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	345221	A. BUILDING _____ B. WING _____	C 05/15/2015

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BRIAN CENTER H & REHAB WEAVERV	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, the facility failed to honor preferences for 2 of 5 residents related to showers and food (Resident #209 and Resident #72). Findings included: 1. Resident #209 was admitted to the facility on 04/23/15. Diagnoses included rib fractures and pneumothorax. An admission Minimum Data Set (MDS) dated 05/05/15 indicated Resident #209 was cognitively intact and required physical help in part of the bathing activity. An interview was conducted with Resident #209 on 05/12/15 at 9:14 AM. She stated she had never been asked how many showers she wanted per week. She explained she would prefer three showers per week but only received two. She stated she had never asked for more showers because she felt two showers per week was the rule. Review of the shower schedule for Resident #209's hall revealed each room and bed was scheduled for two showers per week on either day shift or evening shift. Review of Resident #209's shower documentation revealed the resident received	F 242	Criteria #1- Resident #209 was interviewed regarding her preferences for bathing and her schedule was changed to meet her preference. Resident #72 was given coffee immediately and the staff member who did not take it to her was educated regarding following the tray card at that time. Criteria #2- All residents have the potential to be affected by this alleged deficient practice. An audit of residents who had not already been interviewed has been conducted by the Admissions Coordinator to verify preferences for all residents . Bathing schedules were adjusted as required for two residents based on the results of these interviews. This audit was completed May 21, 2015. Starting June 4, 2015 the dietary department will send out empty coffee cups on the trays of the residents who have stated they want coffee with their meals as an additional indicator to the staff to serve coffee with that meal without the resident having to ask for it. It will also	6/12/15

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

Electronically Signed | 06/05/2015

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F 242	Continued From page 1 one shower the week she was admitted, two showers the second week, and two showers the third week. Resident #209 had received two showers the week of the survey and was scheduled for a third shower. An interview was conducted with Nurse Aide (NA) #4 on 05/13/15 at 10:25 AM. She stated showers were scheduled based on what room and bed each resident was in. An interview was conducted with Nurse #3 on 05/13/15 at 10:53 AM. She stated each resident was assigned a shower based on the room and bed to which they were admitted. An interview was conducted with the Director of Nursing on 05/13/15 at 3:11 PM. She stated residents were assigned showers based on room and bed. She explained residents were asked about shower preference on admission; however, that had started recently and she was not sure if Resident #209 had been assessed for shower preferences on admission. An interview was conducted with the Administrator on 05/14/15 at 10:38 AM. She stated residents were assigned a shower based on room number on admission. She explained residents were told on admission the facility offered two showers per week and asked the resident if that was acceptable. The Administrator further stated the Admissions Coordinator was responsible for telling the resident the facility's routine shower schedule on admission, but there was no policy or expectation as to whom the Admissions Coordinator was supposed to disseminate the information. 2. Resident #72 was admitted to the facility 11/26/10 with diagnosis which included altered mental status, schizophrenia and mood disorder. The current Minimum Data Set assessment	F 242	be listed on the tray card as before. Criteria 3- The facility has adopted a new interview tool based on a recommendation from the company divisional team for use during the admission process to identify resident preferences. Interview will conducted by the Admission Coordinator/Designee be After the interview is completed on each admission, information regarding any resident preference including bathing schedules that needs adjusted will be given to the Unit Manager and the UM will communicate that information to the shower team. Nursing staff will be educated by the DON/Unit Manager/Weekend Supervisor regarding adhering to resident preferences including bathing schedules and communicating a resident's request for a change in bathing schedules to the DON or UM. The education will also include the new practice of the dietary department placing an empty coffee cup on the tray of those residents who have requested coffee. The education will be completed by June 8th. The DON/Unit Manager/Weekend Supervisor will randomly interview 5 residents weekly for 4 weeks and then monthly for 2 months to verify bathing preferences are being followed. Random observations of meal service to verify the honoring of preferences will be completed 3 times a week for 4 weeks then monthly for 2 months by the DON/Unit Manager/Weekend Supervisor on four halls each time with the halls being rotated to evaluate each one to verify	

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F 242	Continued From page 2 dated 03/05/15 indicated Resident #72 had moderate/severe cognitive impairment. The care plan for Resident #72 included a problem area dated 05/14/15 for weight loss/nutritional risk potential related to mental status, medications, chronic disease (schizophrenia, depression, dementia, constipation). One of the approaches to this problem area was, offer preferred foods with meal assistance for set up and determine individual likes and dislikes. A Diet history/food preference list dated 09/24/14 indicated a preference for coffee with the breakfast meal. On 05/15/15 at 8:05 AM staff were observed distributing breakfast trays on the hall Resident #72 resided. Two carts were sent to the hall; one an open cart and one a closed cart. The tray for Resident #72 was on the open cart. A carafe of coffee and mugs were included on the closed cart. Observations of the breakfst tray line that morning from 7:30 AM-8:00 AM noted coffee was not sent on individual trays but provided with food delivery carts. On 05/15/15 at 8:40 AM observations were made of Resident #72 in her room. The tray card for Resident #72 indicated a preference for coffee with the breakfast meal. Coffee had not been served to Resident #72 and she reported if she wanted coffee she had to ask for it. Resident #72 stated she typically would ask staff for coffee when staff returned and picked up her breakfast tray. On 05/15/15 at 8:50 AM Nurse Aide #5 reported she normally did not work on the hall Resident #72 resided and that she typically reviewed the residents tray cards to determine beverage preferences. Nurse Aide #5 stated she was told	F 242	dietary is sending out the coffee cups as expected and that the staff is serving the coffee as expected. Opportunities will be corrected as identified. Criteria 4- The results of these audits will be reported by the DON in the monthly Quality Assurance Performance Improvement meeting for 3 months and then quarterly on an ongoing basis. The committee will evaluate and make further recommendations as indicated.	

