STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING ______ B. WING ______	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TARBORO	**1000 WESTERN BOULEVARD TARBORO, NC 27886**

(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 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: The facility failed to complete a significant change in status assessment for 1 of 21 residents reviewed (Resident #35). Findings included: Resident #35 had been admitted to the facility on 2/08/2016. Diagnoses included cerebrovascular disease, low back pain, pancreatitis, hypertension, depression and seizures. Resident #35's admission minimum data set (MDS) dated 2/15/2016 indicted he was cognitively intact, required extensive assistance with bed mobility, and transfers and required total assistance with dressing, toileting, hygiene and bathing. Resident #35 was noted to be always incontinent of bowel and bladder. Resident #35's most recent quarterly MDS dated 5/06/2016 indicated he had moderate cognitive impairment, required limited assistance with bed mobility, transfers, dressing and hygiene and	F 274	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law" F274 Corrective action affected resident Resident #35 MDS was modified to reflect a significant change and the resident�s current status. Corrective action potential residents Residents who may have had the	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	Continued From page 1 required extensive assistance with toileting and total assistance with bathing. Resident #35 was noted to be frequently incontinent of bowel and bladder. This MDS indicated Resident #35 had a decline in his cognitive function, improvements in some of his activities of daily living (ADL) function and in his bowel and bladder function. An interview with Nurse Aide (NA) #2 was conducted on 6/07/2016. The NA stated she had been working with Resident #35 for about 6 months. The NA stated Resident #35's abilities with performing ADL tasks had improved over the past few months. The NA stated he was now able to help with bathing and dressing and was able to propel himself in the wheelchair. An interview with Nurse #2 was conducted on 6/08/2016 at 3:20 PM. The nurse stated Resident #35's physical abilities had improved over the past few months and he was now able to help with many ADL tasks. An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA stated the facility had thought Resident #35 was to be discharged to an assisted living facility and a significant change in status assessment had not been done. The DRA also stated when the discharge was delayed a significant change in status assessment should have been completed. An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated the MDS should be accurate and reflect the resident's status.	F 274	potential to be affected will be identified by an audit of MDS to be completed by the Director of Resident Assessment (DRA). If necessary the MDS will be updated with this audit to reflect current status. Measures The Area Vice President (AVP) conducted an inservice on 6/9/2016 to all 3 MDS nurses and DRA concerning accurately reflecting resident status on each assessment and comprehensive careplan. Clinical Assessment Reimbursement Specialist (CARS) conducted an inservice on 6/17/16 with a lecture, PowerPoint and review of RAI manual including developing, reviewing and revising comprehensive careplans. An audit form was initiated for DRA to audit MDS□s to accurately reflect the resident status. This will be done weekly for 4 weeks then monthly for 3 months. Monitoring DRA will report the findings of the review to Quality Assurance Performance Improvement (QAPI). In QAPI, we will review and analyze for patterns and trends to ensure continued compliance.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		7/7/16

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F 278	Continued From page 2 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money 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 MDS for 7 of 21 residents whose MDS were reviewed (Resident #253, #132, #151, #57, #171, #82 and #252). Findings included: 1. Resident #253 had been admitted to the facility on 5/02/2016. The hospital history and physical note for Resident #253 dated 4/23/2016 included an	F 278	F278 Corrective action affected resident Resident # 253, #132, #151, #57, #171, #82 and #252 Minimum Data Set (MDS) assessments were modified to reflect accuracy and residents current status. Corrective action potential residents	

