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	345562	A. BUILDING _____ B. WING _____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID 0YSC11.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		2/12/16

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

Electronically Signed | 02/11/2016

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F 156	Continued From page 1	F 156		

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 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

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F 156	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of resident council minutes, the facility failed to display resident rights and state agency contact information for resident access. The findings included: A review of resident council minutes was conducted on 01/14/2016 at 4:00 PM and revealed that resident rights were distributed at each meeting and if there were questions they were answered. Minutes from the 09/14/2015 meeting indicated that all residents' rights were read as requested by the residents attending the meeting. An interview with Resident #90, Resident Council President, was conducted on 01/13/16 at 11:45 AM and revealed she was not aware where the Resident's Rights or Advocacy Agency contact information was posted in the facility. An observation on the main hallway between the nursing units occurred on 01/13/2016 at 03:50 PM and revealed that the ombudsman contact information was not posted. The state agency information for expressing concerns was not accessible to all residents including residents in	F 156	Clear Creek Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 1/18/16, the administrator posted the ombudsman contact information and increased the font size of the state agency information for expressing concerns on	

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F 156	Continued From page 3 wheelchairs due to its location above the water fountains. A review of the resident admission packet on 1/13/2016 at 04:30 PM revealed a statement defining what an ombudsman's role was included in the packet but not contact information for the ombudsman. An interview with the Activity Director occurred on 1/13/2016 at 02:50 PM and revealed that she had not had anyone ask for contact information for the ombudsman, state agency for concerns or for the location of the survey results. She stated she gave out copies of the resident rights at each meeting and answered any questions about them if the residents asked her. An interview with the Administrator occurred on 01/14/16 at 10:00 AM revealed residents rights were included in the admission packet and were posted in the hallway. She stated the state agency information was available for residents posted in the hallway.	F 156	the posting located in the main hallway between nursing units in order to be accessible for all residents including residents in wheelchairs. The location of the state agency was relocated from above the water fountains by the maintenance director. On 1/18/16, a 100% of all state agency postings was completed for ombudsman contact information and accessibility of the state agency information for all residents including residents in wheelchairs. No negative findings were identified. On 1/26/16, the activities director held a resident council meeting to ensure residents know the location of the Resident□s Rights and Advocacy Agency contact information. On 1/26/16, the administrator added the ombudsman□s contact information to the admission packet. On 2/5/16, the administrator in serviced the director of nursing, activities director, admissions director, and social worker on the following: 1. All state agency postings must have the ombudsman□s contact information and be in a location accessible for all residents including residents in wheelchairs 2. All residents must be informed of the location of state agency information to include Resident□s Rights or Advocacy Agency to include the ombudsman□s contact information and the state agency information for	

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F 156	Continued From page 4	F 156	expressing concerns. On 1/26/16, the administrator in serviced the admissions director that the ombudsman□s contact information must be included in all admission packets. Beginning 2/5/16, the administrator utilized a monitoring tool titled Postings to monitor for contact information of state agencies and accessibility for residents including residents in wheelchairs. The Postings audit tool will be utilized weekly x 6 weeks by the administrator. The QI nurse will present findings at the next Executive Quality Improvement Committee. The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area and to determine the need for and/or frequency of continued QI monitoring.	
F 157 SS=D	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	F 157		2/12/16

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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 an observation, staff interviews, physician interview and medical record review, the facility failed to notify the physician of aspiration precautions necessary for treatment of dysphagia for 1 of 12 sampled residents reviewed for physician notification (Resident #91).

Resident #91 was admitted to the facility on 08/28/14. Diagnoses included dementia, abnormal posture, feeding difficulties and dysphagia.

A quarterly Minimum Data Set dated 09/28/15 assessed Resident #91 with impaired cognition, independent with eating and required set up

F-tag Failure to notify physician of speech therapy recommendations

What measures did the facility put in place for the resident affected:

On 01/15/2016 the Director of Nursing notified the physician of resident # 91 speech
Therapy recommendation to include aspiration precautions.

What measures were put in place for residents having the potential to be

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F 157	Continued From page 6 assistance during meals. A diet order dated 11/09/15 recorded that Resident #91 should receive all liquids presented before or after meals and not with foods. Review of speech therapy (ST) discharge notes dated 11/10/15 recorded in part that Resident #91 met therapy goals and that Resident #91 and nursing staff were educated to separate liquids from solids during meals for increased safety and to decrease the risk of complications from aspiration. The ST note recorded that a diet order was written for liquids to be present separately from foods. Further medical record review revealed there were no physician's progress notes or a physician's order regarding Resident #91 receiving liquids separate from foods. On 01/13/16 at 08:16 AM, Resident #91 was observed drinking nectar thickened orange juice with ST staff assistance. ON 01/13/16 at 08:17 AM, Resident #91 received her breakfast meal. Review of the tray card revealed Resident #91 required nectar thickened liquids received before or after meals, but no fluids with foods. Once Resident #91 received solid foods, her breakfast meal tray was set up by ST staff, Resident #91 was encouraged to feed herself solid foods and drink her remaining fluids after her meal. Resident #91 complied with this recommendation. An interview on 01/15/16 at 2:14 PM with the Assistant Dietary Manager (ADM) revealed she was responsible for updating tray cards with diet orders once received and kept a copy of the diet	F 157	affected? On 01/25/16 the Speech Therapist audited 100% of resident□s with speech therapy recommendations to ensure physician was notified of all recommendations. What systems were put in place to prevent the deficient practice from reoccurring? On 01/20/16 the Staff Facilitator started in-servicing 100% of the licensed nurses and therapy department related to notifying the physician of all speech therapy recommendations. This in-service will be 100% completed on. 02/11/16 How the facility will monitor systems put in place: On 01/25/16 the DON/ADON/SDC/ and/or QI nurse began auditing all residents receiving speech therapy to ensure physician notification of recommendations using the Speech Therapy Recommendation audit tool. The audit will be completed 5xweek for 4 weeks then weekly x 8 weeks then monthly x 3 months. The monthly QI committee will review the results of the Speech Therapy Recommendation Audit monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring,	

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F 157	Continued From page 7 order for record. The ADM stated she received the diet order slip for Resident #91 not to receive fluids with solid foods from ST in November 2015 and added this recommendation to the Resident's tray card. The ADM stated she did not notify the Physician of the new diet orders, but rather thought the department who made the recommendation would do that. An interview on 01/15/16 at 2:48 PM with the Director of Rehabilitation (DR) revealed Resident #91 was currently on ST caseload for swallowing difficulties. The DR stated that Resident #91 has a ST recommendation to offer fluids before and/or after meals, but not during meals. The DR stated that staff should remove the fluids from the Resident's sight to encourage her to focus on her meal for a decreased risk of aspiration. The DR further stated that due to staff turnover, therapy staff were still educating all the staff. The DR also stated that therapy recommendations were written as a diet order, given to dietary staff to update the resident's tray card, but were not presented to the Physician for review or written as a physician's order. An interview on 01/15/16 at 4:46 PM with the Director of Nursing revealed she expected therapy staff to notify the Physician of therapy recommendations so that nursing staff would be aware of the recommendations and all nursing staff would be educated. An interview on 01/15/16 at 5:37 PM with the Physician revealed that due to the specific nature of the ST recommendations for Resident #91 regarding aspiration precautions she would prefer the recommendation have come to the attention of the Physician. The Physician stated she was	F 157	and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 157	Continued From page 8 not made aware that Resident #91 required fluids separate from solids due to swallowing difficulties, but had she been made aware she would have reviewed the recommendations for consideration of writing a physician's order to alert nursing staff of the Resident's swallowing precautions. An interview on 01/15/16 at 6:12 PM with the Administrator revealed she would have expected therapy staff to have notified the Physician and nursing staff of ST recommendations for Resident #91 so that all staff could have monitored this and been educated.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of resident council minutes, the facility failed to post a notice of the location of the state survey results. The findings included:	F 167	On 1/18/16, the administrator posted sign to tell where survey results are located, the ombudsman contact information and increased the font size of the state agency information for expressing concerns on the posting located in the main hallway between nursing units in order to be	2/12/16

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F 167	Continued From page 9 A review of resident council minutes was conducted on 01/14/2016 at 4:00 PM and revealed that residents' rights were distributed at each meeting and if there were questions they were answered. Minutes the 09/14/2015 meeting document that all residents' rights were read as requested by the resident attending the meeting. An interview with Resident #90, Resident Council Representative, was conducted on 01/13/16 at 11:45 AM and revealed she was not aware if the facility's last state survey results were available to residents. An observation on the main hallway between the nursing units occurred on 01/13/2016 at 03:50 PM and revealed that the location of the state survey results for residents and the public to access was not posted. The print size of the the information for the state agency and phone number was too small, and the sign was located too high for residents in wheelchairs to access and read. The state survey results were in a notebook in the lobby. An interview with the Activity Director occurred on 1/13/2016 at 02:50 PM and revealed that she had not had anyone ask for contact information for the ombudsman, state agency for concerns or for the location of the survey results. She stated she gave out copies of the resident rights at each meeting and answered any questions about them if the residents asked her. An interview with the Administrator occurred on 01/14/2016 at 10 AM revealed residents' rights were included in the admission packet and were posted in the hallway. She stated the state agency information was available for residents	F 167	accessible for all residents including residents in wheelchairs. The location of the state agency was relocated from above the water fountains by the maintenance director. On 1/18/16, a 100% of all state agency postings was completed for ombudsman contact information, survey results and accessibility of the state agency information for all residents including residents in wheelchairs. No negative findings were identified. On 1/26/16, the activities director held a resident council meeting to ensure residents know the location of the Resident□s Rights, Advocacy Agency contact information and survey results On 1/26/16, the administrator added the ombudsman□s contact information and where the survey results are located to the admission packet. On 2/5/16, the administrator in serviced the director of nursing, activities director, admissions director, and social worker on the following: 1. All state agency postings must have the ombudsman□s contact information and be in a location accessible for all residents including residents in wheelchairs 2. All residents must be informed of the location of state agency information to include Resident□s Rights or Advocacy Agency to include the ombudsman□s contact information and the state agency information for expressing concerns 3. Where the survey results are located. On 1/26/16, the administrator in serviced	