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F 242	Continued From page 3 not to give Resident #72 coffee unless "she asked for it". Nurse Aide #5 stated she did not know the reason Resident #72 was not supposed to be given coffee when the breakfast tray was delivered. On 05/15/15 at 8:57 AM the Director of Nursing (DON) stated her expectation was for staff to honor any stated preferences on the residents tray card, including coffee. The DON stated a resident should not have to ask for coffee on a daily basis. On 05/15/15 at 10:25 AM Nurse Aide #6 (who routinely works on the hall Resident #72 resided) reported it takes a lot of coffee to meet the needs of residents residing on her hall every morning. She recalled telling Nurse Aide #5 that Resident #72 does not always drink her coffee and not to offer unless requested. Nurse Aide #6 stated coffee should have been offered to Resident #72 with her breakfast meal. In a follow-up interview on 05/15/15 at 1:17 PM Resident #72 stated she did not know why she always had to ask for coffee in the morning because it was "on her ticket" (tray card).	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, family interview and staff interviews, the facility failed to keep the showers clean, floors clean, trash emptied, and the dining area clean on 3 of 5 hallways.	F 253	1.Corrective actions have been taken for the residents affected by the alleged deficient practice. The shower rooms identified in the survey received a deep clean on 5/13/15 including the whirlpool,	6/12/15

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F 253	Continued From page 4 The findings included: 1. Observations of the facility revealed the following soiled areas on the 600 hall: a. On 05/11/15 at 4:00 PM the inside of the 600 hall whirlpool tub had black residue in the jet ports. The floor in front of and to the side of the shower stall was soiled. This remained the same when observed on 05/12/15 at 9:05 AM. On 05/12/15 at 3:27 PM the shower room on 600 hall was observed with multiple linen carts in the room, having a strong urine odor, having brown smears on the tile floor, having black residue around each jet in the dry whirlpool tub, and having puddles of slimy, water along the edges of the shower and against the wall by the whirlpool that had dusty residue floating on the water. There was a razor cap on the floor, a black piece of plastic on the floor, and the tile and grout along the floor and up the wall in the shower and the wall leading to the whirlpool was black with mold up several feet on the wall. A cognitively impaired resident was observed taken to this shower room and showered on 05/12/15 at 3:44 PM. Following the shower on 05/12/15 at 4:27 PM, Nurse Aide (NA) #1 stated the odor in the shower room came from the linen barrels that were getting full and in the shower room. She further stated the linen barrels were to be kept in the soiled utility room. b. During observations made on the 600 hall on 05/12/15 at 9:50 AM, the kitchenette area revealed the following after the housekeeper had cleaned it after the breakfast meal: *upper cabinet contained stuffed animals and a	F 253	the floors and shower stalls. The linen barrels on 600 hall were cleaned and moved to the soiled linen room. The drawers and cabinets in the kitchen area of the 600 hall dining room were also deep cleaned on 5/13/15. The floors on 600 hall near room 602 and 610 were inspected on 6/2/15 and there were no black marks at that time. Resident #100 room was inspected on 6/2/15 and the floor had been mopped, the trash had been emptied and the bathroom was clean. Resident # 30 room was inspected on 6/2/15 and the bathroom was clean at that time. Resident # 138 room was inspected on 6/2/15 and there was no soiled spots on the wall or on the floor. Resident # 28 wheelchair was inspected on 6/2/15 and was cleaned at that time. Resident #64 room was inspected on 6/2/15 and mopped at that time. On 5/15/15 Housekeeping Manager toured facility to assure that no additional housekeeping issues needed attention. 2. Corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. All shower rooms were inspected on 5/13/15. There were no additional housekeeping issues identified in the shower rooms. Drawers and cabinets were inspected in the main dining room, nourishment rooms, soiled utility rooms, and ice machine rooms. Nourishment room and Ice machine room drawers and cabinets were deep cleaned. Floors were inspected in the entire facility on 6/3/15. Rooms 107, 104, 209,and 611 required attention to floors. Additional inspection on	

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F 253	Continued From page 5 plastic drinking cup with at least an inch of dried solid brown unidentifiable substance; *a drawer covered in dried brown spillage; *the dishwasher contained a book, a stuffed animal, had dried red substance in the bottom with condiment papers and a spoon. *a drawer had dried flaky substance inside; *the bottom cabinets had debris and trash located in the back of each shelf. Observations revealed the area remained the same when observed on 05/12/15 at 3:27 PM. c. During observations made on the 600 hall on 05/12/15 beginning at 3:27 PM, the hall floors had black skid marks on the floor by Room 602, by the shower door close to Room 610, by the shower room across from the medical supplies closet, and by the kitchen/dining room on the unit. During interview on 05/12/15 at 4:04 PM, the Housekeeping Director (HD) stated he scheduled 3 housekeeping staff 7 days a week to work from 7 AM to 3 PM. In addition, there was a floor tech and himself who worked as late as need be to clean up things that occurred after the housekeepers left for the day at 3 PM. HD stated he expected the housekeepers to clean all horizontal and vertical surfaces, "anything they see needs cleaning", sweep and mop the floors, clean the sinks and the toilets and dust high and low. One shower room was cleaned weekly, but the housekeepers were expected to enter the shower room daily to check on it's condition. Once a week the shower rooms were to be cleaned via dusting and cleaning the toilets, sinks and cleaning surfaces horizontally and vertically. HD further stated the shower rooms were scheduled to be deep cleaned monthly.	F 253	6/3/15 found soiled floors identified in 600 hall nurses station which were swept and mopped at that time, Soiled floors were identified in 600 hall and they were swept and mopped,Over flowing trash was identified in three patient rooms, PT gym and PT offices. Trash was emptied. Wall splatters were identified in one resident room and on hallways and was cleaned. Wheelchairs were inspected on 6/3/15 and a wheelchair cleaning day was scheduled to clean all facility wheelchairs on 6/8/15. Facility inspection on 6/3/15 indicated no additional housekeeping issues at that time. 3. Measures put in place to assure that the alleged deficient practice will not reoccur include: Work assignments have been developed to assure that each housekeeping position has clearly defined areas of responsibility for their daily cleaning and that all patient areas are cleaned daily and supplies replenished. All housekeepers have been trained on the new assignments and work task. Each area of the facility is on a deep clean schedule for once a month. Shower rooms are on a deep clean schedule for twice a month. Wheelchairs will be deep cleaned when the room is deep cleaned. Wheelchairs will be wiped down as needed on a daily basis. 4. Housekeeping Manager/Assistant Manager will perform QCI inspections on each deep cleaned room. Housekeeping Manage/Assistant Manager will perform daily QCI on additional assignments for each housekeeper each day. Administrator will perform QCI with	

