DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	C 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	**2575 W 5TH STREET GREENVILLE, NC 27834**

(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 2/02/20 through 2/06/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # A18711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/02/20 through 2/07/20. 3 of the 15 complaint allegations were substantiated. Event ID# A18711	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a surety bond or similar protection for 69 of 69 residents with funds deposited in the resident trust account. The findings included: On 02/05/2020 at 10:15 AM an interview with the business office manager indicated 69 facility residents currently had funds deposited in the trust account. She stated the current balance of the resident trust account was $73,033.20. The business office manager further indicated she did not have any information regarding a surety bond or similar protection for the resident trust fund.	F 570	1. A current surety bond in the amount of $150,000 will be obtained for the resident trust account at the facility by 3-6-2020. 2. This surety bond will cover the resident trust account at the facility along with all of the individual accounts that each resident has. 3. An audit will be performed on a yearly basis, with the first one to take place by 3-6-202, to ensure that the surety bond on the resident trust account is current. This audit will be performed by the Administrator or their designee.	3/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/01/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 570	Continued From page 1 On 02/05/2020 at 11:00 AM an interview with the administrator indicated he did not have any information regarding a surety bond or similar protection for the resident trust fund account and would try to get the information from the owner of the facility. On 02/05/2020 at 5:00 PM an interview with the administrator indicated he had spoken to the facility owner who was trying to get the information regarding a surety bond or similar protection for the resident trust fund account from his insurance company. On 02/06/2020 at 12:13 PM an interview with the administrator indicated he called the corporate business office for information on a surety bond or similar protection for the resident trust fund account and was referred back to the facility owner. He further indicated the facility owner was still trying to get in touch with his insurance company and neither he nor the facility owner had any information regarding the dates of coverage or the amount of coverage for a surety bond or similar protection for the resident trust fund. On 02/06/2020 at 12:49 PM review of the resident trust fund account report indicated the current balance of the resident trust fund was $165,416.15. An interview with the business office manager at that time indicated 69 facility residents currently had funds deposited in the resident trust account. She went on to say this was the highest recorded balance since the facility switched over to the current record system on 05/01/2019. On 02/06/2020 at 2:44 PM an interview with the administrator indicated the facility owner still had	F 570	4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that the surety bond on the resident trust account is current.	

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F 570	Continued From page 2 not provided him with any information regarding a surety bond or similar protection for the resident trust fund account. He went onto say he was baffled because he had never had any trouble getting the information regarding this protection before. The administrator further indicated he was aware of the requirement for the facility to provide a surety bond or similar protection for resident funds deposited in the trust account.	F 570		
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 observation, staff, resident and family interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of hearing, behaviors, vision and Pre-Admission Screening and Resident Review (PASARR) status for 4 of 25 residents whose MDS assessments were reviewed (Resident #8, Resident #34, Resident #88, and Resident #92). The findings included: 1. Resident #8 was admitted to the facility on 2/25/15 with diagnoses that included hypertension and hyperlipidemia. Resident #8's annual Minimum Data Set (MDS) assessment dated 1/19/20, an annual assessment revealed in section B, Resident #8 was assessed as having adequate hearing.	F 641	1. Resident #8's assessment dated 1-18-2020 was edited to show that the resident is hard of hearing. Resident #34's assessment dated 12-1-2019 was edited to show that the resident exhibited behaviors during the look back period. Resident #88's assessment dated 12-8-2019 was edited to show that resident uses corrective lenses. Resident #92's assessment dated 1-13-2020 was edited to show that the resident has a Level I PASSR. 2. The facility Social Worker was inserviced on making sure to code all those resident that are hard of hearing, have exhibited behaviors, that use corrective lenses and on making sure the correct level of PASSR is coded on MDS's.	3/6/20

