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	345026	A. BUILDING _____ B. WING _____	C 05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 06/27/16 because of the results of the Informal Dispute Resolution (IDR) process with the following deletions/changes for Event ID# CPF411: F241: deletion of examples 1b, 1c, and example 2 and reduction of scope and severity to D. F242: deletion of all references of residents going outside the facility in example 1a, and deletion of exampled 1b and 1c. F252: deleted by the survey team.	F 000		
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 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	F 157		6/3/16

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

Electronically Signed | 05/31/2016

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F 157	Continued From page 1 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 staff, nurse practitioner and family member interviews, the facility failed to notify the physician and an interested family member of the inability to use the right arm and increased need for assistance with ambulation for 1 of 3 residents who experienced a change in condition (Resident #47). The findings included: Resident #47 was admitted to the facility on 07/31/13 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. Review of Resident #47's quarterly Minimum Data Set (MDS) dated 03/31/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #47 required supervision and set up to walk with no impairment in function range of motion. Review of Resident #47's care plan dated 04/04/16 revealed Resident #47 walked with a rolling walker with staff to provide assistance as needed. Review of a nursing note dated 04/24/16 revealed	F 157	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F157 Resident #47's family was notified on 4-24-16 by #47's primary nurse. Resident #47 was assessed by the Nurse Practitioner on 4/25/16 and a neurology consult was ordered. On 4/27/16 resident #47 was seen by neurologist. Identification of potentially affected residents and corrective actions taken: All residents have the potential to be affected. The 24 hour report sheets were reviewed for all residents for the last 7	

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F 157	Continued From page 2 Nurse #2 documented Resident #47 complained of right hand and arm swelling with "noticeable decrease in ability to use it." Nurse #2 documented Resident #47's family member requested the nurse practitioner (NP) to see Resident #47 tomorrow (04/25/16). Review of the NP acute visit note dated 04/25/16 revealed the NP documented Resident #47 described the right arm as "useless." The NP documented a mild right facial droop, inability to grasp a walker with the right hand and right arm weakness. The NP ordered a neurology consultation. Review of a physician's note dated 04/25/16 revealed the physician documented Resident #47's right arm presented with complete paralysis which could indicate another stroke. Review of a neurologist consultation dated 04/27/16 revealed the neurologist documented Resident #47 exhibited a new right hemianopia (decreased vision) with diminished strength in the right arm and hand. The neurologist ordered a MRI of the brain, carotid ultrasound and transthoracic echocardiogram. Interview with Resident #47's family member on 05/03/16 at 1:35 PM revealed Resident #47 called the family member the evening of 04/23/16. Resident #47 informed the family member, he was upset due to the inability to use his right arm. The family member explained she came to the facility on 04/24/16, saw Resident # 47 could not use the right arm and spoke to Nurse #2. The family member reported Nurse #2 informed her Resident #47's name would be placed on the list to be seen the next day since it	F 157	days by the DON and QA team to ensure that the responsible parties and families were properly notified of any changes in conditions. This was completed by May 25 2016. Systematic Changes: All Nurses, RNs and LPNs (full, part time and PRN) were in-serviced by the Director of Nursing on the need to notify the responsible parties and medical provider of any change in condition. This will be completed as of June 3, 2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance Plan: Monday through Friday The Daily Clinical Meeting Nurses and DON will review the nursing 24 hour report with all progress notes for the last 24 hours and on Monday progress notes for 72 hours in PCC, incident reports, new MD orders, and any resident with a change of condition has documentation that the responsible party and medical provider were notified of the change. This will be done daily Monday through Friday and on Monday for the weekend for at least three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. The weekly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of	

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F 157	Continued From page 3 was Sunday and no doctor or nurse practitioner was available. Interview with Nurse #1 on 05/04/16 at 3:25 PM revealed she cared for Resident #47 on 04/23/16 and 04/24/16 during the evening shift. Nurse #1 reported Resident #47 required 2 persons and a gait to stand at the walker. Nurse #1 reported she did not take Resident #47's vital signs, physically assess all extremities or notify the nursing supervisor. Nurse #1 reported she did not notify Resident #47's family member and physician. Telephone interview with Nurse #2 on 05/04/16 at 4:25 PM revealed she cared for Resident #47 on 04/23/16 and 04/24/16 during the day shift. Nurse #2 reported Resident #47 could not use the right arm and required the extensive assistance of 2 persons to stand at the walker. Nurse #2 explained she spoke with Resident #47's family member on 04/24/16 who requested Resident #47 be seen by a physician or NP. Nurse #2 reported she did not notify the physician. Telephone interview with the Nurse Practitioner (NP) on 05/05/16 at 8:57 AM revealed Resident #47's loss of right arm use and increased weakness of both legs could be indicative of a transient ischemic attack or another stroke although a delay in treatment would not alter the outcome. The NP reported the facility should notify the physician or NP on-call when changes in condition such as experienced by Resident #47 occur. Interview with the Director of Nursing (DON) on 05/05/16 at 11:18 AM revealed she expected staff	F 157	the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Completion: June 3, 2016	

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F 157	Continued From page 4 to notify the physician and Resident #47's family member when loss of right arm use and increased assistance required to walk occurred.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to obtain permission from cognitively intact residents before going through their personal belongings causing the residents to feel childlike and un-important for 1 of 5 residents sampled for dignity and respect (Resident #9). The findings included: 1. a. Resident #9 was initially admitted to the facility on 11/07/13 and was re-admitted on 06/13/14 with diagnoses which included kidney disease, obstructive sleep apnea, gout, heart failure, and history of pneumonia. Review of the quarterly Minimum Data Set (MDS) dated 04/07/16 coded Resident #9 as cognitively intact and required limited assistance from staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Further review of the MDS revealed Resident #9 utilized a walker and a wheelchair for locomotion.	F 241	F 241 Corrective Action for Resident Affected: On 5-30-16, the Administrator personally met with Residents #9, regarding the removal of personal items that occurred back in September, 2015. Additionally, see systemic changes below for corrective action regarding those residents who may have had personal items removed. Systemic Changes: The Director of Nursing in-serviced the full time, part time and PRN Nurses and CNAs. Topics included: • Items should never be removed from a patient's room without asking their permission or the permission of their responsible party. This will be completed by June 3, 2016. This information has been integrated into the standard orientation training and in the	6/3/16

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F 241	Continued From page 5 Review of the monthly Resident Council Minutes dated 09/18/15 through 04/12/16 revealed the following: · On 09/25/15 a "special" resident council meeting was called and led by the Administrator and the Director of Nursing (DON). Per the minutes it was explained to the residents in attendance that the main priority of the facility was the health and safety of all residents. The residents were advised that their personal hygiene items were removed in accordance to the Centers for Medicare and Medicaid Services (CMS) and the Occupational Safety and Health Administration (OSHA) guidelines. The resident council minutes further revealed the personal items removed were any items which had a label on it that read "keep out of reach of children" and all aerosol sprays such as hairsprays and deodorants, rubbing alcohols, and retinol containing lotions, nail polish remover, and mouth wash. Items listed which were permitted was hair grease, Vaseline, alcohol free mouthwash, and non-aerosol deodorants. · On 10/02/15 a "special" resident council meeting was called and read in part that administration was present during the meeting and apologized to the residents again for removing their personal hygiene belongings in the manner in which they did. · On 12/01/15 the resident council meeting minutes read in part "staff will be met with to remind them to increase the room inspections to ensure corrections were made to meet the management and resident expectations." On 05/03/16 at 8:45 AM, an interview was conducted with Resident #9. The resident stated "this is not home, it is a dictatorship, a prison." Resident #9 further stated the Administrator and	F 241	required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Nurse Unit Mangers will monitor this issue using the QA Survey Tool. Interview 5 alert and oriented patients to determine if they have had anything removed from their rooms without permission. Any issues will be reported to the Administrator and Director of Nursing. This will be done weekly for one month and then monthly for at least three months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Completion: June 3, 2016	

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Director of Nursing (DON) had a nurse aide (NA) go through the residents' rooms, their drawers, and all of their personal belongings, and removed all aerosol sprays, rubbing alcohol, mouthwash with alcohol content, and perfumes/colognes. Resident #9 indicated no one asked his permission to go through his belongings and it was done while he was out of his room at a resident council meeting. Resident #9 stated he was told by administration after the fact that the items had been collected, placed in a bag in a locked office, and that the personal hygiene items would be given to the families. Resident #9 further stated he had asked for a copy of the facility rules/regulations in regards to these items not being allowed on the facility's premises and nothing had ever been provided to him. Resident #9 indicated the resident's had been told that the items were removed for the safety of all residents especially the residents with dementia that wandered in and out of other residents' rooms. Resident #9 stated it made him feel like a child, irresponsible, angry, and "like a dog underneath the porch." Also, Resident #9 indicated he had used rubbing alcohol on his face after he shaved and had used Listerine mouthwash all of his adult life, and was now being told he could no longer use his personal hygiene items due to the safety aspect of residents with dementia. He further indicated "I am the one being punished since I don't have dementia."

On 05/04/16 at 3:00 PM, a follow up interview was conducted with Resident #9. The resident stated the Administrator and the DON had attended some of the Resident Council meetings and had apologized for removing their personal hygiene items without their permission. Resident #9 further stated even though administration had

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apologized the residents were told that their items would not be returned nor were they allowed to be used in the facility.

On 05/04/16 at 3:43 PM an interview was conducted with Nurse Aide (NA) #4. She stated she was not employed with the facility when the resident's personal hygiene items were confiscated. NA #4 further stated she had been informed by her supervisor that she should remove all aerosol sprays or products which contained an alcohol content and was instructed to give them to the floor nurse or the nurse supervisor. NA #4 indicated she had not removed any items from a resident's room.

On 05/04/16 at 3:47 PM an interview was conducted with Nurse #5. She stated she was aware administration had instructed an NA to go through the resident's rooms and collect all of the aerosol sprays, any products which contained an alcohol content, or any item with a label which read "keep out of reach of children." Nurse #5 further stated the NA which was instructed to remove the items was no longer employed at the facility. Nurse #5 indicated all staff had been instructed should any of the items be found or observed in a resident's room the items were to be collected, locked up in the medication storage room until the resident's family could pick them up, and also the staff was to inform the Assistant Director of Nursing (ADON) or the DON.

On 05/05/16 at 6:05 AM an interview was conducted with NA #5. NA #5 stated she was unaware that the residents were not supposed to have aerosols or items which contained an alcohol content. NA #5 further stated she had never removed any of a resident's personal

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hygiene items from their rooms.

On 05/05/16 at 6:15 AM an interview was conducted with NA #6. NA #6 stated she was instructed by management that all aerosols, items which contained an alcohol content, and items which were labeled with the words "keep out of reach of children" were to be removed from the residents' rooms. NA #6 further stated she had never removed a resident's personal hygiene items from their room.

On 05/05/16 at 6:22 AM an interview was conducted with Nurse #6. Nurse #6 stated should a resident have any type of aerosols in their rooms due to a fire hazard and for the safety of the dementia residents that she had been instructed by management to remove those items and to give them to the ADON. Nurse #6 further stated she was unable to recall if she had removed any personal hygiene items or aerosols from a resident's room.

On 05/06/16 at 9:15 AM an interview was conducted with NA #7. NA #7 stated she was informed by management that a resident was not allowed to have any aerosols in their rooms. She further stated she was informed by management should she see any aerosols, products which contained an alcohol content, or an item with a label which read "keep out of the reach of children" that they were expected to remove the items and turn them into the ADON.