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F 253	Continued From page 6 Follow up interview with HD on 05/12/15 at 5:03 PM revealed he preferred to check the shower rooms himself each day. Each housekeeper was responsible to deep clean one room each day per the schedule and the shower rooms were scheduled for deep cleaning each month. HD provided a deep cleaning schedule which showed the each of the 4 shower rooms were deep cleaned once a month - scheduled for 05/31/15 - along with the equipment rooms and storage rooms. HD stated he had not checked the shower rooms this date. The Administrator and HD went then to the 600 hall shower room at approximately 5:11 PM where both agreed the smell was from the linen barrels and the moldy floors and walls with standing water and soiled floor were dirty and needed to be cleaned. At this time HD stated he had not checked on this room last week. The Administrator stated the linen barrels should be in the utility room. At approximately 5:15 PM on 05/12/15 the Administrator and HD inspected the 600 hall dining/kitchenette area. HD stated the drawers and cabinets should be checked and cleaned daily as needed. Observations revealed the same dirty cabinets,drawers and dish machine as noted previously. Both Administrator and HD stated the kitchenette needed attention. On 05/13/15 at 7:35 AM Housekeeper #2 was interviewed. She confirmed she worked 5 days a week 7 AM to 3 PM. She was responsible for the rooms on the 600 secured unit, half of 500 hall, and half of 100 hall. She stated she was responsible for dusting, wiping down the overbed tables, sinks, mirrors, dusting the closet tops, cleaning the toilets, sweeping and mopping the floors and picking up the trash. Housekeeper #2	F 253	Housekeeping Manager once a week for one month and then twice a month ongoing or as needed. Housekeeping Manager will inspect each patient room identified in survey resident interview once per week for 90 days. Results of the QCI and quality control inspections will be reviewed in QAPI each month and changes may be made to the plan of correction as needed x 90 days and then at least quarterly .	

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stated she has to rush to get each room cleaned and that HD will step in and help. Housekeeper #2 stated she was unable to clean the shower room yesterday but cleaned it Monday, although she did not sweep and mop the floors Monday because she had too much to do. Housekeeper #2 further stated that she had never cleaned the cabinets or drawers in the 600 hall dining room/kitchenette since coming to work approximately 4 months ago.

On 05/13/15 at 3:05 PM Nurse Aide (NA) #2 stated she rotated halls. She stated the housekeeping was terrible. She stated the trash was not always emptied, feces has been found on the floor in the shower rooms.

Interview with NA #3 on 05/13/15 at 3:28 PM, revealed that she worked second shift and found housekeeping not good. She stated the bathrooms were not clean, trash was not emptied, and there would be no toilet paper or paper towels in the holders.

On 05/14/15 at 10:38 AM the Floor Tech stated during interview, that he dust mopped all the floors and removed the trash first thing in the morning. After breakfast he stated he mopped and buffed the hall floors. He further stated that 600 hall floors were especially difficult to keep clean because of the type of residents who resided in the secured unit, especially in front of the dining room area. He further stated there was no floor tech scheduled for the weekends.

On 05/14/15 at 5:30 PM a family member of a resident on the 600 hall approached the surveyor with some concerns, one of which had to do with housekeeping issues. The family stated about 3

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to 4 weeks ago, he had gone out and purchased a toilet brush and scrubbed the resident's toilet because there was a build up of residue.

2. On 03/19/15 there was a complaint noted in Resident Council Meeting notes that a resident had an incontinent episode on the floor and the roommate put a Kleenex on the spot which stayed there all day and smelled. documentation revealed the remedy was that the housekeepers were inserviced on daily routines, time management and making rounds throughout the day.

Observations on 05/12/15 at 4:18 PM revealed the shower room on the 200 hall smelled musty and had slimy residue around the edges where the floor meets the wall. The bottom foot of tiles and grout in the shower had a brown substance which came off with a wet paper towel.

During interview on 05/12/15 at 4:04 PM, the Housekeeping Director (HD) stated he scheduled 3 housekeeping staff 7 days a week to work from 7 AM to 3 PM. In addition, there was a floor tech and himself who worked as late as need be to clean up things that occurred after the housekeepers left for the day at 3 PM. HD stated he expected the housekeepers to clean all horizontal and vertical surfaces, "anything they see needs cleaning", sweep and mop the floors, clean the sinks and the toilets and dust high and low. One shower room was cleaned weekly, but the housekeepers were expected to enter the shower room daily to check on it's condition. Once a week the shower rooms were to be cleaned via dusting and cleaning the toilets, sinks and cleaning surfaces horizontally and vertically. HD further stated the shower rooms were

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scheduled to be deep cleaned monthly.

Follow up interview with HD on 05/12/15 at 5:03 PM revealed he preferred to check the shower rooms himself each day. Each housekeeper was responsible to deep clean one room each day per the schedule and the shower rooms were scheduled for deep cleaning each month. HD provided a deep cleaning schedule which showed the each of the 4 shower rooms were deep cleaned once a month - scheduled for 05/31/15 - along with the equipment rooms and storage rooms. HD stated he had not checked the shower rooms this date. With the Administrator and HD the shower rooms were reinspected. Regarding the 200 hall shower, the Administrator stated that the floor did not appear like it had not been mopped daily but stated the tile needed to be deep cleaned.

On 05/13/15 at 3:05 PM Nurse Aide (NA) #2 stated she rotated halls. She stated the housekeeping was terrible. She stated the trash was not always emptied, feces has been found on the floor in the shower rooms.

Interview with NA #3 on 05/13/15 at 3:28 PM, revealed that she worked second shift and found housekeeping not good. She stated the bathrooms were not clean, trash was not emptied, and there would be no toilet paper or paper towels in the holders.

On 05/14/15 at 9:55 AM Housekeeper # 3 was interviewed. She stated she worked every weekend to cover call outs. She was responsible for the resident rooms on 200 hall, 300 hall, the front offices and main dining room. She stated the work load was too much to do and she tried to

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stay over to finish and HD also pitched in to cover. She further stated she did not always have time to sweep and mop each room and would spot mop spills.

On 05/14/15 at 10:38 AM the Floor Tech stated during interview, that he dust mopped all the floors and removed the trash first thing in the morning. After breakfast he stated he mopped and buffed the hall floors. He further stated there was no floor tech scheduled for the weekends.

3. On 05/11/15 at 11:28 Resident #100, who's most recent quarterly Minimum Data Set assessed her as being cognitively intact, stated she did not recall anyone coming into her room and mopping on the weekends. She stated they do not mop her floor every day but usually every other day. Staff do not clean her bathroom everyday and the trash gets really full.

Interview with Resident #30, whose Minimum Data set dated 04/21/15 coded him as having intact cognition, stated on 05/12/15 at 7:55 AM that his bathroom was cleaned every other day. Saturday the toilet was dirty. Resident #30 reported that his roommate's family came in and scrubbed the room over the weekend.