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F 167	Continued From page 10 posted in the hallway and state survey results were in a notebook in the lobby.	F 167	the admissions director that the ombudsman□s contact information and survey results must be included in all admission packets. Beginning 2/5/16, the administrator utilized a monitoring tool titled Postings to monitor for contact information of state agencies and accessibility for residents including residents in wheelchairs. The Postings audit tool will be utilized weekly x 6 weeks by the administrator. The QI nurse will present findings at the next Executive Quality Improvement Committee. The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area and to determine the need for and/or frequency of continued QI monitoring.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to see a chair that prevented rising was a restraint, and failed to provide a medical diagnosis for the use of a	F 221	Criteria 1 On 1/14/2016, the director of nursing (DON) obtained a physician□s order for resident #156 for a scoot chair in recline	2/12/16

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F 221	Continued From page 11 physical restraint for 1 of 1 sampled resident (Resident #156). Findings included: Resident #156 was admitted to the facility on 12/11/15. He had diagnoses including cerebral vascular accident (CVA) with left sided weakness, dementia and a history of falls. The admission Minimum Data Set (MDS) dated 12/18/16 indicated Resident #156 was severely cognitively impaired and required extensive assistance for activities of daily living (ADL). The assessment indicated the resident was unsteady with surface to surface transfers and was only able to stabilize with human assistance. The assessment indicated there was no restraint in place, there had been two or more falls since admission, and the Restraint Care Area Assessment did not trigger for further evaluation. The Care Plan (dated 12/25/15) did not indicate a restraint was in place for this resident. There was no physician order for a restraint in Resident #156's medical record. During an interview with a family member on 01/11/16 at 4:25 PM, Resident #156 was observed in a reclined wheelchair with a pommel cushion in place. The family member stated, "He (Resident #156) forgets he can't walk." and added he had sustained some falls since his CVA. The family member also indicated the facility staff had put the chair in the reclined position just that day and added, "So far he hasn't been able to get out of it." On 01/13/16 at 9:46 AM, Resident #156 was observed in the unit dayroom watching television.	F 221	position. On 02/05/16, the hall nurse obtained a clarification order for the scoot chair in reclining position related to decreased safety awareness, poor balance, and decreased cognition related to dementia. Criteria 2 On 1/18/2016 a 100% audit of residents to identify if any positioning devices, chairs, or other items would be identified as a restraint was completed by administrative nurses. No other residents were identified as having restraints in place. Criteria 3 The Director of Nursing and Rehab Manager started 100% in-servicing of all licensed nurses and 100% of rehab staff on what is considered a restraint and obtaining a physician□s order with a medical diagnosis on 1/21/2016. The in-service will be completed by 2/12/16. All new employees will receive in-service during new employee orientation. Criteria 4 Beginning 2/8/16, the DON, assistant director of nursing (ADON), staff development coordinator (SDC), and QI Nurse will monitor all residents by utilizing a Restraint audit tool to ensure that all residents that have a restraint have a physician□s order to include a medical diagnosis for the use of the physical restraint. The Restraint audit tool will be completed 5x/week for four weeks then weekly for 8 weeks then monthly for three months.	

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F 221	Continued From page 12 The resident had the pommel cushion in place and the wheelchair was in the reclined position. On 01/13/15 at 3:35 PM, Resident #156 was observed in the unit dayroom and appeared to be asleep in front of the television. The resident had the pommel cushion in place and the wheelchair was in the reclined position. Resident #156 was observed in the therapy room on 01/14/16 at 1:23 PM. With the pommel cushion in place and the chair in the reclined position, the Occupational Therapist (OT) asked the resident to try and stand up. The resident attempted three times to get up from the chair and then sat back and shook his head to indicate he could not get up. On 01/15/16 at 4:05 PM, the Assistant Director of Nursing (ADON) was interviewed about who was responsible for ensuring there was a medical reason for Resident #156's restraint. The ADON said, "Therapy assessed him initially so they should have gotten an order to recline it if it was being used as a restraint. We didn't intend to use it as a restraint but if someone decided to put it in the reclined position we should have gone through the steps."	F 221	The QI nurse will present all findings to the Executive Quality Improvement Committee. The Executive Quality Improvement Committee will review the results of the audits monthly x 6 months with recommendations and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	
F 244 SS=C	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		2/12/16

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F 244	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on resident council representative and staff interviews and record review the facility failed to resolve grievances regarding medication administration documented in 4 of 6 months resident council minutes. Findings included: A review of the resident council minutes dated 07/2015-12/2015 revealed the residents had concerns regarding dietary services, amount of time to answer call bells, staffing on units, medication administration, housekeeping, dietary services regarding food portions and choices. A review of the grievance follow up revealed that the resident concerns regarding medication administration were not resolved. July 16, 2015 minutes revealed a concern regarding wait times for pain medications. The 10/12/2015 resident council minutes documented concerns regarding a resident awakened at 4:00 AM for medications. Review of the 11/09/2015 Resident council minutes revealed concerns about wait time for medications and the 12/06/2015 resident council minutes revealed a resident concern about medication passes being "organized". An interview on 01/13/2016 at 11:50 AM with Resident #90, the resident council representative, revealed that she was aware that it was her right to have a process for addressing concerns. An interview on 01/13/2016 at 02:50 PM with the Activity Director revealed the process she used for notification and seeking resolution for a concern was to send out to each department manager a grievance resolution form for the manager to complete. They return the completed form to her and she filed it in the resident council minute's book behind the minutes to that resident	F 244	F tag failure to respond to group grievances and recommendations What measures did the facility put in place for the resident affected: On 1/26/2016 a resident council meeting was held. Concerns from previous council meetings were addressed. The residents present at the meeting were without concerns voiced. What measures were put in place for residents having the potential to be affected: On 1/26/2016 a resident council meeting was held. Concerns from previous council meetings were addressed. The residents present at the meeting were without concerns voiced. Survey and federal postings were explained to resident□s including the location of postings. Administrator informed residents that if they wanted the Administrator and/or another department head to attend the meeting they could invite them and they would attend. What systems were put in place to prevent the deficient practice from reoccurring: On 1/18/2016 the Administrator in-serviced the Activities Director/Social Worker on writing resident concerns up	

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F 244	Continued From page 14 council meeting. The Administrator signed off on the resolutions to the concerns. She stated there have been multiple times that medication administration has been brought up in the resident council meetings. An interview with the Administrator on 01/14/2016 at 10:00 AM revealed she expected all grievances to have resolutions. She provided documentation of nursing staff in-services regarding administration of pain medication dated 07/19/2015, discontinuation of oral medications dated 10/02/2015 and administration of medications to be given within one hour of the time indicated on the medication administration record. The grievance follow-up forms were general statements that did not indicate details of the follow-up that occurred. The grievance follow-up form dated 10/12/15 revealed the department response to be "staff re-educated on conversations in resident areas and ensuring meds given in a timely manner." This grievance follow-up form was not dated by either the department supervisor or the administrator. There was no documentation of audits or observations to support staff consistently demonstrating medication administration that indicated resolution of the medication administration concerns brought forward by residents.	F 244	on a resident concern form and giving the concern to the Administrator in a timely manner for follow-up. How the facility will monitor systems put in place: After each resident council meeting the Administrator and/or DON will review meeting minutes to ensure a resident concern form has been completed for concerns discussed during meeting. Concerns will be addressed in a timely manner. The monthly QI committee will review the minutes of the resident council meeting monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the	F 273		2/12/16

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F 273	Continued From page 15 facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a comprehensive assessment within 14 days after admission to the facility for 1 of 22 sampled residents (Resident #189) reviewed for comprehensive assessments. The findings included: Resident #189 was admitted to the facility on 12/16/15 and was cognitively impaired. Resident #189's diagnoses included atrial fibrillation, hypertension, cerebral vascular accident and depression. Resident #189 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. A review of the admission MDS, with an ARD date of 12/23/15, revealed under Section Z Assessment Administration (Z0500) that MDS Nurse #2 verified via electronic signature Resident #189's assessment was completed on 01/04/16. A review of the Care Area Assessment (CAA) Triggers indicated the following care areas were triggered Resident #189: Cognitive Loss/Dementia, Communication, Activities of Daily Living (ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Pressure Ulcer, Psychotropic Drug Use, and Pain. A further review of the CAAs for Resident #189 indicated MDS Nurse #2	F 273	F Tag late MDS assessments What measures did the facility put in place for the resident affected: The MDS nurse completed resident #189□ assessment 1/4/16. The MDS nurse reviewed the resident□s schedule to ensure future assessments were scheduled to be completed on time. What measures were put in place for residents having the potential to be affected: On 1/27/2016 an audit was completed by the facility consultant using the MDS in progress list and MDS scheduler to identify late assessments. All late assessments will be completed by 2/12/2016. What systems were put in place to prevent the deficient practice from reoccurring: The MDS Consultant in-serviced the MDS Coordinator, MDS nurse, and DON related to guidelines for timely completion of all OBRA MDS assessments as well as timely completion of Care Area Assessments and Care Plan Completion on 1/26/2016.	