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F 278	Continued From page 3 active problem list of: acute respiratory failure, atrial fibrillation, anemia, coronary artery disease, cerebrovascular disease, depression and dementia. The hospital discharge summary for Resident #253 dated 5/2/2016 included discharge diagnoses of: non-ST elevation myocardial infarction (heart attack), coronary artery disease, atrial fibrillation, depression, dementia, acute respiratory failure, cerebrovascular disease and anemia. The standing physician orders dated 5/02/2016 indicated " will accept hospital history and physical, discharge summary and diagnosis list as current: yes. " Resident #253's admission minimum data set (MDS) dated 5/09/2016 indicated he had moderate cognitive impairment, required supervision to limited assistance with activities of daily living (ADL) and was dependent for bathing. He had received antianxiety, antidepressant, diuretic medications and used oxygen. He had also received skilled therapy services. The MDS assessment did not include any medical diagnoses. An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA stated diagnoses were obtained from the hospital discharge summary, the hospital history and physical, physician notes and orders. The DRA also stated diagnoses should have been included on the admission MDS assessment. An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated the MDS should be accurate and include current diagnoses. 2. Resident #132 had been admitted to the facility on 12/31/2015.	F 278	Residents who may have had the potential to be affected will be identified by a MDS audit completed by the Director of Resident Assessment (DRA). If necessary the MDS will be updated with this audit to reflect accuracy and residents current status. Measures The Area Vice President (AVP) conducted an inservice on 6/9/2016 to all 3 MDS nurses and DRA concerning accurately reflecting resident status on each assessment and comprehensive careplan. Clinical Assessment Reimbursement Specialist (CARS) conducted an inservice on 6/17/16 with a lecture, PowerPoint and review of RAI manual including developing, reviewing and revising comprehensive careplans. An audit form was initiated for DRA to audit MDSs for accuracy coding and reflect the residents status. This will be done weekly for 4 weeks then monthly for 3 months. Monitoring DRA will report the findings of the review to Quality Assurance Performance Improvement (QAPI). In QAPI, we will review and analyze for patterns and trends to ensure continued compliance.	

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F 278	Continued From page 4 The hospital discharge summary for Resident #132 dated 12/31/2015 included discharge diagnoses of essential hypertension and syncope. The standing physician orders dated 1/06/2016 indicated " will accept hospital history and physical, discharge summary and diagnosis list as current: yes. " Resident #132's admission minimum data set (MDS) was dated 1/07/2016 and indicated Resident #132 had moderate cognitive impairment. He had required supervision with eating, limited to extensive assistance with activities of daily living (ADL) and total assistance with bathing. An unstageable pressure ulcer was noted. Medications received included insulin and an anticoagulant. The MDS assessment did not include any medical diagnoses. An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA stated diagnoses were obtained from the hospital discharge summary, the hospital history and physical, physician notes and orders. The DRA stated diagnoses should have been included on the admission MDS assessment. An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated the MDS should be accurate and include current diagnoses. 3. Resident #151 had been admitted to the facility on 2/11/2016. Admission diagnoses included: bipolar disorder, diabetes, hypertension, paraplegia and anemia. a. Resident #151's admission minimum data set (MDS) dated 2/11/2016 indicated she had been alert and oriented. Diagnoses included: bipolar disease, diabetes, hypertension, paraplegia and anemia. The MDS did not indicate Resident #151 had been identified as a Preadmission Screening	F 278		

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F 278	Continued From page 5 and Resident Review (PASRR) level 2 (a resident identified as having a serious mental illness as defined by state and federal guidelines) resident. Care plans initiated on 2/18/2016 included: Resident has a Level F (approved for 60 days short term admission) PASRR. An interview was conducted the social worker (SW) on 6/07/2016 at 3:36 PM. The SW stated the admissions department would alert the SW and the MDS department of any PASRR level 2 residents who had been admitted and updated the PASRR list monthly. The SW stated it had been her responsibility to code the PASRR information on the MDS assessment and to initiate a care plan for the PASRR resident. An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA stated PASRR information and PASRR care plans were coded by the SW. The DRA indicated the PASRR information had been missed being marked. An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated the MDS should be accurate. b. Resident #151's admission minimum data set (MDS) dated 2/11/2016 indicated she had been alert and oriented. Diagnoses included: bipolar disease, diabetes, hypertension, paraplegia and anemia. The MDS assessment indicated she had received antidepressant medication. A review of the February 2016 medication administration record (MAR) indicated Resident #151 had received an antipsychotic and not an antidepressant medication. Care plans initiated on 2/18/2016 included: 1. Potential for drug related complications associated with use of psychotropic medications	F 278		

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F 278	Continued From page 6	F 278		

related to: Anti-Depressant medication. 2. Potential for drug related complications associated with use of psychotropic medications related to: Anti-psychotic medication.