On 05/12/15 at 11:13 AM Resident #138's family was interviewed. Family stated that they were wising Sunday night and there appeared to be feces on the wall where the air conditioning unit was plugged in. It was dried runs down the wall and had a strong smell. Family reported it to the nurse and left. Family stated they had found feces on the floor in the past.

Observations on 05/12/15 at 4:20 PM revealed

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the 100 hall shower room had mold in the grout on the floor by the edges of the walls.

During interview on 05/12/15 at 4:04 PM, the Housekeeping Director (HD) stated he scheduled 3 housekeeping staff 7 days a week to work from 7 AM to 3 PM. In addition, there was a floor tech and himself who worked as late as need be to clean up things that occurred after the housekeepers left for the day at 3 PM. HD stated he expected the housekeepers to clean all horizontal and vertical surfaces, "anything they see needs cleaning", sweep and mop the floors, clean the sinks and the toilets and dust high and low. One shower room was cleaned weekly, but the housekeepers were expected to enter the shower room daily to check on it's condition. Once a week the shower rooms were to be cleaned via dusting and cleaning the toilets, sinks and cleaning surfaces horizontally and vertically. HD further stated the shower rooms were scheduled to be deep cleaned monthly.

Follow up interview with HD on 05/12/15 at 5:03 PM revealed he preferred to check the shower rooms himself each day. Each housekeeper was responsible to deep clean one room each day per the schedule and the shower rooms were scheduled for deep cleaning each month. HD provided a deep cleaning schedule which showed the each of the 4 shower rooms were deep cleaned once a month - scheduled for 05/31/15 - along with the equipment rooms and storage rooms. HD stated he had not checked the shower rooms this date. With the Administrator and HD the shower rooms were reinspected. At 5:08 PM, the Administrator stated the tile and grout in the 100 hall shower room would not come clean with just mopping that it too needed

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deep cleaning.

On 05/13/15 at 7:35 AM Housekeeper #2 was interviewed. She confirmed she worked 5 days a week 7 AM to 3 PM. She was responsible for the rooms on the 600 secured unit, half of 500 hall, and half of 100 hall. She stated she was responsible for dusting, wiping down the overbed tables, sinks, mirrors, dusting the closet tops, cleaning the toilets, sweeping and mopping the floors and picking up the trash. Housekeeper #2 stated she has to rush to get each room cleaned and that HD will step in and help.

On 05/13/15 at 7:48 AM, Housekeeper #1 stated she was responsible for the resident rooms on half of 100 hall, half of 500 hall, all of 400 hall, the nursing station, utility rooms, break room and the 100 hall shower room. She worked 7 Am to 3 PM 5 days a week. She stated there was a floor tech who mopped the hall floors and she just spot mopped places. She has one room to deep clean daily. She further stated there used to be 4 housekeepers but now just 3 routinely.
She stated she tried to clean the shower rooms first thing in the morning but sometimes the grout and tiles required a lot of scrubbing. She further stated that she has had to skip cleaning rooms due to time shortage.

On 05/13/15 at 3:05 PM Nurse Aide (NA) #2 stated she rotated halls. She stated the housekeeping was terrible. She stated the trash was not always emptied, feces has been found on the floor in the shower rooms.

On 05/13/15 at 3:12 PM a family member of Resident #28, who resided in this room, stated that she has had to clean the wheelchair of the

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F 253	Continued From page 13 resident before, latest being last Friday or this past Monday due to food caked on it. The family complained about the room being dirty and showed the surveyor pictures of the overflowing trash can in the bathroom and debris littering the floor and bathroom. she stated the pictures were taken last Friday. The family further stated that she visits 2 to 3 times per week and housekeeping concerns was a constant problem. On 05/13/15 at 3:22 PM, Resident #64 stated her room was not swept and mopped daily. Her most recent Minimum Data Set dated 03/24/15 coded her with intact cognitive skills. Interview with NA #3 on 05/13/15 at 3:28 PM, revealed that she worked second shift and found housekeeping not good. She stated the bathrooms were not clean, trash was not emptied, and there would be no toilet paper or paper towels in the holders. On 05/14/15 at 10:38 AM the Floor Tech stated during interview, that he dust mopped all the floors and removed the trash first thing in the morning. After breakfast he stated he mopped and buffed the hall floors. He further stated that 600 hall floors were especially difficult to keep clean because of the type of residents who resided in the secured unit, especially in front of the dining room area. He further stated there was no floor tech scheduled for the weekends.	F 253		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		6/12/15

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F 332	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility ' s medication error rate was greater than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.54%, for 2 of 6 residents observed during medication pass (Residents #208 and #106). Findings included: 1) Resident #208 was admitted to the facility on 05/06/15. Diagnoses included high cholesterol. A Minimum Data Set was not available due to recent admission. A medication administration observation was conducted for Resident #208 beginning at 8:05 AM on 05/15/15. Nurse #5 was observed to administer atorvastatin, a high cholesterol medication, 10 milligrams (mg) 2 tablets by mouth to Resident #208. Review of Resident #208's medical record revealed a physician order dated 05/07/15 ordering atorvastatin 10 mg 1 tablet by mouth daily for cholesterol. An interview was conducted with Nurse #5 on 05/15/15 at 9:16 AM. She stated she gave two tablets of atorvastatin because the medication administration record said to give 20 mg. She explained she only had 10 mg tablets of atorvastatin in her medication cart so she gave two tablets to equal 20 mg of atorvastatin. An interview was conducted with the Director of Nursing on 05/15/15 at 9:42 AM. She stated her expectation was for the nurses and medication aides to administer the medication as prescribed by the physician. 2a) Resident #106 was readmitted to the facility	F 332	1. Medication error forms were completed for medication errors made for res #208 and #106. The nurse caring for resident #106 was immediately in-serviced regarding the errors she made and how the situations should have been handled. 2. All residents have the potential to be affected by this alleged deficit practice. All nurses were interviewed and asked if there are any other medications being given at incorrect times and there were none. MAR to cart checks were also completed to make sure the correct medications were in the cart for the nurse to administer. All MARS were checked for accuracy between May 26-May 31. 3. All nurses and Certified Medication Aides will receive medication management class by June 8th. The two nurses involved in the medication errors will be individually educated by the DON by June 5th. 4. The DON/ADON/UM or weekend supervisor will perform random audits of Medication Administration Records on 10 random residents weekly for 12. weeks. Opportunities identified as a result of these audits will be corrected by the DON/ADON/UM or weekend supervisor. Also, medication pass evaluations will be done with 2 nurses per week by the	

