STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 157 SS=B	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident, family and staff interviews, the facility failed to notify responsible party of new medications ordered by	F 157	1. Resident #58's responsible party was notified of all recent orders by the Director of Clinical Services of all new orders	10/30/15

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

Electronically Signed | 10/24/2015

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F 157	Continued From page 1 the physician and that speech therapy was being initiated (Resident #58) and failed to notify a resident of a new roommate (Resident #18) for two of two sampled residents reviewed for notification. The findings included: 1a. Resident #58 was admitted to the facility 11/21/13. Cumulative diagnoses included dementia. A Quarterly Minimum Data Set (MDS) dated 8/6/15 indicated Resident #58 was severely impaired in cognition. A family interview was conducted on 10/5/15 at 4:03PM. The family member was Resident #58's legal guardian and was the responsible party to be notified of any changes in condition, treatments and/or medications. She stated she was not notified when any medications/ treatments were initiated or changed. A review of the physician orders revealed a physician's order dated 7/28/15 for Ketoconazole 2% cream (antifungal cream), apply to rash/ scaly areas on forehead/ face twice daily x two weeks. Nursing progress notes were reviewed and revealed no documentation that the responsible party was notified of the new medication. On 10/6/15 at 3:10PM, Nurse #1 stated nursing staff notified the responsible party any time there were new physician's orders, a change in resident condition and/or changes in treatment. She stated documentation that the responsible party/ family was notified would be noted in the nursing progress note section of the medical record.	F 157	within the past 6 months on 10/9/2015. Resident #18 suffered no harm related to not having been notified of a new roommate. Resident and Roommate are getting along well. 2. All residents residing in the facility have the potential to be affected. A record review was completed by the Director of Clinical Services and Nursing Staff on 10/27/15 to identify any new orders written in the past 30 days and the resident and/or responsible party were notified by the Director of Clinical Services on 10/27/15 if this notification was not documented. The director of Nursing documented any notifications. 3. The Director of Clinical Services reeducated Nurses currently employed by 10/30/15 on the requirements to notify the resident and/or the responsible party of any changes in the resident's condition including but not limited to medications, therapy, mental status and physical status. Nurses were also educated that upon notification the nurse must document in the nurses notes that notification has been completed. Any nurse who did not received the training will receive the training prior to the next scheduled shift. The Director of Clinical Services reeducated the Social Worker and the Admission Persons by 10/30/15 regarding the use of the Room Change Notification Form to be completed prior to any room change which documents notification of the room and roommate changes.	

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F 157	Continued From page 2 On 10/6/15 at 3:15PM, Administrative staff #1 stated she expected nursing staff to notify family of any medication changes, order changes and/or medical condition changes at the time medications, treatments and/or resident condition changed. On 10/6/15 at 3:35PM, Nurse #2 was interviewed via telephone. She stated the family/ responsible party would be notified of any physician orders and documentation would be done in the nursing notes. She stated she noted the order for Ketoconazole on 7/28/15 and she should have documented in the nursing notes if she had notified the family of the physician order. 1b. Resident #58 was admitted to the facility 11/21/13. Cumulative diagnoses included dementia. A Quarterly Minimum Data Set (MDS) dated 8/6/15 indicated Resident #58 was severely impaired in cognition. A family interview was conducted on 10/5/15 at 4:03PM. The family member was Resident #58's legal guardian and was the responsible party to be notified of any changes in condition, treatments and/or medications. She stated she was not notified when any medications/ treatments were initiated or changed. A review of the physician's orders revealed a physician's order dated 6/23/15 for speech therapy for evaluation and treatment and a clarification order also dated 6/23/15 speech therapy intervention five times a week x two weeks for diagnosis of dysphagia (difficulty swallowing) to include swallow functions, oral	F 157	The third shift nurses will review each resident's medical record each night to validate that all orders written have corresponding documentation of notification. The Director of Clinical Services will be notified of any discrepancies and will make the necessary notifications and document. 4. The Executive Director, Director of Clinical Services, or Nurse Manager will complete Quality Improvement monitoring of 5 random resident records for documentation of notification of order changes and/or room changes 5 times a week for 2 months, then 3 times weekly for 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	

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F 157	Continued From page 3	F 157		

care and staff education.

A review of the nursing notes and speech therapy notes revealed no documentation that the responsible party was notified of the initiation of speech therapy.

On 10/6/15 at 3:10PM, Nurse #1 stated nursing staff notified the responsible party any time there were new physician's orders, a change in resident condition and/or changes in treatment. She stated documentation that the responsible party/ family was notified would be noted in the nursing progress note section of the medical record. She stated that therapy staff would notify the responsible party/ family if they were providing treatment for a resident.

On 10/6/15 at 3:15PM, Administrative staff #1 stated she expected nursing staff to notify family of any medication changes, order changes and/or medical condition changes at the time medications, treatments and/or resident condition changed. She stated therapy staff would communicate with the family regarding therapy services.

On 10/06/15 at 3:19PM, the physical therapy rehabilitation director stated she did not know if therapy services notified family members when a resident was receiving therapy services. She stated they notified the physician but did not notify family/ responsible party when services were initiated.

Attempts were made on 10/6/15 at 3:40PM and 10/7/15 at 9:14AM to speak to the nurse who transcribed the speech therapy consult order and messages were left with no return call.

