STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING _____ B. WING _____	07/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION CENTER	2006 S 16TH STREET WILMINGTON, NC 28401

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		8/14/15

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

Electronically Signed | 07/30/2015

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 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on facility documentation and staff interviews, the facility failed to provide evidence that a Medicare non-coverage letter was issued two days prior to Medicare coverage ending for two of three Medicare non-coverage letters reviewed. (Resident #38 and Resident #46). The facility also failed to post advocacy contact phone numbers and addresses in the facility for three of three days of the survey. The findings included: 1. Review of a Medicare non-coverage letter for Resident #38 revealed that Medicare coverage ended on 3/2/15 and Resident #38 was notified and signed the letter on 3/1/15. During an interview on 7/16/15 at 3:25 PM, Business Office personnel revealed that they were only responsible for filing the Medicare non-coverage letters. During an interview on 7/16/15 at 3:45 PM the facility Social Worker stated that she did not complete the Medicare non-coverage letter for Resident #38, because it was prior to her employment with the facility. During an interview on 7/17/15, the Administrator stated that the letters should have gotten out two days earlier. 2. Review of a Medicare non-coverage letter for	F 156	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #38 and Resident # 46 have been discharged from the facility. Administrator posted Advocacy contact phone numbers and addresses on the bulletin board near the facility lobby area. 2. Interventions for residents identified as having the potential to be affected: Records for residents who received "Notice of Medicare Non-Coverage" in the past 30 days were reviewed to ensure "Notice of Medicare Non-Coverage" was issued at least 48 hours prior to Medicare coverage ending date. After review, all notices were given at least 48 hours prior	

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F 156	Continued From page 3 Resident #46 revealed that Medicare coverage ended on 6/2/15 and Resident #46 was notified and signed the letter on 6/1/15. During an interview on 7/16/15 at 3:25 PM, Business Office personnel revealed that they were only responsible for filing the Medicare non-coverage letters. During an interview on 7/16/15 at 3:45 PM the facility Social Worker stated that she knew that the resident had to be notified two days prior to Medicare coverage ending. She revealed that she did not know if the resident wrote the wrong date on the letter. During an interview on 7/17/15, the Administrator stated that the letters should have gotten out two days earlier. During an observation on 7/15/15 at 11:42 AM, there were no telephone contact numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. During an observation on 7/15/15 at 4:25 PM, there were no telephone contact numbers of all State client advocacy groups, the protection and advocacy network and Medicaid Fraud Unit and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156	to Medicare coverage ending date. Administrator posted Advocacy contact phone numbers and addresses on the bulletin board near the facility lobby area. 3. Systematic Change: Social Service Director was re-educated by the facility Administrator on ensuring timely notification of Medicare non-coverage with emphasis on ensuring notification is given at least 48 hours prior to Medicare coverage ending date. Administrator will randomly audit "Notice of Medicare Non-Coverage" letter for five (5) residents monthly for a minimum of three (3) months to ensure notification is given at least 48 hours prior to Medicare coverage ending date. Facility Administrator was re-educated by the facility Regional Clinical Director on the requirement of F-tag 156 and ensuring required postings are posted in the facility. Administrator will randomly audit to ensure required Advocacy addresses and phone numbers are posted in the facility. Audits will be completed monthly for a minimum of three (3) months. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the Administrator will report "Notice of Medicare Non-Coverage" and "Required	

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F 156	Continued From page 4 misappropriation of resident property in the facility. Observations included the bulletin board near the lobby area and business office the wall adjacent to the facility dining room as well as other prominent locations throughout the facility. During an observation on 07/16/2015 at 8:05 AM there were no telephone contact numbers of all State client advocacy groups, the protection and advocacy network and Medicaid Fraud Unit and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Observations included the bulletin board near the lobby area and business office the wall adjacent to the facility dining room as well as other prominent locations throughout the facility. During an interview on 07/16/2015 at 10:19 AM Resident #99 revealed that telephone contact numbers were usually posted on the bulletin board near the business office, but he did not know whether or not the information was there or if the information was correct. During an observation on 07/16/2015 at 4:30 PM there were no telephone contact numbers of all State client advocacy groups, the protection and advocacy network and Medicaid Fraud Unit and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Observations included the bulletin board near the lobby area and business office the wall adjacent to the facility dining room as well as other prominent locations throughout the facility.	F 156	Posting" audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 156	Continued From page 5 During an observation on 07/16/2015 at 8:05 AM there were no telephone contact numbers of all State client advocacy groups, the protection and advocacy network and Medicaid Fraud Unit and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Observations included the bulletin board near the lobby area and business office the wall adjacent to the facility dining room as well as other prominent locations throughout the facility. During an observation on 07/17/2015 at 9:43 AM there were no telephone contact numbers of all State client advocacy groups, the protection and advocacy network and Medicaid Fraud Unit and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Observations included the bulletin board near the lobby area and business office the wall adjacent to the facility dining room as well as other prominent locations throughout the facility. During an interview on 07/17/2015 at 11:42 AM the Administrator stated he wanted to see a form with agencies that need to be identified on that list or guidance on what agency numbers to be posted.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		8/14/15