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F 641	Continued From page 3 During an interview on 2/3/20 at 9:00 AM Resident #8 stated she had difficulty hearing. An interview was conducted with Nursing Assistant (NA) #8 on 2/4/20 at 4:14 PM who stated Resident #8 had difficulty hearing. During an interview with NA #9 on 2/4/20 at 4:16 PM she reported Resident #8 was hard of hearing. An interview was conducted with MDS Nurse #1 on 2/5/20 at 3:00 PM who stated section B of the MDS assessment was conducted by the facility social worker. During an interview with Social Worker #1 on 2/5/20 at 3:12 PM she stated Resident #8's 1/19/20 MDS assessment should have reflected Resident #8 was hard of hearing. During an interview with the administrator on 2/6/20 at 11:00 AM he indicated Resident #8's MDS assessment completed on 1/19/20 should have accurately reflected her hearing difficulty. 2. Resident #34 was admitted to the facility on 12/12/13 with diagnoses that included heart failure and hypertension. A nurse's note dated 11/27/19 revealed Resident #34 displayed behaviors such as care refusals and attempting to strike staff. Resident #34's quarterly Minimum Data Set (MDS) assessment dated 12/1/19 revealed in Section E no behaviors were exhibited by the resident.	F 641	3. An initial audit will be completed by 3-6-2020 on the most recent MDS's to ensure that those residents who were hard of hearing, exhibited behaviors, used corrective lenses and that the correct level of PASSR were all coded correctly. An additional audit will be performed to ensure that those MDS assessments completed that week were accurately coded if a resident was hard of hearing, exhibited behaviors, used corrective lenses and that the correct level of PASSR was listed. This audit will be performed weekly x 4 weeks and then monthly x 3 months. The audit will be completed by the facility MDS staff or their designee. 4. The results of these audits will be taken to the facility QA&A committee meetings to ensure that the recently completed MDS assessment were coded correctly for those residents who are hard of hearing, exhibited behaviors, used corrective lenses and to make sure the correct level of PASSR is coded.	

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F 641	Continued From page 4	F 641		

During an interview on 2/5/20 at 3:00 PM the MDS Nurse #1 reported Resident #34's MDS assessment should have accurately reflected behaviors. She stated Section E of the MDS assessment was completed by social work.

An interview was conducted on 2/5/20 at 3:12 PM with Social Worker #1 who stated she did not review Resident #34's progress notes to complete Section E of the MDS assessment dated 12/1/19. She confirmed Resident #34's 12/1/19 MDS was inaccurate because it did not indicate the resident had refused care and attempted to hit others.

During an interview on 2/6/20 at 11:00 AM the administrator indicated Resident #28's MDS assessment should have accurately reflected exhibited behaviors.

3. Resident #88 was admitted to the facility on 12/22/17 with diagnoses that included hypertension and dementia.

During an interview with Resident #88 on 2/3/20 at 11:15 AM he was observed wearing glasses. Resident #88's Minimum Data Set (MDS) assessment dated 12/8/19, an annual assessment revealed adequate vision with no corrective lenses in Section B of the assessment.

During an interview on 2/5/20 at 3:00 PM the MDS Nurse #1 reported Resident #88's MDS assessment should have accurately reflected his use of corrective lenses. She stated Section B of the MDS assessment was completed by social work.

An interview was conducted on 2/5/20 at 3:12 PM

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F 641	Continued From page 5 with Social Worker #1 who indicated Resident #88's corrective lenses should have been reflected in his 12/8/19 MDS assessment. During an interview on 2/6/20 at 11:00 AM the administrator indicated Resident #88's MDS assessment should have accurately reflected his use of corrective lenses. 4. Resident # 92 was admitted to the facility on 1/6/20 with diagnoses that included hypertension and dementia. She was discharged to the community on 1/17/20. Resident #92's Admission Minimum Data Set (MDS) assessment dated 1/13/20 revealed Resident #92 was coded as requiring a level II Pre-Admission Screening and Resident Review (PASSR) in Section A of the assessment. An interview was conducted with Social Worker #1 on 2/5/20 at 3:12 PM who stated Resident #92's MDS assessment was coded in error. She explained that Resident #92 did not require a level II review as her level I review revealed no level II PASSR review was necessary. During an interview on 2/6/20 at 11:00 AM the administrator indicated Resident #88's MDS assessment should have accurately reflected her level I PASSR status.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		3/6/20

