothyroidism, and peripheral vascular disease

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F 641	Continued From page 7	F 641		

(PVD).

The quarterly Minimum Data Set (MDS) assessment dated 10/4/19 indicated Resident #64 had severe cognitive deficit, required one-to-two-person total assistance with activities of daily living (ADLs), and was incontinent of bladder and bowel. The previous MDS dated for 9/20/19 documented that the resident required two-person extensive assistance with bed mobility, locomotion on the unit, toilet use, and personal hygiene.

During an interview with Nurse #2 on 11/20/19 at 10:30 AM she stated that the resident requires total assistance by one to two staff members for all ADLs and a mechanical lift is used to transfer Resident #64 from his bed to his wheelchair. She stated that this assistance was required prior to 9/20/19.

During an observation on 11/20/19 at 11:10 AM the resident was transferred from his wheelchair to his bed using a mechanical lift by three staff members to perform incontinence care.

During an interview with MDS #1 and MDS #2 on 11/20/19 at 1:35 PM they stated that they code based on what the nurse assistants (NAs) documented. If the NAs documented extensive assistance, then extensive assistance would be documented in the MDS. They stated that education needed to be given to the NAs so they could correctly identify extensive assistance versus total assistance.

During an interview with the Director of Nursing on 11/21/19 at 2:15 PM, she stated that Resident #64 had required total assistance with all ADLs

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F 641	Continued From page 8	F 641		

for a long time and the MDS should reflect that.
6. Resident #109 was admitted to the facility on 11/20/2013 with diagnoses including: Parkinson's disease, dementia, hypokalemia, major depressive disorder, and kidney failure.

A review of the admission MDS dated 9/13/19 revealed Resident #109 was actively taking the following classes of medications for at least 7 days either prior or during his last MDS assessment: antipsychotic, antidepressant, hypnotic, anticoagulant, antidepressant, diuretic, and opioid.

A review of the physician's orders for September 2019 revealed Resident #109 had an active order dated 4/29/19 for Risperdal (an antipsychotic) 0.5 milligrams (mg) by mouth twice daily. No other medication orders from the above medication classes noted on the resident's 9/13/19 MDS were found.

A review of the Medication Administration Record for September 2019 revealed Resident #109 received only Risperdal 0.5 mg (an antipsychotic), but was not receiving any antidepressant, hypnotic, anticoagulant, antidepressant, diuretic, or opioid medications as specified on the 9/13/19 MDS assessment.

An interview with the MDS nurses #1 and #2 on 11/21/19 at 10:47 AM revealed Resident #109's quarterly MDS assessment dated 09/13/19 was not accurate. The MDS nurses specified on Resident #109's 9/13/19 MDS assessment antipsychotic medications should have been the only medication class with 7 days denoted-all other medication classes on the MDS assessment should have read 0 days taken.

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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)- (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	F 656		12/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 10 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 observation, staff interviews and record review, the facility failed to develop a care plan that addressed the use of oxygen for 1 of 5 residents (Resident #27) reviewed for oxygen therapy and failed to develop a care plan that addressed a pressure ulcer for 1 of 3 residents (Resident #64) reviewed for pressure ulcers. Findings included: 1. Resident #27 was admitted to the facility on 6/13/18, discharged to the hospital on 11/8/19 and re-admitted to the facility on 11/14/19 with diagnoses that included, in part, pneumonia, hypoxemia and dyspnea. A physician order dated 11/14/19 stated, "Oxygen via nasal cannula or face mask at 2-5 liters per minute continuously for respiratory distress/shortness of breath." The quarterly Minimum Data Set (MDS) assessment dated 9/6/19 indicated Resident #27 was cognitively intact. He had shortness of breath or trouble breathing when lying flat and received oxygen therapy. The care plan, updated 9/11/19, had not addressed the use of oxygen. An observation of Resident #27 was made on 11/18/19 at 10:36 AM. The resident was lying in bed with oxygen on at 3.5 liters via nasal cannula.	F 656	Resident number 27 had their comprehensive care plan updated to reflect the use of Oxygen on 11/22/2019. Resident #64 had their care plan updated to reflect current Pressure ulcer on 11/25/2019. All Residents have the potential to be affected if their Comprehensive care plans are not current and reflective of current status so the Director of Clinical Services provided the MDS Department with an in-service on 12/18/2019 regarding Comprehensive care plans. The MDS Department and the DON completed a 100% audit of all active residents care plans on 12/13/2019 to ensure all pressure ulcers and oxygen use is care planned. The Regional Director of Clinical Services will completed a weekly audit of 20% of completed Comprehensive care plans for one month. The results of the audit will be reviewed at the Monthly QA meeting and further audits will be at the discretion of the QA Team.	