On 05/06/16 at 10:15 AM an interview was conducted with Nurse #7. Nurse #7 stated she had been advised by management that residents were not allowed to have any type of aerosols, rubbing alcohol, or mouth wash in their rooms or

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in their possession related to ensuring the safety of all residents. Nurse #7 further stated she had not read or seen a policy in regards to the removal of a residents' personal belongings.

On 05/06/16 at 11:55 AM an interview was conducted with the ADON. She stated she was unaware of a policy or guidelines from CMS or OSHA in regards to aerosols and toxins being in resident rooms. She further stated she was also unaware if the requirement was corporation wide or if it was for their building only. The ADON indicated she was informed by management, the Administrator and DON, that residents were not allowed to have hairsprays, any aerosols, nail polish remover, any alcohol containing contents; which included mouth wash and rubbing alcohol, spray deodorants, colognes/perfumes, or any odor reducing sprays, such as "febreze" in their rooms. She further indicated she expected the nursing staff to remove the items mentioned as they had been instructed to do so by management.

On 05/06/16 at 4:50 PM an interview was conducted with the DON. She stated that she and the Administrator wanted to ensure the safety of the residents and had made it a requirement that there were to be no aerosols, air fresheners, nail polish remover, alcohol containing items, or hairsprays allowed in the facility. She further stated the residents and family members were advised they could have pump type hairsprays or a non-alcohol containing mouth wash. The DON also stated that should a resident want to keep rubbing alcohol, and did not want to use the alcohol pads the facility had, then that item would be kept in the medication cart and the resident would be allowed to use that item as they

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F 241	Continued From page 10 requested. The DON further stated "but the items are not allowed in the residents' rooms." The DON was asked if there was a facility policy and could a copy of that policy be obtained. The DON stated "I don ' t know if the policy has been written or not." There was no policy provided.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to allow residents their choice of personal hygiene products causing the resident to feel irresponsible. The facility also failed to honor a resident's choice for the number of showers in a week causing the resident to feel un-clean for 4 of 7 residents sampled for choices (Residents #9, and #192). The findings included: 1. a. Resident #9 was initially admitted to the facility on 11/07/13 and was re-admitted on 06/13/14 with diagnoses which included kidney disease, obstructive sleep apnea, gout, heart failure, and history of pneumonia.	F 242	F 242 On 5-30-16, the Administrator met with and reviewed the revised policy for personal hygiene products with resident #9, #165 and #69. On 5-30-16, Resident #9 was evaluated by the Interdisciplinary Care Plan Team to determine if he could self-administer rubbing alcohol. The facility provided a new bottle of rubbing alcohol for Resident #9. On 5-30-16, the MDS Nurse met with resident #192 to determine shower preferences. Corrective Action for Resident Potentially Affected:	6/3/16

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F 242	Continued From page 11 Review of the quarterly Minimum Data Set (MDS) dated 04/07/16 coded Resident #9 as cognitively intact and required limited assistance from staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Further review of the MDS revealed Resident #9 utilized a walker and a wheelchair for locomotion. On 05/03/16 at 8:45 AM, an interview was conducted with Resident #9. The resident stated "this is not home, it is a dictatorship, a prison." Resident #9 further stated the Administrator and Director of Nursing (DON) had a nurse aide (NA) go through the residents' rooms, their drawers, and all of their personal belongings, and removed all aerosol sprays, rubbing alcohol, mouthwash with alcohol content, and perfumes/colognes. Resident #9 indicated no one asked his permission to go through his belongings and it was done while he was out of his room at a resident council meeting. Resident #9 stated he was told by administration after the fact that the items had been collected, placed in a bag in a locked office, and that the personal hygiene items would be given to the families. Resident #9 further stated he had asked for a copy of the facility rules/regulations in regards to these items not being allowed on the facility's premises and nothing had ever been provided to him. Resident #9 indicated the resident's had been told that the items were removed for the safety of all residents especially the residents with dementia that wandered in and out of other residents' rooms. Resident #9 stated it made him feel like a child, irresponsible, angry, and "like a dog underneath the porch." Also, Resident #9 indicated he had used rubbing alcohol on his face after he shaved and had used Listerine mouthwash all of his adult life, and was now being told he could no longer	F 242	All residents have the potential to be affected by this practice. By 6-3-16, the RN Nurse Unit Managers will meet with all cognitively intact residents to determine shower preferences, ensure that they know where they can go outside and reviewed the updated personal hygiene product policy. The policy has been updated to include: Aerosols cannot be stored near heat producing devices. This includes heater units, hair dryers, TVs, and oxygen concentrators. We prefer that non-aerosol products be used when possible. Over the counter medications cannot be stored in a patients room unless the patient has been evaluated by the care plan team to determine if they are safe to self-administer. If they are deemed safe an MD order must be obtained. All over the counter medications must be stored in a locked drawer in the patient's room. It is preferred that any item that is labeled "keep out of the reach of children" should be stored either behind the bathroom door or in the locked bedside drawers. Systemic Changes The Director of Nursing in-serviced the full time, part time and PRN nursing and CNAs. This is to be completed by June 3, 2016. Topics included: • Shower preferences and schedules should be followed. Shower schedules can be located on CNA tasks in POC and at nurse's station on assignment sheet. • Aerosols cannot be stored near heat	

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F 242	Continued From page 12 use his personal hygiene items due to the safety aspect of residents with dementia. He further indicated "I am the one being punished since I don't have dementia." On 05/04/16 at 3:43 PM an interview was conducted with Nurse Aide (NA) #4. She stated she was not employed with the facility when the resident's personal hygiene items were confiscated. NA #4 further stated she had been informed by her supervisor that she should remove all aerosol sprays or products which contained an alcohol content and was instructed to give them to the floor nurse or the nurse supervisor. NA #4 indicated she had not removed any items from a resident's room. On 05/04/16 at 3:47 PM an interview was conducted with Nurse #5. She stated she was aware administration had instructed an NA to go through the resident's rooms and collect all of the aerosol sprays, any products which contained an alcohol content, or any item with a label which read "keep out of reach of children." Nurse #5 further stated the NA which was instructed to remove the items was no longer employed at the facility. Nurse #5 indicated all staff had been instructed should any of the items be found or observed in a resident's room the items were to be collected, locked up in the medication storage room until the resident's family could pick them up, and also the staff was to inform the Assistant Director of Nursing (ADON) or the DON. On 05/05/16 at 6:05 AM an interview was conducted with NA #5. NA #5 stated she was unaware that the residents were not supposed to have aerosols or items which contained an alcohol content. NA #5 further stated she had	F 242	producing devices. This includes heater units, hair dryers, TVs, and oxygen concentrators. We prefer that non-aerosol products be used when possible. • Over the counter medications cannot be stored in a patients room unless the patient has been evaluated by the care plan team to determine if they are safe to self administer. If they are deemed safe an MD order must be obtained. All over the counter medications must be stored in a locked drawer in the patient's room. • It is preferred that any item that is labeled "keep out of the reach of children" should be stored either behind the bathroom door or in the locked bedside drawers. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Nurse mangers will monitor this issue using the QA Survey Tool. Interview 5 alert and oriented patients to determine if they have been allowed to have personal items of their choice, and if shower preferences have been honored. Any issues will be reported to the Administrator. This will be done weekly for one month and then monthly for at least 3 month or until resolved by Quality	

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F 242	Continued From page 13 never removed any of a resident's personal hygiene items from their rooms. On 05/05/16 at 6:15 AM an interview was conducted with NA #6. NA #6 stated she was instructed by management that all aerosols, items which contained an alcohol content, and items which were labeled with the words "keep out of reach of children" were to be removed from the residents' rooms. NA #6 further stated she had never removed a resident's personal hygiene items from their room. On 05/05/16 at 6:22 AM an interview was conducted with Nurse #6. Nurse #6 stated should a resident have any type of aerosols in their rooms due to a fire hazard and for the safety of the dementia residents that she had been instructed by management to remove those items and to give them to the ADON. Nurse #6 further stated she was unable to recall if she had removed any personal hygiene items or aerosols from a resident's room. On 05/06/16 at 9:15 AM an interview was conducted with NA #7. NA #7 stated she was informed by management that a resident was not allowed to have any aerosols in their rooms. She further stated she was informed by management should she see any aerosols, products which contained an alcohol content, or an item with a label which read "keep out of the reach of children" that they were expected to remove the items and turn them into the ADON. On 05/06/16 at 10:15 AM an interview was conducted with Nurse #7. Nurse #7 stated she had been advised by management that residents were not allowed to have any type of aerosols,	F 242	Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Completion: June 3, 2016	

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rubbing alcohol, or mouth wash in their rooms or in their possession related to ensuring the safety of all residents. Nurse #7 further stated she had not read or seen a policy in regards to the removal of a residents' personal belongings.

On 05/06/16 at 11:55 AM an interview was conducted with the ADON. She stated she was unaware of a policy or guidelines from CMS or OSHA in regards to aerosols and toxins being in resident rooms. She further stated she was also unaware if the requirement was corporation wide or if it was for their building only. The ADON indicated she was informed by management, the Administrator and DON, that residents were not allowed to have hairsprays, any aerosols, nail polish remover, any alcohol containing contents; which included mouth wash and rubbing alcohol, spray deodorants, colognes/perfumes, or any odor reducing sprays, such as "febreze" in their rooms. She further indicated she expected the nursing staff to remove the items mentioned as they had been instructed to do so by management.

On 05/06/16 at 4:50 PM an interview was conducted with the DON. She stated that she and the Administrator wanted to ensure the safety of the residents and had made it a requirement that there were to be no aerosols, air fresheners, nail polish remover, alcohol containing items, or hairsprays allowed in the facility. She further stated the residents and family members were advised they could have pump type hairsprays or a non-alcohol containing mouth wash. The DON also stated that should a resident want to keep rubbing alcohol, and did not want to use the alcohol pads the facility had, then that item would be kept in the medication cart and the resident

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would be allowed to use that item as they requested. The DON further stated "but the items are not allowed in the residents' rooms." The DON was asked if there was a facility policy and could a copy of that policy be obtained. The DON stated "I don't know if the policy has been written or not." There was no policy provided.

2. Resident #192 was re-admitted to the facility on 08/12/15 with diagnoses which included chronic Clostridium difficile (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon), inflammation of the pancreas, type II diabetes and dementia.

A review of the most recent quarterly Minimum Data Set (MDS) dated 03/08/16 indicated Resident #192 was cognitively intact for daily decision making. The MDS further indicated Resident #192 required limited assistance with hygiene but extensive assistance with bathing and he exhibited no behaviors or rejection of care.

A review of shower schedules for Resident #192 for the last 30 days revealed he had received showers on Wednesday and Saturday on the 7:00 AM - 3:00 PM shift on 04/06/16; 04/09/16; 04/13/16; 04/16/16; 04/23/16; 04/30/16 and 05/04/16. Further review of the shower schedule revealed Resident #192 had refused a shower on 04/20/16 and 04/27/16 but was not given a shower on an alternate date.

During an interview on 05/03/16 at 08:18 AM

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Resident #192 stated he usually had 1-2 showers a week but he preferred to have 3 showers a week. He explained when he didn't get a shower he washed off in the bathroom as best as he could. He further explained facility staff had not asked him about his preferences or choices for showers after he was readmitted to the facility.