An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA indicated Resident #151 had received an antipsychotic and not an antidepressant medication and this had been mismarked on the admission MDS.
An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated the MDS should be accurate.

4. Resident #57 was admitted to the facility 5/11/09 with diagnoses which included coronary artery disease, congestive heart failure, end stage renal disease, diabetes, dementia and hemiplegia.
The Quarterly Minimum Data Set (MDS) from 8/11/15 indicated Resident #57 had 2 venous/arterial ulcers and no diabetic ulcers.
The Quarterly MDS from 11/3/15 indicated Resident #57 had 2 venous/arterial ulcers and no diabetic foot ulcers.
The Quarterly MDS from 1/26/16 indicated Resident #57 had no venous/arterial ulcers and answered yes to a diabetic foot ulcer.
The Annual (MDS) from 4/19/16 indicated Resident #57 had no venous/arterial ulcers and no diabetic foot ulcers.
An interview was conducted on 6/8/16 at 9:59 AM with Nurse #3 who was responsible for treatments. She stated that Resident #57's left foot wound had been classified as a venous ulcer until after her left great toe amputation (March 2015) and at that time, the attending physician

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F 278	Continued From page 7 had changed the classification from a venous ulcer to a diabetic foot ulcer. A review of the wound evaluation flow sheet showed the left foot wound classified as a diabetic foot ulcer on 4/19/16. An interview was conducted on 6/9/16 at 8:55 AM with the Director of Resident Assessments. She stated the MDS staff obtained supporting documentation for the Skin Conditions section of the MDS from the chart and wound care nurse ' s documentation. After review of the Wound Evaluation Flow Sheet, she stated the MDS should have indicated Resident #57 as having a diabetic foot ulcer. An interview was conducted 6/9/16 at 1:00 PM with the Director of Nursing. She stated her expectation was for the staff to follow the guidelines of the MDS to ensure accuracy. 5. Resident #171 was re-admitted to the facility on 4/20/2016, with diagnoses to include of fracture of the left lower leg. A wound evaluation flow sheet dated 4/11/2016 revealed a stage 1 pressure ulcer to the sacrum. The flow sheet included weekly details of the pressure ulcer, including entries on 5/3/2016 and 5/10/2016 which continued with stage 1 pressure ulcer to sacrum treatment. Resident # 171's 14 day Minimum Data Set (MDS) assessment dated 5/4/2016 revealed a stage one pressure ulcer present on admission. The resident's 30 day MDS assessment dated 5/16/2016 revealed there was no pressure ulcer, and no pressure ulcer on the prior assessment. An interview was conducted with the MDS nurse #1 on 6/8/2016 at 4:15 PM. The nurse stated he usually looked at the resident's orders for pressure ulcer treatment and did not see the order, so he assumed it was healed, and did not	F 278		

