STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING ______ B. WING ______	C 09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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=B	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		10/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/12/2015

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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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.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide a Medicare Non-Coverage letter and rights to appeal for 2 of 3 sampled residents who were discharge from Medicare services (Residents #14 and Resident #75). The findings include: 1. A record review of the Notice of Medicare Provider Non-Coverage form revealed Resident #14 was not provided notification of Medicare Non-Coverage by the facility and given the right to appeal. The facility was not able to verify through documentation that Resident #14 received notification of Medicare Non-Coverage in writing. An interview with the Business Office Manager on 09/18/15 at 2:35 PM stated she was responsible for providing the Medicare Non-Coverage notices to residents and families. During the interview, she stated Resident #14 should have been notified at least a few days prior to ending of Medicare services and given the right to appeal. She further stated the expectation was for Medicare Non-Coverage forms to be issued timely and residents given the right to appeal. Interview with Administrator on 09/17/15 at 3:56 PM stated the expectation was for Medicare Non-Coverage notices to be provided to residents prior to the ending of the Medicare services to notify residents of their right to appeal. 2. Review of the Notice of Medicare notice for Resident #75 revealed the effective date on which coverage of nursing services ended on 06/04/15. A review of the Skilled Nursing Facility Advance Beneficiary Notice dated 06/04/15 revealed	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 center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F-156 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Per citation, Center failed to provide a Notice of Provider Non-coverage letter and appeal rights to resident # 14 and #75. The Center was unable to verify documentation of Resident¿s #14 Notice of Medicare Provider Non-coverage. Resident¿s #75 Notice of Medicare Provider Non-coverage was not completed timely in order to allow the resident to file an appeal. Both residents discharged prior to survey from the center	

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F 156	Continued From page 3 Resident #75 signed the document on 06/03/15. An interview with the Business Office Manager on 09/18/15 at 2:35 PM stated she was responsible for providing the Medicare Non-Coverage notices to residents and families. During the interview, she stated, Resident #75 should have been notified at least a few days prior to ending of Medicare services and given the right to appeal. She further stated the expectation was for Medicare Non-Coverage forms to be issued timely and residents given the right to appeal. Interview with Administrator on 09/17/15 at 3:56 PM stated the expectation was for Medicare Non-Coverage notices to be provided to residents prior to the ending of the Medicare services to notify residents of their right to appeal.	F 156	2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: On October 5, 2015, all current skilled residents¿ records were reviewed to determine if skilled Medicare services will end within the next 48 hours to determine if a Medicare Notice of Non-coverage should be issued for the resident to file an appeal. At this time, no current residents will be ending skilled services within the next 48 hours. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: On October 13, 2015, the MDSC Consultant provided education to the MDSC, Administrator, DON, and BOM that the resident¿s Notice of Medicare Non-coverage must be issued 48 hours prior last covered Medicare Part A Skilled day. The MDSC or BOM will create the Notice of Medicare Provider Non-coverage within 48 hours of ending Medicare skilled services. The BOM or MDSC will issue the Notice of Medicare Non-coverage to all resident¿s or all resident¿s POA¿s prior to or no less than 48 hours to ending skilled services in order in order to allow time to file an appeal MDS. If the resident chooses to end their skilled services prior to skilled services being terminated then notation will be documented by the DC Planner or designee in the residents chart indicating	

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F 156	Continued From page 4	F 156	why a Notice of Medicare Non-coverage was not issued. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The MDS Consultant will audit 5 residents¿ MDS who are ending skilled Medicare Part A services for timely filing of Notice of Medicare Non-coverage. Any issues identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC and BOM. The issue will be reviewed and discussed within the QA program. If compliant with schedule, then audit will be conducted as needed. ¿ 1 week for 4 weeks ¿ Twice a month for 1 month ¿ Monthly for 4 months	
F 241 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews (Residents #47 and #2), staff interviews, and	F 241	F-241 1. How corrective action will be	10/16/15

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F 241	Continued From page 5 record reviews the facility left 1 of 1 resident exposed after wound care (Resident #5); the facility provided disposable cups to residents during 3 of 4 meals observed.; and 3 of 8 residents who required assistance with dining were not fed at eye level by staff. (Residents #166, #188, and #43). The findings included: 1. Resident #5 was admitted to the facility on 06/24/15 with diagnoses that included vascular disease and decreased blood flow to extremities. His most recent Minimum Data Set dated 07/01/15 indicated his cognition could not be determined due to memory loss. He was assessed to require extensive assistance with activities of daily living, had venous/arterial wounds on his legs, and received dressings to his leg wounds. On 09/15/15 at 3:45 PM an observation was made of Resident #5 sitting up in his bed. He was lethargic and difficult to wake. His lower extremities were uncovered. The soiled dressings on his legs had been cut off and were lying in his bed entangled with the blankets, and beneath his legs. Resident #5's legs were blackened and sloughing tissue was observed coming off of his legs. Blackened, decayed tissue was observed in the bed mixed in with his blankets, lying in the floor at the foot of the bed, and continued to slough, peel and flake from his lower extremities. On 09/15/15 at 3:50 PM Nurse #4 was asked to come into Resident # 5's room. He stated he was the nurse taking care of Resident #5 on this day. Nurse #4 indicated he had been notified approximately one hour earlier that the Nurse Practitioner had removed the dressings from Resident #5's lower extremities and had not been replaced. Nurse #4 indicated Resident #5 was left in bed with no wound dressings, and stated that	F 241	accomplished for each resident found to have been affected by the deficient practice: 1) Resident #5 dressing applied by nurse on the unit on the day of discovery of 9/15/2015. 2) Resident #47 was seen for beverage preferences on 9/18/15 and was asked if she would prefer her milk and juice in non-disposable beverage cups and res stated ¿whatever you all want to do would be fine with me, honey¿ and was thankful for the visit and voiced no additional preferences at present. Resident #2 was seen for beverage preferences on 9/18/15 and was asked if she would prefer her juice or other beverages (res stated she does not drink milk) in non-disposable beverage cups and res stated ¿that would be nice¿. 3) Resident #166 ¿ Once identified SDC in-serviced CNA¿s on shift that they needed to sit and feed residents and not stand over them. 4) Resident #188 - Once identified SDC in-serviced CNA¿s on shift that they needed to sit and feed residents and not stand over them. 5) Resident #43 - Once identified SDC in-serviced CNA¿s on shift that they needed to sit and feed residents and not stand over them. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:	