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F 273	Continued From page 16 signed each triggered care area that was checked for care planning as being completed on 01/04/16. On 01/14/16 at 7:01 PM an interview was conducted with MDS Nurse #1 who stated the triggered CAAs for Resident #189's Admission MDS dated 12/23/15 should have been completed by 12/29/15 rather than 01/04/16. MDS Nurse #1 stated the nursing signature with date on each triggered care area indicated that each care area assessment was completed on 01/04/16. MDS Nurse #1 stated the nursing signature at the end of the assessment indicated the MDS assessment was completed on 01/04/16. MDS Nurse #1 stated MDS Nurse #2 worked part time to assist MDS Nurse #1 with coding MDS. MDS Nurse #1 stated MDS Nurse #2 was working on 01/04/16 and completed and signed the assessment on 01/04/16 for Resident #189. On 01/15/16 at 8:57 AM an interview was conducted with the Director of Nursing (DON) who stated her expectations were that the MDS Nurse would have completed and signed the assessment timely for Resident #189. The DON stated she was not sure why the assessment was not completed and signed timely for Resident #189 because more than one MDS nurse was working during that time period. On 01/15/16 at 12:52 PM an interview was conducted with MDS Nurse #2 who stated she worked part time at the facility. MDS Nurse #2 stated she was aware that she was completing Resident #189's assessment late on 01/04/16. MDS Nurse #2 stated she signed the CAAs and Resident #189's assessment on 01/04/16 which	F 273	How the facility will monitor systems put in place: On 2/8/16, the DON and/or ADON began monitoring began monitoring the MDS assessments to ensure all parts of assessments are completed on or before due date using the MDS completion assessment tool. The DON and/or ADON will audit assessments 5times a week for 4 weeks weekly for weekly for 8 weeks then monthly for 3 months. The QI nurse will present all findings from the MDS completion assessment tool at the monthly QI committee. The monthly QI committee will review the results of the MDS completion audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 273	Continued From page 17 indicated the date the assessment was actually completed.	F 273		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to complete a significant change assessment for 1 of 2 sampled residents who experienced a significant change (Resident #132) reviewed for pressure ulcer and nutrition. The findings included: Resident #132 was admitted to the facility on 11/28/15. An admission Minimum Data Set (MDS) dated 12/05/15 indicated Resident #132 was cognitively intact. Resident #132 diagnoses were coded as	F 274	FTag 274 Comprehensive assessment after significant change What measures did the facility put in place for the resident affected: The MDS coordinator scheduled resident #132 significant change assessment with an ARD of 1/16/2016. The completed assessment was transmitted to the National Repository and accepted on 2/1/2016.	2/12/16

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F 274	Continued From page 18 atrial fibrillation, coronary artery disease, peripheral vascular disease, congestive heart failure, hypertension, diabetes mellitus and renal insufficiency. Resident #132 required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. Resident #132 was coded as having on admission 1 stage III pressure ulcer, 1 unstageable pressure ulcer, 1 vascular/arterial ulcer, and a diabetic foot ulcer. A review of the wound care nurse's wound ulcer flow sheet indicated Resident #132 had developed after admission to the facility an unstageable pressure ulcer, suspected deep tissue injury (DTI) to right heel on 12/7/15. A review of the wound care physician's progress note dated 12/7/15 indicated Resident #132 had an unstageable pressure ulcer to his right heel that had developed longer than one day prior to wound physician's assessment on 12/07/15. A review of the wound care nurse's wound ulcer flow sheet indicated Resident #132 had developed after admission to the facility a pressure ulcer to left heel on 12/14/15. A review of the physician's progress note dated 12/14/15 indicated Resident #132 had an unstageable pressure ulcer to the left heel that had developed longer than 6 days prior to wound physician's assessment on 12/14/15. A review of Resident # 132's 14 day MDS assessment dated 12/13/15 revealed under Section K Swallowing/Nutrition Status that Resident #132 had a weight of 185 pounds. A review of Resident #132's 30 day MDS	F 274	What measures were put in place for residents having the potential to be affected: On 2/4/2016 100% of residents were audited for significant change related to pressure ulcers and weight loss since the most recent comprehensive MDS assessment by the MDS consultant. Significant change assessments were scheduled for four additional residents. These assessments were completed on or before 2/12/2016. What systems were put in place to prevent the deficient practice from reoccurring: On 1/26/2016 the MDS coordinator, MDS nurse, DON, and SDC were in-serviced by the facility consultant related to the identification of, guidelines for, and completion of significant change in status assessment as per the RAI manual v1.13. this in-service was completed on 01/26/16. How the facility will monitor systems put in place: Beginning 2/12/2016, the DON, SDC, and/or QI nurse will audit residents with pressure ulcers and weight loss using the significant change audit tool. The audit will be completed weekly x 12 weeks then monthly x 3 months. The DON and/or ADON will present findings to the monthly QI committee. The	

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F 274	Continued From page 19 assessment dated 12/26/15 revealed under Section K Swallowing/Nutrition Status that Resident #132 had a weight of 179. Resident #132 had lost 6 pounds in 13 days On 01/13/16 at 9:46 AM wound care was observed being provided by the wound nurse to an unstageable pressure ulcer to Resident #132's right heel that had developed after admission to the facility on 12/07/15. On 01/13/16 at 1:11 PM an interview was conducted with MDS Nurse #1 who stated she did not know that Resident #132 had developed in the facility 2 unstageable pressure ulcers since the admission Minimum Data Set assessment of 12/05/15. MDS Nurse #1 reviewed the physician wound care notes and verified Resident #132 had developed after admission to the facility an unstageable pressure ulcer to the right heel on 12/07/15 and an unstageable pressure ulcer to the left heel on 12/14/15. MDS Nurse #1 stated she should have coded a significant change assessment for Resident #132 rather than a 30 day assessment. MDS Nurse #1 stated she missed coding the significant change MDS and missed the 2 unstageable heel pressure ulcers for Resident #132 that developed after admission to the facility. MDS Nurse #1 stated she would have to complete a significant change assessment for Resident #132. On 01/14/16 at 9:28 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was for MDS Nurse #1 to have coded the MDS correctly to reflect Resident #132 had a significant change. The DON stated Resident #132 had developed after admission to the facility a pressure ulcer to his	F 274	monthly QI committee will review the results of Significant Change Audit Tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 274	Continued From page 20 right heel on 12/07/15 and pressure ulcer to his left heel on 12/14/15. The DON stated her expectation was for MDS Nurse #1 to have performed an actual observation of Resident #132 and compared data and not relied on information from Resident #132's record to code the MDS. An additional interview was conducted with MDS Nurse #1 on 01/14/16 at 6:08 PM. MDS Nurse #1 stated she should have coded a significant change for weight loss for Resident #132. MDS Nurse #1 stated she would have to modify Resident #132's MDS to reflect a significant change occurred. An additional interview was conducted with the DON on 01/15/16 at 8:50 AM. The DON stated her expectation was that MDS Nurse #1 would have submitted a significant change MDS for Resident #132 and that the MDS would have been accurately coded by MDS Nurse #1. The DON stated her expectation was for MDS Nurse #1 to have performed an actual observation of Resident #132 prior to completing the MDS to assure accuracy of the MDS assessment and determined a significant change MDS was needed for Resident #132.	F 274		
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.	F 278		2/12/16

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F 278	Continued From page 21 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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #47) identified as a Level II PASRR resident. Findings included: Resident #47 was readmitted to the facility on 06/02/15 with diagnoses including persistent mood affective disorders and major depression. A review of Resident #47's comprehensive Minimum Data Set (MDS) dated 06/09/15 indicated the resident was not considered by the state Level II Preadmission Screening and	F 278	What measures did the facility put in place for the resident affected: MDS modified to identify correct PASARR number 1/25/2016 by facility MDS consultant. Assessment transmitted to National Repository 1/27/16 by MDS Coordinator. On 1/27/16 the modified assessment was accepted by the National Repository. What measures were put in place for residents having the potential to be affected:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 22 Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #47 was included among the residents named on the list. The MDS Coordinator was interviewed on 01/13/16 at 12:37 PM, regarding the accuracy of Resident #47's comprehensive MDS. When it was revealed the MDS did not reflect the Level II PASRR determination for this resident, the MDS Coordinator stated she didn't know why it was not accurate. She indicated the facility Social Worker (SW) had recently left the position and the new SW had not yet started. She was unsure who was currently responsible for providing the information regarding Level II PASRR but that she herself had coded the assessment and it should have been accurate. On 01/15/16 at 12:08 PM, the Administrator was interviewed. The Administrator stated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.	F 278	100% audit of resident Pasarr numbers completed 1/25/2016 by the facility MDS consultant. The MDS assessments for residents identified with a level II pasarr were audited by the MDS facility consultant 1/25/2016. Two additional MDS assessments were modified to correct the pasarr number by the facility MDS consultant 1/25/2016. On 1/27/16 the MDS Coordinator transmitted the assessments to the National Repository. On 1/27/16 the modified assessments were accepted by the National Repository. What systems were put in place to prevent the deficient practice from reoccurring? The facility MDS consultant in-serviced the MDS Coordinator, MDS nurse, and DON related to the correct coding of Pasarr numbers when completing a comprehensive MDS assessment on 1/26/2016. The facility MDS consultant in-serviced the MDS Coordinator, MDS nurse, Social Worker, and AR Bookkeeper related to how to put the Pasarr numbers in the resident electronic record and where to locate the Pasarr number. How the facility will monitor systems put in place: On 1/27/16 the Administrator, DON and Admissions Nurse began monitoring Pasarr numbers of admissions to ensure Pasarr numbers are correct in the resident electronic record and to ensure the MDS nurse is aware of the Pasarr	