During an interview on 05/06/16 at 9:40 AM Nurse Aide #9 stated she was assigned to care for Resident #192 and he was scheduled to receive 2 showers a week. She explained Resident #192 was cooperative with care but sometimes when he felt bad he did not want to take a shower. She further explained if he requested a shower on another day they would try to fit it into the schedule.

During an interview on 05/06/16 at 10:30 AM the long term care Unit Manager/Assistant Director of Nursing explained residents were provided with a shower twice a week and on non-shower days they could have a bed bath or sponge off in the bathroom. She stated they did not offer residents more than 2 showers a week but if a resident requested an additional shower they would try to fit it into the shower schedules. She explained showers were provide to residents on first and second shifts Monday through Saturday. She further explained no showers were provided on third shift or on Sundays.

During an interview on 05/06/16 at 5:08 PM the Director of Nursing stated when residents were admitted to the facility they were scheduled to receive 2 showers a week. She further stated residents could ask for more than 2 showers a week but they did not have a system in place to re-evaluate resident's choices for showers after

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F 242	Continued From page 17 they had been admitted to the facility.	F 242		
F 244 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on a review of Food Committee Meeting minutes for 3 months (November 2015, February 2016, and April 2016), Resident Council Meeting minutes for 1 month (March 2016), 1 of 2 dining observations on 4 of 6 halls, 2 of 2 resident interviews (Resident #329 and #54), staff interviews, and a review of medical records, the facility failed to resolve resident grievances expressed during Resident Council and Food Committee Meetings related to late meal delivery. The findings included: 1 a. Review of April 2016 Food Committee Meeting minutes revealed residents expressed that 2nd shift nurse aides were on the computer instead of passing out meal trays after kitchen delivered meals to the units. Residents expressed that they received cold food related to nurse aides not passing out meal trays timely. The facility response was to advise the unit manager of resident concerns with 2nd shift nurse aides on the computer instead of passing out meal trays when the carts arrived to the units.	F 244	F 244 Corrective Action for Resident Affected: On 5-31-16, the Administrator will meet with resident council (via Special Resident Council Meeting) to go over plans to resolve the concerns of late meal delivery. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. See systemic changes below for corrective action for residents. Systemic Changes: On May 31, 2016 the Vice President of Liberty Healthcare Clinical Services in-serviced the administrator and activity coordinator on the following: To provide a more timely response to resident council and food committee concerns meeting will be held monthly. The Administrator will provide a brief update at the beginning of	6/3/16

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F 244	Continued From page 18 During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced. During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this. b. Review of March 2016 Resident Council Meeting minutes revealed residents expressed that during the lunch meals, nurse aides disappeared and food trays were left sitting on the	F 244	the meeting regarding the changes or corrections made regarding concerns voiced at the previous meeting. The Administrator will not attend the closed session of the meeting unless asked to by the committee members. If an area is not resolved after two months the Administrator will notify the Regional Food Service Director of Operations for discussion to develop an action plan. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Every month a review will be conducted of the Food Committee minutes and the Resident Council to ensure that resolution to grievances and concerns occur timely. Any issues will be reported to the Administrator. This will be done monthly for at least 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 244	Continued From page 19 cart instead of being passed out in a timely manner. The facility responded to this grievance by conducting audits on meal delivery and noted nurse aides were present for meals and passing trays out in a timely manner. During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced. During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal	F 244	Date of Completion: June 3, 2016	

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delivery and that staff was working to address this.

c. Review of February 2016 Food Committee Meeting minutes revealed residents expressed that nurse aides were not passing out meal trays in a timely manner and requested to have staff announce to nurse aides when the trays were on the way to the units.

Review of the facility response to the February 2016 meeting revealed there was no documentation of a facility response to this voiced concern.

During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced.

During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but

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this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.

d. Review of November 2015 Food Committee Meeting minutes revealed residents expressed that nurse aides were taking too long to deliver meals which caused residents to have to request to have their food to be reheated due to late trays.

The facility response to this grievance was to advise nursing of resident complaints regarding nurse aides taking too long to pass out meal trays.

During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced.

During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued

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family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.

e. Resident #329 was admitted to the facility on 03/08/16. Review of an admission Minimum Data Set (MDS) assessment dated 03/15/16 assessed Resident #329 with clear speech, understood, able to understand, intact cognition and required supervision with meals. During an interview on 05/02/16 at 03:46 PM, Resident #329 stated that her lunch was late on Sunday, 05/01/16, which was not unusual, she routinely received her meals 30 - 40 minutes after the posted meal times and that occasionally a staff member would advise her that the meal was going to be late.

During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00

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PM. The CDM stated the he had to arrange meal times according to medication administration times and that he could not change meal delivery times unless nursing changed the medication administration times. The CDM also stated that if the dietary department ran late with meal delivery, he went to the units to inform nursing staff and residents as to when the meal trays would be delivered. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced.

During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.

f. Resident #54 was admitted to the facility on 05/08/15. Review of an annual MDS dated 04/14/16 assessed Resident #54 with clear speech, understood, able to understand, intact cognition and required set up assistance only with meals. During an interview on 05/05/16 at 01:08 PM, Resident #54 stated that she had voiced

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concerns in the past to staff regarding routinely receiving her meals late. Resident #54 stated that she received lunch/supper on 05/01/16 (Sunday) late because of something that happened in the kitchen and that she did not receive her breakfast that morning (05/05/16) until 10:15 AM. Review of the posted meal delivery schedule revealed breakfast trays to this Resident's hall were due at 9:00 AM.

During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. The CDM stated the he had to arrange meal times according to medication administration times and that he could not change meal delivery times unless nursing changed the medication administration times. The CDM also stated that if the dietary department ran late with meal delivery, he went to the units to inform nursing staff and residents as to when the meal trays would be delivered. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced.

During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability

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and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.

2. A review of the posted meal delivery schedule revealed supper trays were to be delivered according to the following schedule:
· 200 hall - Cart 1 at 5:55 PM and Cart 2 at 6:05 PM
500 hall - 6:15 PM
· 400 hall - 6:30 PM
· 600 hall - 6:35 PM

During an observation in the kitchen on 05/01/16 of the supper meal, the tray line began at 05:15 PM. The tray line was observed from 05:15 PM until 07:25 PM with the following concerns noted that resulted in a delay of the meal delivery:
· At 05:25 PM, dietary staff (DS) #1 requested the certified dietary manager (CDM) prepare chicken for residents on a mechanical soft diet.
· At 05:59 PM the CDM instructed DS #1 to conduct temperature monitoring of all hot foods on the tray line due a resident's meal tray identified with foods less than 135 degrees Fahrenheit (F).
· At 06:09 PM, DS #1 informed the CDM that she had run out of vegetables and needed more vegetables to continue the tray line.
· At 06:22 PM, DS #1 plated vegetable soup

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identified with a temperature that was less than 135 degrees F and the soup was reheated.
· At 6:52 PM, DS #1 informed the CDM that she had run out of mashed potatoes and vegetables. At 6:56 PM, Cart 1 was delivered to the 600 hall while additional foods were prepared to continue to tray line. Black eyed peas and vegetables were prepared and Cart 2 was delivered to the 600 hall at 7:28 PM.

During a dining observation of the supper meal on 05/01/16 (Sunday), the following meal delivery times were noted:
· 200 hall (Cart 1) - 06:17 PM; 22 minutes later than the posted delivery time
· 500 hall - 06:37 PM; 22 minutes later than the posted delivery time
· 400 hall - 06:50 PM; 20 minutes later than the posted delivery time
· 600 hall (Cart 1) - 06:56 PM; 16 minutes later than the posted delivery time
· 600 hall (Cart 2 - a second cart was delivered due to a delay in the tray line) - 7:28 PM; 52 minutes later than the posted delivery time

An interview on 05/01/16 at 06:34 PM with Nurse #8 revealed she routinely worked every other weekend and observed delivery of the supper meal from the dietary department to the 600 hall between 7 PM to 7:30 PM and sometimes as late as 8 PM.

An interview on 05/01/16 at 06:41 PM with Nurse Aide (NA) #7 revealed the supper meal cart for the 400 hall usually arrived from the dietary department between 06:45 PM and 07:00 PM.

During an interview on 05/01/16 at 07:10 PM, dietary staff (DS) #1 stated that she was the

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F 244	Continued From page 27 routine 2nd shift cook every other weekend. DS #1 stated "We need another person on the line to help, it slows me down when I have to try to keep everything on the line and do all of my own prep, if we run out of something I have to prepare more, sometimes we are late with the meals because of this." During an interview on 05/01/16 at 07:36 PM with the certified dietary manager (CDM) he revealed that, in terms of the timeliness of the meal delivery, the cook should have had a back-up of foods so that "we don't run out of food during the line" and that the mechanical soft chicken should have been prepared before the tray line began. The CDM stated that the cook usually did not have anyone assisting them with meal preparation and had to learn to manage the tray line on their own. During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him and expressed during Resident Council/Food Committee Meetings regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		6/3/16

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F 246	Continued From page 28 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to provide assistance with getting out of bed to be able to attend a supervised scheduled 9:30 AM smoking time for 1 of 2 residents who smoke (Resident #239). The findings included: Resident #239 was admitted to the facility on 04/22/15 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. Review of Resident #239's quarterly Minimum Data Set (MDS) dated 04/01/16 revealed an assessment of intact cognition. The MDS indicated Resident #239 required the extensive assistance of 2 persons with transfer. Review of the facility's smoking policy dated 04/19/16 revealed supervised smoking times occurred at 9:30 AM, 12:00 PM, 2:30 PM, 5:00 PM and 8:00 PM. Observation on 05/04/16 at 9:22 AM revealed Resident #239 awake and in bed. Observation on 05/04/16 at 9:48 AM revealed	F 246	F 246 Resident #239 did get up after the 9:30AM smoke break and was able to attend the next scheduled smoke time. Identification of potentially affected residents and corrective actions taken: All residents who have a scheduled smoke time have the potential to be affected by this practice. See systemic changes below for corrective action. Systemic Changes All Nurses, RNs and LPNs, CNAs and Transportation/Central supply personnel (full, part time and PRN) were in- serviced by the Director of Nursing that some smokers will require supervision to smoke. Times have been arranged for these residents and staff must take the patients to smoke at this time. In-servicing is to be completed by June 3, 2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance	

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F 246	Continued From page 29 Resident #239 awake and in bed. Interview with Resident #239 at 9:49 AM revealed she required assistance of staff to transfer into a wheelchair. Resident #239 explained she smoked and missed the smoke break. Resident #239 reported she missed smoke breaks several times a week because staff did not "get me up in time." Resident #239 explained she would not get an extra smoke break to make up for the one missed. Interview with Nurse Aide (NA) #3 on 05/04/16 at 10:01 AM revealed delays occurred at times with Resident #239's out of bed time due to other residents' needs. Interview with the transportation/central supply coordinator on 05/04/16 at 12:02 PM revealed she supervised the 9:30 AM smoking break 5 days a week. The transportation/central supply coordinator reported Resident #239 missed the 9:30 AM smoking breaks approximately "2 to 3 times a week since staff are busy with others." Interview with the Director of Nursing (DON) on 05/06/16 at 11:32 AM revealed she was not aware Resident #239 missed the 9:30 AM smoking breaks due to inability to be assisted out of bed. The DON explained she expected staff to adjust the assignment in order for Resident #239 to attend the 9:30 AM smoking break.	F 246	Process to verify that the change has been sustained. The Unit Manager will check daily that the residents assigned to scheduled smoke breaks have been Out of Bed for their scheduled times. If the resident chose to not get up for that scheduled time the Unit Manager will check that there is documentation. On May 31, 2016 the Director of Nursing in-serviced the unit manager on this systemic change. Quality Assurance Plan: To ensure compliance the DON will interview all smokers weekly to ensure that they have been allowed to smoke according to the scheduled times. Identified issues will be reported the Administrator and the Quality Assurance Committee for appropriate action and intervention. This will be done weekly for one month and then monthly for at least three months. The QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director, with verification of his attendance, along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		6/3/16