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F 241	Continued From page 6 dead skin and soiled dressings lying on the bed and in the floor was not appropriate. He revealed he was not aware Resident #5 had been left in this condition. On 09/15/15 at 3:55 PM the Director of Nursing (DON) was asked to come to Resident #5's room. She immediately stated the condition he was left in was inappropriate. She stated his dressings should have been changed immediately after they were removed. The DON put on gloves and began assisting in cleaning up Resident #5 and the surrounding area. On 09/15/15 at 4:10 PM an interview was conducted with the DON. She stated there had been a miscommunication between the medical staff and the nursing staff. She stated it was her expectation this type of miscommunication should not occur and no resident should be left in that condition. The DON revealed Resident #5 should not have been left with his lower extremities exposed, and soiled dressings and skin debris in the bed with him. On 09/17/15 at 10:30 AM an interview was conducted with Nurse #3. She stated it was her expectation that when staff is notified that a dressing has been removed, the staff should respond immediately and check the dressing. She indicated the incident with Resident #5 should not have occurred and everyone has felt terrible about it. Nurse #3 stated it was a lapse in communication that led to him lying in bed with his wounds exposed to anyone that may have entered the room. On 09/18/15 at 10:50 AM an interview was conducted with the DON. She stated her expectations were not met with the treatment of Resident #5. She revealed she expected better communication between the medical staff and the nursing staff. The DON indicated when the	F 241	1) No other patients identified as having exposure issues after being notified by surveyor of Resident #5¿s incident. Spoke to Medical Director in regards to Nurse Practitioners action of leaving resident wound uncovered. 2) On October 5-9th, all current residents with BIMS score of 12 or greater (59 residents) were interviewed for beverage container preferences and all 59 residents had no opposition to our new plan of having juice and milk beverages served in plastic beverage cups instead of disposable plastic containers and milk cartons. All remaining residents will be served beverages in non-disposable beverage cups as well unless otherwise specifically requested by the resident at meal time. 3) Nursing staff in-serviced on sitting and feeding residents at eye level and conversing with residents during the meal. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: 1) Nursing staff, was educated on making sure that when dressing changes are accomplished, that the wound is not left exposed while the nurse walks away and if notified by a practitioner that a wound needs to be dressed they need to stop what they are doing and ensure that wound has not been left exposed. 2) By October 15, 2015 All dietary and nursing staff were in-serviced on: 1) The use of non-disposable beverage containers during meal service unless	

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F 241	Continued From page 7 dressing was removed, staff should have been available to check and redress the wound if needed. 2 A. A breakfast meal dining observation occurred on 09/16/15 at 9:13 AM on the 100 hall and revealed resident breakfast meals included the use of disposable cups and containers (made of polystyrene foam and plastic) in use for coffee, juice, and milk. An interview occurred on 09/16/15 at 9:27 AM with nurse aide #3 (NA #3). During the interview, NA #3 was observed pouring coffee into a polystyrene foam cup for a resident on the 100 hall. The beverage cart was observed with only polystyrene foam cups available for use. NA #3 stated she worked at the facility for the last 7 years and had always offered coffee to residents using disposable cups and that she had not been trained to offer coffee to residents using non-disposable cups. A lunch meal dining observation occurred on 09/16/15 in the main dining room at 1:05 PM and revealed resident lunch meals included the use of disposable cups and containers (made of polystyrene foam and plastic) in use for lemonade and ice water. A breakfast meal dining observation occurred on 09/17/15 from 8:01 AM until 8:31 AM on the 100 and 200 halls and revealed resident breakfast meals included the use of disposable cups and containers (made of polystyrene foam, paper and plastic) in use for coffee, juice, milk, and carbonated beverages. An interview with the certified dietary manager	F 241	specifically requested by the resident. 2) Our new system that will be implemented, which is to have beverage carts sent to the halls with bulk service milk, juice, and tea that will be poured into beverage cups for each resident prior to meal based on resident choice of beverage. 3) The importance of checking meal tickets for resident food preferences to ensure patient satisfaction through accurate delivery of listed meal ticket preferences. By October 15th all nursing staff were in-serviced on feeding residents at eye level and involving residents in meaningful conversation during meal times. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: 1) DON, Unit Manager or Department Head will do walking rounds as assigned by Administrator to observe for exposure issues and address with staff if found immediately. ¿ Daily, Monday thru Friday for four weeks. ¿ 2x weekly x 8 weeks ¿ once weekly x 8 weeks ¿ once monthly x 7 months 2) The dietary manager will conduct tray accuracy audits to ensure resident preferences are provided at mealtimes as per ticket. A breakfast, lunch, and dinner meal will be audited. ¿ Daily, Monday thru Friday for four	

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F 241	Continued From page 8 (CDM) occurred on 09/17/15 at 09:26 AM and revealed the following inventory of non-disposable beverage cups was available for use: · 150 glasses for cold beverages (used primarily in the main dining room) · 143 glasses for cold beverages (used primarily for residents who dined in their rooms) · 50 white clear cups for cold beverages · 36 white clear cups for cold beverages (in storage) A total of 379 glasses or cups were available for use for cold beverages. · 27 insulated mugs for hot beverages · 77 white ceramic mugs for hot beverages A total of 104 insulated mugs or ceramic mugs were available for use for hot beverages. A follow-up interview on 09/18/15 at 1:42 PM with the CDM revealed she was not aware that such a small quantity of insulated mugs was available for use for hot beverages. The CDM stated that dietary staff was trained to prepare and deliver a beverage cart to each unit for the breakfast meal to include coffee, ceramic cups, insulated mugs and disposable cups. The CDM stated that disposable cups were used because some residents requested them. The CDM stated that if a resident did not specifically request the use of a disposable cup, she expected nursing staff to offer the resident beverages in non-disposable cups. The CDM further stated that other beverages like milk and juice were delivered to the facility in disposable containers and that dietary staff were trained to place disposable milk cartons and juice containers on the resident's meal tray. The CDM stated that she had always provided residents with milk, juice and cereal in disposable containers and was unaware that	F 241	weeks. ¿ 2x weekly x 8 weeks ¿ once weekly x 8 weeks ¿ once monthly x 7 months 3) DON, Unit Manager or Department Heads will observe 2 meals a day as assigned by Administrator to observe that patients dining experience is enhanced by feeding residents at eye level and conversing with the resident. Any issue will be addressed with staff if found immediately and DON or Administrator notified of the incident. ¿ Daily, Monday thru Friday for four weeks. ¿ 2x weekly x 8 weeks ¿ once weekly x 8 weeks ¿ once monthly x 7 months Audits will be brought to QA review monthly x 4 to ensure continued compliance and/or revision to plan if needed.	