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F 241	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with resident and staff the facility failed to treat a resident with dignity and respect by failing to cover an indwelling urinary catheter bag for 1 of 1 resident reviewed having a catheter. (Residents #78). The findings included: Resident # 78 was admitted to the facility on 3/19/11 and readmitted on 2/6/15 with diagnoses which included urinary retention and stage 4 pressure ulcer. The most recent assessment was a quarterly Minimum Data Set (MDS) dated 5/15/15 and a significant change MDS dated 2/13/15 which indicated Resident #78 was moderately impairment in cognitive skills for daily decision making. A care plan dated 2/6/15 addressed the resident's need for indwelling urinary catheter due to urinary retention. Interventions included catheter care every shift and as needed. During an observation on 7/14/15 at 2:24 PM Resident #78 was sitting in a wheelchair in the hall outside Room # 18 with a urinary catheter bag hanging from his wheelchair. The urinary cateter bag was not covered exposing the urine in the bag. Other residents and staff were observed walking down the hall in view of the uncovered catheter bag. On 7/14/15 at 3:41 PM Resident #78 was observed receiving catheter care by Nursing	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #78 catheter bag was immediately covered on 07/15/15. 2. Interventions for residents identified as having the potential to be affected: A facility audit was conducted by the Staff Development Coordinator (SDC) on 07/15/15 to ensure residents with catheters had privacy covers covering the catheter bag. No other resident was found with uncovered catheter bags. 3. Systematic Change: Licensed Nurses and Certified Nursing Assistants (CNA) were re-educated on ensuring resident catheter bags are	

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F 241	Continued From page 7 Assistant (NA#3) and NA#4. After providing care NA#4 placed the catheter bag on the right side of Resident #78 ' s bed leaving the catheter bag uncovered. On 7/15/14 at 10:45 AM Resident #78 was observed with the urinary catheter bag hanging from his bed frame not covered. During an interview with Resident #78 he revealed that the urinary catheter bag was supposed to have a cover but he did not want to get anyone in trouble and would ask someone to get a cover for his catheter bag. On 7/16/15 at 8:35 AM the Director of Nursing (DON) stated she expected residents with a catheter would have the catheter bag placed in a "dignity bag." On 07/16/15 at 11:03 AM the Treatment Nurse stated when she had last changed Resident #78's catheter she failed to put a "dignity bag" on the catheter bag.	F 241	covered. Newly hired Licensed Nurses and CNAs will be educated during their orientation period on ensuring resident catheter bags are covered. Catheters will be audited by the SDC to ensure catheter bags are covered. SDC will perform audits weekly for a minimum of three (3) months. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the SDC will report audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		8/14/15

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F 278	Continued From page 8 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 14 of 35 Residents (Residents 61, 74, 41, 27, 97,104, 9, 84, 98, 44, 93, 51, 136 and 115) residents for accurate diagnoses under Section I on the Minimum Data Set (MDS). The findings included: 1. Resident #61 was admitted to the facility on 10/14/10 and readmitted on 9/13/12 with diagnoses of hyponatremia. Review of the most recent Minimum Data Set (MDS) Assessment dated 6/15/15 did not assess Resident #61 as having Hyponatremia under Section I - Active Diagnoses. Review of the Physician's orders for the month of July 2015 revealed the physician had ordered	F 278	This plan of correction is the center¿s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident: No residents were identified as being affected. 1. Resident #61¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS.	

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F 278	Continued From page 9 sodium chloride 1 gram 4 times a day for hyponatremia.on 4/7/15. During an interview with the MDS Coordinator on 7/15/15 at 4:15 PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I. on the MDS assessment. 2. Resident #74 was admitted to the facility on 12/14/10 and readmitted 12/10/14 with diagnoses including hypertension. Review of the most recent significant change Minimum Data Set (MDS) dated 5/15/15 for Resident #74 revealed he was not assessed as having Hypertension under Section I-Active Diagnoses. Review of the Physician's orders for the month of July 2015 revealed the physician had ordered on 4/7/15 nitroglycerin .2 mg per hour for hypertension. During an interview with the MDS Coordinator on 7/15/15 at 4:15 PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of	F 278	Corrected MDS has been transmitted to CMS. 2. Resident #74¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 3. Resident #41¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 4. Resident #27¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 5. Resident #97¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 6. Resident #104¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 7. Resident #9¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 8. Resident #84¿s MDS was corrected	

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F 278	Continued From page 10 medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I. on the MDS assessment. 3. Resident #41 was admitted to the facility on 10/9/06 and readmitted on 5/12/11 with diagnoses including allergies. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 5/22/15 Revealed Resident #41 was not assessed as having allergies under Section I-Active Diagnoses. Review of the Physician's orders for the month of July 2015 revealed the physician had ordered on 4/7/15 Cetirizine HCL 10 mg 1 tab by mouth every day for allergies. During an interview with the MDS Coordinator on 7/15/15 at 4:15 PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment.	F 278	on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 9. Resident #98¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 10. Resident #44¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 11. Resident #93¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 12. Resident #51¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 13. Resident #136¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to CMS. 14. Resident #115¿s MDS was corrected on 7/16/15 to include appropriate diagnosis in section I of the MDS. Corrected MDS has been transmitted to	

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F 278	Continued From page 11 The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I. on the MDS assessment. 4. Resident #27 was admitted to the facility on 12/30/14 with diagnoses including Hypothyroidism, Constipation and Anemia. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 7/7/15 did not assess Resident #27 as having Hypothyroidism, Constipation and Anemia under Section I - Active Diagnoses. Review of the Physician ' s Orders for July 2015 documented orders for Synthroid 24 micrograms every day for Hypothyroidism, Senna S 8.6 milligrams every day for Constipation and Ferrous Sulfate 325 milligrams every day for low Hemoglobin/Hematocrit. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I on the MDS	F 278	CMS. 2) Interventions for residents identified as having potential to be affected: MAR (Medication Administration Record) will be printed for all MDS assessments completed beginning 7/20/15. All medication diagnosis will be compared to MDS assessments. Diagnosis will be added to MDS as appropriate and as space allows in the I Section of the MDS assessments. 3.) Systemic Change The MDS Nurses have been will be in-serviced by the Director of Nursing regarding coding of active Medical Diagnosis in section I of the MDS. Any newly hired MDS Nurses will also be in-serviced regarding coding of Active Medical Diagnosis in section I of the MDS. The Director of Nursing or Designee will audit 20 completed MDS assessments each month for the next 3 months to ensure coding of Active Diagnosis is complete and correct. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the MDS Coding of Section I audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is	