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F 157	Continued From page 4 2. Resident #18 was admitted to the facility on 5/4/12 with multiple diagnoses including Depressive Disorder. The quarterly Minimum Data Set (MDS) assessment dated 7/21/15 indicated that Resident #18's cognition was intact. On 10/5/15 at 3:04 PM, Resident #18 was interviewed. She indicated that she had several roommates in the past and she had not been informed every time a new roommate was placed in her room. She added that the last time she had a new roommate was in July, 2105. On 10/6/15 at 11:20 AM, administrative staff # 2 was interviewed. She indicated that the facility had no social worker at the moment. She indicated that the social worker had left the facility in August, 2015 and she had been filling in as a social worker. She acknowledged that the roommate of Resident #18 was transferred to her room on July 9, 2015. She revealed that the facility didn't have a policy in informing the resident of a new roommate but she would inform the social worker (who ever will be hired) to notify the resident of a new roommate and to document the notification in the records.	F 157		
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		10/30/15

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure a resident had clean, dry linens while resting in bed for 1 (Resident #63) of 1 sampled resident ' s. Findings included: Resident #63 was admitted 5/28/13 and had cumulative diagnoses including dementia, glaucoma and anxiety. Review of the Care Plan dated last updated 4/20/15 revealed a plan of care for " Incontinence and Pressure and " Activities of Daily living " assistance. Review of the Quarterly Minimum Data Set (MDS) dated 7/12/15 revealed the resident was cognitively impaired. On 10/7/15 interview with Nursing Assistant #2 (NA #2) at 4:26 PM revealed that on 9/14/15 she worked the 3 PM - 11 PM shift and was Resident #63 ' s assigned Nursing Assistant (NA). She added that NA #3 was the assigned NA for Resident #63 on the 7 AM - 3 PM shift that day and that she believed this was that day that she had found Resident #63 ' s bed sheets wet through to the mattress. NA #2 stated that while she was giving Resident #63 incontinent care for the first time that shift, at 6 PM and with a family member present, she rolled the resident over and noticed that under the dry incontinent pad the resident ' s sheets were soaked through to the mattress cover. She added that once she got the mattress cover off she saw that the mattress was also wet. NA #2 stated that she cleaned the resident ' s bed, made it with clean linens and repositioned the resident. NA #2 said Resident #63 did not seem that bothered by her wet sheets. NA #2 also said she reported the incident	F 241	1. Resident #63 no longer resides in the facility. 2. All residents residing in the facility have the potential to be affected. Each bed in the facility was checked by the Director of Clinical Services and the Nurse Manager to ensure all linens were clean and dry on 10/8/2015. 3. The Director of Clinical Services reeducated facility staff currently employed by 10/30/15 on dignity (wet/soiled linens) and checking and changing linens on rounds as well as reporting any questionable dignity issue to a facility department head. Any facility staff member who has not received the training prior to 10/30/15 will be unable to work until training in completed. 4. The Executive Director, Director of Clinical Services, Nurse Manager or Customer Care Liaison will complete quality improvement monitoring of 5 random resident rooms to ensure linens are clean and dry 5 times a week for 2 months, then 3 times weekly for 4 weeks, then 1 time weekly for 2 months and may continue in the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement monitoring form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance and Performance Improvement Committee monthly.	

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F 241	Continued From page 6 to Nurse #4. On 10/7/15 at 4:36 PM interview with Nurse #4 revealed she did recall this incident being reported to her and said that the resident was immediately changed. Nurse #4 said she probably reported the incident to Nursing Management but she wasn ' t sure. On 10/7/15 at 5 PM interview with Administrative Staff #4 revealed that neither she nor Administrative Staff #1 had been aware of the above incident on 9/14/15. She stated that Nurse #4 should have reported it on the 24 hour report so that it would have been reviewed in the stand-up meeting the following morning. Administrative Staff #4 added that they would have gotten written statements from both NA #2 and NA #3 as well as Nurse #4. She stated suspended on the circumstances they may also have NA #3 and conducted a neglect investigation. On 10/7/15 at 5:10 PM a call was placed to NA #3 for interview however the telephone number was out of service.	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.	F 242		10/30/15

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F 242	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interviews, the facility failed to allow 2 (Residents # 68 & # 27) of 2 sampled residents, who were evaluated as a safe smoker, to smoke anytime. The findings included: 1. Resident #68 was admitted to the facility on 10/13/14 with multiple diagnoses including major depressive disorder. The care area assessments (CAAS) dated 10/2014 indicated that Resident #68 enjoyed reading and smoking. The quarterly Minimum Data Set (MDS) assessment dated 8/20/15 indicated that Resident #68 had moderate cognitive impairment and had no behavioral symptoms. On 5/13/15 and 9/15/15, Resident #68 was evaluated as a safe smoker by administrative staff #1. On 10/5/15 at 3:25 PM, Resident #68 was observed near the door to the designated smoking area waiting for the staff to take her to smoke. At 3:30 PM, the resident was observed smoking with a staff member. On 10/7/15 at 8:56 AM, Resident #68 was interviewed. She stated that she had asked to smoke outside the smoking times which were 6:30 AM, 9:30 AM, 11:30 AM, 1:30 PM, 3:30 PM, 6:30 PM and 9:30 PM but she was told to stick to the scheduled smoking times. On 10/7/15 at 10:50 AM, administrative staff #1 was interviewed. She acknowledged that she had evaluated Resident #68 as a safe smoker but	F 242	1. Resident #27 was re-assessed and deemed to be a safe smoker on 10/9/15 by the Director of Clinical Services. Resident #68 was re-assessed on 10/9/15 and deemed to be unsafe to smoke without proper supervision by the Director of Clinical Services. 2. All residents residing in the facility that smoke have the potential to be affected. All additional smokers residing in the facility on 10/9/15 were re-assessed by the Director of Clinical Services. 3. The Director of Clinical Services reeducated the nursing and administrative staff by 10/30/15 on the right to make choices concerning safe smoking. Any resident deemed as a safe smoker may go out to smoke as he/she desires as long as it is not impending on the resident's treatment regimen. Any nursing or administrative staff that has not received the Right to Make Choices safe smoking education prior to 10/30/15 will be unable to work until he/she has received the Right to Make Choices concerning safe smoking education. 4. The executive Director, Director of Clinical Services, or Nurse Manager will complete Quality Improvement monitoring of each safe smoker residing in the facility to ensure that they are able to smoke freely. Monitoring will be done 5 times a week for 2 months, then 3 times weekly for 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Performance Improvement Committee determines	