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F 645	Continued From page 6 §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. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 7 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 interview and record review the facility failed to initiate a screening for a level II Pre-Admission Screening Resident Review (PASRR) for 2 of 3 residents reviewed for PASSR (Resident #72 and Resident #80). The findings included: 1. Resident #72 was admitted to the facility 5/23/11 with diagnoses that included major depressive disorder. Resident #72's minimum data set (MDS) assessment dated 12/29/19 revealed Resident #72 was assessed with severe cognitive	F 645	1. Resident #72's and #88's PASSR were updated and are now current. 2. The facility Social Worker was inserviced on making sure that all PASSR's within the facility are current and not expired. 3. An initial audit will be completed by 3-6-2020 to ensure that the PASSR's for all residents in the facility were current. A additional audit will be completed to ensure that that there are no expired PASSR's. This audit will be completed	

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F 645

Continued From page 8
impairment.

Review of Resident #72's level II Pre-Admission Screening Resident Review revealed an expiration date of 7/23/17.

An interview with Social Worker #1 on 2/5/19 at 3:42 PM was conducted. She stated according to her records it appeared that a review had been requested on 3/29/19. The social worker stated she made that request and to her knowledge results had not been received. She reported she should have followed up and did not do so. The social worker stated she would initiate another review if needed. She indicated that she is advised by the Admissions Coordinator if a resident has a level II upon admission. The social worker stated sometimes she is unaware of resident's level II status.

During an interview with the Administrator on 2/6/20 at 11:00 AM he indicated Resident #72's level II PASSR should have been initiated prior to the expiration date with the results present in her record by the social worker.

2. Resident #88 was admitted to the facility on 12/22/17 with diagnoses that included bipolar disorder.

Resident #88's minimum data set (MDS) assessment dated 12/8/19 revealed he was assessed to be cognitively intact.

Review of Resident #88's level II Pre-Admission Screening Resident Review revealed an expiration date of 4/30/18.

An interview with Social Worker #1 on 2/4/20 at

F 645

monthly x 4 months. The audit will be completed by the facility Administrator or their designee.

4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that there are no expired PASSR's on residents residing in the facility.

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F 645	Continued From page 9 8:48 AM was conducted. She reported Resident #88 was scheduled for short-term rehabilitation. The social worker added that she was on leave during this time, so it should have been completed by the Admission Coordinator. She reported there had been turnover in the Admission office, so she was unsure why the review was not requested. She indicated that she was advised by the Admissions Coordinator if a resident has a level II upon admission. The social worker stated she was not made aware of Resident #88's status and he has not had a review since admission. The social worker requested a review on 2/4/20. During an interview with the Administrator on 2/6/20 at 11:00 AM he indicated Resident #88's level II PASSR should have been initiated prior to the expiration date with the results present in his record by the social worker.	F 645		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility failed to follow physician orders for oxygen at 2 liters per minute (LPM) for 1 of 3 residents reviewed for oxygen use (Resident #51). Findings included:	F 658	1. Resident #51's oxygen concentrator was set to 2L/minute as ordered by the physician. 2. The facility nurses were inserviced on making sure that all residents have their oxygen set to the doctor ordered settings.	3/6/20