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F 278	Continued From page 12 assessment. 5. Resident #97 was admitted to the facility on 5/29/13 with diagnoses including Insomnia. Review of the most recent Significant Change Minimum Data Set (MDS) Assessment dated 6/9/15 did not assess Resident #97 as having a diagnosis of Insomnia under Section I - Active Diagnosis. Review of the Physician ' s orders for July 2015 documented an order for Trazadone 150 milligrams every night for Insomnia. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I on the MDS assessment. 6. Resident #104 was admitted to the facility on 11/14/14 with diagnoses including Hypokalemia and Gastroesophageal Reflux (GERD). Review of the most recent quarterly Minimum	F 278	sustained ongoing.	

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F 278	Continued From page 13 Data Set (MDS) Assessment dated 4/16/15 did not assess Resident #104 as having GERD or Hypokalemia under Section I - Active Diagnoses. Review of the Physician ' s orders for July 2014 documented Resident #104 having an order for Klor-Con 20 milliequivalents every day for Hypokalemia and an order for Pantoprazole every day for GERD. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I on the MDS assessment. 7. Resident #9 was admitted to the facility on 1/24/13 and re-admitted on 4/4/15 with a diagnosis of Benign Prostatic Hypertrophy (BPH). Review of the most recent Minimum Data Set (MDS) Assessment dated 6/25/15 did not assess Resident #9 as having BPH under Section I - Active Diagnoses. Review of the Physician ' s Orders for July 2015 documented Resident #9 receiving Tamsulosin	F 278		

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F 278	Continued From page 14 0.4milligrams every 24hours for BPH. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I on the MDS assessment. 8. Resident #84 was admitted to the facility on 8/11/14 with diagnoses including Constipation. Review of the most recent Minimum Data Set (MDS) Assessment dated 4/30/15 did not assess Resident #84 as having Constipation under Section I on the MDS assessment. Review of the Physician ' s Orders for the month of July 2015 documented an order for Senna S 8.6milligrams every day for Constipation. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is	F 278		

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F 278	Continued From page 15 receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I on the MDS assessment. 9. Resident #98 was admitted to the facility on 10/14/13 and re-admitted on 12/26/13 with diagnoses including Constipation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 6/17/15 did not assess Resident #98 as having Constipation under Section I-Active Diagnoses. Review of the Physician ' s Orders for the month of July 2015 documented an order for Amitiza softgel 24 micrograms twice daily for Chronic Constipation. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate	F 278		

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F 278	Continued From page 16 diagnoses to be in Section I on the MDS assessment. 10. Resident # 44 was admitted on 1/17/14 with diagnosis that included depression and anxiety. Review of the most recent Minimum Data Set (MDS) Assessment dated 5/27/15 did not assess resident # 44 as having insomnia under Section-I Active Diagnosis. Review of the Physician's Orders for the month July 2015 revealed the physician had ordered melatoin 3 mg. given at bedtime for insomnia on 4/17/15. During an interview with the MDS Coordinator on 7/15/15 at 4:15 PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. The Director of Nursing (DON) on 7/16/15 at 1:49 pm stated her expectation was for accurate diagnoses to be in Section I. on the MDS assessment. 11. Resident #93 was originally admitted to the facility on 6/23/15 with diagnoses including Hyperlipedemia, Hypertension and Coronary Artery Disease. Review of the most recent Admission Minimum Data Set (MDS) Assessment dated 6/30/15 did not assess Resident #93 as having constipation	F 278		

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F 278	Continued From page 17 and anemia under Section I - Active Diagnoses. Review of the Physician's Orders for the month of July 2015 revealed the physician had ordered Miralax Powder, 17 grams by mouth for constipation and an Iron tablet 325 mgs. by mouth daily for anemia. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. During an interview on 7/16/15 at 1:49 PM, the Director of Nursing (DON) stated that the accurate diagnoses are expected to be in t.he Section I of the Minimum Data Set (MDS) assessment 12. Resident #51 was originally admitted to the facility on 6/12/15 with diagnoses including End Stage Renal Disease and Atrial Fibrillation. Review of the most recent Admission Minimum Data Set (MDS) Assessment dated 6/19/15 did not assess Resident #93 as having asthma, high cholesterol and gastro esophageal reflux disease (gerd) under Section I - Active Diagnoses. Review of the Physician's Orders for the month of July 2015 revealed the physician had ordered Nebulizer treatment every 8 hours for shortness of breath, Lipitor 40 mgs. by mouth daily for high	F 278		

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F 278	Continued From page 18	F 278		

cholesterol, Omeprazole 20 mgs., 1 by mouth daily, take 30 to 60 minutes before eating for Gastro Esophageal Reflux Disease and Prevacid capsule, delayed release 30 mgs. 1 capsule by mouth every day for Gastro Esophageal Reflux Disease.

During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment.

During an interview on 7/16/15 at 1:49 PM, the Director of Nursing (DON) stated that the accurate diagnoses are expected to be in t.he Section I of the Minimum Data Set (MDS) assessment

13. Resident #136 was originally admitted to the facility on 4/21/15 with diagnoses including Hypertension, Hemiparesis, Congestive Heart Failure and Anxiety Disorder.
Review of the most recent Minimum Data Set (MDS) Medicare 60 day assessment dated 6/22/15 did not assess Resident #136 as having restless leg syndrome and gastro esophageal reflux (gerd) under Section I - Active Diagnoses.