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F 241	Continued From page 9 these disposable containers should not be used routinely. The CDM also stated that the facility ordered glassware monthly and had sufficient supply, but that she had just not used all of the glassware available. An interview with the administrator occurred on 09/18/15 at 2:45 PM and revealed that she had noticed the use of disposable foam cups in the dining room and spoke to the CDM about a more uniform tableware system. The administrator stated that she was aware that the use of disposable tableware could be used for extenuating circumstances, but she did not expect the use of disposable tableware on a daily basis. B. Review of a quarterly minimum data set dated 06/10/15, revealed Resident #47 was assessed with impaired cognition. On 09/17/2015 at 08:31 AM, Resident #47 was observed feeding herself breakfast in her room. Resident #47 received coffee in a disposable (polystyrene foam) cup and orange juice in a plastic container. Resident #47 was drinking her orange juice from a straw which had been punched through a hole in the foil cover of the plastic cup. Resident #47 responded with the following when asked if she had a preference regarding the receipt of disposable containers, "Yeah, I would prefer my coffee in a coffee cup and my juice in a juice glass, everybody does, but I don't give them a hard time about it, they are good to me here." Resident #47 stated she had not been asked by staff her preference regarding the use of disposable tableware. c. Review of a quarterly minimum data set dated	F 241		

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08/07/15 revealed Resident #2 was assessed with intact cognition.

On 09/17/2015 at 8:33 AM, Resident #2 was observed eating her breakfast in her room. Resident #2 received a carbonated beverage in a disposable (polystyrene foam) cup and a disposable carton (paper) of milk. When asked if she had a preference for receiving her beverages in disposable containers, Resident #2 stated "I would prefer to have my beverages in non-disposable cups and glasses, but this is what they send." She also stated that she had not been asked by staff her preference regarding the use of disposable tableware.

3. Resident #166 was re-admitted to the facility on 07/02/15 with diagnoses to include Alzheimer's disease, aphasia, cerebrovascular disease and dementia.

An admission minimum data set dated 07/08/15 assessed Resident #166 with moderately impaired cognition and required limited to extensive staff assistance with activities of daily living to include eating.

On 09/16/2015 at 09:13 AM Resident #166 was observed sitting up in bed with the head of bed raised and her eyes closed. Her breakfast meal tray was set-up and on the over bed table positioned in front of her, across her bed. Nurse Aide #6 (NA #6) was observed to enter the room of Resident #166 with the bed height raised to approximately waist height of NA #6. NA #6 encouraged Resident #166 to awake and eat her breakfast to which the Resident responded. NA #6 offered to feed Resident #166 and the Resident accepted the assistance. NA #6 stood to

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the Resident's left, looking down towards the Resident's head. NA #6 fed Resident #166 from 09:13 AM until 09:22 AM while she stood looking down towards the Resident. A chair was observed available in the Resident's room, but was not used by NA #6 while she fed Resident #166.

An interview with NA #6 occurred on 09/16/15 at 09:22 AM. NA #6 stated that Resident #166 was capable of feeding herself at times, but required encouragement and at times assistance with her meal.

Interview with Nurse #3, the unit coordinator, on 09/16/15 at 9:43 AM revealed staff should sit and feed residents at eye level.

Interview with the Director of Nursing on 09/16/15 at 9:47 AM revealed she expected staff to assist residents with meals while seated to be at eye level and not stand while feeding.

A follow up interview with NA #6 occurred on 09/17/2015 at 09:06 AM and revealed that she was aware that a chair was available in the room when she fed Resident #166 breakfast on 09/16/15. NA #6 further stated "I suppose I could have used that chair, but I initially came in just to encourage her, but I ended up staying longer and feeding her." NA #6 also stated that she had not been previously trained to sit and feed residents at eye level, but realized now that would be better so that the resident did not feel rushed.

4. Resident #188 was admitted to the facility on 08/25/15 with diagnoses which included advanced dementia.

Review of Resident #188's admission Minimum

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F 241	Continued From page 12 Data Set (MDS) dated 09/01/15 revealed an assessment of short and long term memory problems. The MDS indicated Resident #188 required the limited assistance of one person with eating. Observation on 09/15/15 at 8:23 AM revealed Nurse Aide (NA) #2 stood at Resident #188's bedside and fed Resident #188 the breakfast meal. The room contained one empty wing chair between the two beds in the semi-private room. Observation on 09/16/15 at 8:31 AM revealed NA #2 stood at Resident #188's bedside and fed Resident #188 the breakfast meal. The room contained one empty wing chair between the two beds in the semi-private room. Interview on 09/16/15 with NA #2 revealed she usually stood while feeding Resident #188. NA #2 explained she received direction from nursing management not to stand while feeding residents and should have moved the chair next to Resident #188's bed. NA #2 could not provide a reason why she did not move the chair and feed Resident #188 at eye level. Interview with Nurse #2, the charge nurse, on 09/16/15 at 9:41 AM revealed staff should sit at the bedside when meal assistance was provided. Nurse #2 explained she did not notice NA #2 standing during the breakfast meal. Interview with Nurse #3, the unit coordinator, on 09/16/15 at 9:43 AM revealed staff should sit and feed residents at eye level. Interview with the Director of Nursing (DON) on 09/16/15 at 9:47 AM revealed she expected staff	F 241		

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F 241	Continued From page 13 to assist residents with meals at eye level and not stand while feeding. The DON reported she expected NA #2 to move the chair to Resident #188's and provide feeding assistance at eye level. 5. Resident #43 was admitted to the facility on 04/27/09 with admitting diagnoses of dysphagia disorder and senile dementia. Review of the Quarterly Minimum Data Set (MDS) dated 07/20/15 revealed Resident #43 had short and long term memory loss and severely impaired daily decision making. The MDS further specified Resident #43 required extensive assistance with eating with a one person physical assist. The MDS revealed Resident #43 is rarely/never understood. On 09/16/15 from 9:01 AM to 9:08 AM Nurse Aide (NA) #1 was observed to stand to the resident's left at the head of bed. The NA#1 was in the resident's peripheral line of view, not in the resident's direct line of view. Throughout the observation, the NA#1 fed the resident while looking down towards the resident, with no conversation or description of the food being offered. The resident had to look up, with her neck hyper-extended in order to receive the food being offered. On 09/16/15 at 9:34 AM, NA#1 stated she should have been seated when she fed Resident #43. She stated she normally sit while feeding residents. She explained she had been trained not to stand, but to sit while feeding residents and maintain eye level. NA#1 stated she stood while feeding Resident #54 because there was not a chair available in the room at the time she assisted Resident #43 with her meal.	F 241		