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F 242	Continued From page 8 she did not want her to smoke unsupervised due to safety reasons. On 10/7/15 at 11:00 AM, Resident #68 was again observed waiting for the smoking time near the door to the designated smoking area. At 11:30 AM, the resident was observed smoking with a staff member. 2. The Smoking Policy dated 11/30/14 stated a resident would be allowed to smoke without supervision if he or she was determined to be a safe smoker. A review of the Resident Smoking Times was conducted. The document stated " All smokers please meet at the door on E Hall and a staff will accompany you out to the covered smoking area with your smoking paraphenalial. " Resident #27 was admitted to the facility on 9/26/14 and readmitted on 11/12/14. A review of the Minimum Data Set dated 7/13/15 revealed the resident was assessed as being cognitively intact. The Plan of Care indicated Resident #27 was assessed for smoking safety. The interventions included to provide scheduled staff supervised smoking times. The Safe Smoking Evaluation dated 10/5/15 was reviewed. Resident #27 was determined to be a safe smoker. An interview was conducted with Administrative	F 242	additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance and Performance Improvement Committee monthly.	

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F 242	Continued From page 9 Staff #1 on 10/7/15 at 1:25 PM. She stated Resident #27 was determined to be a safe smoker. She stated the resident would have been allowed to smoke without supervision if he desired to do so. Administrative Staff #1 stated the residents were not allowed to smoke unsupervised due to safety concerns. An interview was conducted with Resident #27 on 10/7/15 at 2:00 PM. The resident stated the facility had not offered to allow him to smoke unsupervised. The resident stated he would have liked to smoke unsupervised.	F 242		
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 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	F 278		10/30/15

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F 278	Continued From page 10 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, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments under the area of smoking for 2 (Residents # 68 & 27) of 2 sampled residents who smokes and the actual height and weight for 3 (Residents # 79, #77 & #74) of 3 sampled residents. Findings included: 1. Resident #68 was admitted to the facility on 10/13/14 with multiple diagnoses including major depressive disorder. The admission Minimum Data Set (MDS) assessment dated 10/20/14 indicated that Resident #68 was not a current smoker. The care area assessment (CAAS) dated 10/20/14 indicated that Resident #68 enjoys reading and smoking. Resident #68 had a smoking evaluation on 5/30/15 and 9/15/15. On 10/5/15 at 3:30 PM and 10/7/15 at 11:30 PM, Resident #68 was observed smoking with a staff member. On 10/7/15 at 3:10 PM, the MDS Nurse was interviewed. She stated that Resident #68 had been a smoker since admission. She indicated that the nurse who completed the admission MDS assessment in October, 2014 was no longer employed at the facility. She acknowledged that	F 278	1. Resident #68 and #27 minimum data set was corrected and coded for smoking by the minimum data set nurse on 10/23/15. Resident #79, #77 and #74 were updated with the weights and heights from admission on 10/23/15 by the minimum data set nurse. 2. All residents residing in the facility have the potential to be affected. All residents' minimum data sets were reviewed by the minimum data set nurse for discrepancies and any corrections needed were made by the minimum data set nurse by 10/30/15. 3. The regional minimum data set nurse reeducated the Minimum data set nurse on the accuracy of coding the resident minimum data set accurately for smoking by 10/30/15. Interdisciplinary team will be educated by 10/30/15 on accuracy of coding on resident minimum data sets. The Minimum data set nurse will review the minimum data set for any blanks and notify the appropriate team member to make any necessary corrections prior to submission of the minimum data set.	

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F 278	Continued From page 11 the admission MDS assessment was not accurate and the resident should have been coded as a current smoker. 2. Resident #79 was admitted to the facility on 6/12/15. The admission MDS assessment dated 6/19/15 was reviewed. The boxes for the height and weight were blank. On 10/7/15 at 3:10 PM, the MDS Nurse was interviewed. She stated that the dietary manager was responsible for entering the data on section K which included the height and the weight. The MDS Nurse also indicated that she expected the dietary manager to enter the actual height and weight and not dashes on the MDS assessment. On 10/7/15 at 3:35 PM, administrative staff #3 was interviewed. She stated that when she completed the admission assessment, the height and weight were not available so she just entered dashes on the boxes for the height and height. 3. Resident # 77 was admitted to the facility on 5/11/15. The admission MDS assessment dated 5/18/15 was reviewed. The boxes for the height and weight were blank. On 10/7/15 at 3:10 PM, the MDS Nurse was interviewed. She stated that the dietary manager was responsible for entering the data on section K which included the height and the weight. The MDS Nurse also indicated that she expected the dietary manager to enter the actual height and weight and not dashes on the MDS assessment.	F 278	4. The Director of Clinical Services or nurse manager will review each minimum data set for accuracy before it is submitted for 2 months, then complete Quality Improvement monitoring of 3 minimum data sets per week for 2 months, then 1 minimum data sets per week for 2 months and may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	

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On 10/7/15 at 3:35 PM, administrative staff # 3 was interviewed. She stated that when she completed the admission assessment, the height and weight were not available so she just entered dashes on the boxes for the height and height.

4. Resident # 74 was admitted to the facility on 4/15/15. The admission MDS assessment dated 4/22/15 was reviewed. The boxes for the height and weight were blank.