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F 656	Continued From page 11	F 656		

On 11/20/19 at 10:31 AM an interview was completed with MDS Nurse #2. She stated Resident #27 was on oxygen due to a history of aspiration pneumonia. She completed the care plan for Resident #27 and explained since he was on continuous oxygen it should have been included in the care plan.

An interview with MDS Nurse #1 on 11/20/19 at 10:35 AM revealed the use of oxygen should have been on Resident #27's care plan. She reported both she and MDS Nurse #2 had been at the facility less than nine months and had to "catch up the care plans" when they first started working at the facility. MDS Nurse #1 explained they used the 24 hour report information when they updated care plans.

During an interview with the Director of Nursing (DON) on 11/21/19 at 11:09 AM she expressed the care plan was supposed to be a snapshot of what was going on with the resident and thought the use of oxygen should be included in the care plan. The DON said MDS Nurse #2 was new to the MDS position and was scheduled to attend a MDS training seminar in the next few weeks.

2. Resident #64 was admitted to the facility on 7/28/15 with diagnoses that included, in part, profound intellectual disabilities, aphasia, hypothyroidism, and peripheral vascular disease (PVD).

A physician's order was placed on 7/17/19 for to apply Silver Sulfadiazine 1% cream to sacrum/coccyx every shift until healed. Another order was placed on 10/11/19 to cleanse with normal saline, apply skin barrier to periwound and cover wound with hydrocolloid dressing.

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	345167	A. BUILDING _____ B. WING _____	C 11/21/2019

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F 656	Continued From page 12 The quarterly Minimum Data Set (MDS) assessment dated 10/4/19 indicated Resident #64 had severe cognitive deficit, required extensive to total assistance with activities of daily living, and was incontinent of bladder and bowel. In Section M, Resident #64 was documented to have a stage 2 pressure ulcer that was not present on admission. The Care Plan dated for 10/13/17 revealed a plan in place for the potential for skin impairment related to incontinence of bowel/bladder, non-ambulatory, PVD, and has bilateral contractures of hands. There was no care plan added to address the actual skin impairment and/or stage 2 pressure ulcer. On 11/20/19 at 1:31 PM an interview was completed with MDS Nurse #1 and #2. They stated that they were unaware that care plans that addressed pressure ulcers were required in addition to the potential for skin impairment care plan. During an interview with the Director of Nursing on 11/21/19 at 2:12 PM she stated that it was expected that care plans reflect what is going on with the resident. She stated that if a resident had a pressure ulcer, she would expect a care plan and additional interventions to be in place to address it.	F 656		
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	F 657		12/19/19

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F 657	Continued From page 13 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update the care plan to reflect a weight loss for 1 of 4 (Resident #64) reviewed for nutrition and continence status for 2 of 2 residents (Resident #105 and Resident #2) reviewed for activities of daily living. The findings included: 1. Resident #64 was admitted to the facility on 7/28/15 with diagnoses that included, in part, profound intellectual disabilities, aphasia, hypothyroidism, and peripheral vascular disease (PVD).	F 657	Resident number 105 had their care plan updated on 11/25/2019 to reflect accurate assistance for adl□s. Resident number 64 had their care plan updated on 11/25/2019 to reflect accurate interventions on the Nutrition care plan to include discontinue of weights. All residents have the potential to be affected by the deficient practice so the MDS department and DON completed a 100% audit of all resident□s nutritional interventions and adl assistance to ensure it was care planned as appropriately.	