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F 241	Continued From page 14 Interview with the Director of Nursing (DON) on 09/16/15 at 9:47 AM revealed she expected staff to assist residents with meals at eye level and not stand while feeding.	F 241		
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 observation, resident interview, staff interviews, and medical record review, the facility failed to honor a residents food preferences for oatmeal and milk for 1 of 4 sampled residents reviewed for having their preferences honored. (Resident #2) The findings included: Resident #2 was admitted to the facility on 02/09/15. A quarterly minimum data set dated 08/07/15 assessed Resident #2 with intact cognition and independent with eating. A care plan updated 08/21/15, documented Resident #2 had the potential for weight fluctuations in part due to poor food intake with a	F 242	F-242 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #2 was seen for food and beverage preferences on 10/5/15. Food preferences were updated by RD and Dietary Manager and entered into mealtracker system. Res was asked if she would prefer her juice or other beverages (res stated she does not drink milk) in non-disposable beverage cups and res stated ¿that would be nice¿. Res was thankful for the visit. 2. How corrective action will be accomplished for those residents having	10/16/15

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goal to maintain adequate nutrition status and interventions which included, in part, staff to provide/serve a diet as ordered and foods per preference.

Resident #2 was observed on 09/17/15 at 8:33 AM seated up in bed eating her breakfast. Her meal tray card recorded "dislikes - milk group, no milk, send oatmeal." Resident #2 received a breakfast meal which included, in part, whole milk, but she did not receive oatmeal. Resident #2 stated during the observation "I don't always get oatmeal and I have asked to get it for breakfast, I don't always say anything because I don't want to bother them, but I have said before that I would like oatmeal for breakfast, I didn't get oatmeal today and I would like it, I get milk every morning and I don't drink milk."

An interview occurred on 09/17/15 at 08:40 AM with nurse aide #7 (NA #7) and revealed that Resident #2 liked oatmeal for breakfast, but that oatmeal was not always sent from the kitchen on her breakfast meal tray. NA #7 stated that when Resident #7 did not receive oatmeal on her tray, the Resident told her if she wanted oatmeal and if the Resident requested it, NA #7 stated "I go get it for her, but she did not ask for the oatmeal today." NA #7 also stated that Resident #2 received milk on her breakfast tray every morning, but that she did not drink milk and further stated that she would tell the kitchen to stop sending her milk.

An interview occurred on 09/17/15 at 08:44 AM with nurse #5, unit coordinator. Nurse #5 stated that the tray card should be used to verify that the resident received the meal according to their preference. Nurse #5 also stated that staff should

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the potential to be affected by the same deficient practice:

All resident mealtracker profiles reviewed and all residents with preferences listed on meal ticket (32 residents identified) will be audited at lunch meal to identify any discrepancies. Findings and corrections will be listed on tray accuracy audit tool. This is to be completed by October 13th.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

By October 15, 2015 All dietary and nursing staff will be in-serviced on the importance of checking meal tickets for resident food preferences to ensure patient satisfaction through accurate delivery of listed meal ticket preferences.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

¿ The dietary manager will conduct tray accuracy audits to ensure res preferences are provided at mealtimes as per ticket. A breakfast, lunch, and dinner meal will be audited 2x weekly x 2 weeks, then once weekly x 2 weeks, then once monthly x 3 months. Audits will be reviewed by Dietary Manager or designee and brought to QA review monthly x 4 to ensure continued compliance and/or revision to plan if needed.

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F 242	Continued From page 16 refer to the card and use it as a guide to make sure the resident received the foods according to their preferences. Nurse #5 stated that the nursing staff who worked with Resident #3 routinely knew that she liked oatmeal with her breakfast and stated, "So if the oatmeal was not on her tray the nurse aide should go get if for her." An interview with dietary aide #1 (DA #1) occurred on 09/17/2015 at 8:57 AM. DA #1 stated that she worked on the breakfast tray line that morning (09/17/15) and one of her responsibilities included to check the tray card for special requests and dislikes. DA #1 could not explain why Resident #2 routinely received milk or why oatmeal was not provided for her breakfast meal that morning. During an interview with the certified dietary manager (CDM) on 09/18/15 at 1:42 PM, the interview revealed that the CDM expected dietary staff to use the tray card to provide residents with foods according to their preference.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		10/16/15

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F 272	Continued From page 17 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to the risk for falls and dental care for 2 of 22 sampled residents (Residents #30 and #3). The findings included:	F 272	F272 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #30¿s Fall CAA from her 8/11/15 Admission MDS was revised to include documentation of findings with a description of the problem, causes, and	

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F 272	Continued From page 18 1. Resident #30 was admitted to the facility on 08/04/15 with diagnoses which included chronic obstructive pulmonary disease, anxiety and atherosclerotic heart disease. Review of Resident #30's admission Minimum Data Set (MDS) dated 08/11/15 revealed an assessment of intact cognition. The MDS indicated Resident #30 required the extensive assistance of one person with transfers and walking. The MDS indicated Resident #30 had one fall prior to admission and received antipsychotic medications. Review of Resident #30's Fall Care Area Assessment (CAA) dated 08/17/15 revealed no documentation of findings with a description of the problem, causes, contributing factors and risk factors related to a fall risk. There was no documentation of input from Resident #30. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. During an interview on 09/15/15 at 9:26 AM, Resident #30 explained arm and leg pain limited her mobility. Resident #30 reported a fear of falling and the need for staff assistance with transfers. Interview with the MDS Coordinator on 09/17/15 at 2:23 PM revealed Resident #30's fall CAA did not contain documentation of an analysis of findings. The MDS Coordinator reported she did not document an analysis and specific information regarding Resident #30 and could not provide a reason for the omission. Interview with the Director of Nursing (DON) on	F 272	contributing factors and risk factors related to a fall risk. The revision was documented in the resident¿s progress notes on October 13, 2015. Resident #3¿s 9/30 Quarterly MDS revealed no dental issues. On October 2, the dentist completed a dental exam, and orders were given. His dental status will be coded correctly on his 10/5/15 Quarterly MDS and it will be updated on his care plan. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: By October 15, 2015, all comprehensive MDS with an ARD of September 15, 2015 or after were reviewed to determine if the Fall CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to a fall risk. The dental status of all current residents were completed by October 15, 2015. Any issues identified were documented in the progress notes and referred to the dentist, or a consultation was made to an outside dentist. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: On October 5, the MDSC Consultant provided education to the MDSC to	