Review of the Physician's Orders for the month of July 2015 revealed the physician had ordered Pramipexole, 0.5 mgs., 1 tablet by mouth three times daily for restless leg syndrome and

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F 278	Continued From page 19 omeprazole, 20 mgs. by mouth once a day gastro esophageal reflux disease. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. During an interview on 7/16/15 at 1:49 PM, the Director of Nursing (DON) stated that the accurate diagnoses are expected to be in t.he Section I of the Minimum Data Set (MDS) assessment 14. Resident #115 was originally admitted to the facility on 5/16/15 with diagnoses including anemia, diabetes mellitus, depression and anxiety. Review of the most recent Minimum Data Set (MDS) Medicare 60 day assessment dated 7/8/15 did not assess glaucoma under Section I - Active Diagnoses. Review of the Physician's Orders for July 2015 revealed the physician had ordered Timolol 2%-0.5% drop, 1 drop in left eye, two times a day for glaucoma on 6/22/15. During an interview with the MDS Coordinator on 7/15/15 at 4:15PM she stated she was not sure why the diagnosis was not included in Section I. She stated that she typically reviews the	F 278		

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F 278	Continued From page 20 medications and codes the MDS from the list of medications the resident is receiving. She further stated if a resident has a diagnosis and is receiving a medication for that diagnosis, the diagnosis is considered " active " and should be listed under Section I on the Minimum Data Set assessment. During an interview on 7/16/15 at 1:49 PM, the Director of Nursing (DON) stated that the accurate diagnoses are expected to be in t.he Section I of the Minimum Data Set (MDS) assessment.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 record review, observations and interviews, the facility failed to provide proper incontinence care for 1 of 5 residents (Resident #61) who were observed receiving perineal care. Review of the facility policy titled, "Perineal Care" revised 10/25/11 read in part, " 11. Separate labia with one hand and wash with the other, using gentle downward strokes from front to back of perineum. 12. Use clean section of washcloth for each stroke. 13 Rinse thoroughly from front to back for each stroke. " Resident #61 was admitted to the facility on 10/14/10 with diagnoses that included	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be	8/14/15

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F 312	Continued From page 21 quadriplegia. Review of the most recent annual Minimum Data Set (MDS) dated 6/16/15 revealed that she was cognitively intact, she required extensive assistance for incontinence care and personal hygiene. Resident #16 was assessed with limited range of motion and was impaired on both sides of her upper and lower extremities. She was assessed as always incontinent of bowel and bladder. A review of the resident Care Area Assessment (CAAS) summary dated 6/15/15 revealed Resident #61 had diagnoses of quadriplegia and had very little use of extremities. She required extensive assistance with all Activity of Daily Living (ADL) including incontinence care. A review of the resident ' s care plan last updated on 1/15/14 revealed Resident # 61 had bowel and bladder incontinence related to quadriplegia. Staff were to provide peri-care after each incontinent episode. On 7/15/15 at 10:15 AM Resident #61 was observed in her room in bed receiving incontinent care by Nursing Assistant (NA #2). NA #2 removed Resident #61 ' s brief. Resident # 61 was observed with a large amount of soft brown formed stool and urine on her buttocks, perineum and between her legs. NA #2 wiped the perineal area with a washcloth and stool was observed on the washcloth. NA#2 then wiped the perineal area with disposable wipes and stool was observed on her gloves and the disposable wipes. She changed her stool soiled gloves but did not wash her hands. NA#2 was observed placing gloves on her hands and turning Resident #16 on her side to clean the resident ' s bottom. NA#2 was observed wiping Resident #61 ' s bottom and the wash cloth was observed to be stained with stool. She placed the stool soiled	F 312	completed by the dates indicated. 1. Interventions for affected resident: NA # 2 was re-educated by the Staff Development Coordinator (SDC) on hand washing and performance of proper peri-care for Resident #61. NA #2 completed appropriate return demonstration to SDC on hand washing and resident pericare. 2. Interventions for residents identified as having the potential to be affected: Certified Nursing Assistants (CNA) were re-educated by the SDC on hand washing and performance of proper pericare. A return demonstration of proper hand washing and resident pericare was required to be performed by CNA staff to ensure proper technique and competency of skill. 3. Systematic Change: Newly hired CNA staff will be educated by the facility SDC during their orientation period on hand washing and proper peri-care. A return demonstration of hand washing and resident pericare will be required to ensure proper technique and competency of skill. Random audits and observations will be performed across all shifts of CNA staff performing hand washing and resident pericare. SDC will observe three (3) CNA's perform hand hygiene and resident peri-care to ensure proper technique and	