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F 278	Continued From page 23	F 278	number using the Pasarr number audit tool. On 1/27/16 the DON began monitoring each comprehensive MDS assessment to ensure proper Pasarr coding using the Pasarr audit tool. The Pasarr number audit will be completed 5x a week for 4 weeks then weekly x 8 weeks then monthly x 3 months. The monthly QI committee will review the results of the Pasarr number audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
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	F 279		2/12/16

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F 279	Continued From page 24 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 observations, record review, and staff interviews the facility failed to develop a comprehensive care plan for 2 of 3 sampled residents reviewed for pressure ulcers (Resident #132 and Resident #95). The findings included: 1. An admission Minimum Data Set (MDS) dated 12/05/15 indicated Resident #132 was admitted to the facility on 11/28/15 and was cognitively intact. Resident #132 diagnoses were coded as atrial fibrillation, coronary artery disease, peripheral vascular disease, congestive heart failure, hypertension, diabetes mellitus and renal insufficiency. Resident #132 required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. Resident #132 was coded as having on admission 1 stage III pressure ulcer, 1 unstageable pressure ulcer, 1 vascular/arterial ulcer, and a diabetic foot ulcer. A record review of the Care Area Assessment (CAA) for pressure ulcer dated and signed by MDS Nurse #1 on 12/07/15 indicated Resident #132 was admitted to the facility with existing stage III pressure ulcer to right ear, unstageable	F 279	What measures did the facility put in place for the resident affected: On 01/27/2016 resident # 132 care plan was updated to include resident pressure ulcer. What measures were put in place for residents having the potential to be affected: On 1/27/16 the Facility MDS Consultant completed a 100% audit of resident□s with pressure ulcers care plans. All care plans were updated as necessary. What systems were put in place to prevent the deficient practice from reoccurring: On 1/26/2016 the MDS consultant in-serviced the SDC, QI nurse, MDS Coordinator, MDS nurse and DON related to pressure ulcers being included in resident□s plan of care. How the facility will monitor systems put in	

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F 279	Continued From page 25 pressure ulcer to coccyx, right calf venous wound, and left foot diabetic wound. MDS Nurse #1 indicated the overall objective was for wound healing and prevention of any additional wounds and indicted a care plan would be developed for Resident #132's pressure ulcers. A review of Nurse #1's wound ulcer flow sheet indicated Resident #132 developed after admission to the facility an unstageable pressure ulcer, suspected deep tissue injury (DTI) to his right heel on 12/7/15 and developed after admission to the facility a pressure ulcer to his left heel on 12/14/15. A review of the wound care nurse's progress note dated 12/07/15 for Resident #132 indicated the following interventions for pressure ulcer care for unstageable pressure ulcer left heel: Boot was to be worn in bed to off-load heel. Heels were to be floated while Resident #132 was in bed. A review of the wound care physician's progress note dated 12/7/15 indicated Resident #132 had an unstageable pressure ulcer to his right heel that had developed longer than one day prior to wound physician's assessment on 12/07/15.The physician's progress note dated 12/14/15 indicated Resident #132 had an unstageable pressure ulcer to his left heel that had developed more than 6 days prior to wound physician's assessment on 12/14/15. The wound care physician recommended the following interventions for wound care: · Unstageable pressure ulcer sacrum (named by MDS Nurse #1 as coccyx): Group-2 mattress, off-load wound, and reposition per facility policy. · Unstageable pressure ulcer suspected DTI	F 279	place: Resident□s with new pressure ulcers will be audited by the DON/ADON/SDC/QI nurse/and/or MDS Coordinator using the New Pressure Ulcer Audit Tool. The audit will be completed 5x/week for 4 weeks then weekly for 8 weeks then monthly for 3 months. All resident□s with pressure ulcers care plan will be audited using the wound QI tool during each facility wound meeting. The monthly QI committee will review the results of the New Pressure Ulcer audit tool and Wound QI audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	

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right heel: Group-2 mattress, float heels while in bed, and off-load wound.
· Unstageable pressure ulcer left heel: Float heels while in bed, off-load wound.
· Diabetic wound left heel: Off-load wound.
· Stage III pressure ulcer right ear: Padded oxygen nasal cannula tubing, off-load wound.

Care plan dated and created on 12/8/15 indicated Resident #132 had a problem of ulceration or interference with structural integrity of layers of the skin caused by prolonged pressure related to immobility and right fractured hip. Goal initiated on 12/08/15 indicated Resident #132's current ulcer would not worsen through next review period of 12/14/15. The following was a complete list of interventions that were created on 12/08/15 to address Resident #132's problem of ulceration: staff were to report to nurse any red or open areas, ensure appropriate pressure relieving device was in place during repositioning, and treatment as ordered by the physician. The care plan for Resident #132 had not been updated since 12/08/15.

On 01/13/16 at 10:21 AM Resident #132 was observed lying in bed on specialty mattress with bilateral heel protective booties on.

On 01/13/16 at 12:49 PM an interview was conducted with Nurse Aide #1 who stated it was usually included in the nurse aide care guide if the resident required booties applied to feet. Nurse Aide #1 verified the current nurse aide care guide did not include placing booties on Resident #132's feet.

On 01/13/16 at 1:11 PM an interview was conducted with MDS Nurse #1 who stated she

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missed creating a pressure ulcer care plan as triggered by the CAA for Resident #132's existing pressure ulcers and wounds to prevent further deterioration of the wounds. MDS Nurse #1 stated she made reference to Resident #132's pressure area as related to right hip fracture on the care plan. MDS Nurse #1 stated she did not indicate the specific pressure ulcer areas and wound sites on Resident #132's care plan that were identified on the CAA and did not care plan interventions for Resident #132's pressure ulcer to right ear and sacrum and diabetic foot wound and venous ulcer on right calf. MDS Nurse #1 stated she did not know about the pressure ulcer that developed on Resident #132 ' s right heel after admission to the facility and was identified on 12/07/15 and left heel pressure ulcer that developed after admission to the facility and was identified on 12/14/15. MDS Nurse #1 stated Resident #132's care plan should have been updated to reflect he had developed right and left heel pressure ulcers after admission to the facility.

On 01/14/16 at 7:43 AM Resident #132 was observed in bed lying on a specialty mattress with eyes closed. Resident #132 had on protective booties to feet and had padded oxygen tubing over ears.

On 01/14/16 at 8:28 AM an interview was conducted with the wound nurse who stated interventions recommended for wound care by the wound physician were communicated with the interdisciplinary team during daily morning meeting. The wound nurse stated the MDS nurse was responsible to update the resident's care plan with information received during daily morning meeting. The wound nurse stated

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Resident #132 was on an air mattress with alternating pressure. The wound nurse stated she implemented booties for Resident #132's heels but stated the heel booties were not on Resident #132's care plan.

On 01/14/16 at 9:28 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #132's care plan would have been created on admission by the MDS nurse to reflect the exact pressure ulcers and wounds that Resident #132 was admitted with. The DON stated her expectation was for the MDS nurse to have created interventions to address Resident #132's stage III pressure ulcer to right ear, pressure sore on sacrum, and other wounds. The DON stated her expectation was for the MDS nurse to have updated Resident #132's care plan to reflect Resident #132 had developed a pressure ulcer to his right heel after admission to the facility and was identified on 12/07/15 and developed a pressure ulcer to his left heel after admission to the facility and was identified on 12/14/15. The DON stated her expectation was for the MDS nurse to have updated Resident #132's care plan with interventions recommended by the wound care physician that included off-load, float heels, place protective booties on heels, and padded oxygen nasal cannula tubing.

2. A review of the medical record revealed that Resident #95 was admitted 04/27/2015. Her diagnoses included atrial fibrillation, acute but ill-defined cerebrovascular disease, and hemiplegia affecting dominant side due to cerebrovascular disease, hypothyroidism, and essential hypertension, and muscle weakness,

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lack of coordination, esophageal reflux and glaucoma, pain in hip. The Minimum Data Set (MDS) on admission dated 05/04/2015 indicated no pressure ulcer. The quarterly MDS dated 10/27/2015 was coded for a current unhealed pressure ulcer Stage 2.
A reviewed of the care plan dated 11/11/2015 revealed no skin interventions or care for a pressure ulcer.