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F 272	Continued From page 19 09/17/15 at 2:49 PM revealed the CAA should contain documentation of a comprehensive assessment which should include an analysis of findings specific to Resident #30. 2. Resident #3 was admitted to the facility on 05/27/15 with diagnoses that included paraplegia, malnutrition, anemia, and a colostomy among others. Review of the quarterly Minimum Data Set (MDS) dated 09/03/15 revealed Resident #3 was cognitively intact and required limited to extensive assistance with most activities of daily living including personal hygiene. No dental issues were indicated on the MDS. Review of the Care Area Assessment dated 06/03/15 revealed dental issues were not triggered and received no further assessment or care planning. Review of Resident #3's care plan dated 09/03/15 indicated no dental issues were identified and no goals and interventions were provided. Review of Resident #3's discharge summary from the hospital dated 07/28/15 indicated he had poor oral hygiene, multiple broken teeth, and multiple dental caries. On 09/14/15 at 11:56 AM an observation of Resident #3 revealed multiple broken and decayed teeth on upper and lower plates. On 09/15/15 at 3:45 PM Resident #3 was observed sitting in the hallway. He was observed to have decayed front teeth, as well as multiple broken and chipped teeth. On 09/14/15 at 11:50 AM an interview was conducted with Resident #3. He stated he had a lot of bad teeth and needed to see the dentist. Resident #3 denied pain or difficulty eating. On 09/15/15 at 4:25 PM an interview with Resident #3 revealed he was told by the Social Worker that he had a dental appointment scheduled, but he had not heard anything else. On 09/17/15 at 9:50 AM an interview conducted	F 272	include documentation of findings with a description of the problem, causes, contributing factors and risk factors related to a fall risk in the Fall CAA. The dental status of residents will be assessed during each MDS in review during the ARD of the MDS look back period by the MDSC or Unit Manager. If the resident refuses a dental exam, then the physician will be notified to complete the exam. Any dental issues identified will be documented in the progress note and directed to the dentist or will be referred to the outside dentist. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The MDS Consultant will audit 5 residents¿ comprehensive MDS to ensure the Fall CAA includes documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to a fall risk in the Fall CAA. The MDS Consultant will audit 5 residents¿ MDS to ensure the resident¿s dental status is correctly coded on the MDS. ¿ 1 time a week for 4 weeks ¿ Twice a month for 1 month ¿ Monthly for 4 months Any issues identified on the audits will be	

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F 272	Continued From page 20 with the Social Worker indicated Resident #3 had a dental appointment scheduled for October 1st. She stated he had been scheduled earlier, but the facility's dental provider had changed, and he was rescheduled. She revealed she had instructed Resident #3 of his new appointment date. On 09/18/15 at 7:55 AM an interview was conducted with the MDS nurse. She stated when she does an MDS assessment on a resident she inspects their mouth and teeth, and makes any notes with regards to dentition and dental needs. The MDS nurse revealed if the resident was interviewable, she would ask them if they had any dental issues, dentures, pain, and problems with chewing or swallowing. The MDS nurse was shown Resident #3's dental assessment and the lack of documented dental issues and needs. She indicated she did not know what happened with Resident #3's dental assessment. The MDS nurse stated he may have been out of the building when she went to assess him, and she intended to check him later. She stated that was what she would normally do, but it was missed. On 09/18/15 at 11:00 AM an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that residents are properly assessed and acknowledged that Resident #3 had not been properly assessed for his dental needs.	F 272	immediately corrected with coaching/discipline as needed to the MDSC. The issue will be reviewed and discussed within the QA program. If compliant with schedule, then audit will be conducted as needed.	
F 278 SS=D	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	F 278		10/16/15

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F 278	Continued From page 21 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 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 staff interviews and medical record review, the facility inaccurately assessed 2 of 24 sampled residents on the minimum data set assessments (MDS). The MDS for Resident #20 incorrectly documented a stage 2 pressure sore and the MDS for Resident #19 did not document the assessment of, or the treatment for, an excoriated peri area. The findings included: 1. Resident #20 was admitted to the facility on 03/25/15. Diagnoses included cancer, diabetes	F 278	F278 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: MDSC modified resident¿s #19 and #20 MDS Section M to correct coding of their skin impairment. Resident #20¿s Admission MDS ARD 4/1/15 was modified on 10/6/15 to remove Stage II pressure ulcer as documentation during the look back period revealed ¿old shearing to the	

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mellitus II, and protein calorie malnutrition, among others.

Review of an admission nursing assessment dated 03/25/15 documented Resident #20 was admitted with old shearing to the left buttock with the application of physician prescribed topical treatment. There was no documentation of a pressure ulcer.

A nurses' note dated 03/28/15 documented that Resident #20 was assessed on admission with a 2.5 centimeter pink old scar noted on the buttocks. The scar was covered with a protective dressing.

A weekly skin assessment for Resident #20 dated 04/01/15 documented that her skin was assessed with "no new skin problems noted."

Review of an admission MDS dated 04/01/15 revealed Resident #20 was assessed with intact cognition and a stage 2 pressure sore present on admission.

During an interview on 09/17/2015 at 4:01 PM, MDS nurse #1 stated that nurse's notes, physician's progress notes, skin assessments and wound records dated 03/25/15 - 04/01/15 should have been reviewed as part of the admission MDS assessment for Resident #20. The MDS Coordinator #1 stated she could not find documentation to support that Resident #20 had a stage 2 pressure ulcer during the review period of 03/25/15 to 04/01/15 for the admission MDS. The MDS nurse who completed this assessment was not available for interview.

During an interview on 09/17/15 at 4:15 PM with

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left buttock¿ and to remove pressure ulcer with pressure ulcer care. Documentation during the look back period did not indicate a stage II pressure ulcer.
Resident #19, 7/30 Quarterly MDS was modified on 10/6/15 to code MASD and skin treatment as documentation during the look back period revealed excoriated perineum area.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

By October 15, 2015, all current resident¿s skin assessments will be reviewed along with the most recent MDS to ensure Section M was coded accurately. Any issues identified as being coded incorrectly, were modified by the MDSC for any coding errors identified in the audit and Unit Manager/Admission Nurse to update patient assessment as needed.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:
On October 5, 2015, the Nurse Consultant and MDSC Consultant provided education to the MDSC that the items coded in section M must have supporting documentation from residents medical records and documentation during the look back period of the ARD of the MDS. The MDSC will review the resident¿s medical records for correct documentation