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F 312	Continued From page 22 washcloth into the bath basin and squeezed out the excess water from the washcloth and then cleaned the resident ' s back side. NA#2 when asked if she was finished with the resident ' s perineal care stated she had finished and then was asked to turn the resident on her back and wipe the resident ' s front side between her legs. NA#2 was observed using a disposable wipe and wiped from front to back of the perineum. The disposable wipe was observed with stool. NA#2 took off her gloves and did not wash her hands. On 07/15/15 at10:25 AM NA #2 stated she did not want to leave the resident and wash her hands because she was afraid the resident might fall out of bed. She further stated she had not spread the resident's legs to observe if the resident ' s perineal area was clean from stool because Resident #61 ' s legs could not open very wide. On 7/15/15 at 10:27 AM Resident #61 stated she could not move while she was in her bed. On 7/16/15 at 8:20 AM the Staff Development Coordinator (SDC) stated that her expectation regarding incontinence care would be for staff to wash their hands after changing their gloves and to change the washcloth and the water after cleaning stool. She further stated the Nursing Assistant should have spread the resident ' s legs to separate the labia to make sure there was no stool remaining. On 7/16/15 at 8:24 AM the Director of Nursing (DON) stated her expectation regarding perineal care was for the staff to follow the facility policy and to dispose of the gloves and wash their hands after being in contact with stool. She further stated the Nursing Assistant should have separated the labia to make sure no stool remained.	F 312	competency of skill, weekly for a minimum of three (3) months. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the SDC will report audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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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 and staff interviews the facility failed to maintain clean and sanitary conditions to prevent food borne illness by failing to maintain one of one large floor fan free of dust and to clean one of one steam table. The findings included: Review of the facility Dietary Operations cleaning schedule revised on 4/17/14 titled " Dietary Cleaning Tasks & Frequencies " listed the steamer, steam table top and steam table wells were to be cleaned after each use. Fans were not listed on the cleaning schedule. During an observation on 7/15/15 at 9:54 AM staff were observed working in the dish machine area. Staff were observed to pull clean dish racks out of the dish machine and onto the drying shelf where a large floor stand fan located beside the drying shelf was observed to be blowing towards the clean side of the dish machine drying shelf. The fan cage was observed covered with dust and grey dust strings that were ¼ inch blowing towards the clean dishes on the drying shelf. During an interview with the Certified Dietary Manager (CDM) on 7/15/15 at 9:54 AM he stated	F 371	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: No residents were affected by these findings. Interventions for residents identified as having the potential to be affected: The Dietary Manager (CDM)immediately removed the fan to have it cleaned at immediately on 7/15/15. Further, the	8/14/15

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F 371	Continued From page 24 that he expected the fan would have no dust on it. The CDM stated the fan was cleaned weekly and would be cleaned immediately. The CDM then removed the fan from the area. During kitchen observation on 7/15/15 at 9: 45 AM the steam table was observed. The 6 foot shelf under side of the steam table shelf was observed to be covered with dried dark colored food particles. The sides of the steam table were observed with a sticky residue and dried dark food particles. During a second observation on 7/16/15 at 2:30 PM the steam table was observed. The 6 foot shelf under side of the steam table shelf was observed to be covered with dried dark colored food particles. The sides of the steam table were observed with a sticky residue and dried dark food particles. In an interview on 7/16/15 at 2:33 PM the CDM stated that he expected staff to clean any debris that could drop into the food. He stated that he discussed with staff weekly, what areas of the kitchen needed to be cleaned and would now assign and document what had been cleaned. The CDM stated the steam table would be cleaned before the next meal service.	F 371	CDM cleaned the steam table, steam table shelves, and tray immediately on 7/16/15. Both the fan and the steam table have been added to the daily cleaning schedule. Systematic Change: The CDM completed a thorough inspection of the kitchen and went over the results with kitchen staff to resolve these findings. The Certified Dietary Manager will in-service kitchen staff on food preparation and service guidelines to include infection control, and cleaning of equipment. All newly hired Nutritional Services Staff will be inserviced on food preparation and service guidelines to include infection control, and cleaning of equipment. The CDM will continue weekly inspections of the cleanliness of the kitchen for the next 10 weeks to include cleanliness of the steam table and fan. The Administrator will observe the weekly inspections during this defined period. Monitoring of the change to sustain ongoing system compliance: The CDM will report the results of the inspections conducted with the Administrator to the Quality Assurance and Performance improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the 10 week trial period.	

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F 431	Continued From page 25	F 431		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		8/14/15

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F 431	Continued From page 26 Based on observations and staff interviews, the facility failed to ensure one (1) of three (3) medication carts remained locked when not in use. (Station 2 medication cart). The findings include: During an observation of the medication cart on Unit 2 on 7/14/15 at 12:30PM the cart was unlocked. The nurse assigned to the medication cart was not seen in the area. During an observation of the medication care on Unit 2 on 7/14/15 at 2:36PM the cart was unlocked. The nurse assigned to the medication cart was not seen in the area. The Staff Development Coordinator (SDC) was at the nursing station and observed the cart with the State Surveyor. During an interview with the SDC on 7/14/15 at 2:37PM she stated that the medication cart should be locked at all times when the staff is not working the cart or in full visual of the cart. During an interview with Nurse #1 on 7/15/15 at 1:15pm she stated that the medication cart should have be locked when she stepped away from the cart and left the floor. During an interview with the Director of Nursing on 7/16/15 at 1:00pm she stated it is expected that the medication cart be locked when the nurse is away from the cart.	F 431	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No residents were affected by this alleged deficient practice. Nurse assigned to medication cart was re-educated on policy regarding proper medication storage and ensuring medication cart is locked when unattended. 2. Interventions for residents identified as having the potential to be affected: Licensed Nurses were re-educated by the facility Staff Development Coordinator (SDC) on proper medication storage and ensuring medication cart is locked when unattended. 3. Systematic Change: Newly hired Licensed Nurses during their orientation period will be educated on	

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F 431	Continued From page 27	F 431	proper medication storage and ensuring medication cart is locked when unattended. Random audits will be performed by the facility Director of Nursing (DON) to ensure medication carts are locked when unattended. Audits will be performed weekly for a minimum of three (3) months. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		8/14/15

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F 441	Continued From page 28 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to ensure proper hand washing between 2 of 5 residents observed during a medication pass (Resident #58 and Resident #66) and failed to wash hands and use a clean washcloth for 1 of 5 resident ' s observed receiving incontinent care (resident #61). The facility failed to handle soiled linens and to clean a shower room for one of two shower rooms observed (shower room #2). The findings include:	F 441	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be	