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F 253	Continued From page 30 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to failed to label resident personal care equipment to prevent use of items to the wrong resident in 3 resident bathrooms on 2 of 6 resident hallways (room #116, #118 and #211) and failed to store wheelchair footrests off the bathroom floor under the sink on 1 of 6 resident halls (room #202). The facility also failed to repair resident doors with broken and splintered laminate for 18 resident rooms on 3 of 6 hallways (Resident room #102, #103, #109, #110, #111, #117, #201, #203, #209, #210, #215, #217, #219, #505, #506, #507, #510 and #514) and failed to repair smoke prevention doors with broken and splintered laminate on the edges on 2 of 6 sets of doors (100 hall and 200 hall). The findings included: 1. a. Observations in the bathroom of room #116 on 05/03/16 at 10:08 AM revealed a bedpan was in a clear plastic bag hanging from the handrail next to the commode that was not labeled with a resident's name. Observations in the bathroom of room #116 on 05/04/16 at 9:05 AM revealed a bedpan was in a clear plastic bag hanging from the handrail next to the commode that was not labeled with a resident's name. Observations in the bathroom of room #116 on 05/05/16 at 9:19 AM revealed a bedpan was in a clear plastic bag hanging from the handrail next to the commode that was not labeled with a	F 253	F253 Personal items for residents #116, #118 and #211 were labeled by staff on 5-6-16. Wheelchair foot rests were stored in the closets on 5-6-16 by staff for resident room 202. Doors and splintered laminate were repaired by maintenance on 5-10-16 for Rooms 102, 103, 109, 110, 111, 117, 201, 203, 209, 210, 215, 217, 219, 505, 506, 507, 510 & 514. Smoke prevention doors were repaired on 100 and 200 hall. Identification of potentially affected residents and corrective actions taken: All residents have the potential to be affected by this practice. On 5-10-16 the Administrator and Maintenance Director rounded on all rooms and general areas. A list of needed repairs to laminate and doors were noted. This list was then utilized to establish a maintenance schedule for repairs. The Nursing Supervisor also observed every semi-private room to ensure that personal items were labeled. Items were either labeled or replaced when found. They also looked for storage of wheelchair footrest to ensure that they were stored in the patient room not the bathroom. Systemic Changes: All Nurses and CNAs (full, part time and	

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F 253	Continued From page 31 resident's name. b. Observations in the bathroom of room #118 on 05/03/16 at 10:12 AM revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. Observations in the bathroom of room #118 on 05/04/16 at 9:12 AM revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. Observations in the bathroom of room #118 on 05/05/16 at 9:25 AM revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. c. Observations in the bathroom of room #211 on 05/03/16 at 10:22 AM revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. Observations on 05/04/16 at 9:20 AM in the bathroom of room #211 revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. Observations on 05/05/16 at 9:42 AM in the bathroom of room #211 revealed a bedpan was in a clear plastic bag hanging from the handrail in the shower that was not labeled with a resident's name. 2. Observations in the bathroom of room #202 on 05/03/16 at 10:30 AM revealed a pair of wheelchair footrests were lying on the floor under the sink. Observations on 05/04/16 at 9:10 AM in the	F 253	PRN) were reeducated by the Director of Nursing on the facility infection control policy which included the proper storage of personal equipment/items. This education will be completed by June 3, 2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. A repair list was established with completion time lines by the Administrator and Maintenance Director. The Maintenance Director was in-serviced on 5-30-16 regarding the need for weekly rounding to update the repair list and timely completion of identified repairs. Quality Assurance Plan: The infection control nurse and or designee will make weekly infection control rounds to ensure compliance with the facilities infection control policy and procedure to include labeling and storing of personal care equipment. Additionally, weekly, the Administrator will round on every room and general area with the Maintenance Director to update the repair list and ensure that other items have been completed according to the designated time frame. This will be done weekly for one month than monthly for at least three months. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. Identified issues will be	

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F 253	Continued From page 32 bathroom of room #202 revealed a pair of wheelchair footrests were lying on the floor under the sink. Observations on 05/05/16 at 9:30 AM in the bathroom of room #202 revealed a pair of wheelchair footrests were lying on the floor under the sink. During an interview on 05/06/16 at 10:25 AM Nurse Aide #10 stated she was assigned on the 100 hall and resident's personal care items should be put away and were not supposed to be stored on the floor. She further stated bed pans and bath basins should be stored in the bathroom with the resident's name written on it. During an interview on 05/06/16 at 10:30 AM with the long term care Unit Manager/Assistant Director of Nursing (ADON) she stated it was the expectation that resident care equipment should be labeled with the resident's last name with a black permanent marker. She further stated each resident had their own shelf in the bathroom and personal care items were supposed to be kept in a clean plastic bag in a drawer of the bedside table or in the bathroom on the shelf. She stated no resident care equipment which included bedpans or bath basins were to be stored on the floor in the resident's bathroom. During a tour and observation on 05/06/16 at 10:40 AM with the long term care Unit manager/ADON she verified in resident room #118 there were 3 bath basins stacked inside each other and were not labeled with the resident's name. She also verified a fourth bath basin was sitting on the floor in the shower with no resident name on it. She confirmed in the bathroom of	F 253	reported immediately to the Administrator, DON or ADON for appropriate action. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Completion: June 3, 2016	

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room #116 there was 1 bedpan in a clear plastic bag that was hanging from a handrail in bathroom without a resident's name. She also confirmed there was a bedpan in the shower of room #211 that was not labeled with a resident name. She acknowledged there was a pair of wheelchair footrests lying on the floor under the sink in room #202 and stated they were not supposed to the stored on the floor under the sink in the resident's bathroom.

During an interview on 05/06/16 at 5:08 PM the Director of Nursing stated it was her expectation that personal care equipment should be labeled with the resident's last name with a black permanent marker and should be stored in a plastic bag on the shelf in the bathroom or placed in the bottom drawer of the resident's bedside table. She explained wheelchair footrests were usually stored in the bottom of the resident's closet but should not be stored on the floor under the sink in the bathroom.

3. a. Observations of Room #102 on 05/03/16 at 11:25 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:08 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 1:45 PM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door.

b. Observations of Room #103 on 05/03/16 at 11:27 AM revealed the door of the resident's room had broken and splintered laminate on the

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edges of the bottom half of the door.
Observations on 05/04/16 at 9:09 AM revealed the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 1:47 PM revealed the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door.

c. Observations of Room #109 on 05/03/16 at 11:29 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:12 AM revealed the door of resident room #109 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 1:50 PM revealed the door of resident room #109 had broken and splintered laminate on the edges of the bottom half of the door.

d. Observations of Room #110 on 05/03/16 at 11:30 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:15 AM revealed the door of resident room #110 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 1:54 PM revealed the door of resident room #110 had broken and splintered laminate on the edges of the bottom half of the door.

e. Observations of Room #111 on 05/03/16 at 11:33 AM revealed the door of the resident's room had broken and splintered laminate on the

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edges of the bottom half of the door.
Observations on 05/04/16 at 9:17 AM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 1:55 PM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door.

f. Observations of Room #117 on 05/03/16 at 11:35 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and the bathroom door had broken and splintered laminate and wood on the edges of the lower half of the door.
Observations 05/04/16 at 9:21 AM revealed the door of resident room #117 had broken and splintered laminate on the edges of the bottom half of the door and the bathroom door had broken and splintered laminate and wood on the edges of the lower half of the door.
Observations on 05/05/16 at 1:57 PM revealed the door of resident room #117 had broken and splintered laminate on the edges of the bottom half of the door and the bathroom door had broken and splintered laminate and wood on the edges of the lower half of the door.

g. Observations of Room #201 on 05/03/16 at 11:38 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:23 AM revealed the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:01 PM revealed

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the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door.

h. Observations of Room #203 on 05/03/16 at 11:40 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:25 AM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:03 PM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door.

i. Observations of Room #209 on 05/03/16 at 11:42 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:27 AM revealed the door of resident room #209 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:05 PM revealed the door of resident room #209 had broken and splintered laminate on the edges of the bottom half of the door.

j. Observations of Room #210 on 05/03/16 at 11:45 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/15 at 9:30 AM revealed the door of resident room #210 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:07 PM revealed

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the door of resident room #210 had broken and splintered laminate on the edges of the bottom half of the door.

k. Observations of Room #215 on 05/03/16 at 11:47 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:33 AM revealed the door of resident room #215 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:09 PM revealed the door of resident room #215 had broken and splintered laminate on the edges of the bottom half of the door.

l. Observations of Room #217 on 05/03/16 at 11:49 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:35 AM revealed the door of resident room #217 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:11 PM revealed the door of resident room #217 had broken and splintered laminate on the edges of the bottom half of the door.

m. Observations of Room #219 on 05/03/16 at 11:51 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:37 AM revealed the door of resident room #219 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:13 PM revealed

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the door of resident room #219 had broken and splintered laminate on the edges of the bottom half of the door.

n. Observations of Room #505 on 05/03/16 at 11:54 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:40 AM revealed the door of resident room #505 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:18 PM revealed the door of resident room #505 had broken and splintered laminate on the edges of the bottom half of the door.

o. Observations of Room #506 on 05/03/16 at 11:56 AM revealed the door of the resident's room had a curved out section of broken and splintered laminate on the edges of the bottom half of the door and was rough to the touch.
Observations on 05/04/16 at 9:43 AM revealed the door of resident room #506 had had a curved out section of broken and splintered laminate on the edges of the bottom half of the door and was rough to the touch.
Observations on 05/05/16 at 2:20 PM revealed the door of resident room #506 had had a curved out section of broken and splintered laminate on the edges of the bottom half of the door and was rough to the touch.

p. Observations of Room #507 on 05/03/16 at 11:58 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:45 AM revealed the door of resident room #507 had broken and

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splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:22 PM revealed the door of resident room #507 had broken and splintered laminate on the edges of the bottom half of the door.

q. Observations of Room #510 on 05/03/16 at 12:01 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:47 AM revealed the door of resident room #510 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:25 revealed the door of resident room #510 had broken and splintered laminate on the edges of the bottom half of the door.

r. Observations of Room #514 on 05/03/16 at 12:04 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 9:50 AM revealed the door of resident room #514 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:27 PM revealed the door of resident room #514 had broken and splintered laminate on the edges of the bottom half of the door.

4. a Observations of the smoke prevention doors on the 100 hall on 05/03/16 at 12:10 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 10:00 AM revealed the smoke prevention doors on the 100 hall had

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broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:30 PM revealed the smoke prevention doors on the 100 hall had broken and splintered laminate on the edges of the bottom half of the door.

b. Observations of the smoke prevention doors on the 200 hall on 05/03/15 at 12:15 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/04/16 at 10:13 AM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 05/05/16 at 2:34 PM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of the bottom half of the door.