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F 658	Continued From page 10 Resident #51 was admitted to the facility on 10/19/16 with a reentry on 6/29/19 with diagnoses that included coronary artery disease and diabetes mellitus. A review of the quarterly Minimum Data Set (MDS) dated 12/09/19 revealed he had severe cognitive impairment. A review of Resident #51's physician orders revealed he had an order dated 8/13/19 for oxygen by nasal cannula (nose) at 2 LPM. Observations made during the survey on 2/02/20 at 8:58 AM, 2/04/20 at 10:08 AM, and 2/04/20 at 3:03 PM revealed Resident #51 had oxygen by nasal cannula at 4 LPM. During an interview with Nurse Aide #1 on 2/04/20 at 1:23 PM she revealed she did not adjust the oxygen concentrator for Resident #51 and had not noticed what setting it was on. She further stated if Resident #51's nasal cannula was dislodged from his nose, she would adjust it and would notify the nurse if he appeared to be having trouble breathing. During an interview with Nurse #1 on 2/04/20 at 3:30 PM she revealed Resident #51 was supposed to have oxygen by nasal cannula at 2 LPM. She further revealed she was responsible for ensuring it was set correctly and she did not know how or when it had been changed. She stated she had glanced at it earlier in the day but had not made sure it was correct. During an interview with Physician #1 on 2/05/20 at 1:47 PM, she stated she expected staff to follow her orders or notify her if they had any	F 658	3. An initial audit will be completed by 3-6-2020 to ensure that the other residents in the facility with orders for oxygen are receiving the physician ordered amount. An additional audit will be completed to ensure that those residents within the facility with physician orders for oxygen are receiving the ordered amount. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be completed by the Assistant Director of Nursing or their designee. 4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that those residents with physician orders for oxygen are receiving the ordered amount.	

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F 658	Continued From page 11 concerns or if Resident #51 had decreased oxygen saturation. She further stated that staff had not contacted her for any concerns or decreased oxygen saturation related to Resident #51. During an interview with the Director of Nursing (DON) on 2/06/20 at 10:44 AM, she stated she expected her staff to follow physician's orders and she did not know why Resident #51's oxygen was not on the correct setting. During an interview with the Administrator on 2/05/20 at 3:07 PM, he stated staff should follow doctor's orders or contact the doctor if they had any concerns.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide nail care for 1 of 7 residents (Resident #5) who were dependent on facility staff for activities of daily living. The findings included: Resident #5 was admitted to the facility on 7/13/12 with diagnoses which included diabetes, pulmonary emboli and atrial fibrillation. The resident's annual Minimum Data Set (MDS)	F 677	1. Resident #5 had their fingernails cleaned on 2-5-2020. 2. The facility nursing staff was inserviced on the importance of keeping residents fingernail clean. 3. An initial audit will be completed by 3-6-2020 to check the fingernail cleanliness of the other residents within the facility. An additional audit will be completed on	3/6/20

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F 677	Continued From page 12 dated 10/10/19 revealed Resident #5 was moderately cognitively impaired. Resident #5 was severely visually impaired, had no behaviors or rejection of care and required extensive assistance for personal hygiene and bathing. The resident's care plan updated 2/3/2020 indicated Resident #5 needed extensive to total assistance with activities of daily living. The interventions included assist as needed with activities of daily living and observe skin condition with daily care. During an observation of Resident #5 on 2/3/2020 at 11:05 AM she was sitting in the dining room. The fingernails on both hands were observed to contain black debris under the nails on both hands. During an observation of Resident #5 on 2/5/2020 at 1:43 PM she was seated in the dining room. Both of her hands were resting on the tabletop. The fingernails on both hands continued to contain black debris under the nails. On 2/5/2020 at 1:50 PM Nursing Assistant #7 (NA) stated she gave Resident #5 a bath that morning and washed the resident's hands with a washcloth. She stated she did not clean her fingernails because the resident had diabetes. She stated she was afraid to put anything under the resident's fingernails. On 2/5/2020 at 2:50 PM Resident #5 stated she had never refused to have her fingernails cleaned. She added someone had just come into the dining room and cleaned her fingernails. On 2/5/2020 at 3:05 PM the Assistant Director of	F 677	all residents in the facility to check for cleanliness of their fingernails. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be completed by the Director of Nursing or their designee. 4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that the fingernails of residents in the facility are being kept clean.	