On 10/7/15 at 3:10 PM, the MDS Nurse was interviewed. She stated that the dietary manager was responsible for entering the data on section K which included the height and the weight. The MDS Nurse also indicated that she expected the dietary manager to enter the actual height and weight and not dashes on the MDS assessment.

On 10/7/15 at 3:35 PM, administrative staff #3 was interviewed. She stated that when she completed the admission assessment, the height and weight were not available so she just entered dashes on the boxes for the height and height.

5. Resident #27 was admitted to the facility on 9/26/14 and readmitted on 11/12/14.

A review of the Admission Minimum Data Set dated 10/3/14 revealed Resident #27 was not coded as a current smoker.

A review of the facility smoking list revealed Resident #27 was documented as a current smoker.

Resident #27 was observed smoking a cigarette during a supervised resident smoking activity on

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F 278	Continued From page 13 10/5/15 at 3:30 PM. An interview was conducted with the MDS Coordinator on 10/7/15 at 3:10 PM. She stated the Admission assessment was not accurate and the resident should have been coded as a current smoker.	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 record review and staff interview the facility failed to develop a care plan for care areas identified as needing a care plan on the most recent Care Area Assessment for 2 (Resident #22	F 279	1. Resident #66 no longer resides in the facility. The Director of Clinical Services developed comprehensive care plan for Resident #22 on 10/24/15, for Resident	10/30/15

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F 279	Continued From page 14 and #66) of 13 residents reviewed for comprehensive care plans, failed to care plan smoking for 1 (Resident #68) of 2 sampled residents and failed to care plan behaviors for 1 (Resident #34) of 1 sampled residents. Findings included: 1. Resident #22 was admitted to the facility on 12/1/10 and had cumulative diagnoses including dementia, failure to thrive and cardiac dysrhythmias. A review of the Annual Minimum Data Set dated 11/11/14 was conducted. The Care Area Assessment Summary revealed the resident was determined to require care plans for Cognitive Loss/Dementia, Urinary Incontinence, Nutritional Status, and Pressure Ulcer. No Care Plans were observed in the resident ' s medical record that addressed these care areas. An interview was conducted with the MDS Coordinator on 10/7/15 at 2:45 PM. She stated the care plans were not completed for Resident #22 due to staffing issues and time constraints. 2. Resident #66 was admitted to the facility on 6/18/15 with multiple diagnoses including acute renal failure, pneumonia, chronic respiratory failure, sarcoidosis, diabetes mellitus, anemia and anxiety. A review of the Admission Minimum Data Set dated 7/8/15 was conducted. The Care Area Assessment Summary revealed the resident was determined to require care plans for Activities of Daily Living, Falls, Nutritional Status, Dehydration and Fluid Maintenance, Pressure Ulcer and Psychotropic Drug Use.	F 279	#68 including an unsafe smoker requiring supervision intervention on 10/24/15, and for Resident #34 for behaviors on 10/24/15. 2. All residents residing in the facility have the potential to be affected. All residents care plans were reviewed by the minimum data set nurse and any corrections needed were made by the minimum data set nurse by 10/30/15. 3. The director of clinical services reeducated the minimum data set nurse and the Interdisciplinary Team by 10/30/15 on the accuracy of comprehensive care plans and updating care plans as needed. 4. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring of 3 random resident care plans for completeness and accuracy 5 times a week for 2 months, then 3 times weekly or 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	

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No Care Plans were observed in the resident ' s medical record.

An interview was conducted with the MDS Coordinator on 10/7/15 at 2:45 PM. She stated the care plans were not completed for Resident #66 due to staffing issues and time constraints.

3. Resident #68 was admitted to the facility on 10/13/14 with multiple diagnoses including major depressive disorder. The admission Minimum Data Set (MDS) assessment dated 10/20/14 indicated that Resident #68 was not a current smoker. The care area assessment (CAAS) dated 10/20/14 indicated that Resident #68 enjoyed reading and smoking.

The nurse's notes were reviewed. The notes dated 5/12, 5/13, 5/16 and 5/17/15 indicated that Resident # 68 was out smoking with family or with the staff.

Resident #68 was evaluated as a safe smoker on 5/30/15 and 9/15/15.

Resident #68 was observed smoking on 10/5/15 at 3:30 PM and on 10/7/15 at 11:30 AM.

The care plan for Resident #68 was reviewed. There was no care plan problem, goal and approaches for smoking.

On 10/6/15 at 4:45 PM, The MDS Nurse was interviewed. She stated that Resident #68 had been a smoker since admission. She indicated that the nurse who completed the comprehensive care plan in October, 2014 was no longer

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employed at the facility. She acknowledged that she had reviewed the resident's care plan on 2/4/15, 5/6/15 and 8/5/15 but she had missed to add smoking to the care plan.

4. Resident #34 was admitted to the facility 10/18/11. Cumulative diagnoses included: dementia, anxiety, depression and psychosis.

An Annual Minimum Data Set (MDS) dated 1/23/15 was reviewed and the Care Area Assessment (CAA) for psychotropic drugs stated NCEPS (psychiatric services) as needed for increased behaviors. This will be addressed in care plan. Resident #34 received Zoloft (antidepressant), Ativan (antianxiety), Zyprexa (antipsychotic) and Trazadone (antidepressant) as ordered with no adverse effects noted. Resident #34 had a diagnosis of dementia, psychosis, depression and anxiety. A CAA for behavioral symptoms dated 2/6/15 indicated behaviors would be care planned.

A Quarterly Minimum Data Set dated 7/18/15 indicated Resident #34 had short term and long term memory impairment and was severely impaired in cognition. Behavior continuously present for inattention and disorganized thinking. Behaviors that fluctuated were altered level of consciousness and psychomotor retardation. Physical behavioral symptoms occurred one to three days during the assessment period. Behavioral or verbal behaviors directed towards others occurred four to six days during the assessment period. Resident #34 received antipsychotic, antidepressant and antianxiety medications seven days during the assessment period.