An observation on 01/13/2016 at 11:46 AM of wound care given by Nurse #1 for Resident #95. Nurse #1 stated she received daily wound care to the pressure ulcer on her sacrum. Nurse #1 stated Resident #95's wound was acquired in house and she has had the pressure ulcer for 4 months. Resident #95 was on a specialty mattress in bed. Nurse #1 checked the settings for the mattress. The Resident's brief was dry. Today the wound had 20% slough, 80% pink granulation. Nurse #1 stated that the wound was progressing with its current treatment daily.

An interview with Nurse #1 on 01/13/2016 at 11:46 AM revealed that Resident #95 had acquired the pressure ulcer on her sacrum while in the facility. She stated the wound was progressing. The specialty mattress, repositioning including being up in her wheelchair with a high density cushion, and monitoring her for incontinence were strategies in place to promote wound healing as well as the daily dressing changes.

An interview occurred on 01/15/2016 at 1:33 PM with MDS Nurse #1. She reviewed the MDS dated 10/27/2015 for Resident #95 which indicated a Stage 2 pressure ulcer. She reviewed the care plan for Resident #95 dated 11/11/2015

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F 279	Continued From page 30 and stated it did not address the Stage 2 pressure ulcer. She stated that it was missed on the care plan and should have been included. An interview was conducted on 01/15/2016 at 3:55 PM with the ADON. She stated that her expectation was that the staff would look at the care guide; use a barrier for incontinence; toilet or check every 2 hours; reposition in chair or in bed; and if care was refused the nurse aide should report it to the nurse and then to me. Care planning meetings are done within 72 hours of admission and then quarterly. The care plans should reflect the needs of the residents. A review of the wound flow sheet 01/11/2016 revealed the wound occurred in house. It was located on the sacrum and measured length 0.8 X width 0.3 X 0.7, with no tunneling. There was undermining 0.9 at 9 o'clock. The exudate was light serous and there was no infection. The wound bed was 85% granulation and 15% necrotic. The physician was informed. Prevention measures included turning and repositioning, incontinence care, low air loss mattress on the bed, high density chair cushion in her wheelchair and a positioning pillow.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a nurse practitioner's	F 281	Criteria 1 On 01/14/16 order for UA C&S was D/C	2/12/16

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F 281	Continued From page 31 order for lab work for 1 of 5 sampled residents (Resident #189) reviewed for physician's lab orders. Findings included: Admission Minimum Data Set (MDS) dated 12/23/15 indicated Resident #189 was admitted to the facility on 12/16/15 and was cognitively impaired. Resident #189 diagnoses were coded as atrial fibrillation, hypertension, cerebral vascular accident (CVA), and depression. Resident #189 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #189 was coded as having a fall within the last 2-6 months prior to admission/entry or reentry and was coded as having 2 falls without injury since admission /entry or reentry or prior assessment. A record review of Resident #189's current care plan dated 12/16/15 revealed an identified problem of at risk for additional falls secondary to history of falls, unsteady gait, and weakness from CVA that occurred on 12/13/15. Goal for prevention of falls that was initiated on 12/17/15 indicated Resident #189 would not have any additional falls and/or serious injury through next review period. Intervention to prevent falls for Resident #189 and was dated 12/17/15 indicated staff were to monitor labs (urinalysis, culture and sensitivity) as ordered and notify physician of results as appropriate. A record review of the Nurse Practitioner's (NP) note dated 01/04/16 indicated Resident #189 was seen at the request of staff for increased confusion. Resident #189 had a history of CVA and confusion. The NP's note further indicated	F 281	by physician Resident was without no signs and symptoms of UTI. 100% percent lab audit was completed on 1/20/2016 by the QI nurse, ADON and Staff facilitator for the last 30 days to assure that all ordered labs by physician are obtained Criteria 2 100% percent lab audit was completed on 1/20/2016 by the QI nurse , ADON and staff facilitator for the last 30 days to assure that all ordered labs by physician are obtained. Criteria 3 01/21/2016 Staff Facilitator in-serviced all licensed nurses on following physician orders for labs, they can not cancel a lab order without a physician order Criteria 4 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator and QI Nurse will monitor all labs to ensure all labs are completed as ordered, this will be will be monitored using the lab audit tool 5 times a week for four weeks weekly for 8 weeks and monthly for 3 months. The Executive Quality Improvement Committee will review the results of the audits Monthly with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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Resident #189 had been treated for a urinary tract infection (UTI) with antibiotics a week prior and had not had any burning with urination. The NP's plan was to obtain a urinalysis with culture and sensitivity and monitor Resident #189 for signs of improving/worsening symptoms.

A record review of NP's order dated 01/04/16 revealed urinalysis with culture and sensitivity for Resident #189.

A review of Resident #189's medical record revealed an absence of urinalysis with culture and sensitivity results as ordered by the NP on 01/04/16.

On 01/14/16 at 1:33 PM an interview was conducted with the Director of Nursing (DON) who stated the urinalysis with culture and sensitivity was not completed as ordered on 01/04/16 for Resident #189. The DON stated after reading the NP's progress note dated 01/04/16 that indicated Resident #189 had an absence of urinary signs and symptoms, she thought the NP no longer wanted a urinalysis with culture and sensitivity completed. The DON stated she looked in the computer and saw that the urinalysis with culture and sensitivity for Resident #189 had been cancelled. The DON stated she verified with the NP on 01/14/16 that the NP wanted the urinalysis with culture and sensitivity completed as ordered for Resident #189. The DON stated she would have staff obtain the urinalysis with culture and sensitivity for Resident #189 on 01/14/16.

On 01/14/16 at 2:29 PM an interview was conducted with the NP who stated she wanted the urinalysis with culture and sensitivity obtained

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F 281	Continued From page 33 for Resident #189 as ordered on 01/04/16 because Resident #189 had a previous UTI and currently had been experiencing signs of increased confusion. The NP stated she wanted to assure that Resident #189's previous UTI was cleared and if the UTI was not cleared then she planned to initiate further treatment for Resident #189.	F 281		
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, staff interviews and medical record review the facility failed to follow speech therapy recommendations for treatment of dysphagia for 1 of 3 sampled residents at risk for aspiration (Resident #91). The findings included: Resident #91 was admitted to the facility on 08/28/14. Diagnoses included dementia, abnormal posture, feeding difficulties and dysphagia. A quarterly Minimum Data Set dated 09/28/15 assessed Resident #91 with impaired cognition, independent with eating and required set up	F 309	F-tag Failure to notify physician of speech therapy recommendations What measures did the facility put in place for the resident affected: On 01/15/2016 the Director of Nursing notified the physician of resident # 91 speech Therapy recommendation to include aspiration precautions. What measures were put in place for residents having the potential to be affected?	2/12/16

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 309	Continued From page 34 assistance during meals. Her care plan, revised November 2015 recorded that Resident #91 was at risk for nutritional deficits related to diagnoses of dementia and dysphagia. Interventions included to provide a diet as ordered, monitor for signs/symptoms of aspiration and therapy consult as needed for evaluation and recommendations. A diet order dated 11/09/15 recorded that Resident #91 should receive all liquids presented before or after meals and not with foods. The diet order was signed by a Speech Therapist. Review of speech therapy (ST) discharge notes dated 11/10/15 recorded in part that Resident #91 met therapy goals and that Resident #91 and nursing staff were educated to separate liquids from solids during meals for increased safety and to decrease the risk of complications from aspiration. The ST note recorded that a diet order was written for liquids to be present separately from foods. ST notes dated 01/0/16 recorded in part that Resident #91 was referred to therapy due to reports from nursing of swallowing difficulties during meals, had a history of dysphagia, was at high risk for aspiration and that skilled ST services were required due to her risk of aspiration. Review of the January 2016 physician's order sheet revealed Resident #91 should receive a regular consistency diet and nectar thickened liquids (NTL) with no straws. Resident #91 was observed on 01/11/16 at 12:54 PM in the dining area with a glass each of nectar thickened (NT) tea and water. Resident #91 was	F 309	On 01/25/16 the Speech Therapist audited 100% of resident□s with speech therapy recommendations to ensure physician was notified of all recommendations. What systems were put in place to prevent the deficient practice from reoccurring? On 01/20/16 the Staff Facilitator started in-servicing 100% of the licensed nurses and therapy department related to notifying the physician of all speech therapy recommendations. This in-service will be 100% completed on. 02/11/16 How the facility will monitor systems put in place: On 01/25/16 the DON/ADON/SDC/QI nurse Rehab manager began auditing all residents receiving speech therapy to ensure physician notification of recommendations using the Speech Therapy Recommendation audit tool. The audit will be completed 5xweek for 4 weeks then weekly x 8 weeks then monthly x 3 months. The monthly QI committee will review the results of the Speech Therapy Recommendation Audit monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for	