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F 677	Continued From page 13 Nursing (ADON) stated she was told by NA #7 that Resident #5's nails needed to be clipped. The ADON said Resident #5's fingernails were dirty, and she cleaned them, but they were not long, so she did not need to clip them. The ADON said the NA should clean the resident's fingernails as part of the daily bath. She added if a resident had diabetes the nails on the feet would need to be cleaned by a nurse but, the fingernails could and should be cleaned by the nursing assistant.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to change the resident's oxygen tubing according to physician's orders for 1 of 3 residents reviewed for respiratory care (Resident #4). The findings included: Resident #4 was admitted to the facility on 9/10/2019 with diagnoses which included congestive heart failure, asthma, chronic obstructive pulmonary (lung) disease and shortness of breath.	F 695	1. Resident #4's oxygen tubing was changed. 2. The facility nurses were inserviced on changing the residents oxygen tubing and when to do so. 3. An initial audit will be completed by 3-6-2020 for all those residents on oxygen to ensure that their oxygen tubing were being changed weekly. An audit will be completed on those resident receiving oxygen to ensure that	3/6/20

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F 695 Continued From page 14

The quarterly Minimum Data Set (MDS) dated 1/12/20 revealed Resident #4 was moderately cognitively impaired, had no behaviors and required total assistance with most activities of daily living.

The care plan for Resident #4 last reviewed on 1/30/20 revealed she was to receive oxygen therapy at 2 liters per minute (lpm) as needed for shortness of breath to maintain oxygen saturations greater than 90%. The interventions included but were not limited to: 1) apply oxygen therapy per orders, 2) encourage resident to wear oxygen per orders, 3) change oxygen tubing weekly per protocol 4) assess breath sounds/air exchange.

The monthly physician's orders revealed an order with a start date of 8/17/19 which read, "Change and date oxygen tubing and nasal canula weekly every night shift every Sunday."

An observation on 2/2/20 at 3:03 PM revealed the Resident #4 was wearing oxygen. The Resident's oxygen tubing was dated 1/20/20.

During an interview with Resident #4 on 2/2/20 at 3:05 PM she stated she was not able to state when the tubing was previously changed by staff.

On 2/2/20 at 3:25 PM Nurse #1 stated the oxygen tubing was supposed to be changed on the 3:00 PM to 11:00 PM shift each week on Sunday. She observed the tubing and stated the date on the tubing was 1/20/20. She stated the tubing should have been changed more frequently.

On 2/2/20 at 3:27 PM the Assistant Director of Nursing (ADON) entered the resident's room and

F 695

their oxygen tubing is being change weekly. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be completed by the Assistant Director of Nursing or their designee.

4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that those residents who are receiving oxygen are having their oxygen tubing changed weekly.

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F 695	Continued From page 15 stated she worked the previous Sunday (1/26/20) on the 3:00 PM to 11:00 PM shift. She said she changed the oxygen tubing for 2 other residents, so she did not know why she did not change the tubing for Resident #4. The ADON added the tubing should have been changed on 1/26/20.	F 695		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure nurse aides received at least 12 hours of documented in-service education annually for 5 of 5 nurse aide files reviewed. The findings included: On 02/06/2020 at 9:59 AM an interview with the assistant director of nursing (ADON) indicated she was responsible for the in-service education and documentation for nurse aides (NA). She stated she was somewhat behind on in-service training. She further indicated NA's received an annual skills checklist evaluation, but she had no documentation indicating each NA had received at least 12 hours of in-service education annually based on this evaluation. A review of training information for NA #2	F 730	1. Monthly inservices have been set up that the CNA's are going to be required to attend so that they receive at least 12 hours/year of inservice training. 2. The facility staff working as CNA's have begun to receive inservices to ensure that they receive their required 12 hours of inservice training per year. The inservices started on 2-13-2020. 3. The monthly inservice sign in sheets will be audited to ensure that all of the employees that are working as CNA's attended the monthly inservices to ensure that they receive at least 12 hours of inservice training per year. This audit will be performed by the DON or their designee.	3/6/20