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F 278	Continued From page 8 included it on the MDS of 5/16/2016. He indicated it was an oversite that he did not document the pressure ulcer was present on the previous assessment. On 6/9/2016 at 11:14 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to follow the guidelines for what was stipulated to document on the MDS. 6. Resident #82 was re-admitted to the facility on 6/24/2015 with diagnoses to include multi drug resistant organism (MDRO) (an infection) and sepsis (an infection). The resident's annual minimum Data Set (MDS) assessment dated 3/24/2016 included diagnoses of MDRO and septicemia. A review of the resident's Medication Administration Record (MAR) for March 2016 revealed no medications were dispensed for infection. On 6/8/2016 at 4:24 PM, an interview was conducted with the MDS nurse. The MDS nurse stated those diagnoses of MDRO and sepsis were from her admission to the hospital in June of 2015 and should not have been included on the MDS assessment of 3/2/42016. On 6/9/2016 at 11:14 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to follow the guidelines for what was stipulated to document on the MDS. 7. a. Resident #252 was admitted on 4/26/16 and readmitted on 5/20/16. Diagnoses included acute respiratory failure, dysphagia, atrial fibrillation and	F 278		

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F 278	Continued From page 9	F 278		

esophageal obstruction.

Review of the hospital discharge summary dated 4/26/16 indicated Resident #252 had an esophageal stricture status post dilation with malnutrition. She had been seen by Speech therapy and cleared for a dysphagia (a diet ordered for residents with difficulty swallowing).

The 5/3/16 Admission Minimum Data Set (MDS) indicated Resident #252 was cognitively intact. No problems with swallowing were identified.

Notes for 5/18/16 at 5:48 PM indicated Resident #252 was hospitalized after being sent out for an endoscopy appointment. Hospital Clinic notes indicated the resident had a diagnoses that included esophagitis and esophageal stricture.

Resident #252 was interviewed on 6/7/16 at 2.47 PM. She stated she had lost weight due to not being able to swallow. The resident reported her esophagus had been dilated to help with swallowing.

During an interview with the Director of Resident Assessment (DRA) and the corporate nurse on 6/9/16 at 8:55 AM, the DRA stated she rarely completed a MDS; adding the MDS was completed by 2 other MDS nurse's. The DRA stated the Dietary Manager (DM) completed the dietary and dental part of the MDS. She added if a resident had been admitted with diagnoses that included esophageal strictures and obstruction, she would expect to see swallowing problems identified on the MDS. Review of the care plan revealed swallowing problems had not been identified for Resident # 252.

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F 278	Continued From page 10 During an interview with the DM on 6/9/16 at 2:30 PM, she acknowledged she coded the dental and dietary sections of the MDS. She added if she had omitted swallowing issues for Resident #252, it had been a mistake. b. Review of the facility Clinical Health Status assessment, dated 4/26/16 indicated the resident had missing teeth. The presence of dentures was not identified. The admission nurse's note, dated 4/27/16 at 6:01 PM indicated the resident had missing natural teeth. The 5/3/16 Admission Minimum Data Set (MDS) indicated the resident was cognitively intact. Issues with the resident's dentures were identified. Resident #252 was interviewed on 6/7/16 at 2.47PM. The resident stated she had no tooth or gum pain and was able to brush her own teeth. During an interview with resident on 6/9/16 at 1:50 PM, she confirmed she had her natural teeth and no dentures or partial plates. On 6/9/16 at 8:55 AM, the Director of Resident Assessment (DRA) and the corporate nurse were interviewed. The DRA stated she rarely completed an MDS and the responsibility of MDS completion was shared with 2 other MDS nurses. The DRA stated the Dietary Manager (DM) was responsible for completion of the dental section of the MDS. The DRA acknowledged marking dentures for a resident that had no dentures was an error.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		7/7/16

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F 279	Continued From page 11 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to care plan the resident's refusal of a splint, his contracture and failed to care plan interventions to maintain the resident's current range of motion for 1 of 2 residents (Resident #198) reviewed for contractures. Findings included: Resident #198 was re-admitted to the facility on 11/15/15 with cerebrovascular disease and a stroke.	F 279	F279 Corrective action affected resident Resident #198 care plan was updated and revised to reflect his comprehensive plan of care including non-compliant with splint. Corrective action potential residents Residents who may have had the potential to be affected will be identified by an audit completed by the Director of Resident Assessment (DRA). If	

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GOLDEN LIVINGCENTER - TARBORO	1000 WESTERN BOULEVARD TARBORO, NC 27886

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Review of nurse's notes from 2/1/16 to 3/8/16 failed to reveal any documentation that indicated the resident refused to wear the splint on his right hand.