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F 309	Continued From page 35 observed drinking independently prior to receipt of her lunch meal. Resident #91 received her lunch meal and staff assistance with tray set up. The tray card for Resident #91, placed next to her lunch meal, recorded that Resident #91 should receive a regular consistency diet, NTL, no straws and fluids before/after meals, not during meals. After tray set up, Resident #91 ate some of her meal and drank some of her fluids with encouragement from staff to eat/drink. On 01/11/16 at 12:58 PM Nurse #2 sat next to Resident #91 and provided continued encouragement and assistance. Nurse #2 offered/encouraged Resident #91 to consume fluids intermittently with her foods, which the Resident accepted. Resident #91 ate 75% of her foods and drank 50% of her fluids. Resident #91 was not observed to demonstrate signs of aspiration as evidenced by coughing/choking. On 01/13/16 at 08:16 AM, Resident #91 was observed drinking NT orange juice with ST staff assistance. On 01/13/16 at 08:17 AM, Resident #91 received her breakfast. Review of the tray card revealed Resident #91's diet was the same as previously described. Once Resident #91 received solid foods, her breakfast meal tray was set up by ST staff, Resident #91was encouraged to feed herself solid foods and drink her remaining fluids after her meal. Resident #91 complied with these recommendations. On 01/13/2016 at 6:20 PM, Resident #91 was observed in the dining area with NT orange juice and water. Resident #91 was observed drinking her fluids independently before receipt of her dinner meal. Resident #91 received her dinner meal with tray set up by nurse aide #1 (NA #1). NA #1 placed the Resident's tray card next to her	F 309	monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 309	Continued From page 36	F 309		

meal. The tray card recorded the same diet order as previously described. NA #1 offered and encouraged Resident #91 to drink fluids between bites of food. Resident #91 accepted and drank her fluids with her meal. Resident #91 ate 75% of her food and drank 100% of her fluids. Resident #91 was not observed to demonstrate signs of aspiration as evidenced by coughing/choking.

A ST note dated 01/14/16 recorded in part that Resident #91 continued to demonstrate reduced risk of aspiration with consuming liquids separately from solids.

An interview on 01/15/16 at 2:14 PM with the Assistant Dietary Manager (ADM) revealed she was responsible for updating tray cards with diet orders once received and kept a copy of the diet order for record. The ADM stated she received the diet order slip for Resident #91 not to receive fluids with solid foods from ST in November 2015 and added this recommendation to the Resident's tray card.

An interview on 01/15/16 at 2:26 PM with Nurse #2 revealed that when she assisted residents with meals, she used the resident's tray card to know what the resident's needs were during the meal. Nurse #2 stated that Resident #91 typically fed herself, but at times during the meal Resident #91 would get fatigued and required some assistance with being fed. Nurse #2 further stated that she was trained on 01/14/16 that Resident #91 should receive fluids before/after meals, and no fluids with foods due to her risk of aspiration. Nurse #2 stated she did not recall reading this recommendation on the tray card for Resident #91 when she assisted the Resident with her lunch meal on 01/11/16, but that she should have

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F 309	Continued From page 37 read the tray card. An interview on 01/15/16 at 2:36 PM with Nurse Aide #2 (NA #2) revealed that Resident #91 typically fed herself, but required staff assistance with tray set up and at times needed to be fed. NA #2 stated she recalled that she was in-serviced last week that Resident #91 should not have fluids during the meal, only before/after. NA #2 stated "I must have forgot that when I set up her tray and offered her some water, it's on her tray card, I will have to pay closer attention." An interview with the Director of Rehabilitation (DR) occurred on 01/15/16 at 2:48 PM. The DR stated that Resident #91 was currently on ST caseload due to swallowing difficulties and risk of aspiration. The DR stated that it was a ST recommendation to offer Resident #91 fluids before/after meals and not during meals to decrease risk of aspiration. The DR expressed that staff should remove the fluids from the Resident's sight so that she could focus on her meal. The DR further stated that if Resident #91 asked for fluids staff would not deny her fluids, but should encourage her to eat first and then drink. The DR also stated that due to staff turnover, ST staff continued to provide education. An interview with the Director of Nursing (DON) on 01/15/16 at 4:46 PM revealed she expected nursing staff to read the tray card and to follow the diet order as written on the tray card. The DON stated that per ST recommendations, Resident #91 should not be offered/encouraged to consume fluids with foods.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		2/12/16

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F 311	Continued From page 38 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interview and medical record review, the facility failed to provide Resident #114 with assistive devices during dining to maintain independence with eating for 1 of 2 sampled residents observed for the use assistive devices. Findings included: Resident #114 was admitted to the facility on 11/01/15. Diagnoses included depression, cerebrovascular disease, arthritis and bilateral hand deformities. An admission Minimum Data Set dated 11/08/15 assessed Resident #114 with intact cognition and requiring staff supervision, cueing, encouragement and tray set-up with meals. The Care Area Assessment (CAA) summary identified Resident #114 at risk for decline in activities of daily living (ADL) and nutrition regarding diagnoses of cerebrovascular accident (CVA) and arthritis and leaving 25% of his meal uneaten. The CAA summary indicated that Resident #114 should receive his diet as ordered and staff should encourage intake/fluids. The care plan for Resident #114 dated 11/12/15 identified that he was at risk of ADL/nutritional decline related to diagnoses (CVA and depression) and required staff assistance to	F 311	ADAPATIVE EQUIPMENT What measures did the facility put in place for the resident affected: On 01/21/16 resident was revaluated by speech therapy for need of assistive device during meals. On 01/21/16 dietary manager notified of recommendation to ensure device will be placed on resident tray card for all meals. On 01/29/16 100 % audit of all residents was completed to identify resident with recommendation for assistive devices. What measures were put in place for residents having the potential to be affected: On 01/29/16 100 % audit of all residents was completed to identify residents with recommendations for assistive devices was completed by Rehab Manager and Dietary Manager with corrections made as necessary on 01/29/16 the dietary manager audited 100% of resident tray cards to ensure correct assistive device was listed and updating tray cards as necessary.	

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F 311	Continued From page 39 restore/maintain maximum function of self sufficiency for ADL. Interventions included to provide diet as ordered, assistance with meals as indicated, set up tray, encourage consumption of meal and therapy consult as needed for evaluation/recommendations. A diet order dated 12/2/15 recorded Resident #114 should receive a blue handled spoon and fork (built-up utensils) with meals. The diet order was written by Certified Occupational Therapy Assistant (COTA) #1. An occupational therapy (OT) discharge summary dated 12/14/15 recorded Resident #114 would perform self feeding with the use of adaptive equipment (built-up utensils). Resident #114 was observed for breakfast on 01/12/16 at 08:37 AM seated in his wheel chair in the dining area. He wore a clothing protector and received 2 boxes of dry cereal with milk, water and juice with tray set up by staff. The tray card next to his plate recorded that Resident #114 should receive a regular consistency diet, meats cut up and built-up utensils (fork/spoon). Resident #114 received regular eating utensils for this meal. He was not offered/encouraged to use built-up utensils and ate his cereal without a built-up spoon. He used the fingers of his right hand to push the cereal/milk onto the regular spoon. He ate 75% of his cereal/milk with minimal food spillage onto his clothing protector. Resident #114 was observed for dinner on 01/13/16 at 6:18 PM seated in his wheel chair in the dining area with a clothing protector in place. He received chicken tenders (cut up by staff), breaded squash, fruit cocktail, a salad (cut up by	F 311	What systems were put in place to prevent the deficient practice from reoccurring: ON 01/30/16 the administrator in-serviced the dietary manager related to assistive devices being listed on the tray cards and being sent out with each meal. The dietary manager began in-servicing the dietary department on assistive devices being on the tray card and placing device on resident tray card for each meal. On 01/31/2016 began in-servicing 100% of nursing staff related to reading resident tray card to check for the need of assistive devices, ensuring the is on the tray card and offering the device for the resident for the resident to use How the facility will monitor systems put in place: The monthly QI committee will review the results of the tray card Audit monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 311	Continued From page 40	F 311		

staff), water and tea with regular utensils. NA #2 set-up his tray. Resident #114 fed himself the dinner meal by pushing his dinner onto a regular fork and fruit cocktail onto a regular spoon using his right hand. He ate 50% of his meal with minimal food spillage onto his clothing protector.

Resident #114 was observed for breakfast on 01/14/16 at 08:17 AM seated in his wheel chair in the dining area with a clothing protector in place. He received 2 boxes of dry cereal, milk, and orange juice with regular utensils. His tray was set up by NA #2. Resident #114 fed himself cereal/milk by pushing the cereal/milk onto a regular spoon with his right hand. He was not offered/encouraged to use built-up utensils. He ate/drank 100% of his breakfast meal with some food spillage onto his clothing protector.

Resident #114 was interviewed on 01/14/16 at 12:01 PM. During the interview, he stated that he used the "foam handled utensils" (built-up utensils) at times when staff provided them. He stated that "sometimes they give them to me, but sometimes they don't."

An interview with the Assistant Dietary Manager (ADM) occurred on 01/15/16 at 2:10 PM. She stated that she received a diet order from the therapy department for Resident #114 to use built-up utensils with his meals and added this recommendation to his tray card. The ADM stated that the built-up utensils were always available and staff should use the tray card for tray set-up and request what they need for the resident. The ADM further stated the built-up utensils were always available but staff may have just forgotten to provide them to Resident #114.

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An interview with NA #2 occurred on 01/15/16 at 2:15 PM. During the interview, she stated that she used the tray card when she set-up a resident's meal tray to know what the resident needed and if necessary she asked the nurse or reviewed the care guide. NA #2 stated that she was aware that Resident #114 required built-up utensils with his meals, but stated he would ask for them when he wanted them and at times he did not always want to use the built-up utensils. NA #2 further stated that she had not informed the nurse/therapy staff of the times Resident #114 declined use of the built-up utensils for further evaluation.