During an interview on 05/06/16 at 10:30 AM the long term care Unit Manager/Assistant Director of Nursing explained staff were expected to tell the Maintenance staff when repairs needed to be made. She further explained they had work orders for staff to fill out and they were kept at each nurse's station with duplicate copies. She stated the Maintenance Director collected the work orders during the day and staff could also call him on the phone or tell him about repairs that needed to be made when he was making rounds or was working on the nursing units. She explained staff could also page the Maintenance Director on the overhead system or they could report to her and she would find him. She stated the Maintenance Director worked Monday through Friday and had various hours dependent on what needed to be done.

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F 253	Continued From page 41 During an interview and environmental tour on 05/06/16 at 4:35 PM with the Administrator and Director of Nursing the Administrator stated the Maintenance Director had left the facility for the day. He stated staff in the facility could report to maintenance when repairs were needed and he had hired a temporary worker to do painting and patching of walls. He stated the worker may have worked on some doors but he was not sure. During the tour the Administrator removed a splintered piece of laminate from the edge of the resident's door of room #215 and stated he expected for staff to report to maintenance when repairs were needed. During an interview on 05/06/16 at 5:08 PM the Director of Nursing stated she had not noticed the splintered laminate on the edges of the resident's doors and had not thought to look at them.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		6/3/16

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F 278	Continued From page 42 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician's orders and review of the Medication Administration Record, the facility failed to assess the use of pain medication when completing an admission Minimum Data Set assessment for 1 of 3 sampled residents reviewed for pain (Resident #87). The findings included: Resident #87 was admitted to the facility on 03/24/16. Diagnoses included diaphragmatic hernia and ileus, among others. Review of the medical record revealed Resident #87 had a physician order dated 03/28/16 for Neurontin 100 milligrams (mg) every evening for pain. Review of the admission Minimum Data Set (MDS) dated 03/31/16 documented that Resident #87 rated her pain as 5 out of 10 on a pain scale when pain was experienced and that she did not	F 278	F278 Corrective Action: Resident #87: A Modification Request was created for the Pain Medication Admission Record Assessment with the Assessment Reference Date of 3/31/2016. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 5/5/2016 and includes the corrected record. Item J0100A has a value of 1, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 5/5/2016. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. All assessments within the last 6 months are currently being reviewed for accuracy for Item Set J0100A started on 5/9/2016.	

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F 278	Continued From page 43 receive scheduled pain medication. Review of the March 2016 medication administration record (MAR) revealed Resident #87 received Neurontin 100 mg every evening for pain from 03/24/16 - 03/30/16. Further review of the medical record revealed a nurse's note dated 03/26/16 which documented that the nurse administered scheduled Neurontin 100 mg to Resident #87 for pain. During an interview on 05/05/16 at 12:02 PM, the MDS Coordinator stated when she completed the admission MDS for Resident #87, she reviewed the March 2016 MAR, using 03/24/16 - 03/31/16 as reference dates, to assess whether or not Resident #87 received scheduled pain medication. The MDS Coordinator stated she missed that Resident #87 received Neurontin 100 mg every evening for pain and that she should have assessed that Resident #87 did receive scheduled pain medication when she completed the Resident's admission MDS. During an interview on 05/05/16 at 1:01 PM, the Director of Nursing stated she would expect the MDS to accurately reflect the use of scheduled pain medication for a resident.	F 278	Systemic Changes: On 5/27/2016 The RN MDS Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA Consultant. The education focused on the Federal regulations at 42 CFR 483.20(b)(1)(xviii),(g), and (h) require that: The assessment accurately reflects the residents status. A registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. The information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) the interdisciplinary team completing the assessment. The Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. The observation period for a particular assessment for a particular	

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F 278	Continued From page 44	F 278	resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. If it did not occur during the look back period, it is not coded on the MDS. The Director of Nursing or RN Designee will review OBRA assessments to ensure accurate coding for item set J0100A. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool. Five residents OBRA assessments will be reviewed weekly for one month, and then monthly for at least three months. The items reviewed on the QA Assessment Accuracy Tool will include: Section J0100: Accuracy of Section J0100A, Identified	

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F 278	Continued From page 45	F 278	issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Completion: June 3, 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		6/3/16

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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 279	Continued From page 46 by: Based on record reviews and staff interviews the facility failed to develop a comprehensive care plan for activities of daily living for 1 of 27 residents whose care plans were reviewed (Resident #258). The findings included: Resident #258 was admitted to the facility on 10/13/15 with diagnoses which included high blood pressure, thyroid disease and dementia. A review of the admission Minimum Data Set (MDS) dated 10/20/15 indicated Resident # 258 was severely impaired in cognition for daily decision making and required extensive assistance with Activities of Daily Living (ADLs) for hygiene and bathing. A review of a Care Area Assessment (CAA) Worksheet dated 10/26/15 indicated Activity of Daily Living (ADL) Functional/Rehabilitation Potential triggered for Resident #258 and included a check mark to address in care plan. A section on the CAAs labeled care plan considerations indicated to maintain Resident #258's current level of functioning and a section for rationale for care plan decision indicated in part Resident #258 required extensive assist with all ADLs including cues and instructions to participate and had memory impairment and poor safety awareness. A review of care plans for Resident #278 revealed there was no care plan for ADLs and there were no ADL interventions listed in any of the care plans for Resident # 258.	F 279	F279 Corrective Action: Resident #258 Resident Care plan was reviewed and updated. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All comprehensive assessments within the last 6 months are being reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was reviewed to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked “YES” has a care plan addressed with interventions in place. This was started on 5/9/16 by the MDS Coordinator. Systemic Changes: On 5/27/16 The LPN/RN MDS Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA consultant. The education focused on Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident’s needs (42 CFR 483.20(b)). The Facility uses the CAAs in identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the	

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	345026	A. BUILDING _____ B. WING _____	C 05/06/2016

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F 279	Continued From page 47 During an interview on 05/06/16 at 2:15 PM with the long term care Unit Manager/Assistant Director of Nursing she verified there was no care plan for ADLs for Resident # 258. She stated she did not know why there was no care plan for ADLs and MDS staff would have to explain. She further stated she would expect to see a care plan for ADLs or interventions for ADLs since Resident # 258 required extensive assistance by staff for ADL care. During an interview on 05/06/16 at 2:25 PM with the MDS nurse she explained Resident #258's last comprehensive MDS assessment was completed in October 2015 and it triggered a Care Area Assessment (CAA) for physical mobility and it should have had ADL interventions listed in it. She stated she had identified a problem with some of the CAAs where physical mobility had triggered but did not have ADL interventions and she had been trying to correct them. She confirmed she was unaware Resident #258 did not have an ADL care plan or that her other care plans did not have ADL interventions in them. She stated after the comprehensive assessment triggered ADLs there should have been a care plan completed for ADLs but she was not sure why it had not been done. During an interview on 05/06/16 at 5:08 PM with the Director of Nursing she stated it was her expectation for resident's who triggered for ADLs on their comprehensive assessments to have a care plan with interventions to address their ADL needs.	F 279	MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident. Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected. CATs provide a “flag” for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning: (1) improvement where possible or (2)	

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F 279	Continued From page 48	F 279	maintenance and prevention of avoidable declines. The CAA process may help the IDT: Identify and address associated causes and effects; Determine whether and how multiple triggered conditions are related; Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests; Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions; Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions; Determine whether a resident could potentially benefit from rehabilitative interventions; Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment. Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link	

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F 279	Continued From page 49	F 279	between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see.42 CFR 483.20(k), Comprehensive Care Plans). The RN coordinator is required to sign and date the Care Area Assessment (CAA) Summary after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days). The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed. The Director of Nursing or RN Designee will review comprehensive assessments to ensure that a comprehensive care plan is completed for each resident per the RAI requirements as listed above. Any issues will be reported to the Director of Nursing or Administrator for appropriate action.	

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F 279	Continued From page 50	F 279	During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Tool. Five residents comprehensive OBRA assessments will be reviewed weekly for one month, and then monthly for at least three months. The items reviewed on the QA Care plan Tool will include: CAAs triggered reviewed, Care plan considerations reviewed, Comprehensive care plan for activities for activities of daily living completed, Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Completion: June 3, 2016	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		6/3/16

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F 309	Continued From page 51 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 staff, nurse practitioner and family member interviews, the facility failed to respond to the inability to use the right arm and increased need for assistance with ambulation for 1 of 3 residents who experienced a change in condition (Resident #47). The findings included: Resident #47 was admitted to the facility on 07/31/13 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. Review of Resident #47's quarterly Minimum Data Set (MDS) dated 03/31/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #47 required supervision and set up to walk with no impairment in function range of motion. Review of Resident #47's care plan dated 04/04/16 revealed Resident #47 walked with a rolling walker with staff to provide assistance as needed. Review of a nursing note dated 04/24/16 revealed Nurse #2 documented Resident #47 complained	F 309	F309 Resident #47 was assessed by the Nurse Practitioner on 4/25/16 and a neurology consult was ordered. On 4/27/16 resident #47 was seen by neurologist. Identification of potentially affected residents and corrective actions taken: All residents have the potential to be affected. The 24 hour report sheets were reviewed for all residents for the last 7 days by the DON and QA team to ensure that changes in condition were identified and the medical providers were notified. This was completed by May 25 2016. Systematic Changes All Nurses, RNs and LPNs (full, part time and PRN) were in-serviced by the Director of Nursing on the need to notify providers of changes in condition. This is to be completed by June 3, 2016 This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that	

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F 309	Continued From page 52 of right hand and arm swelling with "noticeable decrease in ability to use it." Nurse #2 documented Resident #47's family member requested the nurse practitioner (NP) to see Resident #47 tomorrow. Review of the NP acute visit note dated 04/25/16 revealed the NP documented Resident #47 described the right arm as "useless." The NP documented a mild right facial droop, inability to grasp a walker with the right hand and right arm weakness. The NP ordered a neurology consultation. Review of a physician's note dated 04/25/16 revealed the physician documented Resident #47's right arm present with complete paralysis which could indicate another stroke. Review of a neurologist consultation dated 04/27/16 revealed the neurologist documented Resident #47 exhibited a new right hemianopia (decreased vision) with diminished strength in the right arm and hand. The neurologist ordered a MRI of the brain, carotid ultrasound and transthoracic echocardiogram. Observation of Resident #47 on 05/03/16 at 10:15 AM revealed he self-propelled in a wheel chair with both feet and the left arm. Resident #47 did not use the right arm or hand. Interview with Resident #47 on 05/03/16 at 10:18 AM revealed the right arm and hand no longer functioned. Resident #47 reported the arm did not hurt but he now required assistance to transfer and could not walk. Interview with Resident #47's family member on	F 309	the change has been sustained. Quality Assurance Plan: Monday through Friday The Daily Clinical Meeting Nurses and DON will review the nursing 24 hour report with all progress notes for the last 24 hours and on Monday progress notes for 72 hours in PCC, incident reports, new MD orders, and any resident with a change of condition has documentation to show that medical providers were notified. To ensure compliance the DON and Nurse Managers will document their review on the daily clinical checklist. This will be done daily Monday through Friday and on Monday for the weekend for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. The weekly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Completion: June 3, 2016	

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F 309	Continued From page 53	F 309		

05/03/16 at 1:35 PM revealed Resident #47 called the family member the evening of 04/23/16. Resident #47 informed the family member, he was upset due to the inability to use his right arm. The family member explained she came to the facility on 04/24/16, saw Resident # 47 could not use the right arm and spoke to Nurse #2. The family member reported Nurse #2 informed her Resident #47's name would be placed on the list to be seen the next day since it was Sunday and no doctor or nurse practitioner was available.