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F 279	Continued From page 17 A review of Resident #34's care plan revealed no care plan for behaviors. Observations of Resident #34 were conducted on 10/5/15, 10/6/15 and 10/7/15. Resident #34 was up in his gerichair daily. Behaviors included yelling/ talking loudly and singing in a very loud voice in the hallway and in the dining room during meal times. On 10/7/15 at 10:40AM, Nurse #3 stated Resident #34's behaviors were usually yelling out. She stated, sometimes, Resident #34 was just singing loudly and, other times, would be yelling for a cigarette. On 10/7/15 at 9:21AM, the Minimum Data Set (MDS) Coordinator stated Resident #34 should have had a care plan in place for behaviors. She stated his behaviors included anxiousness, yelling and cursing. The MDS Coordinator reviewed the care plan for Resident #34 and stated there was a behavior care plan but nothing was marked, therefore no care plan for behaviors was in place.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		10/30/15

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F 280	Continued From page 18 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interview, the facility failed to review/revise the care plan for 2 of 8 Residents (Resident #41 for pressure ulcer and Resident #58 for falls) reviewed for care planing and failed to invite a resident to participate in care plan meetings for 2 (Resident #68 and #58) of 2 sampled Residents reviewed for care plan participation. Findings included: 1. Resident # 41 was admitted to the facility on 2/18/15 with multiple diagnoses including Alzheimer's Disease. The quarterly Minimum Data Set (MDS) assessment dated 8/7/15 indicated that Resident # 41 had one unstageable pressure ulcer. The care plan dated 8/17/15 was reviewed. The care plan problem did not include the unstageable pressure ulcer. One of the care plan problems was " resident has the potential for impaired skin integrity. " The wound care specialist reports were reviewed. The reports indicated that the wound care specialist had seen the pressure ulcer of Resident #41 on 7/6/15. The assessment was unstageable pressure ulcer on the right heel	F 280	1. Resident #68 care plan was updated on 10/24/15 by the minimum data set nurse. Resident #58 care plan was updated reflecting the needed changes by the minimum data set nurse in coordination with the Director of Clinical Services and the responsible party was notified on 10/9/15. Resident #41 care plan was updated reflecting the needed changes by the minimum data set nurse on 10/29/15. A new social worker was hired on 10/16/15. 2. All residents residing in the facility have the potential to be affected. All residents care plans were reviewed by the minimum data set nurse and any corrections needed were made by the minimum data set nurse by 10/30/15. Resident and/or family were notified of any changes by the minimum data set nurse by 10/30/15. 3. The director of Clinical Services reeducated the minimum data set nurse	

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F 280	Continued From page 19 measuring 2 x (by) 2.3 centimeters (cm). The pressure ulcer had 100% eschar (piece of dead tissue on the skin). On 10/6/15 at 12:07 PM, the MDS Nurse was interviewed. She acknowledged that she had reviewed the care plan for Resident #41 but she missed to revise the skin problem to include the unstageable pressure ulcer on the right heel. On 10/7/15 at 2:25 PM, dressing change observation was conducted. The right heel pressure ulcer was observed to have 100% eschar with no drainage noted. The ulcer was cleaned with normal saline and betadine was applied. 2. Resident #68 was admitted to the facility on 10/13/14 with multiple diagnoses including major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 8/20/15 indicated that Resident #68 had moderate cognitive impairment. On 10/5/15 at 12:05 PM, Resident #68 was interviewed. She stated that she had not been invited to participate in the care planning meetings. The social worker progress notes were reviewed. There were no documentation that Resident #68 was invited to the care plan meetings. On 10/6/15 at 11:25 AM, administrative staff #2 was interviewed. She stated that the facility had no social worker at the moment. The social worker had left the facility in August, 2015 and she had been filing in. She added that the MDS Nurse was sending a list of residents whose care	F 280	and Interdisciplinary Team on the accuracy of comprehensive care plans and updating care plans as needed by 10/30/15. The Executive Director oriented the Director of Social Services on the responsibility of scheduling care plan meetings and inviting the residents and the resident responsible party in writing on 10/26/15. 4. The Director of Clinical Services and/or the minimum data set nurse will monitor records of residents scheduled for care plan meetings Monday through Friday for 6 months to ensure that all notification has been made and may continue if the Quality Assurance and Improvement Committee determines additional monitoring is needed to maintain compliance. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring of 3 random resident care plans for completeness and accuracy 5 times a week for 2 months, then 3 times weekly or 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Improvement Monitor form. The results of the Quality Improvement monitoring will be reported by the director of nursing or minimal data set nurse to the Quality Assurance	

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F 280	Continued From page 20 plan meeting was coming up. Then the social worker sent out the invitation letter to the responsible party (RP) and the resident and a copy of the invitation letter was kept in the chart. On 106/15 at 12:05 PM, the MDS Nurse was interviewed. She stated that the social worker was responsible for inviting the RP and the resident to the care plan meeting. The MDS Nurse admitted that the interdisciplinary team (IDT) had not been meeting quarterly for the care plan meeting. On 10/6/15 at 4:40 PM, administrative staff #2 revealed that she had looked at the records and could not find documentation that the RP and the resident were invited to the care plan meetings. She also stated that she could not find a copy of the invitation letter that was sent to the RP and the resident. 3. Resident #58 was admitted to the facility 11/21/13. Cumulative diagnoses included: dementia and vertigo. A Quarterly Minimum Data Set (MDS) dated 8/6/15 indicated Resident #58 was severely impaired in cognition. He was independent with transfers and ambulation in the room and corridor. Balance was steady and no impairment was noted in range of motion. An observation on 10/5/15 at 10:38 AM revealed Resident #58 had a fall mat on the left side of his bed. He did not have a bed alarm in place at the time of the observation.	F 280	Performance Improvement Committee monthly.	