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F 730	Continued From page 16 indicated a hire date of 05/02/2018. There was no dated documented training provided that showed NA #2 received at least 12 hours of in-service education in one (1) year based on performance. A review of training information for NA #3 indicated a hire date of 08/17/2001. There was no dated documented training provided that showed NA #3 received at least 12 hours of in-service education for one (1) year based on performance. A review of training information for NA #4 indicated a hire date of 10/21/2014. There was no dated documented training provided that showed NA #4 received at least 12 hours of in-service education in one (1) year based on performance. A review of training information for NA #5 indicated a hire date of 04/18/2017. There was no dated documented training provided that showed that NA #5 received at least 12 hours of in-service education in one (1) year based on performance. A review of training information for NA #6 indicated a hire date of 12/29/2017. There was no dated documented training provided that showed NA #6 received at least 12 hours of in-service education in one (1) year based on performance. In an interview on 02/06/2020 at 1:52 PM the DON indicated she was not aware of the requirement for NA's to receive at least 12 hours of in-service education in one (1) year based on performance evaluation including abuse and dementia training. On 02/06/2020 at 2:31 PM an interview with the administrator indicated he did not know how many hours of in-service education were required	F 730	4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that the CNA's are attending the monthly inservices to ensure that they are receiving 12 hours of inservice training per year.	

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F 730	Continued From page 17 for NA's but felt the facility's NA's should be receiving the required hours and documentation of the training provided should be available when it was needed.	F 730		
F 758 SS=D	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; §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	F 758		3/6/20

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F 758	Continued From page 18	F 758		

§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 observation, staff interviews, physician interview, and record reviews, the facility failed to limit the duration of the use of an as needed (PRN) psychotropic drug to 14 days or have a prescriber document a rationale in the resident's medical record for an extension of the drug's use beyond 14 days for 1 of 1 residents (Resident #84) reviewed for unnecessary medications.

Findings included:

Resident #84 was admitted to the facility on 12/5/2019 with diagnoses which included Alzheimer's disease, dementia, and anxiety disorder.

A quarterly Minimum Data Set (MDS) dated 1/6/2020 revealed Resident #84 was cognitively impaired. The MDS showed the resident had no moods or behaviors and received no anti-anxiety medication during the assessment's look back period.

1. Resident #84's Ativan was given a stop date.

2. The facility nurses were inserviced about ensure that those psychotropic mediations that need a stop date due in fact have a stop date listed.

3. An initial audit was completed to ensure that the psychotropic medications that need a stop date all have one.

An audit will be completed by 3-6-2020 to ensure that all psychotropic medications that need a stop date have an appropriate stop date. This audit will be completed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the DON or their designee.

4. The results of this audit will be taken to the facility QA&A committee meetings to

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F 758	Continued From page 19 A physician dated 1/7/2020 specified Ativan 0.5 milligrams (mg) by mouth every 4 hours as needed (PRN) for anxiety with no stop date indicated. The order was signed by the physician on 1/8/2020. Resident #84's medication administration records for the months of January 2020 and February 2020 revealed a PRN order for Ativan with no stop date. A pharmacist consultant recommendation dated 1/27/2020 addressed to Resident #84's primary care physician revealed a recommendation to please provide a duration of therapy for the as needed Ativan. The Ativan recommendation was signed by the physician on 1/29/2020. An observation on 2/4/2020 at 2:00 pm of the 300-hall medication cart revealed Resident #84 had 22 Ativan 0.5 mg tablets in the narcotic box. During an interview with Physician #1 on 2/5/2020 at 1:58 pm, she stated Resident #84's Ativan order should have a stop date or a rationale if used beyond 14 days. The Administrator stated during an interview on 2/6/2020 at 2:32 pm, that Resident #84's PRN Ativan order should have had a stop date. The Administrator explained that the responsibility for accurate orders was a multiteam effort and someone should have caught that the resident's Ativan order did not have a duration date when the order was given by the physician.	F 758	ensure that all psychotropic medications that need a stop date have an appropriate stop date.	
F 814 SS=B	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		3/6/20