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F 441	Continued From page 29 Review of the facility policy "Hand washing/Hand Hygiene" dated 8/12 read in part "this facility considers hand hygiene the primary means to prevent the spread of infections." "When to Wash Hands 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact ... h. Before and after assisting a resident with personal care... " 1. During a medication pass observation on 7/14/15 at 11:30 AM Nurse #2 was observed to enter Resident #58 ' s room and take the resident ' s pulse oxygen level and hold the resident ' s hand and also pat her on the back. She then took the pulse oximeter to the medication cart and placed it in the drawer and then recorded the pulse oxygen level on the computer. Nurse #2 did not wash her hands after direct contact with resident #58. Nurse #2 then began dispensing medications for resident #66. She dropped one tablet on the medication cart and picked it up and placed it into the medication cup. She then entered resident 66 ' s room and began giving the medications. One medication dropped in the bed and Nurse #2 picked up the medication and placed it into the resident ' s mouth. Following the medication pass, Nurse #2 washed her hands. During an interview with Nurse #2 on 7/14/15 at 11:31 AM she stated she was supposed to wash her hands in between resident contact. During an interview with the Director of Nursing	F 441	completed by the dates indicated. 1. Interventions for affected resident: No resident were affected by this alleged deficient practice. Nurse #2 and NA #2 were re-educated by facility Staff Development Coordinator (SDC) on importance of hand washing before and after direct resident contact, after personal care and after removing gloves. A return demonstration was provided by Nurse #2 and NA #2 to ensure skills competency of hand washing. Nurse #2 was provided education by facility SDC on proper infection control practices during medication administration including ensuring medications are discarded if pills fall on contaminated surfaces such as medication cart and/or bed. NA#2 was re-educated by facility SDC on performance of proper peri-care. A return demonstration of pericare was provided by NA #1 to ensure proper technique and competency of skill. Shower Room #2 was cleaned by Housekeeping staff on 7/14/15. 2. Interventions for residents identified as having the potential to be affected: Licensed Nurses and Certified Nursing Assistants (CNAs) were re-educated by	

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F 441	Continued From page 30 on 7/16/15 at 2:00 PM she stated it was expected that hands are to be washed in between resident to resident care and going from doing a task to giving medications. If a medication is dropped it is not to be used or given. It is to be discarded in trash. 2. During observations on 7/14/15 at 10:55 AM, 12:43 PM, 2:07 PM and 4:26 PM of Shower room #2 there was dried green matter on the floor near the handrail on right side of shower room and two washcloths with brown matter observed on the shower room floor. There was also used toilet paper with brown stains on the floor. There was a sign hanging on the wall reading " discard dirty linens in nearest cart on your hallways or take to the back. No more leaving linen on the floor!!! Thanks housekeeping. " During all four observations the floor was dry and the equipment not moved. During an observation on 7/14/15 at 11:44 AM of shower room #2 with NA #1, she observed the soiled wash cloths, the soiled toilet paper and the stool on the floor. She did not pick the wash cloths up. During a follow up observation on 7/14/15 at 4:40 PM with the Director of Nursing and the Staff Development Coordinator of Shower room #2 the floor was observed to have dried green matter nearest the handrail, there were two soiled wash cloths on the floor and the toilet paper with stains was observed on the floor. During an interview with the Housekeeper on 7/14/15 at 11:44 AM she stated that she was responsible for Shower room #2. She stated she was responsible for the floors and nursing was responsible for removing any soiled or unused clean linen from the shower room. During an interview with Nursing Assistant (NA) #1 on 7/14/15 at 11:46 AM she stated that it was	F 441	facility SDC on importance of hand washing before and after direct resident contact, after personal care and after removing gloves. A return demonstration of proper hand washing was required to be performed to ensure proper technique and competency of skill. Licensed Nurses were educated by facility SDC on proper infection control practices during medication administration including ensuring medications are discarded if pills fall on contaminated surfaces such as medication cart and/or bed. CNAs were re-educated by facility SDC on performance of proper peri-care. A return demonstration of pericare was provided by CNA staff to ensure proper technique and competency of skill. Licensed Nurses and CNAs were re-educated on proper handling and disposal of soiled linen. Housekeeping Staff were re-educated by the Housekeeping Supervisor on ensuring shower rooms are thoroughly cleaned daily and periodically monitoring shower rooms throughout the day for cleaning as needed. 3. Systematic Change: Newly hired Licensed Nurses and CNAs will be educated during their orientation period on proper hand washing and handling of soiled linens.	

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F 441	Continued From page 31 the responsibility of each NA who uses the shower room to remove any linens, clean or soiled in the room after showering a resident. During an interview with the Director of Nursing on 7/14/15 at 4:44 PM and the Staff Development Coordinator it was stated that housekeeping was responsible for the floors and the NAs are responsible for picking up all linens and placing them in a bag and removing them from the shower area. The DON stated that the stool on the floor should have been cleaned today by housekeeping. During an interview with the Regional Manager of Housekeeping on 7/15/15 at 11:10 AM he stated that his housekeepers are contract and are trained using the 7 step method. He stated the housekeepers are to clean the floors and empty the trash. He stated the nursing staff are responsible for removing any linen from the shower room. He further stated that the housekeeper is responsible for doing a walkthrough of the shower room three times during the day shift. During an interview with the Director of Nursing on 7/16/15 at 2:00 PM she stated that it is expected that linens are bagged and picked up when care completed and not left on the floor. Review of the facility policy "Hand washing/Hand Hygiene" dated 8/12 read in part " this facility considers hand hygiene the primary means to prevent the spread of infections. " "When to Wash Hands. 5. Employees must	F 441	Newly hired Licensed Nurses will be educated during their orientation period on infection control practices during medication administration. Newly hired CNAs will be educated during their orientation period on proper technique for providing pericare. Newly hired Housekeeping Staff will be educated during their orientation period on ensuring shower rooms are thoroughly cleaned daily and periodically monitoring shower rooms throughout the day and cleaning as needed. 4. Monitoring of the change to sustain system compliance ongoing: Pericare audits will be performed by the facility SDC. SDC will audit (3) CNAs weekly for three (3) months to ensure proper pericare performance. Also, audits will include ensuring staff properly wash hands before and after resident contact, personal care and/or after removal of gloves. Facility observation audits will be randomly performed by SDC weekly for three (3) months to ensure nursing staff perform hand hygiene before and after resident contact, personal care and/or after removal of gloves. Also, audits will include observing for proper disposal of soiled linens. Medication Pass Observations will be randomly performed to ensure proper	