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An observation on 10/6/15 at 10:15AM revealed Resident #58 lying in bed. No bed alarm was visible and the fall mat was noted on the floor on the left side of his bed.

A care plan dated 7/18/14 and last reviewed on 8/6/15 indicated Resident #58 had a history of falls with no injury. Interventions/ approaches included, in part, bed alarm. The use of a fall mat was not included on the care plan.

On 10/06/15 at 2:39 PM, the MDS Coordinator stated it was her responsibility to review and revise the care plan for falls. She stated the care plans were updated when the MDS was completed. The MDS Coordinator reviewed the care plan for falls and stated the bed alarm must have been discontinued and she was not aware that there was a fall mat being used for Resident #58

On 10/7/15 at 8:06 AM, NA#1 stated she had provided care for Resident #58 and stated that Resident #58 used to have a bed alarm but that had been discontinued and a fall mat was being used. NA#1 went to Resident #58's room and checked Resident #58 ' s bed. She stated there was not a bed alarm in place. The fall mat was noted lying in place next to the bed.

4. Resident #58 was admitted to the facility 11/21/13. Cumulative diagnoses included: dementia and vertigo.

A family interview was conducted on 10/5/15 at 4:03 PM. The family member was Resident #58's legal guardian and was the responsible party to be notified of any changes in condition, treatments and/or medications. She stated she

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F 280	Continued From page 22 was not included in decisions regarding medications, therapy and/or treatments for Resident #58. A review of the medical record revealed Resident #58 had a quarterly MDS completed on 8/6/15 that indicated he was severely impaired in cognition. His care plan had been last reviewed on 8/6/15. On 10/7/15 at 8:18 AM, Administrative staff #2 stated the social worker was responsible for informing residents and family members of care plan conferences. She stated the social worker had resigned in August and she was the interim social worker at this time. Administrative staff #2 said she could not find any documentation that the family of Resident #58 had been informed of care plan conferences. On 10/07/15 at 8:49 AM, the MDS Coordinator stated she updated the care plan when she completed the MDS and the care conferences were held at another time. She stated the care plan conferences for Resident #58 had been scheduled for 2/4/15, 5/6/15 and 8/5/15. She stated they did not have a sheet that documented when conferences care were held or who attended care conferences. She stated some of the care conferences had not been done and they had not been having routine care conferences for some time. She also stated the social worker was the person who sent out the letters inviting the family members to care conference.	F 280		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		10/30/15

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F 314	Continued From page 23 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess and treat a pressure ulcer for 1 (Resident #63) of 3 sampled resident ' s. Findings included: Resident #63 was admitted 5/28/13 and had cumulative diagnoses including dementia, glaucoma and anxiety. Review of the Care Plan dated last updated 4/20/15 revealed a plan of care for " Incontinence and Pressure and " Activities of Daily living " assistance. Review of the Quarterly Minimum Data Set (MDS) dated 7/12/15 revealed the resident was cognitively impaired, was not at risk for pressure ulcers and, and had no healed or unhealed pressure ulcers. On 10/7/15 interview with Nursing Assistant #2 (NA #2) at 4:26 PM revealed that on 9/14/15 after giving Resident #63 incontinent care she observed that the resident ' s skin was breaking down with redness on her bottom and both heels from pressure. She added that Nurse #4 was aware of the reddened areas. Review of the Interdisciplinary Progress Notes	F 314	1. Resident #63 no longer resides in the facility. 2. All residents residing in the facility have the potential to be affected. All residents had a skin assessment completed on 10/10/15 by the Director of Clinical Services and the Nurse Manager. Any identified skin issues were documented on a Pressure Ulcer Documentation Form or a Non Pressure Skin Documentation Form. The physician was contacted for treatment orders and responsible parties were notified. 3. The Director of Clinical Services reeducated all staff currently working at the facility by 10/30/15 to report any observed skin issues to the unit nurse or a nurse manager. The Director of Clinical Services reeducated the nurses currently working at the facility by 10/30/15 on the need to complete admission and weekly skin assessments, to properly document the issue on a Pressure Ulcer Documentation Form or a Non Pressure Ulcer Documentation Form, to contact the	

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F 314	Continued From page 24 dated 9/14/15 - 9/19/15 and Medical Record for 9/14/15 - 9/19/15 revealed no documentation or assessment regarding the resident ' s reddened skin areas. Review of the Physician ' s Orders dated 9/14/15 - 9/19/15 revealed no treatment orders for the resident ' s reddened skin areas. Review of the Interdisciplinary Progress Notes dated 9/20/15 at 6 PM revealed " coccyx reddened (with) open area app (approximate) size of a nickel. Slough appears to cover opening, red areas noted up spine and on heels family states heels have worsened overnight even with them being suspended in air the fact that poor nutrition and generalized deterioration of patient would prevent wound healing and make her much more apt to breakdown was discussed (with family) " , " will turn pt (patient) from side to side as her comfort allows " . Review of the Medical Record 9/20/15 - 9/21/15 including the Physician ' s Orders revealed treatment orders for the reddened or open areas on the resident ' s skin, no assessment regarding the measured size of the reddened areas on the resident ' s skin, no measurement of the opened area on her coccyx and no documentation regarding treatment. On 10/6/15 at 5:23 PM Telephone Interview with Nurse #4 revealed that the resident ' s family was concerned about the redness on the resident ' s bottom just before she expired on 9/21/14. She added that when Resident #63 ' s skin started to break down, the resident was actively dying and it was not preventable. Nurse #4 said the resident was repositioned for comfort but that she seemed	F 314	physician for treatment orders, begin treatment, and notify the responsible party. 4. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring of completed skin assessments and treatment sheets 5 times a week for 2 months, then 3 times weekly or 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Performance Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	