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F 332	Continued From page 15 on 03/27/15. Diagnoses included gastrointestinal bleeding and diabetes. An admission Minimum Data Set dated 04/03/15 indicated Resident #106 was cognitively intact. A medication administration observation was conducted for Resident #106 beginning at 8:43 AM on 05/15/15. Nurse #1 was observed to administer pantoprazole, an antacid pill, 40 milligrams (mg) 1 tablet by mouth. The resident's breakfast tray was observed to be empty on the bedside table. Review of Resident #106's medical record revealed a physician order dated 03/27/15 ordering pantoprazole 40 mg 1 tablet by mouth before breakfast. Review of the medication administration record revealed the pantoprazole to be scheduled at 7:00 AM. An interview was conducted with Nurse #1 on 05/15/15 at 9:25 AM. She stated the resident's pantoprazole should have been administered before breakfast, as ordered by the physician. An interview was conducted with the Director of Nursing on 05/15/15 at 9:42 AM. She stated her expectation was for the nurses and medication aides to administer the medication as prescribed by the physician. 2b) Resident #106 was readmitted to the facility on 03/27/15. Diagnoses included gastrointestinal bleeding and diabetes. An admission Minimum Data Set dated 04/03/15 indicated Resident #106 was cognitively intact. A medication administration observation was conducted for Resident #106 beginning at 8:43 AM on 05/15/15. Nurse #1 was observed to administer sennosides, a stool softener, 8.6 milligrams (mg) 2 tablets by mouth to Resident #106. Review of Resident #106's medical record	F 332	DON/ADON/UM/Staff Development until all nurses have had the evaluation (time allotted to evaluate all nurses will not to exceed 12 weeks). Medication Med Pass Observations will be conducted at hire during orientation and then ant least annually for each nurse by the Pharmacy Consultant/DON/ADON/UM/Staff Development .The results of the audits will be reported in the Quality Assurance Performance Improvement monthly meetings for 3 months and then quarterly. The committee will evaluate and make further recommendations as indicated.	

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F 332	Continued From page 16 revealed a physician's order set for May 2015 ordering sennosides-docusate sodium 8.6 mg-50 mg 1-2 tablets by mouth daily as needed for constipation. An interview was conducted with Nurse #1 on 05/15/15 at 9:25 AM. She stated the medication sennosides was not the same medication as sennosides-docusate sodium, and she should have administered sennosides-docusate sodium, as prescribed by the physician. An interview was conducted with the Director of Nursing on 05/15/15 at 9:42 AM. She stated her expectation was for the nurses and medication aides to administer the medication as prescribed by the physician.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, review of the dish machine log book and interviews the facility failed to ensure the final rinse temperature of the dish machine reached a minimum of 180 degrees Fahrenheit (F), food was covered in the walk in freezer, clear plastic pitchers in clean storage were clean and a spray bottle in the food	F 371	1. Corrective action has been accomplished for the alleged deficient practice in regard to the inappropriate dish machine temperatures by changing to hand washing the dishes using sanitizer at the time of discovery. The dish machine was serviced and repaired on 5/12/15.	6/12/15

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F 371	Continued From page 17 production area was labeled with content. The findings included: 1. On 05/11/15 at 9:50 AM observations were made of two dietary staff working at the dish machine. Four racks of dishes including trays, plate covers, mugs and cups were observed processed through the dish machine with the highest temperature reached through the final rinse cycle of 155 degrees F. These dishes were placed in clean storage by the dietary aide. At 9:55 AM the dietary aide noted the final rinse temperature gauge and reported it to management staff. Management staff were unable to resolve the issue with the final rinse temperature and utilized the three compartment sink to manually sanitize additional dishware until a contract company could address the issue with the dish machine. On 05/12/15 at 3:40 PM the Food Service Director reported the dish machine was serviced by the contract company, problems were identified and observations of the dish machine noted the final rinse temperature was now reaching 180 degrees F. Review of the service company repair record noted problems with the control thermostat in the booster heater, pressure regulator and rinse temperature thermometer. 2. During the initial tour of the facility kitchen on 05/11/15 at 8:55 AM a 10 pound box of 3 ounce servings of salisbury steak was observed open to air in the walk in freezer. The individual servings of steak were in a open plastic bag, inside the box, with the product exposed to air. On 05/12/15 at 3:40 PM the bag of salisbury steaks was observed sealed and the Food Service Director reported it was her expectation that	F 371	Corrective action was accomplished with regard to the labeling and dating of food by wrapping, labeling, and dating the item at the time of discovery. Corrective action has been taken in regard to the soiled pitchers by removing them from service at the time of discovery. Corrective action has been taken in regard to the unmarked spray bottle by removing it from service at the time of discovery. 2. Facility residents have the potential to be affected by inappropriate dish machine temperatures therefore the Dietary Manager audited the temperature logs for the past 30 days to assure that temperatures have been at appropriate levels. There was no additional incidents of temperatures at unacceptable levels during that time period. Facility residents have the potential to be affected by inappropriate labeling, dating, and storage of food therefore the Dietary Manager completed an audit of all refrigerators and freezers to ensure that all items were labeled, dated, and stored appropriately. Facility residents have the potential to be affected by the alleged deficient practice in regard to soiled items therefore the Dietary Manager completed an audit of the kitchen to assure that no dirty items were stored with clean items. Facility residents have the potential to be affected by the alleged deficient practice in regard to the unmarked spray bottle therefore the dietary manager conducted an audit of the kitchen to assure that no additional unmarked spray bottles were in use in the kitchen 3. Measures put in place to assure that	