An interview with COTA #1 occurred on 01/15/16 at 3:07 PM. COTA #1 stated that Resident #114 was referred for OT on 10/11/15 for left-sided weakness from a recent CVA and bilateral hand deformities; he was discharged on 12/14/15. COTA #1 stated that on 11/26/15 a self feeding goal was added which indicated Resident #114 would perform self feeding with the use of adaptive equipment (built-up utensils). COTA #1 stated at discharge Resident #114 was independent with the use of the built-up utensils, had less food spillage with its use and was able to control adding food to the spoon better because of his hand deformities. COTA #1 stated that staff should offer the built-up utensils with each meal, but if Resident #114 expressed to staff that he did not want to use the adaptive equipment, this should have been reported to therapy staff for further evaluation of adaptive equipment that would help maintain his independence with eating.

An interview with the Director of Rehabilitation (DR) occurred on 01/15/16 at 3:55 PM. DR stated that she would expect nursing staff to provide

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F 311	Continued From page 42 Resident #114 with the built-up utensils with each meal and advise the therapy department if he declined its use for evaluation of adaptive equipment that would help maintain his independence with eating. The Director of Nursing was interviewed on 01/15/16 at 4:52 PM and revealed she expected nursing staff to follow the diet order on the tray card for Resident #114 regarding the use of built-up utensils and inform therapy staff if a resident declined the use of adaptive equipment.	F 311		
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	F 356		2/12/16

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F 356	Continued From page 43 for review at a cost not to exceed the community standard. 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, staff interviews and record review the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift, and failed to post the correct census with each shift for 3 of 5 days of the survey conducted from 01/11/16 to 01/15/16. Findings included: On 01/11/16 at 10:55 AM the facility staffing and census was posted at a bulletin board on the front hall across from the Therapy room. It indicated census was at 89 on all three shifts that day. Record review revealed the census was actually 92 for the 3-11 and 11-7 shifts on 01/11/16. On 01/12/16 at 8:25 AM, observation revealed the posted staffing was still dated for 01/11/16 with a census of 89 residents. At 12:25 PM on 01/12/16, the posted staffing was changed to reflect the staffing for 01/12/16. It indicated census was at 91 on all three shifts that day. Record review revealed the census was actually 90 for all three shifts on 01/12/16. Observation on 01/13/16 at 8:11 AM revealed the posted staffing was for 01/12/16 with a census of 91 for all three shifts. On 01/13/16 at 9:35 AM, observation revealed the posted staffing was still for 01/12/16. At 10:26 AM on 01/13/16 the posted	F 356	Ftag posting with accurate census and timely What measures did the facility put in place for the resident affected: Census posting corrected 01/15/2016 What measures were put in place for residents having the potential to be affected: Census posting corrected 01/15/2016 What systems were put in place to prevent the deficient practice from reoccurring: On 1/18/16 the Administrator, DON and Staff Facilitator started an in-service for all nurses, Admissions Coordinator, and Scheduler related to updating census within 30 minutes of shift change. In-service will be completed 2/11/16. How the facility will monitor systems put in place: On 01/18/2016 the DON/ADON/QI/ and/or	

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F 356	Continued From page 44 staffing had been changed to reflect staffing on 01/13/16. During an interview on 01/13/16 at 6:35 PM, the Director of Nursing stated the Staffing Coordinator was responsible for posting and updating the Posted Staffing. During an interview on 01/15/16 at 4:01 PM, the Assistant Director of Nursing (ADON) said the Staffing Coordinator was responsible for posting the staffing when she arrived in the morning around 7:30 AM, and was also responsible for updating staffing and census for the 3-11 shift. The ADON stated the nurse on the 500/600 hall was supposed to update as needed for the 11-7 shift. The ADON indicated posted staffing information should be timely and accurate for all shifts.	F 356	SDC began auditing the census posting using the census posting audit tool. The audit will be completed 5x week x four weeks, then weekly x 8 weeks then monthly x 2 months. The monthly QI committee will review the results of the census audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry bowls before stacking, failed to ensure plates and bowls were free of	F 371	F 371 Sanitary Conditions Criteria 1	2/12/16

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F 371	Continued From page 45 dried food particles, and failed to date opened food items in storage. Findings included: 1. During the initial tour, beginning at 10:59 AM on 01/11/16, food items without labels and dates were found in the walk-in freezer. These items included three partial bags of hotdog buns that were not labeled or dated to indicate when they had been opened. A bag containing four pie shells was also found without a label or expiration date. On 01/15/16 at 8:04 AM the Dietary Manager (DM) indicated opened food items, food items removed from original packaging, and leftover food items should have labels and dates on them. He stated that dietary employees who opened food items or placed leftovers in storage were responsible for placing labels and dates on them. 2. During the initial tour, conducted with the Assistant Dietary Manager on 01/11/16 at 11:24 AM, dishes were being removed from the dishwasher. Review of the bowls revealed that 4 of 45 bowls were stacked on top of one another with moisture inside of them. A follow-up tour was conducted with the Dietary Manager (DM) on 01/13/16 at 9:20 AM. In the clean dish area at that time, 4 of 9 plates and 11 of 38 bowls were found to have dried with some food particles still on them. There were also 5 of 10 small bowls that were stacked on top of one another with moisture inside of them. At 8:04 AM on 01/15/16, the DM stated before stacking kitchenware into storage it was to be air dried. He also stated it was the responsibility of the dietary employee placing dishware into	F 371	On 1/12/16, the Dietary manager disposed of the expired bread in a trash receptacle were removed from the bag on bins and changed. Criteria 2 On 01-15-16. The dietary manager and dietary staff were in-serviced on labeling and dating all products after they have opened or taken out of original container. On 01/12/16, the Dietary Manager completed a 100% audit of all resident foods to ensure no expired foods were in the dietary department to include bread. Any negative findings were immediately corrected. Criteria 3 On 01/15/16, the Dietary Manager in-serviced 100% of Dietary Staff on Sanitary Conditions. The in-service included A. Foods must be stored, prepared, distributed and served under sanitary conditions B. Expired food must be discarded immediately to include bread. Criteria 4 On 01/15/16, the Administrator initiated an audit tool titled labeling and dating Audit Tool to monitor all wet nesting five times weekly for four weeks, weekly for four weeks, then monthly times three months. Any negative findings will be corrected immediately. The Dietary Manager and/or the Assistant will present findings from the Audit Tools at the monthly QI committee meetings for six months for further recommendations.	

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F 371	Continued From page 46 storage, to check for dried food particles. He explained dishware found with dried food particles on it, was to be scrubbed and re-run through the dish machine until clean.	F 371	The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area. And to determine the need for and or/ frequency of continued QI monitoring.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of a facility policy, the facility failed to document administration of a narcotic (Percocet) and analgesics (Tylenol and Tramadol) to include the route, time, reason, and the effectiveness of the medication after administration for 2 of 4 sampled residents reviewed for pain management (Residents #15 and #47). The findings included:	F 514	F Tag 514 PRN Pain Medication Effectiveness What measures did the facility put in place for the resident affected: On 1/28/2016 resident #15 had a pain assessment completed by a RN reporting that resident□s PRN pain medication is	2/12/16

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F 514	Continued From page 47 A facility policy dated 03/09/15 recorded in part "Nursing Guidelines: When documenting the degree of pain relief on the pain management log, reassess the resident and document the degree of pain relief 60 minutes after oral analgesic administration." 1. Resident #15 was admitted to the facility on 09/04/15 after a mechanical fall. Diagnoses included subarachnoid hemorrhage, subdural hemorrhage, hypertension, seizures, hemorrhage of gastrointestinal tract, convulsions, and depression. A pain assessment dated 09/04/15 recorded that Resident #15 was verbal, consistently able to make her needs known and received as needed (PRN) pain medication that was effective for relief. Resident #15 had a physician's order dated 09/4/15 for Tylenol Extended Relief (ER) 500 milligrams (mg) every (q) 6 hours prn for pain. Resident #15 had a physician's order dated 09/11/15 for Percocet (narcotic) 5-325 mg q 6 hours prn for pain. An admission Minimum Data Set dated 09/11/15 assessed Resident #15 with intact cognition and prn pain medication required/received for frequent pain which the Resident rated 7 out of 10 on a pain scale. Review of a neurology consult dated 09/24/15 recorded a physician's order for Resident #15 to continue Percocet (narcotic) 5-325 mg q 6 hours prn for pain.	F 514	effective. On 2/3/2016 resident #47 had a pain assessment completed by a RN reporting that resident□s PRN medication is effective. What measures were put in place for residents having the potential to be affected: A pain assessment was completed on 100% of residents by a RN. All assessments were completed by 2/12/2016. No negative findings were identified. What systems were put in place to prevent the deficient practice from reoccurring: On 1/27/16 the facility consultant, director of nursing (DON), and staff development coordinator(SDC) started an in-service with 100% of licensed staff related to the importance of documentation of PRN pain medications to include the medication given, the reason, the time given, the reason, the route, and the effectiveness. In-servicing was completed 2/12/16. All newly hired licensed staff employees will receive in-service with new employee orientation. How the facility will monitor systems put in place: Beginning 2/1/2016, the DON, assistant director of nursing (ADON), SDC, and/or QI nurse will audit documentation of effectiveness of prn medication given using the Documentation of Effectiveness	