Interview with the occupational therapist (OT) on 05/04/16 at 12:10 PM revealed Resident #47 was discharged from OT after successful treatment for left shoulder arthritic pain on 04/14/16. The OT reported she assessed Resident #47 at the NP's request on 04/25/16. The OT explained Resident #47's right arm was flaccid which was different. The OT explained Resident #47 used to have active strength and range of motion in the right upper extremity. The OT reported Resident #47 required stand by assistance with ambulation with a walker when discharged from therapy on 04/14/16.

Interview with Nurse Aide (NA) #1 on 05/04/16 at 2:47 PM revealed she cared for Resident #47 on 04/23/16 and 04/24/16 during the day shift. NA #1 reported Resident #47 could not hold on to the walker and required 2 persons and a gait belt to walk a few steps. NA #1 explained Resident #47 could not use the right arm. NA #1 explained she reported Resident #47's increased need for assistance to Nurse #2.

Interview with Nurse #1 on 05/04/16 at 3:25 PM revealed she cared for Resident #47 on 04/23/16

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F 309	Continued From page 54	F 309		

and 04/24/16 during the evening shift. Nurse #1 reported Resident #47 required 2 persons and a gait to stand at the walker. Nurse #1 reported she did not take Resident #47's vital signs, physically assess all extremities or notify the nursing supervisor.

Interview with NA #2 on 05/04/16 at 3:45 PM revealed she cared for Resident #47 on 04/23/16 and 04/24/16 during the evening shift. NA #2 reported Resident #47 could not use the right arm which she reported to Nurse #1.

Telephone interview with Nurse #2 on 05/04/16 at 4:25 PM revealed she cared for Resident #47 on 04/23/16 and 04/24/16 during the day shift. Nurse #2 reported Resident #47 could not use the right arm and required the extensive assistance of 2 persons to stand at the walker. Nurse #2 explained she spoke with Resident #47's family member on 04/24/16 who requested Resident #47 be seen by a physician or NP. Nurse #2 reported she could not recall if she took resident #47's vital signs or assessed his extremities. Nurse #2 reported she did not notify the nursing supervisor.

Telephone interview with the Nurse Practitioner (NP) on 05/05/16 at 8:57 AM revealed Resident #47's loss of right arm use and increased weakness of both legs could be indicative of a transient ischemic attack or another stroke although a delay in treatment would not alter the outcome.

Interview with the Director of Nursing (DON) on 05/05/16 at 11:18 AM revealed she expected staff to respond to a change in Resident #47's condition. The DON explained the response

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F 309	Continued From page 55 should include a documented assessment and plan.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and family interviews the facility failed to remove facial hair for 1 of 6 sampled residents for Activities of Daily Living (Resident #258). The findings included: Resident #258 was admitted to the facility on 10/13/15 with diagnoses which included high blood pressure, thyroid disease, dementia and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/19/16 indicated Resident #258 was severely impaired in cognition for daily decision making and required extensive assistance with hygiene and bathing. During an observation on 05/04/16 at 8:22 AM Resident #258 was sitting in a wheelchair at a table in the living room while breakfast was being served and had long white chin hairs on the left side of her chin and at the bottom of her chin.	F 312	F312 Resident #258 is cognitively impaired for daily decision making and requires extensive assistance with hygiene and bathing. The chin hair was removed at the family's request. Identification of potentially affected residents and corrective actions taken: All residents have the potential to be affected by this deficient practice. All residents were assessed for unwanted facial hair and assistance to remove was provided if the resident or RP requested. Those residents who identified they did not want facial hair removed will be care planned as a personal preference and added as a task reminder on ADL task assignment in POC. Those residents that require assistance with removal of facial hair will have this added to their ADL task assignment in POC. This was completed by assigned CNA on 5-6-16.	6/3/16

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F 312	Continued From page 56 During an observation on 05/05/16 at 6:23 AM Resident #258 was sitting in a wheelchair in the living room and was holding her right hand up to her head and had long white chin hairs on the left side of her chin and at the bottom of her chin. During an observation on 05/06/16 at 9:37 AM Resident #258 was seated in the living room with long white chin hairs on the left side of her chin approximately 1/4 to 1/2 inch in length and at the bottom of her chin approximately 1/4 to a 1/2 inch in length. During an observation and interview on 05/06/16 at 2:18 PM with the long term care Unit Manager/Assistant Director of Nursing she confirmed Resident #258 had long white hairs on the left side of her chin and at the bottom of her chin. She explained Resident #258 was usually cooperative with care but sometimes staff had to redirect her. She stated she did not know if family wanted Resident #258's facial hair removed but if they did she would have expected for staff to have shaved them. During an interview on 05/06/16 at 2:19 PM with Resident #258's family she confirmed she wanted Resident #258's chin hairs removed and she expected the staff to remove them when they provided her care. She explained she had brought a hair removal product to the facility for staff to use to remove Resident #258's facial hair and she expected for them to use it. During an interview on 05/06/16 at 5:08 PM the Director of Nursing stated resident's facial hair should be removed as part of their Activities of Daily Living (ADL) care. She further stated if a resident could not tell staff they wanted facial hair	F 312	Systemic Change: All CNAs (full, part time and PRN) were reeducated on the facility's shaving policy by the Director of Nursing. This is to be completed by June 3, 2016. All residents will have their task assignments updated as to the preference of facial hair if required. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance Plan: The Don and or designee will monitor residents for facial hair and resident's preference weekly for one month and then monthly for at least three months. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. Identified issues will be reported immediately to the Administrator, DON or ADON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads.	

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F 312	Continued From page 57 removed then staff should ask the resident's responsible party if they wanted the resident's facial hair removed and should do what they requested.	F 312	Date of Completion: June 3, 2016	
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on 1 of 2 dining observations on 4 of 6 halls, 1 of 1 tray line meal observations, 2 of 2 resident interviews (Resident #329 and #54), staff interviews, a review of medical records, and a review of the facility's posted meal schedule, the facility failed to serve meals according to the meal schedule with a potential to delay resident's receipt of medications and participation in activities and therapy. The findings included: A review of the posted meal delivery schedule revealed supper trays were to be delivered according to the following schedule: · 200 hall - Cart 1 at 5:55 PM and Cart 2 at 6:05 PM - 500 hall - 6:15 PM · 400 hall - 6:30 PM · 600 hall - 6:35 PM During an observation in the kitchen on 05/01/16 of the supper meal, the tray line began at 05:15 PM. The tray line was observed from 05:15 PM	F 362	F362 Corrective Action for Resident Affected: An audit tool was immediately put into place by the Dietary Manager to monitor daily meal service. Additionally, the Dietary Manager or designee began conducting daily meal meetings with dietary staff on both shifts. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice. The audit tool began on 5-2-16, to monitor meal schedule, meal delivery and proper expedition of meal service. Daily meal meetings began 5-30-16 to address previous days concerns/issues, if any and planning of that days meals. Systemic Changes: A follow-up in service will be conducted by	6/3/16

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ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 362	Continued From page 58 until 07:25 PM with the following concerns noted that resulted in a delay of the meal delivery: · At 05:25 PM, dietary staff (DS) #1 requested the certified dietary manager (CDM) prepare chicken for residents on a mechanical soft diet. · At 05:59 PM the CDM instructed DS #1 to conduct temperature monitoring of all hot foods on the tray line due a resident's meal tray identified with foods less than 135 degrees Fahrenheit (F). · At 06:09 PM, DS #1 informed the CDM that she had run out of vegetables and needed more vegetables to continue the tray line. · At 06:22 PM, DS #1 plated vegetable soup identified with a temperature that was less than 135 degrees F and the soup was reheated. · At 6:52 PM, DS #1 informed the CDM that she had run out of mashed potatoes and vegetables. At 6:56 PM, Cart 1 was delivered to the 600 hall while additional foods were prepared to continue to tray line. Black eyed peas and vegetables were prepared and Cart 2 was delivered to the 600 hall at 7:28 PM. During a dining observation of the supper meal on 05/01/16 (Sunday), the following meal delivery times were noted: · 200 hall (Cart 1) - 06:17 PM; 22 minutes later than the posted delivery time · 500 hall - 06:37 PM; 22 minutes later than the posted delivery time · 400 hall - 06:50 PM; 20 minutes later than the posted delivery time · 600 hall (Cart 1) - 06:56 PM; 16 minutes later than the posted delivery time · 600 hall (Cart 2 - a second cart was delivered due to a delay in the tray line) - 7:28 PM; 52 minutes later than the posted delivery time	F 362	the Contracted Corporate Registered Dietitian on June 1, 2016. All dietary staff, including dietary managers, were in attendance. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included adhering to posted meal schedule, results due to delays of meal service; e.g.; mediation pass, therapy, etc. Kitchen production to be planned timely with sufficient quantities to begin tray line according to schedule, preparing special order items timely so process is not delayed. All monitoring tools/audits will be completed and findings will be reported to the weekly and quarterly QA meetings. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Dietary Manager or Consultant Dietitian for the Contracted Dining and Nutrition Services will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. This will be completed daily for four weeks, then weekly for one month, then monthly for at least three months. Identified issues will be reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 362	Continued From page 59 An interview on 05/01/16 at 06:34 PM with Nurse #8 revealed she routinely worked every other weekend and observed delivery of the supper meal from the dietary department to the 600 hall between 7 PM to 7:30 PM and sometimes as late as 8 PM. An interview on 05/01/16 at 06:41 PM with Nurse Aide (NA) #7 revealed the supper meal cart for the 400 hall usually arrived from the dietary department between 06:45 PM and 07:00 PM. During an interview on 05/01/16 at 07:10 PM, dietary staff (DS) #1 stated that she was the routine 2nd shift cook every other weekend. DS #1 stated "We need another person on the line to help, it slows me down when I have to try to keep everything on the line and do all of my own prep, if we run out of something I have to prepare more, sometimes we are late with the meals because of this." During an interview on 05/01/16 at 07:36 PM with the certified dietary manager (CDM) he revealed that, in terms of the timeliness of the meal delivery, the cook should have had a back-up of foods so that "we don't run out of food during the line" and the mechanical soft chicken should have been prepared before the tray line began. The CDM stated that the cook usually did not have anyone assisting them with meal preparation and had to learn to manage the tray line on their own. Resident #329 was admitted to the facility on 03/08/16. Review of an admission Minimum Data Set (MDS) assessment dated 03/15/16 assessed Resident #329 with clear speech, understood, able to understand, intact cognition and required supervision with meals. During an interview on 05/02/16 at 03:46 PM, Resident #329 stated that	F 362	quarterly QA Meeting to ensure compliance. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	

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F 362	Continued From page 60	F 362		

her lunch was late on Sunday, 05/01/16, which was not unusual, she routinely received her meals 30 - 40 minutes after the posted meal times and that occasionally a staff member would advise her that the meal was going to be late.

Resident #54 was admitted to the facility on 05/08/15. Review of an annual MDS dated 04/14/16 assessed Resident #54 with clear speech, understood, able to understand, intact cognition and required set up assistance only with meals. During an interview on 05/05/16 at 01:08 PM, Resident #54 stated that she had voiced concerns in the past to staff regarding routinely receiving her meals late. Resident #54 stated that she received lunch/supper on 05/01/16 (Sunday) late because of something that happened in the kitchen and that she did not receive her breakfast that morning (05/05/16) until 10:15 AM. Review of the posted meal delivery schedule revealed breakfast trays to this Resident's hall were due at 9:00 AM.