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F 371	Continued From page 18 opened boxes of food product are sealed with wrap prior to placing in the freezer. 3. On 05/11/15 at 10:15 AM five clear pitchers stored ready for use on shelving in the facility kitchen were observed with brown flaked matter adhered to the interior wall of the pitchers. The corporate dietary manager was present at the time of the observation and noted the pitchers were used for ice tea. In the presence of the corporate dietary manager the brown flaked matter was brushed with a finger stroke and was easily removed from the interior wall of the pitcher. The corporate dietary manager removed the pitchers for cleaning. 4. On 05/12/15 at 4:00 PM an unmarked clear spray bottle was observed on shelving, in the food production area. Clear droplets were observed adhered to the interior wall of the spray bottle. The Food Service Director reported the spray bottle should have been labeled to content and was unaware what liquid had been inside the spray bottle.	F 371	the same alleged deficient practice does not reoccur include: Dietary Manager will conduct an in-service educating dietary staff about correct dish machine temperatures and alternative dish washing procedures. Dietary Manager will in-service Dietary staff in regard to the appropriate food storage, labeling, dating, and wrapping. Dietary Manager will in-service the Dietary staff regarding the appropriate storage requirements of dirty and clean items. The Dietary Manager will in-service the Dietary staff in regard to the requirements for labeling of all bottles. 4. Compliance for the above survey issues will be monitored by: Dietary Manager has implemented a form requiring staff to record the dish machine temperatures 5 times per shift for wash/rinse times 90 days. Dietary Manager will check form daily M-F to validate compliance and that the temperatures are accurate. Dietary Manager will conduct freezer/refrigerator audits to assure appropriate storage, labeling, and dating of food. Dietary Manager will conduct kitchen audits to assure that there are no dirty items being stored with clean items. Dietary manager will conduct kitchen audits to assure that there are no un-marked bottles in use in the kitchen. Monitors will continue for 5 times a week for 4 weeks, 3 times a week for 8 weeks, and 1 time a week for 4 weeks or more as needed. Results of monitoring tools will be reviewed in QAPI monthly for 90 days and then at least quarterly and the Plan of Correction revised as needed.	

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide medications for 2 of 7 residents sampled for medication review (Residents #160 and #24). Findings included: 1) Resident #160 was admitted to the facility on 02/28/15. Diagnoses included diabetes. An admission Minimum Data Set dated 03/07/15 indicated Resident #160 was cognitively intact and received insulin injections. Review of the facility's list of medications stocked in the electronic medication dispensing system revealed insulin aspart was a routinely stocked	F 425	1. When the nurse discovered res #106 did not have the prescribed insulin, she followed policy by obtaining an order from the physician for an insulin that was available. Regarding res #24 who had missed a medication in September secondary to it being unavailable, the medication cart was checked on 5/14/15 and that resident's medications were available at that time. 2. All residents have the potential to be affected by this alleged deficit practice.	6/12/15

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F 425	Continued From page 20 medication. A medication administration observation was conducted for Resident #160 beginning on 05/13/15 at 4:35 PM. After obtaining the resident's blood sugar, Nurse #2 noticed Resident #160's prescribed insulin was neither in the medication cart nor the medication room refrigerator. The nurse then checked the backup supply and realized there was no insulin aspart available. On 05/13/15 at 4:52 PM, Nurse #2 notified the physician via telephone the facility had no insulin apart to administer to the resident. The physician ordered a one-time dose of a different type of insulin stocked by the facility. Nurse #2 then administered the insulin to Resident #160 as prescribed by the physician. An interview was conducted with Nurse #1 on 05/14/15 at 9:47 AM. She stated when a medication was noted to be low, the nurse was supposed to remove the medication order sticker and fax it to the pharmacy so the prescription could be refilled. She explained the pharmacy delivered medication every night of the week. The nurse went on to state the pharmacy could have medications available from the backup pharmacy near the facility in as little as two to three hours. She also stated the facility had an electronic medication dispensing system stocked with many common medications. An interview was conducted with Nurse #4 on 05/14/15 at 10:17 AM. She stated she administered the last available dose of insulin aspart to Resident #160 on 05/13/15, pulled the medication order sticker, and faxed it to the pharmacy so it would be delivered that evening. She stated nurses were supposed to order medications from the pharmacy before the resident's supply was depleted. The nurse stated	F 425	MAR to cart checks were completed by the DON and no other medication was found to be unavailable. The Pyxis was also checked to verify the medications that were expected to be available were available and except for the missing insulin, all other medications were available. 3. In the case of res #106 and #24, one nurse was responsible for both errors. She was immediately verbally educated by the DON and again formally educated by the DON regarding the expectations for obtaining medications. All nurses will be in-serviced by June 8th regarding the proper procedure for obtaining medications to ensure that each resident has his/her prescribed medications. The nurses will also be in-serviced regarding what to do in the event a medication is unavailable. 4. The DON/Unit Manager/Weekend Supervisor will audit MARS and medication carts for 10 random residents weekly for 12 weeks to ensure MARS are correct and medications are available. Also, the back up medications expected to be in the Pyxis will be checked weekly for 12 weeks to ensure there is no lapse in the pharmacy refill of medications when the last one is used. Opportunities identified as a result of these audits will be corrected by the DON/Unit Manager/Weekend Supervisor and further education and/or disciplinary action will be taken. The results of the audits will be reported by the DON in the monthly	

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F 425	Continued From page 21 she was not sure why Resident #160's insulin aspart was not ordered before the supply was depleted. An interview was conducted with the Director of Nursing (DON) on 05/14/15 at 11:26 AM. She stated she expected nurses to order medications from the pharmacy before the resident was completely out of the medication. The DON stated she was not sure why the facility had no insulin to administer to the resident. A follow-up interview was conducted with the DON on 05/15/15 at 1:24 PM. She stated the pharmacy monitored the electronic dispensing system and sent more medications when the facility's supply reached zero. The DON further stated the pharmacy last sent insulin aspart on 04/20/15, the supply was depleted, and she was not sure why the pharmacy did not restock the supply. 2) Resident #24 was admitted to the facility on 04/28/12. Diagnoses included acute kidney failure and neuropathy. A review of Resident #24's medical record revealed a physician's order dated 08/29/14 indicated oxycodone, a narcotic pain medication, had been ordered twice daily to help manage the resident's pain. Further review of the medical record revealed the resident did not receive the following doses of oxycodone: 09/16/14 at 9:00 AM and 09/16/14 at 9:00 PM. The documentation on the back of the medication administration record indicated the resident did not receive the oxycodone because the medication was not available. A review of Resident #24's care plan dated 02/27/15 revealed pain was identified with goals and interventions in place to manage pain. A review of an annual Minimum Data Set (MDS) dated 03/02/15 revealed Resident #24 was cognitively intact and had frequent pain, rated at 5	F 425	Quality Assurance Performance Improvement Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.	