Orders written by Unit Manager (UM) #1 on 3/7/16 at documented Resident #198's splint was discontinued due to the resident's refusal to wear the splint.

The 5/3/16 Annual Minimum Data Set (MDS) indicated Resident #198 had short term memory problem, intact long term memory and moderately impaired cognitive skills for daily decision making. Rejection of care was not coded. The resident required extensive with most activities of daily living and was identified with a functional limitation of range of motion on one side for the upper extremity and lower extremity. The resident was not coded as participating in a restorative nursing program to include passive or active ROM, splint or brace assistance. The care area assessment for activities of daily living identified Resident #198 had contractures, but indicated the resident was not a candidate for therapy.

Resident #198's care plan reviewed on 5/15/16 did not identify refusal of care or contractures as a problem for Resident #198.

On 6/6/16 at 2:39 PM, an observation was made. A splint was seen laying on his nightstand. On command, the resident was able to take his left hand and bend his right fingers outward, but was unable to fully extend the fingers of his right hand.

An observation on 6/7/16 at 7:30 AM revealed Resident #198 was unable to fully extend his right

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necessary the care plan will be updated with this audit to reflect current status.

Measures
The Area Vice President (AVP) conducted an inservice on 6/9/2016 to all 3 MDS nurses and DRA concerning on accurately reflecting resident status on each assessment and comprehensive care plans. Clinical Assessment Reimbursement Specialist (CARS) conducted an inservice on 6/17/16 with a lecture, PowerPoint and review of RAI manual including developing, reviewing and revising comprehensive care plans.

An audit form was initiated for DRA to audit MDS□s and care plans for accuracy to reflect the resident status. This will be done weekly for 4 weeks then monthly for 3 months.

Monitoring
DRA will report the findings of the review to Quality Assurance Performance Improvement (QAPI). In QAPI, we will review and analyze for patterns and trends to ensure continued compliance.

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hand.

The Assistant Director of Nursing (ADON) was interviewed on 6/8/16 at 10:53 AM. The ADON stated range of motion exercises were provided during the provision of care by the nursing assistants (NA).

The Certified Occupational Therapy Assistant was interviewed on 6/8/16 at 2:33 PM. After reviewing the electronic records, the COTA stated Resident #198 was last evaluated by therapy on 9/22/16 after he was readmitted due to flaccid hemiplegia that affected self-care. She read from the evaluation that Resident #198 had an upper extremity contracture with mild impairment of his fine motor skills. Discharge from therapy occurred on 10/19/15.

NA #1 was interviewed on 6/8/16 on 2:47 PM. She stated she knew residents required splinting for a contracture when she would see a splint laying in the resident's room. She stated Resident #198 required a splint to be placed for 2 hours and then removed for 2 hours; adding that she had placed the splint on Monday, 6/6/16. NA #1 stated when the resident tired of the splint, he would start grabbing at it and then, she removed the splint. The NA added she had not been notified the splint had been discontinued and range of motion should be performed during care.

UM #1 was interviewed on 6/8/16 at 3:09 PM. She stated the order to discontinue the splint had been written because Resident #198 refused to wear the splint. The refusal had been reported by the NAs and the UM added she had confirmed the refusal by speaking with Resident #198. The nurse acknowledged there was no documentation

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F 279	Continued From page 14 in the nurse's notes that documented Resident #198's refusal to wear the splint. An interview was held with the Director of Resident Assessment (DRA) and the Corporate Nurse on 6/9/16 at 8:55 AM. The DRA stated she rarely completely the MDS and she was not involved in the development of care plans. As the RDA, she expected the other MDS nurses to care plan issues that triggered during assessment if the issues were appropriate for the individual resident and expected them to care plan any issue that had the potential to negatively impact the resident's ability to participate in care. The RDA added refusal of care or to wear a splint should have been care planned. Review of the care plan by the Corporate Nurse revealed there was no care plan for Resident #198's refusal to wear the splint, his contracture and no care plan to maintain his current range of motion.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		7/7/16