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F 814	Continued From page 20 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to keep the dumpster area free from debris for 1 of 1 dumpster. The findings included: On 2/4/2020 at 2:30 PM an observation of the dumpster area with Dietary Manager #1 revealed there were a number of various items on the ground. Items observed on the ground directly behind the dumpster were 2 broken dust pans, 2 broken rakes, 1 patio umbrella, 1 empty 4-ounce juice container, a piece of aluminum foil. Observed on the ground on the left rear side of the dumpster was a lid to a 55 gallon trash can which was filled with water and also contained 2 clear 8-ounce plastic cups, numerous clear lids and other various debris. During the observation on 2/4/2020 at 2:30 PM Dietary Manager #1 stated she was not aware of how long the items had been behind the dumpster. She stated the maintenance staff usually cleaned the area around the dumpster. On 2/4/2020 at 2:35 PM during an observation the facility Administrator stated the debris on the ground behind the dumpster needed to be cleaned up and he would have the Maintenance Director clean the area. On 2/4/2020 at 3:35 PM the Maintenance Director stated he had his employees to clean the area behind the dumpster because it needed to be	F 814	1. The area behind the dumpster was cleaned on 2-4-2020 when the dumpster was picked up to be emptied. 2. The facility dietary staff and environmental services staff were inservices regarding making sure that there is no debris around the dumpster. 3. An initial audit will be completed by 3-6-2020 to ensure that there is no debris around the dumpster. An additional audit will be performed to ensure that the area around the dumpster is kept clean and free of debris. This audit will be completed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the Administrator or their designee. 4. The results of these audits will be taken to the facility QA&A monthly meetings to ensure that there has been no debris issues around the dumpster.	

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F 814	Continued From page 21 cleaned. He stated the maintenance staff were responsible for the dumpster area but he could not state when the area was last cleaned.	F 814		
F 865 SS=C	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain documentation and develop a plan that described the process for conducting Quality Assurance and Performance Improvement committee (QAPI) activities. Findings included: Record review of the facility's QAPI records revealed minutes for the prior monthly meetings for the past 12 months. The monthly meeting included notes related to falls, nutrition, and	F 865	1. A QAPI plan will be initiated by 3-6-2020 to ensure that all residents have a responsible party listed in Point Click Care. 2. The ADON was inserviced on how to QAPI an area of concern and the process involved. 3. The facility QA&A committee will identify areas that need to have a QAPI plan initiated in their monthly meetings.	3/6/20

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F 865	Continued From page 22 incidents. The QAPI records did not contain a plan that described the process for conducting the facility's QAPI activities. During an interview with the Assistant Director of Nursing (ADON) on 02/06/20 at 11:10 AM, she stated she oversaw the facility's QAPI program. She stated she had never been taught how to formally develop a QA process for identified areas of concern, plans of correction, or monitoring tools related to QAPI. She stated she had not developed monitoring or measuring tools or tangible auditing tools and she confirmed the facility did not have a plan that described the facility's process to conduct QAPI activities. During an interview with the Director of Nursing (DON) on 2/06/20 at 11:46 AM, she stated there were no QAPI monitoring tools or formal process for identifying areas of concern or plans of correction. She further stated she was unaware of the need for a formal process related to QAPI or the need to have a plan to describe the process for conducting QAPI activities. During an interview with the Administrator on 2/06/20 at 1:16 PM, he stated they have a monthly QAPI meeting and discuss trends, but he was unaware of the need for a formal process to document areas of concern, develop plans of correction, or monitoring tools.	F 865	An audit will be completed to ensure that the facility has a QAPI plan implemented for any area of concern. This audit will be completed monthly x 4 months. The audit will be completed by the facility Administrator or their designee. 4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that any areas of concern that have been identified are being monitored by a QAPI program.	
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-	F 947		3/6/20