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F 425	Continued From page 22 on a scale of 0 to 10. Review of the facility's list of medications stocked in the electronic medication dispensing system revealed oxycodone was a routinely stocked medication. An interview was conducted with Nurse #4 on 05/14/15 at 10:17 AM. She stated she remembered the oxycodone not being available for Resident #24 in September 2014. She explained the resident had depleted the card sent by the pharmacy and the nurses had ordered more. The nurse further stated the pharmacy did not send more so the nurses used the supply available in the electronic dispensing system until that supply was also depleted. She also stated the situation was highly unusual, which was why she remembered it. An interview was conducted with the Director of Nursing (DON) on 05/14/15 at 11:26 AM. She stated in order for the pharmacy to restock controlled substances, like oxycodone, she had to fill out a form required by the Drug Enforcement Agency (DEA). The DON explained she ordered controlled substances weekly, if needed, based on an inventory list printed from the electronic dispensing system. She verified she had ordered more oxycodone from the pharmacy for the electronic dispensing system on 09/24/14. The DON further stated her expectation was for nurses to order medications from the pharmacy before the supply was depleted.	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		6/12/15

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F 514	Continued From page 23 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to keep complete and accurate medical records for 2 of 7 residents sampled for medication review, resulting in one medication error (Residents #208 and #106) and 1 of 3 residents sampled for discharge review (Resident #195). Findings included: 1. Resident #208 was admitted to the facility on 05/06/15. Diagnoses included high cholesterol. A Minimum Data Set was not available due to recent admission. During a medication administration observation on 05/15/15 beginning at 8:05 AM, Nurse #5 was observed to administer 2 tablets of atorvastatin 10 milligrams (mg) to Resident #208 by mouth. Atorvastatin was a medication prescribed to manage the resident's high cholesterol. Review of Resident #208's medical record revealed a physician order dated 05/07/15 ordering atorvastatin 10 mg 1 tablet by mouth daily for cholesterol. Review of Resident #208's medication administration record (MAR) revealed an entry with instructions to administer atorvastatin 20 mg 1 tablet by mouth daily.	F 514	Criteria 1- A medication error form was completed for res #208. The MD was notified of the error and the MAR was corrected. Res #106 MAR had already been corrected and a medication error form had been completed. Regarding res #195, the DON made a late entry regarding the details of the transfer. Criteria 2- All resident records have the potential to be affected by this alleged deficit practice. 100% of the MARS were checked for accuracy between May 26th and May 31st by the DON and Unit Managers with no other discrepancies being found. Criteria 3- The DON educated the nurses involved in the transcription error involving res #208 and the discharging nurse for res #195. The nurse involved in Res #106 had been previously educated regarding the error. All licensed nurses will be educated by June 8, 2015 regarding proper documentation when discharging a resident and regarding transcribing orders	

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F 514	Continued From page 24 An interview was conducted with Nurse #5 on 05/15/15 at 9:16 AM. She stated she gave two tablets of atorvastatin because the MAR said to give 20 mg. She explained she only had 10 mg tablets of atorvastatin in her medication cart so she gave two tablets to equal 20 mg of atorvastatin. An interview was conducted with the Director of Nursing (DON) on 05/15/15 at 9:42 AM. She stated she expected the nurse who received the physician's order to correctly transcribe the order to the medication administration record (MAR). She explained she expected the Unit Coordinator to follow-up the next day to double-check the MAR against the physician's order for accuracy. 2) Resident #106 was admitted to the facility on 03/27/15. Diagnoses included diabetes. An admission Minimum Data Set dated 04/03/15 indicated Resident #106 was cognitively intact. A review of Resident #106's medical record revealed the physician order dated 03/27/15 prescribing insulin aspart 3 units by subcutaneous injection before meals. Further review revealed the resident did not receive ordered insulin from 04/01/15 to 04/07/15. A physician's order dated 04/08/15 indicated the insulin aspart order was missing from the April 2015 medication administration record (MAR). The resident then began receiving the ordered insulin on 04/08/15. An interview was conducted with the Director of Nursing on 05/15/15 at 9:42 AM. She stated her expectation was for the nurses and medication aides to administer the medication as prescribed by the physician. An interview was conducted with Unit Manager #1 on 05/15/15 at 10:06 AM. She stated the MAR was printed by the pharmacy and had omitted the order for Resident #106's insulin. She explained	F 514	correctly by DON/ADON/UM or weekend supervisor. The DON/ADON/UM or weekend supervisor will do chart to MAR audits on 10 random residents weekly for 12 weeks. Opportunities identified as a result of these audits will be corrected and additional education provided as needed. Also, the DON/ADON/UM or weekend supervisor will audit all charts of residents discharged to a hospital for accurate and complete documentation for 3 months. Opportunities identified as a result of these audits will be corrected by the DON/ADON or UM. Criteria 4- The results of these audits will be reported by the DON in the monthly Quality Assurance Performance Improvement Committee for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.	

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a nurse checked the new MAR against the previous month's orders and a second nurse verified all the orders on the new MAR were correct. She stated it was simple human error the order for the routine insulin aspart was omitted.

2. Resident #195 was admitted to the facility on 02/17/15 with diagnoses including Huntington's Chorea and urine retention.

The physician's admission history and physical dated 02/19/15 noted Resident #195 had episodic violent behaviors, decreased memory, was not sleeping well, and was not happy to be in the nursing facility.

Review of the hospital discharge summary dated 02/24/15 noted the hospital suggested hospice services at the skilled nursing facility as her condition continued to decline in the hospital. The summary further noted that Resident #195 had received rib fractures following a fall at home and that Resident #195 had occasionally gotten violent with family when she did not get what she wanted.

The admission Minimum Data Set (MDS) dated 02/24/15 coded her as having intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), being sometimes understood, usually understanding, having no behaviors, and requiring extensive assistance with most activities of daily living skills. She was coded as being frequently incontinent, having had one fall and receiving antidepressants, antianxiety, and diuretic medications, and receiving therapy services.

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The only other physician note was dated 03/10/15 which stated Resident #195 was doing better in terms of ambulating with therapy, had a good appetite, had frequent anxiety and wanted to return home.

Although she did not trigger for a Care Area Assessment related to behaviors, a care plan related to behaviors was developed for Resident #195. The care plan originating on 02/28/15 indicated she had target behaviors including a history of slapping family and hollering for help if call not answered immediately. The goal was to have no behaviors. Interventions included to address needs promptly. Another behavior care plan was established 03/13/15 for the problem that she has had rapid progression of her disease over the past few months and that her behaviors include yelling, agitation, demanding toward staff, and throwing her phone on the floor when her call was unanswered. The goal was to not have any increased episodes of the behaviors. The interventions included anticipating, assessing and meeting her needs promptly, assisting in developing more appropriate methods of coping and interacting, if reasonable discuss behavior with the resident, monitor behavior episodes and attempt to determine the cause, praise improvement, and obtain a psych consult as ordered.