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F 280	Continued From page 15 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility failed to revise care plans for activities of daily living (ADL) for 1 of 21 residents whose care plans were reviewed (Resident #35). Findings included: Resident #35 had been admitted to the facility on 2/08/2016. Diagnoses included cerebrovascular disease, low back pain, pancreatitis, hypertension, depression and seizures. Resident #35's admission minimum data set (MDS) dated 2/15/2016 indicted he required extensive assistance with bed mobility, and transfers and required total assistance with dressing, toileting, hygiene and bathing. Resident #35's care plan for physical functioning deficit related to self-care impairment due to old cerebrovascular accident (CVA) had been initiated on 2/23/2016. Interventions included locomotion assistance requiring total assist upon admission, dressing assistance requiring total care upon admission, toileting assistance requiring total assistance upon admission and personal hygiene assistance requiring total assistance upon admission. Resident #35's most recent quarterly MDS dated 5/06/2016 indicated he required set up assistance for locomotion, required limited assistance with bed mobility, transfers, dressing and hygiene and required extensive assistance with toileting and total assistance with bathing. A resident care planning conference was	F 280	F280 Corrective action affected resident Resident #35 MDS and careplan were modified to reflect a significant change and the resident□s current status of improvement. Corrective action potential residents Residents who may have had the potential to be affected will be identified by an audit of MDS and careplan to be completed by the Director of Resident Assessment (DRA). If necessary the MDS will be updated with this audit to reflect current status. Measures The Area Vice President (AVP) conducted an inservice on 6/9/2016 to all 3 MDS nurses and DRA concerning on accurately reflecting resident status on each assessment. Clinical Assessment Reimbursement Specialist (CARS) conducted an inservice on 6/17/16 with a lecture, PowerPoint and review of RAI manual.	

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F 280	Continued From page 16 conducted on 5/10/2016. The resident care planning conference note sheet indicated the care plan had been discussed with the responsible party. The care plan coordinator, social worker, activity coordinator and dietary manager had been in attendance. Resident #35's care plan for physical functioning deficit did not indicate updates or revisions to reflect improvement in activities of daily living (ADL) since 2/23/2016. An interview with nurse aide (NA) #3 was conducted on 6/07/2016 at 3:20 PM. The NA stated resident #35 required assistance with ADLs, was able to propel himself in his wheelchair and usually knew when he needed to be toileted. An interview with Resident #35 was conducted on 6/07/2016 at 3:25 PM. Resident #35 stated the NAs assist him with bathing, dressing and toileting, transfers and set up his tray for eating. Resident #35 had been observed propelling himself in the halls. An observation of Resident #35 was made on 6/08/2016 at 7:20 AM. After set-up by NA #2, Resident #35 was observed independently washing his face, arms, upper body and groin. Resident #35 was able to move his arms and legs and turn to his side to assist with getting dressed. An interview with Nurse #2 was conducted on 6/08/2016 at 3:20 PM. The nurse stated Resident #35's physical abilities had improved over the past few months and he was now able to help with many ADL tasks. An interview was conducted with the Director of Resident Assessment (DRA) on 6/09/2016 at 8:55 AM. The DRA stated care plans should be	F 280	An audit form was initiated for DRA to audit MDS�s and careplans to accurately reflect the resident status. This will be done weekly for 4 weeks then monthly for 3 months. Monitoring DRA will report the findings of the review to Quality Assurance Performance Improvement (QAPI). In QAPI, we will review and analyze for patterns and trends to ensure continued compliance.	