During a follow up interview on 05/05/16 at 03:23 PM, the CDM stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. The CDM stated the he had to arrange meal times according to medication administration times and that he could not change meal delivery times unless nursing changed the medication administration times. The CDM also stated that if the dietary department ran late with meal delivery, he went to

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F 362	Continued From page 61 the units to inform nursing staff and residents as to when the meal trays would be delivered. During an interview on 05/05/16 at 3:52 PM, the Administrator stated that due to continued family/resident concerns expressed to him regarding food palatability and timeliness of meal delivery, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the resident/family concerns with food palatability and the timeliness of meal delivery and that staff was working to address this.	F 362		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interview and review of approved menus, the facility failed to serve a 4 ounce portion of mashed potatoes, vegetables and rice, according to the approved menu, to 6 of 6 residents observed (Residents #141, #69, #58, #165, #98, and #169) during 1 of	F 363	F363 Corrective Action for Resident Affected: Resident #141, #69, #58, #165, #98 and #169's meal trays were retrieved from the cart, discarded, then re-plated and	6/3/16

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F 363	Continued From page 62 1 tray line meal observations. The findings included: An observation of the supper tray line on 05/01/16 at 5:32 PM revealed the tray line included mashed potatoes, rice, green beans and broccoli/cauliflower mixed vegetables. Review of the menu revealed that the rice and vegetables were to be served in a ½ cup (4 ounce) portion. Dietary staff (DS) #1 was observed serving 3/8 cup (3 ounce) portion of mashed potatoes, rice, green beans and pureed broccoli/cauliflower mixed vegetables. DS #1 stated she had already served the 1st cart to the 100 hall and she was now serving the 2nd cart to the 100 hall. Review of the delivery cart revealed DS #1 plated 3/8 cup (3 ounces) of mashed potatoes, rice, green beans or pureed vegetables for Residents #141, #69, #58, #165, #98, and #169. DS #1 stated that she usually used the menu and the "Scoop (Disher) Chart" which was posted next to the steam table when she set up the tray line, but she stated "I did not do that this time." During an interview on 05/01/16 at 05:59 PM the certified dietary manager (CDM) stated staff are trained to use the "Scoop (Disher) Chart" to setup the tray line, staff should compare the portion requirements on the menu to the posted chart to ensure correct portions are served. He stated that when he was in the kitchen, he typically monitored the tray line for correct portions, but that he did not notice that the tray line was set up with the wrong utensils.	F 363	reserved with correct portion sizes. An audit tool was immediately put into place by the Dietary Manager to monitor daily meal service. Additionally, the Dietary Manager or designee began conducting daily meal meetings with dietary staff on both shifts. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice. The audit tool began on 5-2-16, to monitor the correct usage of appropriate scoop sizes, compliance with established recipes and adhering to appropriate portions sizes. Also on 5-2-16, spreadsheets were reprinted and made available to all dietary staff. Copies of scoop size sheets were provide to dietary staff to use for reference. Systemic Changes: A follow-up in service will be conducted by the Contracted Corporate Registered Dietitian on June 1, 2016. Those required to be in attendance include all dietary staff and dietary managers. Any dietary staff not available on 6-1-16 will not be allowed to work until they are in-serviced. Information presented will include compliance with established recipes, adhering to appropriate portions sizes, reviewing spreadsheets during production, using appropriate portioning tools and checking portion accuracy on tray line prior to tray leaving the kitchen. All monitoring tools/audits will be completed and findings will be reported to	

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F 363	Continued From page 63	F 363	the weekly and quarterly QA meetings. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Dietary Manager or Consultant Dietitian for the Contracted Dining and Nutrition Services will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. This will be completed daily for four weeks, then weekly for one month, then monthly for at least three months. Identified issues will be reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		6/3/16

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F 364	Continued From page 64 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on a review of Food Committee Meeting minutes for 4 months (April 2016, March 2016, January 2016 and December 2015), 4 of 4 resident interviews (Resident #9, #345, #329 and #54), a test tray, 1 of 1 tray line observations with hot foods less than 135 degrees Fahrenheit plated for 2 of 2 residents observed (Residents #204 and #49), staff interviews, and a review of medical records, the facility failed to prepare foods to preserve nutritional value and provide foods per resident preference for taste and temperature during 1 of 2 dining experiences observed. The findings included: 1. a. Review of Food Committee Meeting minutes for April 2016 revealed residents expressed that "Ice cream is always melted when getting it, food is too watery and had no taste at all." Resident #9 was re-admitted to the facility on 06/13/14. A quarterly Minimum Data Set assessment dated 04/07/16 assessed Resident #9 with clear speech, understood, able to understand, and independent with eating. Resident #9 attended the April 2016 Food Committee Meeting and expressed that the cornbread falls apart, beans were dry, meals were served cold related to trays being passed out late and boiled eggs were cold. Resident #9 stated in an interview on 05/03/16 at 08:45 AM that the food was horrible and that he often	F 364	F364 Corrective Action for Resident Affected: An audit tool was immediately put into place by the Dietary Manager to monitor utilization of recipes by all production staff, monitoring safe cooking temperatures and recording on log, tasting foods prior to service for palatability, offering meal/food substitutions and honoring resident's preferences on a daily basis. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice. Recipes were reprinted and made available to all dietary staff, production counts being provided prior to each meal service and re-education provided to cooks on preferred palatability, appearance and temps of foods. The Dietary Manager is also to attend resident/food council meeting and obtain feedback from residents to enhance resident satisfaction, interview newly admitted residents daily for food preferences and complete a weekly chart audit of dietary orders. The audit tool will begin on 6-1-16 to monitor the above.	

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F 364	Continued From page 65 received bread that was tough all around the edges. He expressed that on 05/01/16 he received soup for lunch that tasted burned and beef stew that was too tough to chew, so the nurse took his tray back to the kitchen. The facility responded to the grievances on 04/14/16 with "Check temp of ice cream while on tray line, checker must make sure cold products are iced down and not melted or above 0 degrees Fahrenheit before serving on hall." Review of Food Committee Meeting minutes for March 2016 revealed Resident #9 stated that he received cold soup, vegetables tasted watery, beans are always dry, and cornbread falls apart every time. The facility responded to the grievances on 3/10/16 with "Adjust tray card to reflect resident preferences." Review of Food Committee Meeting minutes for January 2016 revealed residents expressed that "Sometimes food is cold when they get it." The facility responded to grievances on 01/14/16, but documentation did not include a response to cold foods. Review of Food Committee Meeting minutes for December 2015 revealed Resident #9 stated he did not like the presentation of the food and vegetables and cornbread was not done. The facility responded to the grievances on 12/10/15 with "Adjust tray card to reflect resident preferences."	F 364	Systemic Changes: An in-service was conducted on May 5, 2016 by the Dietary Manager. Those who attended were all dietary production staff. The in-service topic included following standardized recipes, serving palatable foods and safe foods. The meeting also addressed the initiation of daily stand-up meetings for both Dietary shifts. A follow-up in service will be conducted by the Contracted Corporate Registered Dietitian on June 1, 2016. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included following standardized recipes, tasting foods prior to service for palatability, monitoring tray line temperatures, meal presentation, adhering to meal delivery schedule to ensure optimal food temps at point of service, monitoring food temps for safety, corrective action for food items not at appropriate temps and honoring food preferences of residents. All monitoring tools/audits will be completed and findings will be reported to the weekly/quarterly QA meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Dietary Manager or Consultant	

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F 364	Continued From page 66 During an interview on 5/05/16 at 3:23 PM the certified dietary manager (CDM) stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. He further stated that if food concerns were expressed in Resident Council meetings, Food Committee meetings or customer satisfaction surveys, the dietary staff worked on the concerns until they were resolved. During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in the process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the concerns with food palatability and that the staff was working to address this. b. Resident #345 was admitted to the facility on 04/18/16. An admission Minimum Data Set dated 04/25/16 assessed Resident #345 with clear speech, understood, able to understand, intact cognition and independent with eating.	F 364	Dietitian for the Contracted Dining and Nutrition Services will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. This will be completed daily for four weeks, then weekly for one month, then monthly for at least three months. Identified issues will be reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	

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Resident #345 was observed on 05/01/16 at 6:30 PM with her supper meal. Resident #245 received baked chicken, cauliflower/broccoli mix, rice, salad, roll, tea, water and cake. When asked if she liked her supper meal, Resident #345 responded "food is halfway, not like home, sometimes its cold."

During an interview on 5/05/16 at 3:23 PM the certified dietary manager (CDM) stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. He further stated that if food concerns were expressed in Resident Council meetings, Food Committee meetings or customer satisfaction surveys, the dietary staff worked on the concerns until they were resolved.

During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the concerns with palatability and that the staff was working to

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address this.

c. Resident #329 was admitted to the facility on 03/08/16. An admission minimum data set dated 03/15/16 assessed Resident #329 with clear speech, understood, able to understand, intact cognition, and required supervision of one staff person with meals.

During an interview on 05/02/16 at 3:46 PM Resident #329 stated that she did not like the food provided by the facility and had expressed to staff that the food did not taste good. Resident #329 stated that in order to have something she could eat for breakfast, she had begun requesting dry cereal, milk and a boiled egg. Resident #329 stated her supper meal on Sunday, 05/01/16 was a ham and cheese croissant; when asked if she enjoyed her supper meal, she replied, "It was food."

During an interview on 5/05/16 at 3:23 PM the certified dietary manager (CDM) stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. He further stated that if food concerns were expressed in Resident Council meetings, Food Committee meetings or customer satisfaction surveys, the dietary staff worked on the concerns until they were resolved.

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During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the concerns with palatability and that the staff was working to address this.

d. Resident #54 was admitted to the facility on 05/08/15. An annual Minimum Data Set dated 04/14/16 assessed Resident #54 with clear speech, understood, able to understand, intact cognition and required set up help only with meals.

Resident #54 was observed on 05/01/16 at 07:31 PM in her room feeding herself supper. Resident #54 received baked chicken, mashed potatoes, cauliflower/broccoli mix, roll, milk, and water. When asked about her supper meal, Resident #54 stated regarding the chicken "They burned it." Resident #54 further stated that she has requested hot water with her meals, but the water is never hot enough and sometimes she receives food that is not cooked enough.

During an interview on 5/05/16 at 3:23 PM the certified dietary manager (CDM) stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he

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monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. He further stated that if food concerns were expressed in Resident Council meetings, Food Committee meetings or customer satisfaction surveys, the dietary staff worked on the concerns until they were resolved.

During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the concerns with palatability and that the staff was working to address this.

e. On 05/01/16 at 07:20 PM, a supper meal test tray for a regular diet was requested and arrived to the 600 hall at 07:28 PM in an enclosed metal cart. The supper meal was plated and covered with an insulated dome lid and bottom. The meal included baked chicken, broccoli/cauliflower mixed, black-eye peas, milk and tea. The Certified Dietary Manager (CDM) added margarine to the broccoli/cauliflower mix but the margarine did not melt. The skin of the baked chicken was observed with a dark/black appearance. The CDM added salt and pepper to

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the black-eye peas. On 05/01/16 at 07:36 PM, after all residents on the 600 hall were served, the CDM and surveyor both tasted the food and agreed that the black-eyed peas were bland, the broccoli/cauliflower mix was cool and bland, the skin of the chicken had a burned/bitter taste and the milk was warm. The CDM stated that since he served margarine and not "real butter", the margarine "did not even melt in hot grits." He stated that the food could be hotter and was "not piping hot."