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F 314	Continued From page 25 more comfortable the less she was moved. On 10/7/15 at 5 PM interview with Administrative Staff #4 revealed that neither she nor Administrative Staff #1 had been aware of the opened area to the resident ' s coccyx. She stated that Nurse #5, who had documented the 9/20/15 note, had not reported it on the 24 hour report or obtained any orders. She added that if the resident ' s skin condition had been reported the areas wound have been assessed and orders for treatment would have been obtained. Administrative Staff #4 also said that Nurse #5 no longer worked at the facility.	F 314		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza	F 334		11/3/15

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F 334	Continued From page 26	F 334		

immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

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F 334	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to offer the pneumococcal vaccine to 5 (Residents # 59, #11, #4, #47 & # 1) of 5 sampled residents and failed to administer the influenza vaccine to 1 (Resident #1) of 5 sampled residents with a consent to receive the vaccine. Findings included: 1. Resident # 59 was admitted to the facility on 4/23/15. The quarterly Minimum Data Set (MDS) assessment dated 8/16/15 indicated that Resident #59's pneumococcal immunization was not up to date. The assessment indicated that Resident #59 was offered pneumococcal immunization but declined. The immunization record for Resident #59 was reviewed. The record did not indicate that the resident was offered the pneumococcal immunization since admission. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the pneumococcal immunization was offered to Resident #59. 2. Resident # 11 was admitted to the facility on 3/18/11. The quarterly Minimum Data Set (MDS) assessment dated 9/10/15 indicated that Resident #11's pneumococcal immunization was not up to date. The assessment indicated that Resident #11 was offered pneumococcal immunization but declined.	F 334	1. Resident #1 did not receive an influenza vaccination for the2014-2015 season. Resident #1 was offered the influenza vaccine and after receiving the Vaccination Information the vaccine was accepted and given on 10/30/15. Resident #59 received the Pneumococcal Vaccination Information and the vaccine was accepted and given on 11/2/15 Resident #11 received the Pneumococcal Vaccination Information and the vaccine was accepted and given on 11/2/15. Resident #4 received the Pneumococcal Vaccination Information and the vaccine was declined. Resident #47 received the Pneumococcal Vaccination Information and the vaccine was accepted and given on 11/2/15. Resident #1 received the Pneumococcal Vaccination Information and the vaccine was accepted and given on 11/2/15. 2. All residents residing in the facility have the potential to be affected. The Director of Clinical Services reviewed each resident¿s record currently residing in the facility on 10/26/2015 to establish a log concerning the immunization status of each resident. The Director of Clinical Services updated the Immunization Forms in the record with any information found in the records or from the resident¿s primary	

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F 334	Continued From page 28 The immunization record for Resident #11 was reviewed. The record did not indicate that the resident was offered the pneumococcal immunization since admission. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the pneumococcal immunization was offered to Resident #11. 3. Resident # 4 was admitted to the facility on 11/12/14. The quarterly Minimum Data Set (MDS) assessment dated 7/13/15 indicated that Resident #4's pneumococcal immunization was not up to date. The assessment indicated that Resident #4 was offered pneumococcal immunization but declined. The immunization record for Resident #4 was reviewed. The record did not indicate that the resident was offered the pneumococcal immunization since admission. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the pneumococcal immunization was offered to Resident #4. 4. Resident # 47 was admitted to the facility on 12/6/11. The annual Minimum Data Set (MDS) assessment dated 7/26/15 indicated that Resident #47's pneumococcal immunization was not up to date. The assessment indicated that Resident #47 was offered pneumococcal immunization but declined. The immunization record for Resident #47 was reviewed. The record did not indicate that the resident was offered the pneumococcal	F 334	physician during the review. The Director of Clinical Services and nurse managers provided educational information to the residents and/or responsible parties and the influenza immunizations were administered or documented as clinically contraindicated or refused per informed consent by 11/3/15. Pneumococcal vaccines will be given 7 days following the influenza vaccines. 3. The Director of Clinical Services reeducated the Interdisciplinary Team and Nurses by 10/30/15 on presenting educational information concerning the influenza and Pneumococcal Vaccinations, notifying the physician for orders to administer the vaccine or establish documented contraindications, obtaining consents, administering the vaccine, and documenting administrations and refusals onto the vaccination log maintained by the Director of Clinical Services and the Vaccination Log in the resident¿s record. Nurses and the Interdisciplinary team members will not be able to work until education for the influenza and pneumococcal vaccines has been completed. A resident vaccination log will be maintained by the Director of Clinical Services or Nurse Manager. The Resident and/or responsible party will be given the vaccination information on the Pneumococcal vaccine and a consent for administration or documentation of declination will be obtained if the resident	