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F 441	Continued From page 32 wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: b. When hands are visibly soiled ..... c. Before and after direct resident contact ... h. Before and after assisting a resident with personal care... " 3. On 7/15/15 at 10:15 AM Resident #61 was observed in her room in bed receiving incontinent care by Nursing Assistant (NA #2). NA #2 removed Resident #61's brief. Resident # 61 was observed with a large amount of soft brown formed stool and urine on her buttocks, perineum and between her legs. NA #2 wiped the perineal area with a washcloth and stool was observed on the washcloth. NA#2 then wiped the perineal area with disposable wipes and stool was observed on her gloves and on the disposable wipes. NA #2 changed her stool soiled gloves but did not wash her hands. NA#2 was observed placing gloves on her hands and turning Resident #16 on her side to clean the resident's bottom. NA#2 was observed wiping Resident #61's bottom and the washcloth was observed to be stained with stool. She placed the stool soiled washcloth into the bath basin and squeezed out the excess water from the washcloth and then cleaned the resident's back side. NA#2 took off her gloves and did not wash her hands. NA#2 did not wash her hands while she cared for the resident and after giving care. On 07/15/2015 at 10:25 AM NA #2 stated she did not want to leave the resident and wash her hands because she was afraid the resident might fall out of bed. On 7/16/15 at 8:20 AM the Staff Development	F 441	infection control practices during medication pass. SDC will observe medication pass of (3) Licensed Nurses weekly for three (3) months. Shower room audits will be performed by the Housekeeping Supervisor and/or Designee weekly for three (3) months to ensure shower rooms are thoroughly cleaned. Monthly for a minimum of three months, results of all audits will be discussed at the Quality Assurance and Performance Improvement Committee meeting. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 441	Continued From page 33 Coordinator (SDC) stated that her expectation regarding infection control during incontinence care would be for staff to wash their hands after changing their gloves. On 7/16/15 at 8:24 AM the Director of Nursing (DON) stated her expectation regarding perineal care was for the staff to follow the facility policy and to dispose of the gloves and wash their hands after being in contact with stool.	F 441		
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews the facility failed to provide full visual privacy for residents whose privacy curtains were not wide enough for 4 of 4 halls. The findings included: 1a. During an observation on 7/16/15 at 2:22 PM Room # 16 was observed with the privacy curtain closed with a 3 foot gap at the window side of the room. 1b. During an observation on 7/16/15 at 3:11 PM Room # 33 was observed with the privacy curtain	F 460	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be	8/14/15

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F 460	Continued From page 34 privclosed with a 3 foot gap at the window side of the room. 1c. During an observation of room #54 on 7/16/15 at 3:37 PM, the privacy curtains did not provide full visual privacy for bed #1 and bed #2. Observation revealed a 12 1/2 inch gap of the privacy curtain at the foot of bed #1 and bed #2's privacy curtain did not provide full visual privacy for two to three feet, from the end of the privacy curtain at to the foot of the bed, to the wall. 1d. During an observation on 7/16/15 at 2:45 PM Room #31 bed B was observed with the privacy curtain closed around the resident with a 2 feet gap at the window side of the room. 1e. During an observation on 7/15/15 at 2:46 PM Room #51 bed B was observed with the privacy curtain closed around the resident with a 3 and 1/2 feet gap at the window side of the room. 1f. On 7/16/15 at 10:47 AM Room 12 bed B was observed with the privacy curtain closed around Resident #78 with an 18 inches gap at the window side of the room. 1g. On 07/16/15 10:42 AM Room 18 bed B was observed with the privacy curtain closed around Resident #78 with a 12 inches gap at the window side of the room. 1h. On 7/17/15 at 9:30 AM Room 19B was observed with the privacy curtain closed around Resident #41 with a 12 inches gap at the window side of the room. 1i. On 7/16/15 1:18 PM Room 1 was observed with the privacy curtain closed around Resident #68 with a 2 feet gap at the window side of the room. 1j. On 7/15/15 at 9:25 AM Room #10 bed B was	F 460	completed by the dates indicated. The following interventions for affected residents were made following survey for affected residents: a. Room #16 ¿ The privacy curtain has been replaced by an appropriate length curtain. b. Room #33 ¿ The privacy curtain has been replaced by an appropriate length curtain. c. Room #54 ¿ The privacy curtain has been replaced by an appropriate length curtain. d. Room #31b ¿ The privacy curtain has been replaced by an appropriate length curtain. e. Room #51b ¿ The privacy curtain has been replaced by an appropriate length curtain. f. Room #12b - The privacy curtain has been replaced by an appropriate length curtain. g. Room #18b ¿ The privacy curtain has been replaced by an appropriate length curtain. h. Room #19b - The privacy curtain has been replaced by an appropriate length curtain. i. Room #1 - The privacy curtain has been replaced by an appropriate length	

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	345002	A. BUILDING _____ B. WING _____	07/17/2015