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F 280	Continued From page 17 updated as needed and quarterly. An interview with the director of nursing (DON) was conducted on 6/09/2016 at 10:55AM. The DON stated care plans should be updated to reflect each resident's current care needs.	F 280		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		7/7/16

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F 441	Continued From page 18 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to disinfect the glucometer (a machine used to test the blood glucose level) after use, per the manufacturer's instructions for 1 of 2 observations. Findings included: The manufacturer's instructions, undated, for cleaning the glucometer included cleaning all external areas of the meter with a moist, lint free cloth and a mild detergent after removing all visible debris. Instructions then directed the user to disinfect the meter with one of the approved disinfecting wipes and gave Environmental Protection Agency (EPA) registration numbers for wipes that were approved for use as well as a selection of 4 wipes from their company. Alcohol wipes, without additional additives, was not listed as an approved wipe for disinfecting the glucometer. Review of the facility policy, revised in August 2012, indicated staff were to use a wipe that was EPA registered as a tuberculocidal agent and was also effective against a broad spectrum of bacteria and contained an equivalent of a 1:10 ratio of bleach that would be effective against clostridium difficile. Further policy instructions indicated after cleansing with the disinfecting wipe, the glucometer would be left damp for the maximal kill time listed on the product label. If the monitor dried prior to the kill time, instructions	F 441	F441 Corrective action affected resident An inservice was done immediately with nurse involved on correct disinfection/cleaning of glucometer per manufacturer instructions and facility policy. Corrective action potential residents Inservice/education to other nurses was done on 6/10/16 for correct disinfection/cleaning of glucometer for potential of affecting other residents. Measures Director of Clinical Education (DCE) will complete skills check list on each nurse and do random skill check offs weekly for 4 weeks then monthly for 3 months. Monitoring DCE will report the findings of the review to Quality Assurance Performance Improvement (QAPI). In QAPI, we will review and analyze for patterns and trends to ensure continued compliance.	

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F 441	Continued From page 19 directed staff to use another wipe to keep the glucometer damp for the specified kill time. Nurse #1 was observed checking the blood sugar level of Resident #13 using a glucometer on 6/8/16 at 4:20 PM. On exiting the room, the nurse stated he was using the "alcohol method" to clean the glucometer. When questioned, he repeated he would clean the glucometer using the "alcohol method". Nurse #1 then opened an alcohol wipe and wiped the exterior of the glucometer and sat the glucometer on top of the medication cart. On interview at this time, the nurse stated the facility policy included disinfecting the glucometer with another type of wipe, but was unable to state what type of wipe. After wiping with the other wipe, the nurse stated he was to let the glucometer dry for 10 seconds. He added he had not used the wipe, indicated in the policy, because he had none on his medication cart; but did acknowledge the wipes were kept in the storage room. Nurse #1 added he had not gone to get the wipes to disinfect the glucometer from the storage room because he had not known there were none on his cart until he started to disinfect the glucometer and he was focused on completing the task. Prior to continuing to the next resident, the nurse asked if he should go to the store room and get the needed wipes to disinfect the glucometer. He was instructed to do what he would normally do in that situation. The nurse proceeded to the store room, returning with another staff member, who opened the drawer to the medication cart and pointed out to Nurse #1 the box of disinfecting wipes sitting in the cart next to the box of alcohol wipes. The nurse had no explanation why he had not seen or used the disinfecting wipes that were on his cart to disinfect the glucometer after completing the blood sugar test on Resident #13.	F 441		

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F 441	Continued From page 20 On 6/8/16 at 4:35 PM, the Director of Nursing (DON) was interviewed. She stated the facility policy and manufacturer's instructions did not include using alcohol wipes to disinfect glucometers. The DON added the risk of not disinfecting the glucometer properly included the spreading of germs. The DON stated Nurse #1 had been trained in the technique for properly cleaning glucometers and presented an in-service sign-in sheet, dated 4/19/16, that included Nurse #1's signature.	F 441		