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F 334	Continued From page 29 immunization since admission. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the pneumococcal immunization was offered to Resident #47. 5a. Resident # 1 was admitted to the facility on 10/18/09. The quarterly Minimum Data Set (MDS) assessment dated 8/1/15 indicated that Resident #1's pneumococcal immunization was not up to date. The assessment indicated that Resident #1 was offered pneumococcal immunization but declined. The immunization record for Resident #1 was reviewed. The record did not indicate that the resident was offered the pneumococcal immunization since admission. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the pneumococcal immunization was offered to Resident #1. 5b. Resident # 1 was admitted to the facility on 10/18/09. The quarterly Minimum Data Set (MDS) assessment dated 8/1/15 indicated that Resident #1 did not receive the influenza vaccine at the facility for this influenza season. The assessment indicated that the reason why the resident did not receive the influenza vaccine was " it was offered and declined. " The immunization record for Resident #1 was reviewed. The record included an informed consent signed by the resident to give the facility permission to administer the influenza vaccine. The resident signed the consent on November	F 334	is due for the vaccination to be administered. The Director of Clinical Services or Nurse Manager will provide the resident and/or responsible party vaccination information concerning the Influenza Vaccines annually, obtain consents or documented contraindications or declination, and administer the vaccine between October 1 and March 31 annually. The Director of Clinical Services will review each new admission for the signed consent or declination and assure that all new admits have received vaccines within seven days of admission. 4. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring to assure that vaccines are offered with educational information and/or administered per consent and proper documentation is maintained in the resident¿s record on 2 residents 5 times a week for 2 months, then 3 times weekly for 4 weeks, then 1 time weekly for 2 months and may continue if the Quality Assurance and Improvement Committee determines additional monitoring is needed to maintain compliance. The vaccination log will be reviewed weekly for 6 months to assure compliance. The results will be documented on a Quality Assurance and Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	

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F 334	Continued From page 30 12, 2014. The immunization record did not have documentation that the influenza vaccine was administered to Resident #1. Administrative staff # 4 was interviewed on 10/7/15 at 2:15 PM. She indicated that the staff assigned to the infection control was no longer employed at the facility and she could not find documentation that the influenza immunization was administer to Resident #1 last influenza season.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		10/30/15

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F 356	Continued From page 31 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post a completed nurse staffing form and the facility failed to post the current nurse staffing form. The findings included: The Daily Nursing Staffing Form dated 10/3/15 was observed to be posted on the bulletin board across from the nurses station on 10/4/15 at 5:33 PM. The staffing information pertaining to the evening and night shifts was not completed. The Daily Nursing Staffing Form for 10/4/15 was not observed to be posted in the facility. An interview was conducted with Administrative Staff #1 on 10/6/15 at 3:47 PM. She stated the current Daily Nursing Staffing Form was expected to be posted. The staffing information for the day, evening and night shifts was expected to be completed at the beginning of each shift. She stated the nurse assigned to the A Hall was expected to complete and post the current Daily Nursing Staffing Form on Saturday and Sunday.	F 356	1. The Executive director corrected the posting immediately when brought to his attention. 2. All residents residing in the facility have the potential to be affected. 3. The Director of Clinical Services reeducated the Interdisciplinary team and nursing staff by 10/30/15 regarding checking the required Daily Nursing Staff form to ensure the daily posting is current and accurate. This education included that the A hall nurse is responsible to update/initiate the Daily Nurse Staffing form prior to leaving the facility for his/her shift for the oncoming shift. An additional check for posting and accuracy for Nursing Staff form posting and accuracy will be conducted by the A hall nurse upon beginning his/her shift. Any Interdisciplinary Team member or nursing staff who has not received this education prior to 10/30/15 will be unable to work until he/she has completed Posted Nursing Staff Information education. 4. The Executive Director or Human Resource Manager will complete Quality Improvement monitoring daily Monday through Friday and the Customer Care	

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F 356	Continued From page 32	F 356	Liaison will complete Quality Improvement monitoring on Saturday and Sunday for 6 months, and monitoring may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain compliance. The results will be documented on a Quality Assurance and Improvement Monitor form. The Human Resource Manager will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly.	
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		10/30/15

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F 520	Continued From page 33 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility ' s Quality Assessment and Assurance committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the recertification surveys dated 11/20/14, 8/22/13 and 7/26/12 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies for assessment accuracy (F278) and develop comprehensive care plans (F279) on the surveys dated 11/20/14 and 8/22/13 as well as a pattern of repeat deficiencies for posted nurse staffing information (F356) on the surveys dated 11/20/14, 8/22/13 and 7/26/12. The continued failure of the facility during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F278 - The facility failed to accurately code the Minimum Data Set (MDS) assessments under the area of smoking for 2 (Residents # 68 & 27) of 2 sampled residents who smokes and the actual height and weight for 3 (Residents # 79, #77 & #74) of 3 sampled residents. F279 - The facility failed to develop a care plan for care areas identified as needing a care plan on the most recent Care Area Assessment for 2 (Resident #22 and #66) of 13 residents reviewed for comprehensive care plans, failed to care plan smoking for 1 (Resident #68) of 2 sampled residents and failed to care plan behaviors for 1	F 520	1. The Executive director conducted a Quality Assurance and Improvement Committee meeting on 10/27/15 to discuss the recitation of tags 278, 279, and 356. 2. All residents residing in the facility have the potential to be affected. 3. The Executive director reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee by 10/30/15 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. Any Interdisciplinary Team member that has not received the Quality Assurance and Improvement education prior to 10/30/15 will be unable to work until he/she has received the Quality Assurance and Improvement education. 4. The Interdisciplinary Team including the facility Medical Director, the Regional Vice President of Operations or the Regional Director of Clinical Services will meet monthly on the third Tuesday of each month to conduct the facility's Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the	

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F 520	Continued From page 34 (Resident #34) of 1 sampled residents. F356 - The facility failed to post a completed nurse staffing form and the facility failed to post the current nurse staffing form. On 10/7/15 at 5:30 PM an interview with the Administrative Staff #5 revealed that he had been monitoring the staff posting on Monday mornings and it had been accurate, however he acknowledged was not sure if it was always correct during the weekend or just corrected on Monday mornings. In regards to the care planning issues, he indicated that an open Social Worker position could have contributed. He added that he felt progress had been made in ensuring MDS accuracy and that it was a work in progress.	F 520	effectiveness of the monitoring of repeat deficiencies F278, F279, and F356 and the prevention of any new repeat deficiencies. Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Executive Director will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee.	