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F 460	Continued From page 35 observed with the privacy curtain closed around the resident with a 6 foot gap at the window side of the room On 7/15/15 9:27 AM Nursing Assistant (NA#2) stated she provided Resident #61 with a bed bath and that she was aware that the privacy curtain did not close completely. On 7/16/15 8:30 AM the Administrator stated if the privacy curtain did not reach completely around the bed then the Nursing Assistant should have reported this to housekeeping. He further stated that when the privacy curtain was hung the curtain should have been the right size. On 7/16/15 8:34 AM housekeeping staff stated he was not aware that the privacy curtains needed to be wide enough to go fully around residents' beds. He stated that he was unaware that the privacy curtain in Room #10 bed B was not wide enough to reach around Resident #61's bed. On 7/16/15 9:19 AM the Resident #61's family member stated that the privacy curtain had a stain on it for about a month and that was the same privacy curtain. She further stated when staff gave care to Resident #61 they did pull the curtain around but it was not wide enough to reach all the way around the bed. She further stated Resident #61's roommate did come around to Bed B side to turn on the TV and was not aware that the curtain should be fully closed. On 7/16/2015 1:25 PM housekeeping staff stated he was the person that hung the privacy curtains and was unaware that the curtains needed to reach all the way around the bed.	F 460	curtain. j. Room #10 - The privacy curtain has been replaced by an appropriate length curtain. Interventions for residents identified as having potential to be affected: 2. The Housekeeping Supervisor and Maintenance Supervisor and Maintenance Assistant completed an audit of 100% of resident rooms. Several rooms were fixed by moving the appropriate length curtains to the appropriate room. Appropriate length curtains will also be ordered as needed. Systematic Change: 3. Housekeepers and Nursing staff were in-serviced on the appropriate length of the privacy curtain, use of pulling the privacy curtain completely closed to ensure privacy, and how to generate work orders for Maintenance and Housekeeping if they find a curtain that is not appropriate length.. Housekeeping staff were also in-serviced on the different lengths of curtains the facility uses and which privacy curtains fit in which rooms. Staff were also in-serviced to use sheets or an extra privacy curtain to ensure privacy until all curtains can be thoroughly inspected and replaced as needed. The Maintenance Supervisor, Housekeeping Manager, or Administrator will audit 5 privacy curtains for 12 weeks to ensure curtains are correct length and close	

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F 460	Continued From page 36 On 7/16/15 at 1:52 PM the Housekeeping Supervisor stated she was aware that all curtains needed to reach all the way around the bed. She stated she was not aware that the privacy curtains were not wide enough. She stated her expectation for staff giving care would be for them to notify housekeeping that the curtains were not wide enough. She further stated housekeeping did check the curtains to make sure they are clean but they did not check to make sure they were wide enough.	F 460	completely. Monitoring of the change to sustain system compliance ongoing: 4. The Quality Assurance Committee will discuss and review the results of the Privacy Curtain Audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	
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 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	F 520		8/14/15

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F 520	Continued From page 37 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, and staff interview, the facility failed to have a functional Quality Assessment and Assurance (QAA) Committee by failing to maintain implemented procedures and monitor these interventions that the committee put into place in August 2014 on a recertification survey and on the current recertification survey. The deficiency was in the area of accurately assessing residents for active diagnoses. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is crossed referred to: F-278: Accurately assessing residents for active diagnoses. Based on record review and staff interviews the facility failed to accurately assess 14 of 35 (Residents 61, 74, 41, 27, 97,104, 9, 84, 98, 44, 54, 45, 38 and 50) residents for accurate diagnoses under Section I on the Minimum Data Set (MDS). Review of the facility revised policy dated 1/22/12 titled, " Quality Assessment & Assurance (QA &A) Committee. " Read in part, "Analyzing survey results and verifying correction of deficiencies." During the recertification survey of 8/27/14 the	F 520	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: The most recent Minimum Data Set (MDS) assessments were corrected for the following residents to reflect accurate coding of diagnoses under Section I of the MDS assessment: Resident # 9 Resident # 27 Resident # 98 Resident # 61 Resident # 97 Resident # 44 Resident # 74 Resident # 104 Resident # 54 Resident # 41	

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F 520	Continued From page 38 facility was cited for failing to accurately assess residents for accurate diagnoses under Section I on the MDS. During the recertification survey on 7/17/15 the facility failed to accurately assess residents for accurate diagnoses under Section I on the MDS. During an interview on 7/17/15 at 12:48 PM the Administrator stated that the MDS Coordinator attended the QA committee meetings. He stated he relied on the MDS staff to let him know when there were issues. He stated that the facility had audited the residents ' MDSs to make sure their medications had an accurate diagnoses. He stated the MDS Consultant came in and selected a sample of random residents and there had been no issues with accuracy. The Administrator further stated he depended on his MDS Coordinators to keep him informed about MDS issues and they had not identified that the MDSs were not accurate During an interview on 7/17/2015 12:49 PM the MDS Coordinator stated the facility had changed systems and everything was on the computer and the MDS staff had just missed it. She stated that they had been monitoring with random audits but they had been looking at antipsychotic medications and failed to look at other medications.	F 520	Resident # 84 Resident # 45 Resident # 38 Resident # 50 2. Interventions for residents identified as having the potential to be affected: Re-education was provided to the facility Quality Assessment and Assurance Committee (QA&A Committee) by the Regional Clinical Director. Education included importance of maintaining an effective QA&A Committee. Education emphasized ensuring the QA &A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities. 3. Systematic Change: Random audits will be completed by the facility Director of Nursing or Designee to validate accuracy of assessments. Audits will be completed on 20 completed MDS assessments monthly for 6 months. Audits will include thoroughly reviewing coding under Section I of the MDS assessment to ensure accuracy of coding. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 6 months, the Director of Nursing will report audit results	

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F 520	Continued From page 39	F 520	to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the 6 months.	