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F 657	Continued From page 14 The quarterly Minimum Data Set (MDS) assessment dated 10/4/19 indicated Resident #64 had severe cognitive deficit, required one-to-two-person total assistance with activities of daily living (ADLs), and was incontinent of bladder and bowel. The previous MDS dated for 9/20/19 documented that the resident required two-person extensive assistance with bed mobility, locomotion on the unit, toilet use, and personal hygiene. There was no weight listed on the MDS and no weight loss noted. On 05/02/2019, the resident weighed 107 lbs. On 06/02/2019, the resident weighed 103 pounds which is a -3.74 % Loss. The last documented weight was on 7/02/2019 at 100lbs. No other weights were listed. Review of Physician orders revealed an order to discontinue monthly weights on 7/10/19 due to palliative goals. Review of a Dietary Note from 10/3/19 stated that Resident #64 had a stage 2 pressure ulcer, needed increased portions of eggs at breakfast to increase protein intake, breakfast intake is 75-100%. He received supplements with meals and had between meal snacks three times a day. Resident #64 remained on comfort measures with no feeding tube and monthly weights were discontinued as ordered. A Care Plan dated for 4/8/19 stated that Resident #64 was at risk for altered nutrition related to need for assist with meals due to intellectual disability and impaired dexterity to bilateral upper extremities. The care plan did not address actual weight loss and interventions in place. One of the	F 657	The Regional Director of Clinical Services provided an in-service to the MDS Department on 12/18/2019 regarding accuracy of care plans. The Regional Director of Clinical Services will conduct 20% audit of completed care plans weekly for one month. The results of the audit will be reviewed at the bi-weekly QA meeting and further audits will be at the direction of the QA Team.	

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F 657	Continued From page 15	F 657		

interventions documented on Resident #64's care plan was to obtain weights.

During an interview with MDS #1 on 11/20/19 at 1:20 PM she stated that the resident's care plan should have been updated to reflect his current nutritional status and that his weights were discontinued.

During an interview with the Director of Nursing on 11/21/19 at 2:15 PM, she stated that Resident #64's care plan should have been updated to reflect his current nutritional interventions. She stated that the resident was no longer getting his weights monthly due to comfort care.

2. Resident #105 was admitted to the facility on 1/29/18 with diagnoses of, in part, lewy body dementia and Parkinson ' s disease.

A comprehensive Minimum Data Set (MDS) assessment dated 11/1/19 revealed Resident #105 required extensive assistance of 2 people for toileting and was always incontinent of bladder.

A care plan dated 11/6/18 indicated Resident #105 was frequently incontinent of bladder related to her altered mental status. The goal was for Resident #105 to remain continent during the waking hours for 90 days. Interventions included, in part, incontinent care after each incontinent episode and encourage fluids while awake.

An observation on 11/20/19 at 12:42 PM revealed Resident #105 in her room sitting in a wheelchair. She was oriented to name only and was unable to make her needs known. An interview in conjunction with the observation with Nursing

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F 657	Continued From page 16	F 657		

Assistant #2 revealed Resident #105 was always incontinent of bowel and bladder and she was unable to let staff know when she had to use the bathroom.

An interview on 11/21/19 at 10:48 with MDS Nurse #2 revealed she had been working at the facility since August. MDS Nurse #2 stated Resident #105 ' s care plan should have been updated when the comprehensive assessment was done. She stated was new to the position and that the care plans were a work in progress, they were still trying to determine the best system to keep the care plans up to date.

3. Resident #2 was admitted to the facility on 7/15/15 with diagnoses of, in part, ataxia and Alzheimer ' s.

The last MDS assessment completed was a quarterly done on 6/28/19 that indicated Resident #2 was always incontinent of bowel and bladder.

A care plan dated 1/13/17 indicated a problem of episodes of urinary incontinence related to decreased mobility, weakness and Alzheimer ' s.

An interview with Nursing Assistant #1 on 11/20/19 at 10:12 A revealed Resident #2 was total care. She stated the staff did everything for her and she was always incontinent of bowel and bladder. She stated Resident #2 was unable to let the staff know she had to use the bathroom.