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F 278	Continued From page 23 the nurse consultant, he stated that based on the admission nursing assessment and weekly skin assessments, the admission MDS for Resident #20 documented in error that Resident #20 had a stage 2 pressure ulcer. 2. Resident #19 was admitted to the facility on 03/01/13. Diagnoses included chronic urinary tract infections, urinary incontinence and diabetes mellitus II, among others. A weekly skin assessment and a nurse's note, both dated 07/27/15, documented Resident #19 received a topical protective cream, per physician's order, for an excoriated peri area each shift with incontinence care. Review of the July 2015 treatment administration record revealed Resident #19 received a topical cream each shift for peri area excoriation, as ordered. Review of a quarterly minimum data set (MDS) dated 07/30/15 revealed Resident #19 was assessed with intact cognition and frequently incontinent of bladder. The MDS did not assess Resident #19 with moisture associated skin damage (MASD) related to bladder incontinence, perspiration, or drainage. An interview occurred on 09/18/2015 at 12:34 PM with MDS nurse #1 and revealed that she completed the quarterly MDS dated 07/30/15 for Resident #19. MDS nurse #1 stated that she reviewed nurse's notes, treatment records, physician's progress notes and weekly skin assessments dated 07/23/15 to 07/30/15 when she completed the assessment. MDS nurse #1	F 278	any wounds, pressure ulcer, or other issues prior to the ARD. If any skin discrepancies are noted, then MDSC to notify DON or Unit Manager of the discrepancy. MDSC and DON or Unit Manager will assess the skin impairment to ensure the wound, pressure ulcer or other skin issues are accurately documented on the weekly skin and wound reports to support correct coding on the MDS. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The MDS Consultant will audit 5 residents¿ MDS who are coded as having a wound, pressure ulcer, or other skin impairment and are actively receiving treatment for their skin issues match the documentation from the residents¿ medical records: ¿ Weekly for 4 weeks ¿ Twice a month for 1 month ¿ Monthly for 4 months Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. The issue will be reviewed and discussed within the QA program.	

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F 278	Continued From page 24 further stated that the quarterly MDS of 07/30/15 should have assessed Resident #19 for the peri area excoriation and the use of a topical cream for treatment as ordered by the physician.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a care plan which included measurable goals and individualized interventions regarding the use of psychoactive medications for 1 of 6 sampled residents reviewed who received psychoactive medications (Resident #30).	F 279	F279 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: On October 5, 2015, the MDSC updated	10/16/15

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F 279	Continued From page 25 The findings included: Resident #30 was admitted to the facility on 08/04/15 with diagnoses which included chronic obstructive pulmonary disease, anxiety and atherosclerotic heart disease. Admission medications included Haldol (an antipsychotic) 1 milligram (mg.) by mouth every 8 hours. Review of Resident #30's admission Minimum Data Set (MDS) dated 08/11/15 revealed an assessment of intact cognition with no behavior problems. The MDS indicated Resident #30 received antipsychotic medications. Review of Resident #30's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/17/15 revealed a decision to proceed to care plan to minimize the risks of Haldol use. Review of Resident #30's care plan dated 08/25/15 revealed the use of Haldol was not included. There were no goals or interventions documented regarding the use of the antipsychotic medication. Interview with the MDS Coordinator on 09/17/15 at 2:23 PM revealed she did not address Resident #30's use of Haldol in the care plan. The MDS Coordinator reported the psychotropic medication should be included in the care plan and the omission was an error. Interview with the Director of Nursing (DON) on 09/17/15 at 2:49 PM revealed she expected Resident #30's care plan to include goals and interventions for the administration of psychotropic medication.	F 279	residents¿ #30 care plan for the use of antipsychotic medication. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All medical records for current residents receiving an anti-psychotropic medication will be audited by October 15, 2015 to ensure that their anti-psychotropic medication was coded correctly on their most recent comprehensive MDS and care planned as indicated in the CAA. The MDS¿s were modified by the MDSC for any coding errors identified in the audit, and completed by October 15, 2015. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: On 9/17/15, the MDSC Consultant provided education to the MDSC that any Care Area Assessment including Anti-psychotropic medication indicated as care planned were addressed in the resident¿s care plan updated. On comprehensive MDS¿s, any resident who are receiving anti-psychotropic medication will care plan medication if the CAA addressed that the item will be care planned. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How facility will monitor corrective	

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F 279	Continued From page 26	F 279	action(s) to ensure deficient practice will not re-occur: The MDS Consultant will audit 5 residents¿ comprehensive MDS who are receiving anti-psychotropic medication to ensure the item was care planned if the CAA addressed that the item will be care planned for the schedule listed below. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. ¿ 1 time a week for 4 weeks ¿ Twice a month for 1 month ¿ Monthly for 1 month Audits will be reviewed by QA&A Committee monthly x4 to ensure continued compliance/revisions to the plan if needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interview and medical record review the facility failed to assess the need for positioning devices, monitor and reposition a resident to maintain a	F 309	F309 1. How corrective action will be accomplished for each resident found to have been affected by the deficient	10/16/15

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Continued From page 27

comfortable upright wheel chair position for 1 of 3 sampled residents reviewed for positioning. (Resident #76)

The findings included:

Resident #76 was admitted to the facility on 07/30/12. Diagnoses included Alzheimer's disease, rheumatoid arthritis, dementia, hand contracture, difficulty walking, general muscle weakness, and a history of falls, among others.

A quarterly minimum data set dated 07/11/15 assessed Resident #76 with severely impaired cognition, requiring extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, wheel chair used as the primary mobility device, impaired range of motion on both sides and unsteady balance.

A care plan, revised 08/06/15 documented Resident #76 had self care performance deficits for activities of daily living (ADL), which included mobility, transfers and positioning; the potential for pain and alteration in comfort. Interventions included staff to provide extensive to total ADL assistance, which included assistance with mobility/positioning for comfort.

Resident #76 was observed on 09/15/15 at 10:37 AM and on 09/16/15 at 10:05 AM seated in her wheel chair at the nurse's station leaning to the left side without support for an upright position.

Resident #76 was observed on 09/16/2015 at 12:55 PM in the main dining room being fed lunch by a family member. Resident #76 was observed leaning to the left without support for an upright position. Her pelvic area was positioned forward

F 309

practice:

¿ Resident #76 was positioned in wheelchair using leg rest on 9/17/2015.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

¿ An audit of the in-house patients by Occupational Therapy of all patients utilizing a wheelchair have proper positioning devices in place by October 15, 2015. If a device is needed then therapy will apply and notify nursing so that device can be added to Kardex.