Review of the nursing notes revealed ongoing documentation of Resident #195's behaviors as follows:
*02/18/15 10:15 AM resident agitated and wanted to go home.
*02/20/15 at 1:48 PM agitated and wanted to go home.
*02/10/15 at 9:30 PM crying and couldn't find her

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phone.
*02/23/15 at 9:33 PM on call bell constantly, medicated with antianxiety medication, wanted someone to talk to and not be left alone.
*03/08/15 at 9:00 PM resident demanded shower although not scheduled shower day.
*03/09/15 at 11:00 PM wanted someone to stay with her and the writer thought she may do better with a more appropriate roommate.
*03/10/15 at 11:40 PM rang or called out frequently for minor things.
*03/13/15 at 2:00 PM continued to frequently use call light and became agitated and yelling help if not answered quick enough. Medicated with antianxiety medications.
*03/16/15 at 2:12 PM resident agitated with staff and other residents were complaining about resident yelling at staff members and constantly using call light. Becomes even more agitated when staff does not respond quick enough.
*03/16/15 at 3:00 PM the Director of Nursing (DON) noted she and the Social Worker (SW) spoke with Resident #195 regarding complaints from other residents that they could not sleep because the resident yelled so much and so loudly. Resident #195 stated she screamed because she needed help. DON reminded the resident that she used her call light and frequently was screaming before staff could even get to the door for supplies after answering the light. Resident #195 agreed to stop yelling.

There were no other notes from the physician, social worker or nursing notes to indicate the circumstances surrounding the physician's order dated 03/17/15 at 12:10 PM for a hospital referral for behaviors. The next nursing note dated 03/18/15 at 8:30 AM revealed the DON received a call from the hospital intake nurse questioning if

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the facility would accept Resident #195 back to the facility after her psychiatric stay at the hospital.

Interview with SW on 05/14/15 at 11:29 AM revealed the SW could not recall the details of Resident #195 being sent to the hospital on 03/17/15. He further stated the nurse would have handled the discharge to the hospital.

Interview with Nurse #1, who transcribed the order for discharge and the transfer information that accompanied the resident to the hospital was conducted on 05/14/15 at 1:33 PM. Nurse #1 stated that Resident #195's behavior deteriorated and she was fixated on being wet at night, even though she was not found wet. She also threw things at staff. Nurse #1 stated that she completed the paperwork but the Unit Manager took the order form the physician.

On 05/14/15 at 1:44 PM, an interview was conducted with the physician. The physician stated that the facility staff had spoken with her about the escalating behaviors of Resident #195. The physician stated she did not know what to do about Resident #195's behaviors and determined that a psychiatric evaluation was the best approach. The physician further stated that the facility had asked if she would agree to a hospital transfer if a hospital bed could be found for Resident #195 which she agreed to. The physician stated that Resident #195 was inappropriate for this facility as she was getting more violent, having anger outbursts, and the facility could not cope with her behaviors as the demands on staff were excessive. The physician hoped that the hospitalization would assit in stabilizing her behaviors.

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F 514	Continued From page 29 The Unit Manager UM) was interviewed on 05/14/15 at 1:50 PM. UM stated Resident #195 stayed on the call light all the time and the family gave permission to send her to the hospital but left prior to transport. She was subsequently admitted to the psychiatric unit at the hospital. The DON stated during interview on 05/15/15 at 8:13 AM that she recalled discussions held with the physician regarding all the behaviors Resident #195 had while at the facility which involved multiple complaints from other residents and having to move residents off of the hall Resident #195 resided on. DON stated that the record did not completely reflect all the circumstances leading up to the transfer to the hospital and she would write a late entry.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		6/12/15

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F 520	Continued From page 30 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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 observations, record reviews, and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2014 following a complaint investigation of February of 2014 and on the current survey. The deficiency of this complaint investigation was in the area of food storage, preparation, and distribution. The continued failure of the facility during 2 federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 371: Based on observations, review of the dish machine log book and interviews the facility failed to ensure the final rinse temperature of the dish machine reached a minimum of 180 degrees Fahrenheit, food was covered in the walk in freezer, clear plastic pitchers in clean storage were clean and a spray bottle in the food production area was labeled with content. During the complaint investigation of February 2014 the facility was cited for failure to wear a beard cover while preparing food on 2 of 2 kitchen observations. The facility was recited for	F 520	1.Corrective actions have been accomplished for the alleged deficient QAPI practices by implementing the above POC for F371 issues identified in this survey. Each deficient practice was corrected at discovery, audits were conducted to identify and correct other instances of the alleged deficient practices, monitors were put in place to measure continued compliance, and the monitor results are to be reviewed in QAPI. 2. Other residents have the potential to be affected by the same alleged deficient QAPI practices. Corrective action has been accomplished by conducting a comprehensive sanitation audit in the Kitchen by Administrator on 6/3/15 to assure that other sanitation issues do not exist in the dietary department. Dietary Department scored 97 out of a possible 100 points on the audit. Three issues were identified. One dented can was stored improperly and was moved to the shelf for dented cans. The lid was not on the trash can and was placed on the trash can. One ceiling vent had lint on it and the lint was cleaned from the vent. Dietary	

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F 520	Continued From page 31 F 371 for failing to ensure kitchen sanitation continued to be maintained. An interview was conducted 05/15/15 at 2:41 PM with the Administrator. The Administrator confirmed she participated in the facility Quality Assessment and Assurance (QA&A) Committee that met monthly. The Administrator explained issues followed by QA&A included kitchen sanitation. The Administrator stated the facility had systems in place for reviews of environmental services which included food sanitation. She expected kitchen sanitation to be maintained and monitored by kitchen management staff.	F 520	staff was in-serviced on the spot as to the audit results. No other sanitation issues were identified by this audit. 3. Systematic changes have been implemented to assure that the alleged deficient practice does not reoccur. The dietary manager has provided in-service to dietary staff in regards to comprehensive sanitation requirements for the dietary department. The Staff Development Coordinator has in-serviced the QAPI Committee on the QAPI process including the ongoing tracking and trending of quality issues identified by survey ,MIV results, CASPER results, or resident concerns. 4. Sanitation standards will be monitored by the Administrator/Dietary Manager conducting a comprehensive sanitation audit of the kitchen 1 times per week for 4 weeks, then every other week for 8 weeks. Administrator/Dietary Manager will continue to conduct a monthly comprehensive sanitation inspection of the kitchen on an ongoing basis. The Regional Dietary Manager will conduct a monthly comprehensive sanitation audit of the kitchen on an ongoing basis. Results of the sanitation audits will be reviewed in QAPI and the plan of correction may be revised as needed. The QAPI committee will track sanitation issues identified each month to assure that effective interventions are sustained.	