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F 514	Continued From page 48 Review of facility records revealed a staff in-service on "Controlled Substance Documentation" dated 11/01/15 which instructed nurses to record the exact time of medication administration and to document on the front/back of the medication administration record (MAR) the reason, route, time and effectiveness of prn medications. A care plan dated 11/16/15 identified Resident #15 with acute chronic pain related to headaches, eye pain and generalized pain. Interventions included to administer pain medication per physician's order and to note the effectiveness. Resident #15 had a physician's order dated 11/30/15 to discontinue the current physician orders for prn pain management (Tylenol/Percocet) and to start Tylenol 325 mg 2 tabs q 6 hours prn pain. Review of facility records revealed a staff in-service dated 12/10/15 which instructed nurses to document the effectiveness of pain medication. Resident #15 had a physician's order dated 12/21/15 to start Percocet 5-325 mg 1 tab q 8 hours prn severe pain. Review of the MAR and nurse's notes for November 2015 - January 2016 (3 months) revealed the following dates when Tylenol/Percocet were documented as administered without documentation to include the reason, route, time and/or effectiveness: Tylenol ER 500 mg q 6 hours prn pain was	F 514	of PRN Medication Audit Tool. The audit will be completed 5x/week for 4 weeks then weekly for 8 weeks then monthly for 3 months. The DON and/or ADON will present findings to the monthly QI committee. The monthly QI committee will review the results of the Documentation of Effectiveness of PRN Medications Audit Tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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administered on:
· 11/13/15 and 11/14/15, no documentation of the effectiveness

Percocet 5-325 mg, 1 tab q 8 hours prn pain was administered on:
· 12/21/15, 01/01/16, 01/03/16 and 01/04/16, no documentation of time, route, reason or effectiveness
· 12/27/15, no documentation of effectiveness

Tylenol 325 mg 2 tabs q 6 hours prn pain was administered on:
· 01/02/16 and 01/04/16, no documentation of the time, route, reason or effectiveness
· 01/08/16 and 01/11/16, no documentation of the effectiveness

A telephone interview with Nurse #3 occurred on 01/15/16 at 10:19 AM. The interview revealed that she administered Tylenol and Percocet per physician's order to Resident #15 in December 2015 for generalized pain. Nurse #3 stated she received a recent in-service which instructed her to document the date, time, route, reason and effectiveness for the administration of narcotics/analgesics, but at times she got busy and did not document. Nurse #3 stated she routinely followed up with residents to determine the effectiveness of pain medication after administration, and if she did not follow-up she would report that to the oncoming nurse for follow up.

A telephone interview with Nurse #4 occurred on 01/15/16 at 10:29 AM. The interview revealed that she administered Tylenol and Percocet per physician's order to Resident #15 in December 2015 and January 2016 for complaints of

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generalized pain. Nurse #4 stated she received a recent in-service which instructed her to document the date, time, route, reason and effectiveness for the administration of narcotics/analgesics. Nurse #4 stated she routinely followed up with residents to determine the effectiveness of pain medication after administration, but at times she got busy and did not always document this follow up.

A telephone interview with Nurse #5 occurred on 01/15/16 at 11:00 AM. The interview revealed she administered prn pain medication to Resident #15 per physician's order in December 2015 for complaints of pain. Nurse #5 stated she was in-serviced and reminded to document the date, time, route, reason and effectiveness for the administration of narcotics/analgesics. Nurse #5 stated it was her typical practice to follow up to determine the effectiveness of the pain medication given, but she did not always document the follow up.

A telephone interview with Nurse #6 occurred on 01/15/16 at 11:46 AM. The interview revealed that she administered Percocet in January 2016 to Resident #15 per physician's order for complaints of headaches. Nurse #6 stated she was recently informed that she should document the date, time, route, reason and effectiveness for the administration of narcotics on the back of the MAR, but sometimes she got busy and did not document.

Attempts to interview nurses who administered pain medication to Resident #15 in November 2015 were unsuccessful.

An interview with the Director of Nursing (DON)

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occurred on 01/15/16 at 1:28 PM. The interview revealed that she expected nurses to assess a resident's complaint of pain, administer pain medication per physician order and document in the medical record the date, time, route, reason, and effectiveness of the pain medication. The DON stated that nurses were educated on this periodically during meetings.

2. Resident #47 was admitted to the facility on 06/02/15 and re-admitted on 11/27/15 after a planned surgery. Diagnoses included depressive disorder, cerebral artery occlusion, toe amputation, cellulitis and chronic foot ulcer.

A care plan dated 06/03/15 identified that Resident #47 was at risk for acute/chronic pain. Interventions included to anticipate the Resident's need for pain relief and to respond appropriately.

Resident #47 had a physician's order dated 06/04/15 for Tramadol (analgesic) 50 milligrams (mg) every (q) 6 hours as needed (prn) for pain.

Review of facility records revealed a staff in-service on "Controlled Substance Documentation" dated 11/01/15 which instructed nurses to record the exact time of medication administration and to document on the front/back of the medication administration record (MAR) the reason, route, time and effectiveness of prn medications.

Resident #47 had a physician's order dated 11/29/15 for Percocet (narcotic) 5-325 1 tab q 4 hours prn for pain.

A quarterly Minimum Data Set dated 12/05/15 assessed Resident #47 with intact cognition,

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occasional pain, rated 3 out of 10 on a pain scale and prn pain medication use.

Review of facility records revealed a staff in-service dated 12/10/15 which instructed nurses to document the effectiveness of pain medication.

Review of the MAR and nurse's notes for November 2015 - December 2015 (2 months) revealed the following dates when Tramadol/Percocet were documented as administered without documentation to include the reason, route, time and/or effectiveness:

Tramadol 50 mg q 6 hours prn pain was administered on:
11/27/15, no documentation of the effectiveness
11/30/15, 12/18/15, and 12/23/15, no documentation of the time, route, reason or effectiveness

Percocet 5-325 mg 1 tab q 4 hours prn pain was administered on:
11/29/15, 12/03/15 and 12/05/15, no documentation of the effectiveness
12/09/15, 12/10/15, and 12/31/15, no documentation of the time, route, reason or effectiveness

A telephone interview with Nurse #3 occurred on 01/15/16 at 10:19 AM. The interview revealed that she administered Tramadol and Percocet per physician's order to Resident #47 in November 2015 for pain. Nurse #3 stated she received a recent in-service which instructed her to document the date, time, route, reason and effectiveness for the administration of narcotics/analgesics, but at times she got busy and did not document. Nurse #3 stated she

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routinely followed up with residents to determine the effectiveness of pain medication after administration, and if she did not follow-up she would report to the oncoming nurse for follow up.

A telephone interview with Nurse #4 occurred on 01/15/16 at 10:29 AM. The interview revealed that she administered Percocet per physician's order to Resident #47 in December 2015 for complaints of pain. Nurse #4 stated she received a recent in-service which instructed her to document the date, time, route, reason and effectiveness for the administration of narcotics/analgesics. Nurse #4 stated she routinely followed up with residents to determine the effectiveness of pain medication after administration, but at times she got busy and did not always document this follow up.

A telephone interview with Nurse #6 occurred on 01/15/16 at 11:46 AM. The interview revealed that she administered Percocet in December 2015 to Resident #47 per physician's order for complaints of leg pain, rated by the Resident as 8 out of 10, for cellulitis. Nurse #6 stated she was recently informed that she should document the date, time, route, reason and effectiveness for the administration of narcotics on the back of the MAR, but sometimes she got busy and did not document.

An interview with the Director of Nursing (DON) occurred on 01/15/16 at 1:28 PM. The interview revealed that she expected nurses to assess a resident's complaint of pain, administer pain medication per physician order and document in the medical record the date, time, route, reason, and effectiveness of the pain medication. The DON stated that nurses were educated on this

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F 514	Continued From page 54 periodically during meetings.	F 514		
F 520 SS=D	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 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record review and facility record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April 2015. This	F 520	F 520 QAA Committee On 1/27/16 the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff	2/12/16

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F 520	Continued From page 55 was for one recited deficiencies that was originally cited in March 2015 on a recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of food storage/sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 371 Food Storage/Sanitation: Based on observation and staff interview the facility failed to air dry bowls before stacking, failed to ensure plates and bowls were free of dried food particles, and failed to date opened food items in storage. The facility was recited for F 371 for failure to store bowls to air dry, storing ready-for-use dishes clean, and recording a date of opening for stored foods. F 371 was originally cited during the March 19, 2015 recertification survey for failure to operate the high temperature dish machine at a final rinse cycle temperature of at least 180 degrees Fahrenheit for heat sanitation. The administrator was interviewed on 01/15/2016 at 5:44 PM. During the interview, the administrator stated that she attributed the repeat deficiency for food storage/sanitation to staff/management turnover in the dietary department and utilizing time/supplies efficiently. The administrator stated that she expected the dietary department to purchase enough dishes so that staff were not dependent on sanitizing/drying dishes in time for the next meal service.	F 520	facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/11/16 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 371 Food Storage/Sanitation. As of 2/11/16, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns.	

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F 520	Continued From page 56	F 520	Corrective action has been taken for the identified concerns related to F 371 Food Storage/Sanitation as reflected in the plan of correction. The Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	