3. Measures to be put in place or systemic changes made to ensure practice will not
Reoccur:

- Nursing and therapy education provided on patient positioning and submitting screens for positioning. Physical Therapy or Occupational therapy or designee will make weekly rounds to ensure that patients in wheelchairs remain positioned correctly. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

- Physical Therapy or Occupational therapy or designee will make weekly

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F 309	Continued From page 28 in her wheel chair, close to her seat's edge and her legs/feet were straight out in front of her. The family member stated during the observation that Resident #76 had wheel chair positioning devices and leg rests used at times to help her maintain an upright wheel chair position. Resident #76 was observed on 09/16/15 at 4:30 PM seated in her wheel chair at the nurse's station with her head hanging down and her eyes closed. Resident #76 was leaning to the left with her pelvic area positioned forward, close to her seat's edge and her legs/feet straight out in front of her. An interview with nurse aide #4 (NA #4) and observation of Resident #76 occurred on 09/17/15 at 2:45 PM. Resident #76 was observed seated in her wheel chair leaning to the left without support for a comfortable upright position. Her pelvic area was positioned forward in her wheel chair, close to her seat's edge and her legs/feet were straight out in front of her. NA #4 stated that she worked with Resident #76 for the past 4 months and noticed that Resident #76 always leaned to the left in her wheel chair. NA #4 stated that was the Resident's usual wheel chair position. NA #4 stated Resident #76 required extensive to total staff assistance with ADL including positioning. NA #7 also stated that she recalled attempting to apply one leg rest to the Resident's wheel chair in the past, but the leg rest did not fit the wheel chair and currently leg rests were not used for Resident #76. NA #4 did not attempt to reposition Resident #76 at the time of this observation. An interview with NA #7 and observation of Resident #76 occurred on 09/17/15 at 2:50 PM.	F 309	rounds to ensure that patients in wheelchairs remain positioned correctly. ¿ weekly x4 ¿ every other week x one month ¿ monthly x2. Audits will be reviewed by DON or designee and reported to QA&A Committee monthly x4 to ensure continued compliance/revisions to the plan if needed.	

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F 309	Continued From page 29 Resident #76 was noted leaning to the left without support for a comfortable upright position. Her pelvic area was positioned forward in her wheel chair, close to her seat's edge and her legs/feet were straight out in front of her. NA #7 stated that she used to provide nursing care for Resident #7 routinely, but recently she was on leave for a few months and just returned. NA #7 stated Resident #76 required extensive to total staff assistance with ADL, including positioning. NA #7 also stated that Resident #76 had always leaned to the left in her wheel chair, but now appeared to lean more. NA #7 was not aware of any positioning devices used for Resident #76 to keep her comfortably upright and did not attempt to reposition the Resident at the time of the observation. An interview with the rehab manager and observation of Resident #76 occurred on 09/17/15 at 2:51 PM. Resident #76 was in her wheel chair leaning to the left without support for a comfortable upright position. Her pelvic area was positioned forward in her wheel chair, close to her seat's edge and her legs/feet were straight out in front of her. Resident #76 was asked if she was comfortable in her wheel chair and shook her head side to side. The rehab manager stated that Resident #76 was recently on therapy caseload for contracture management, but not for wheel chair positioning. The rehab manager stated that elevated leg rests, when applied, did assist Resident #76 to be in a more upright position in her wheel chair, but were not used routinely, because in the past, Resident #76 used her feet to propel in her wheel chair at times. The rehab manager stated that Resident #76 was dependent on staff for wheel chair positioning. She expressed that nursing staff should monitor her and reposition her to keep her upright; if an	F 309		

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F 309	Continued From page 30 upright position could not be maintained, Resident #76 should be referred to therapy for wheel chair management. The rehab manager was observed to apply 2 elevated leg rests to the wheel chair of Resident #76 which positioned the Resident upright and without leaning to the left. Resident #76 was asked again, after she was repositioned in her wheel chair with elevated legs rests, if she was comfortable and she shook her head up and down. An interview occurred on 09/17/2015 at 2:59 PM with nurse #6. Nurse #6 stated that Resident #76 did lean to the left in her wheel chair, at times and also slid forward as the day progressed "as she gets tired." Nurse #6 stated she expected the nurse aides to monitor the wheel chair position for Resident #76 and if she was observed leaning or positioned forward in her wheel chair, staff should reposition her upright or offer to lay her down in bed for comfort. An interview occurred on 09/17/15 at 3:01 PM with nurse #7 who stated Resident #76 typically leaned to the left with her pelvic area seated close the edge of her wheel chair seat. Nurse #7 Also stated Resident #76 was dependent on staff for repositioning and mobility and she had not known Resident #76 to use positioning devices to assist her with a more upright position. An interview occurred on 09/17/2015 at 3:29 PM with NA #8 who stated she worked with Resident #76 for the prior 2 years. NA #8 stated that Resident #76 did lean to the left in her wheel chair at times and she required staff's assistance to reposition her upright in her wheel chair. An interview occurred on 09/18/2015 at 1:57 PM	F 309		

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F 309	Continued From page 31 with occupational therapist #1 (OT #1) and revealed Resident #76 was discharged from OT services for contracture management on 09/16/15. OT #1 stated Resident #76 was not referred for wheel chair positioning and she had not noticed wheel chair positioning problems for Resident #76 during her therapy sessions. OT #1 stated that Resident #76 did not bend her legs and at times elevated leg rests were used to assist her with an upright position, but that the Resident did not use the elevated leg rests consistently. The OT #1 stated Resident #76 should be evaluated for wheel chair positioning to determine what devices, if any would be necessary to maintain the Resident in an upright position.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review the facility failed to safely transfer Resident#54 who was lowered to the floor and sustained a fracture for 1 of 4 sampled residents reviewed for accidents. The findings included: Resident #54 was admitted to the facility on	F 323	F323 1. How the corrective action will be accomplished for the resident(s) affected: CNA was re-educated and counselled on Mechanical Lifts requiring 2 person transfer as care plan indicated. Sit to Stand Lift removed from the hall and	10/16/15

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F 323	Continued From page 32 01/26/12 with admitting diagnoses of chronic obstructive pulmonary disease, hypertension and acute renal failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated 05/29/15 revealed Resident #54 was cognitively intact and required extensive assistance with bed mobility and transfers and one person assist for transfers. A review of the MDS revealed Resident #54 had no previous falls since prior assessment. Review of Resident #54's Nursing notes revealed the following: A nursing progress notes dated 08/24/15 revealed while resident was being changed the resident started to shake while on the lift. The progress note further revealed NA#1 lowered resident to the floor, to prevent resident from falling. On 08/25/15 at 7:48 AM revealed Resident #54 had a status post fall due to being lowered to the ground from the hoyer lift. The nurse's notes further revealed an x-ray was ordered due to pain. A nurses notes dated 08/25/15 at 9:28 AM revealed Resident #54 right knee was swollen but had no redness. A change of condition nurse's note dated 08/25/15 at 10:57 AM revealed x-ray results received and Resident #54 had right knee fracture and Resident #54 was sent out to hospital for evaluation. Review of nurse's notes dated 08/25/15 dated 11:10 AM revealed 911 dispatch called to transport resident to hospital for evaluation per	F 323	placed out of service. 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: Re-educate CNA/Nursing staff on lifting techniques completed by October 19, 2015. The lift had new slings ordered and will remain out of service until new slings arrive. 3. Measures in place to ensure practices will not occur: Daily incident reports for falls associated with mechanical lifts will be reviewed to ensure mechanical transfers had two people present, by the Unit Manager/DON. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How the facility plans to monitor and ensure correction is achieved and sustained: Audit all falls associated with the use of mechanical lifts for 3 months and if needed, re-educate or provide written counselling for not following transfer techniques for mechanical lifts. These audits will be presented to the Quality Assurance Committee for review and modification if needed.	