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(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
F 947	Continued From page 23 §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure nurse aides received abuse training annually for 5 of 5 nurse aide files reviewed and failed to ensure nurse aides received dementia training annually for 1 of 5 nurse aide files reviewed. The findings included: On 02/06/2020 at 9:59 AM an interview with the assistant director of nursing (ADON) indicated she was responsible for the in-service education and documentation for nurse aides (NA). She stated she was somewhat behind on in-service training. She stated she thought NA's had received abuse training this past year but could not find any documentation indicating the dates of the abuse training or which NA's attended. The ADON went on to say the facility had participated in the Virtual Dementia Tour this past year.	F 947	1. Monthly inservices have been set up that the CNA's are going to be required to attend so that they receive at lease 12 hours/year of inservice training including the topics of dementia management, resident abuse prevention, care of the cognitive impaired and any areas of weakness identified in performance reviews. 2. The facility staff working as CNA's have begun to receive inservices to ensure that they receive their required 12 hours of inservice training per year. The inservices started on 2-13-2020. 3. The monthly inservice sign in sheets will be audited to ensure that all of the employees that are working as CNA's attend the monthly inservices to ensure that they receive at least 12 hours of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	C 02/07/2020

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F 947	Continued From page 24 A review of training information for NA #2 indicated a hire date of 05/02/2018. There was no dated documented training provided to show NA #2 received abuse training in one (1) year based on date of hire. A sign in sheet for Virtual Dementia Tour indicated NA #2 received dementia training on 01/10/2020. On 02/06/2020 at 12:45 PM an interview with NA #2 indicated she thought she recalled receiving abuse and dementia training in the facility this past year, but she could not recall the dates and had no documentation of the training. A review of training information for NA #3 indicated a hire date of 08/17/2001. There was no dated documented training provided to show NA #3 received abuse or dementia training in one (1) year based on this date of hire. On 02/06/2020 at 12:01 PM an interview with NA #3 indicated she thought she received abuse and dementia training in the past year, but she could not recall the dates and had no documentation of the training. A review of training information for NA #4 indicated a hire date of 10/21/2014. There was no dated documented training provided to show NA #4 received abuse training in one (1) year based on date of hire. A sign in sheet for Virtual Dementia Tour indicated NA #4 received dementia training on 07/24/2019. On 02/06/2020 at 12:04 PM an interview with NA #4 indicated he thought he received abuse and dementia training this past year but could not recall the dates and had no documentation of the training.	F 947	inservice training per year including the topics of dementia management, resident abuse prevention, care of the cognitively impaired and any areas of weakness identified in performance reviews. This audit will be completed monthly ongoing to ensure that each employee who works as a CNA receives their required 12 hours of training yearly. The audit will be completed by the DON or their designee. 4. The results of this audit will be taken to the facility QA&A committee meetings to ensure that those employees who work as CNA's receive at least 12 hours of inservice training per year including the topics of dementia management, resident abuse prevention, care of the cognitively impaired and any areas of weakness identified in performance reviews.	

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F 947	Continued From page 25	F 947		

A review of training information for NA #5 indicated a hire date of 04/18/2017. There was no dated documented training provided to show NA #5 received abuse training in one (1) year based on date of hire. A sign in sheet for Virtual Dementia Tour indicated NA #5 received dementia training on 07/24/2019.

On 02/06/2020 at 12:27 PM an interview with NA #5 indicated she thought she received abuse and dementia training this past year but did not recall the dated and had no documentation of the training.

A review of training information for NA #6 indicated a hire date of 12/29/2017. There was no dated documented training provided to show NA #6 received abuse training in one (1) year based on date of hire. A sign in sheet for Virtual Dementia Tour indicated NA #6 received dementia training on 01/10/2020.

On 02/06/2020 at 12:31 PM an interview with NA #6 indicated he though he received abuse and dementia training this past year but could not recall the dates and had no documentation of the training.

On 02/06/2020 at 1:28 PM an interview with the director of nursing (DON) indicated she thought the facility did an abuse training last year but could not recall the date or provide any sign in sheets or other documentation regarding the date or which staff attended.

On 02/06/2020 at 2:31 PM an interview with the administrator indicated he thought the facility provided abuse training in April or May of 2019

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F 947	Continued From page 26 but could not provide any sign in sheet documentation to indicated this or which staff attended.	F 947		