An interview on 11/21/19 at 10:48 with MDS Nurse #2 revealed she had been working at the facility since August. MDS Nurse #2 stated Resident #105 ' s care plan should have been updated when the comprehensive assessment

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F 657	Continued From page 17 was done. She stated was new to the position and that the care plans were a work in progress, they were still trying to determine the best system to keep the care plans up to date.	F 657		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facilities Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place following the recertification and complaint survey conducted on 12/6/18. This was for three deficiencies that were originally cited in the areas of Comprehensive Assessments and Timing (F636), Quarterly Minimum Data Set (MDS) Assessments at least every three months (F638), and Accuracy of MDS Assessments (F641) in December 2018 and recited on the current recertification and complaint investigation survey of 11/21/19. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. Findings included: This tag is cross referenced to:	F 867	The original Plan of Correction from 12/6/2018 will be reviewed by the QAA Committee and updated as necessary. The Plan of Correction will be implemented upon completion of the review. The QAA Committee will complete the review of the 12/6/2018 Plan of Correction to identify any past deficiencies and ensure compliance going forward. The Administrator or designated representative will review the Plan of Correction from 12/6/2018 to ensure all measures and recommendations are being followed. This review will continue weekly for 4 weeks then monthly for 6 months. The Administrator or designated representative will report findings of the weekly and monthly reviews to the QAA	12/19/19

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F 867	Continued From page 18 1. F636- Comprehensive Assessments and Timing- Based on observations, record review and staff interviews, the facility failed to complete an annual comprehensive MDS (minimum data set; a tool used for resident assessment) assessment within 366 days for 1 of 23 residents reviewed. (Resident #2) During the facility's recertification and complaint investigation survey on 12/06/18, the facility failed to complete an annual comprehensive assessment within 366 days for 1 of 28 residents (Resident # 9) reviewed for comprehensive assessments. An interview was conducted with the MDS nurse on 11/21/19 at 10:32 AM who stated she was unaware of the missed MDS assessments. She further revealed that she was new to the role and felt like she had not received appropriate training yet regarding MDS completion. An interview conducted with the Director of Nursing (DON) on 11/21/19 at 11:08 AM revealed the facility did have an active Quality Assessment and Assurance Committee and they met usually every other Wednesday. The DON revealed the committee was currently working on mock evacuations and emergency preparedness and the committee meetings had been focused more on care than MDS charting. 2. F638- Based on record reviews and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment for 1 of 23 residents selected to be reviewed for Resident Assessments. (Resident #6). During the facility's recertification and complaint	F 867	Committee to determine if the measures put in place are adequate or if any updates are necessary. The Administrator or designated representative will report finding once a month for 6 months. If necessary, the QAA Committee will extend reports until substantial compliance is achieved.	

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F 867	Continued From page 19	F 867		

investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for Resident Assessments. (Resident # 5, 3, 24, and 19).

An interview was conducted with the MDS nurse on 11/21/19 at 10:32 AM who stated she was unaware of the missed MDS assessments. She further revealed that she was new to the role and felt like she had not received appropriate training yet regarding MDS completion.

An interview conducted with the Director of Nursing (DON) on 11/21/19 at 11:08 AM revealed the facility did have an active Quality Assessment and Assurance Committee and they met usually every other Wednesday. The DON revealed the committee was currently working on mock evacuations and emergency preparedness and the committee meetings had been focused more on care than MDS charting.

3. F641- Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications received for 5 of 23 (Resident # ' s 20, 73, 105, 1 and 106) residents reviewed and functional status for 1 of 1 residents (Resident #64) reviewed for nutrition.

During the facility's recertification and complaint investigation survey on 12/06/18, the facility was cited at F-641 for failing to accurately code the Minimum Data Set (MDS) assessment for a resident receiving a medication for 1 of 1 (Resident #18) residents reviewed for Unnecessary Medications.

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F 867	Continued From page 20 An interview was conducted with the MDS nurse on 11/21/19 at 10:32 AM who stated she was unaware of the MDS assessments were inaccurate. She further revealed that she was new to the role and felt like she had not received appropriate training yet regarding MDS completion. An interview conducted with the Director of Nursing (DON) on 11/21/19 at 11:08 AM revealed the facility did have an active Quality Assessment and Assurance Committee and they met usually every other Wednesday. The DON revealed the committee was currently working on mock evacuations and emergency preparedness and the committee meetings had been focused more on care than MDS charting.	F 867		