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F 323	Continued From page 33 verbal order from NP. Nurse's note on 08/25/15 at 11:25 AM revealed Resident #54 was transported by Emergency Medical Services to the hospital. Review of an x-ray report dated 08/25/15 revealed a right distal femur fracture (knee). Review of the Incident/Accident report documented on 08/24/15 at 9:45 PM recorded in part, that the assigned nurse aide (NA) informed the nurse that she was transferring Resident #54 using a sit to stand lift. During the transfer Resident #54 started to shake. The NA stated, "I lowered resident (Resident #54) to floor so she would not fall." When the nurse entered the room, she observed Resident #54 lying on the floor beside her bed. Resident #54 was asked what happened and stated, "I did not fall, she put me on the floor". Review of the physician consult document dated on 09/02/15 revealed Resident #54 had a femur fracture. On 09/16/15 at 10:20 AM an interview was conducted with Resident #54 related to the fall she experienced on 08/24/15. Resident #54 stated on 08/24/15 she was out of bed sitting in her wheelchair in her room. Resident #54 stated she mentioned to NA #1 she was ready for bed and needed to be changed. Resident #54 stated she was transferred to the lift only by one NA#1. Resident #54 explained she was not able to stand for a long period of time on the lift due to her knees getting weak. Resident #54 revealed after her knees gave out she was lowered to the floor. Resident #54 further stated two staff members always assisted with her transfers. Resident #54 stated she believed her fall could have been	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING ______ B. WING ______	C 09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 34 avoided if NA#1 would have requested for another staff member to assist her with the transfers. During the interview, Resident #54 stated they conducted x-rays and explained she was admitted to the hospital the next day for a femur fracture. Interview with Nurse Aide (NA) #1 on 09/16/15 at 3:55 PM revealed Resident #54 was alert and oriented. She explained Resident #54 requested to be put back to bed. She stated when Resident #54 was on the sit to stand lift she started shaking and she became nervous and lowered Resident #54 closer to the edge of the bed and she was lowered to the floor. NA#1 stated Resident #54 required a two person assist but could not find staff to assist and she transferred Resident #54 without the proper assistance. NA#1 explained she was re-educated after Resident #54's fall that two staff members were required to assist with lift transfers. A telephone interview was conducted on 09/17/15 at 3:05 PM with Nurse#1. She stated Resident #54 was alert and oriented. She stated she was working on 08/24/15 the night Resident #54 fell. She stated she didn't witnessed the incident. She stated she was called to the room to assess Resident #54 after a reported fall. She explained Resident #54 should not been transferred with one person assist. During the interview, Nurse #1 reported Resident #54 required two person assist when using the sit to stand lift. She further stated NA#1 should have waited until someone was available to assist her and should not have transferred the resident alone. Interview with Nurse#2 was conducted on 09/17/15 at 3:55 PM stated she was informed	F 323		

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F 323	Continued From page 35 NA#1 transferred Resident #54 with one person assist on 08/24/15. Nurse#2 stated she was made aware of the incident by Nurse#1 the same night the accident occurred. During the interview, Nurse #2 stated she was aware Resident #54 was lowered to the floor. Nurse #2 stated Resident #54 required two people to assist with transfers. Interview conducted with Director of Nursing (DON) on 09/17/15 at 4:04 PM stated NA#1 transferred Resident #54 with a one person assist. The DON explained NA#1 was re-educated and counseled on mechanical lifts requiring two person transfer. During the interview, she stated the mechanical device would remain out of order until all staff were trained on all three shifts. She further stated the expectation is for staff to use two person assist for the lifts to help prevent any further injuries.	F 323		
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.	F 520		10/16/15

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F 520	Continued From page 36 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 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, 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 October of 2014. This was for a recited deficiency which was originally cited in September of 2014 on a recertification survey and on the current recertification survey. The deficiency was in the area of dignity and respect. 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 cross referred to: F 241: Dignity and Respect: Based on observations, resident interviews (Residents #47 and #2), staff interviews, and record reviews the facility left 1 of 1 resident exposed after wound care (Resident #5); the facility provided disposable cups to residents during 3 of 4 meals observed.; and 3 of 8 residents who required	F 520	F520 1. How the corrective action will be accomplished for the resident(s) affected: F241 ¿ See associated tag for individual interventions 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: Individual actions denoted on said area for citations F-241. 3. Measures in place to ensure practices will not re-occur: Education provided to Facility Administration by Corporate Consultant on QA process and it¿s relation to Plan of Correction by October 15, 2015. Administrator, DON, Unit Manager, or designee will ensure completion of audits for F241 on Mondays, Wednesday and Fridays for a period of 2 months, then	

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F 520	Continued From page 37 assistance with dining were not fed at eye level by staff. (Residents #166, #188, and #43). The facility was recited for F 241 when a resident was left exposed after wound care, staff failed to provide non-disposable cups to residents and failed to feed residents at eye level during dining. F 241 was originally cited during a recertification survey in September 2014 for the facility's failure to remove food dropped on a resident's hospital gown. An interview with the administrator on 09/18/2015 at 2:18 PM revealed that since the recertification survey in September 2014, the facility had experienced significant staff turnover, which included both nursing and administrative staff. The administrator stated that both she and the Director of Nursing were new to the facility and they were currently in the process of developing systems for better communication between staff, better coordination of resident care and implementing nurse management on all shifts. The administrator further stated that F 241 had not remained corrected more than likely due to a lack of checks and balances, staff turnover in administration and leadership on the nursing units for monitoring.	F 520	every Wednesday x10 months. Tag will be discussed during morning meeting Monday-Friday and documented by Administrator/designee. 4. How the facility plans to monitor and ensure correction is achieved and sustained: The Administrator/DON will present audits to QA&A monthly times 12 months for review and revision as needed. This time frame can be extended at the discretion of the Administrator/DON based on findings of audits.	