During a follow up interview on 5/05/16 at 3:23 PM the CDM stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. He further stated that if food concerns were expressed in Resident Council meetings, Food Committee meetings or customer satisfaction surveys, the dietary staff worked on the concerns until they were resolved.

During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further

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stated that he was aware of the concerns with palatability and that the staff was working to address this.

f. During an interview on 05/01/16 at 2:54 PM, dietary staff (DS) #1 stated that she was the weekend dinner cook every other weekend. DS #1 stated that she started preparing the supper meal about 1:00 PM and placed the chicken in the oven to bake between 1:45 PM to 2:00 PM on 350 degrees Fahrenheit (F). DS #1 stated that she planned to leave the chicken in the oven until 5:00 PM.
On 5/01/16 from 02:54 PM until 03:31 PM an observation of meal preparation for the supper tray line revealed the following concerns with food palatability:
· The convection oven was observed with 6 long sheet pans of chicken. The oven temperature was set to 350 degrees F. The chicken was observed with a darkened/black exterior surrounded by liquid chicken fat that was bubbling.
· On 05/01/16 at 3:31 PM, DS #1 was observed to remove 3 pans of baked chicken from the oven. Temperature monitoring conducted by DS #1 revealed the chicken was 191 degrees F. DS #1 covered the chicken with foil wrap and placed 3 pans of chicken in the warmer which was set to 210 degrees F. DS #1 stated she would leave the chicken in the warmer until she started the supper tray line around 5:00 PM. DS #1 then reduced the convection oven temperature to 200 degrees F and stated she would leave the 3 remaining pans of chicken in the oven until she started the supper tray line at 5:00 PM. The chicken was observed with a darkened/black exterior.
On 05/01/16 from 05:08 PM to 06:22 PM, an

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observation of the supper tray line and temperature monitoring revealed the following concerns related to food palatability:

· Baked chicken had a dark/black exterior; 192.3 degrees F

· Broccoli/cauliflower had a brownish, water-logged appearance; 184.9 degrees F

· Rice had a brownish color; 200.2 degrees F

· 14 bowls of vegetable soup were plated and covered with lids and left on the stove, away from a direct heat source. A bowl of vegetable soup was placed on the meal tray for Resident #49; the tray was placed on the cart for delivery. Temperature monitoring revealed the soup for Resident #49 was 119.1 degrees F.

· The supper meal for Resident #204 was plated and remained on the tray line uncovered from 05:40 PM to 05:46 PM. Staff covered the plate and then placed it on the meal cart for delivery. Temperature monitoring revealed the Resident ' s baked chicken was 118 degrees F, rice was 56.4 degrees F and broccoli/cauliflower mix was 118 degrees F.

On 05/01/16 at 07:36 PM, during an interview with the CDM, he stated that the broccoli/cauliflower mix that was served at the beginning of the supper tray line "looked a little mushy." The CDM stated that frozen vegetables could be cooked in the steamer in about 5 minutes. The CDM stated he trained staff to maintain hot foods on the tray line at least 141 degrees, cover foods as soon as they are plated and to keep foods like soup in the warmer until served. He stated he would have to re-educate the cooks on the appropriate timing for meal preparation.

On 05/05/16 at 01:40 PM an interview with DS #1 revealed that when she prepared the supper meal every other weekend, she typically tried to have

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F 364	Continued From page 74 all the foods in the oven by 02:30 PM. DS #1 stated she typically cooked baked chicken for 2 ½ hours. DS #1 stated "I go by how much time I think it (chicken) needs and I also use the recipes, I just wanted to make sure the chicken was done." DS #1 further stated that the bowls of soup should have been placed in the warmer rather than left on the stove away from a direct heat source. DS #1 also stated that once meals are plated, the foods should be covered to make sure the foods stay hot. During a follow up interview on 5/05/16 at 3:23 PM the CDM stated that he routinely worked with staff to educate them on temperature monitoring, following procedures/recipes, customer service issues, and doing things right. The CDM stated that he monitored for the use of recipes 3 times weekly and conducted test trays twice weekly. The CDM stated that during test tray audits he had previously identified concerns with following recipes and as a result he re-educated staff to make sure the right seasonings were being used. During an interview on 05/05/16 at 3:52 PM the Administrator stated that due to continued family/resident concerns expressed to him and resident concerns expressed in Resident Council, his plan was to have a new dietary contract in place to address these issues before the next annual survey, but this was still in process. He stated that since the facility's last annual survey in October 2015 some improvements were made in the dietary department, but these corrections did not stay consistent. The administrator further stated that he was aware of the concerns with palatability and that the staff was working to address this.	F 364		
F 371	483.35(i) FOOD PROCURE,	F 371		6/3/16

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F 371 SS=E	Continued From page 75 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to 1) plate hot foods that were at least 135 degrees Fahrenheit for 2 of 2 residents observed (Residents #49 and #204), 2) conduct hand hygiene between clean and dirty tasks and prior to making direct contact with resident's food for 6 of 6 resident observed (Residents #347, #351, #335, #220, #110, and #136) and 3) 3 staff failed to wear beard restraints during meal preparation, for 1 of 1 tray lines observed. The findings included: 1. a. During an observation of the supper tray line on 05/01/16 at 05:40 PM, dietary staff (DS) #1 was observed to plate a supper meal for Resident #204 to include baked chicken, rice, mixed vegetables and a roll. The Resident's plate was left uncovered on the tray line until 05:46 PM at which time DS #2 covered the meal and placed the meal tray on the cart for delivery. Temperature monitoring was conducted on 05/01/16 at 05:48 PM and revealed the following temperatures: · Chicken 118 degrees Fahrenheit (F)	F 371	F371 Corrective Action for Resident Affected: Resident #49 and #204 meals were reheated to proper serving temperature. The Dietary Manager completed an immediate in-service with all staff on 5-1-16, regarding taking food temps, hand hygiene, cross contamination and use of beard/hair restraints. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice. An audit tool was immediately put into place by the Dietary Manager to monitor daily meal service and to monitor safe food handling. The Dietary Manager completed an in-service with all staff on 5-1-16, regarding taking food temps, hand hygiene, cross contamination and use of beard/hair restraints.	

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F 371	Continued From page 76 · Rice 56.4 degrees F · Mixed vegetables 118 degrees F An interview with the certified dietary manager (CDM) on 05/01/16 at 05:59 PM revealed he trained staff to keep hot foods at least 141 degrees F or above on the tray line. The CDM instructed DS #1 to recheck temperatures of all foods on the tray line and foods that were less than 135 degrees F were placed in the steamer and re-thermalized. An interview on 05/05/16 at 01:40 PM with DS #1 revealed hot foods should be 180 degrees F on the tray line and residents' meals should be covered as soon as they are plated. b. On 05/01/16 from 05:08 PM to 05:20 PM dietary staff (DS) #3 was observed to plate 14 bowls of vegetable soup for the supper meal. The bowls of soup were left on the stove without a direct heat source. On 05/01/16 at 06:22 PM, DS #1 gave DS #2 a bowl of vegetable soup for Resident #49. DS #2 placed the vegetable soup on the Resident's meal tray and placed the tray on the cart for delivery. Temperature monitoring revealed the vegetable soup was 119.1 degrees F. The CDM stated that the soup should be reheated and was observed to place the soup in the microwave and re-thermalized. An interview on 05/05/16 at 01:40 PM with DS #1 revealed hot foods should be 180 degrees F on the tray line and the soup should be plated as needed or if plated in advance, soup should be kept in the warmer rather than plated and left on the stove without a heat source. 2. On 05/01/16 from 06:07 PM to 07:10 PM, dietary staff (DS) #1 was observed, while wearing gloves, to pick up visibly soiled oven mittens (dried food and stains) to remove hot foods from the oven, removed the mittens, opened oven	F 371	Systemic Changes: An in-service was conducted on May 5, 2016 by the Dietary Manager. Those who attended were all dietary production staff. The in-service topic included taking food temps, hand hygiene, cross contamination and use of beard/hair restraints. The meeting also addressed the initiation of daily stand-up meetings for both Dietary shifts. A follow-up in service will be conducted by the Contracted Corporate Registered Dietitian on June 1, 2016. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included ensuring optimal food temps at point of service, monitoring food temps for safety, corrective action for food items not at appropriate temps, hand hygiene, cross contamination and use of beard/hair restraints. All monitoring tools/audits will be completed and findings will be reported to the weekly/quarterly QA meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Dietary Manager or Consultant Dietitian for the Contracted Dining and Nutrition Services will monitor this issue using the "Dietary QA Audit" tool. All	

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F 371	Continued From page 77 doors and used a soiled cloth (food stains and food debris) to wipe spilled food from the tray line with the same gloves. Then DS #1 plated dinner rolls for Residents #347, #351, #335, #220, #110, and #136 with gloved hands, but DS #1 did not conduct hand hygiene or don clean gloves. During an interview on 05/01/16 at 01:00 PM DS #1 stated she did not realize she touched soiled items without changing her gloves. She stated she was trained to wash hands and change gloves out whenever the gloves became dirty and to use utensils to plate food. During an interview on 5/05/16 at 03:23 PM, the CDM stated that staff were trained to conduct hand hygiene anytime their hands or gloves contacted non-food items, and they know they should not use soiled mittens during meal prep, the mittens will need to be laundered or we will need to get some new ones. 3. On 05/01/16 the following staff were observed during meal preparation for the supper meal without beard restraints in place: On 05/01/16 at 03:13 PM dietary staff (DS) #2 was observed with facial hair to both sides of his face and no beard restraint in place. DS #2 was observed to pour tea into cups of ice to serve residents iced tea for supper. On 05/01/16 from 05:08 PM to 05:20 PM DS #3 was observed with facial hair to his chin and no beard restraint in place. DS #3 was observed to plate 14 bowls of vegetable soup for the supper meal. On 05/01/16 at 05:25 PM the certified dietary manager (CDM) was observed with facial hair to his cheeks and chin and no beard restraint in place. On 05/01/16 from 05:25 PM to 07:19 PM the CDM was observed to cook ground meat, cook steam vegetables twice, reheat vegetable	F 371	areas will be monitored daily. This will be completed daily for four weeks, then weekly for one month, then monthly for at least three months. Identified issues will be reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	

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F 371	Continued From page 78 soup in the microwave, cook mashed potatoes, cook black-eyed peas and conduct temperature monitoring. During an interview on 05/05/16 at 03:23 PM, the CDM stated that the staff with facial hair should use beard guards; he stated "We have them and use them, I am not routinely on the tray line, so I forgot to wear my beard restraint." The CDM stated that he did not notice that there were dietary staff with facial hair who were not wearing a beard restraint.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		6/3/16

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F 431	Continued From page 79 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to refrigerate unopened insulin pens as per the affixed label on the medication, failed to remove expired insulin, failed to date a vial of tuberculin purified protein (TB serum), a vial of bacteriostatic agent, a vial of lidocaine, and a bottle of nitroglycerin when opened from 4 of 6 medication carts. The findings included: A review of the facility's policy titled "Medication Storage in the Facility" undated read in part medications requiring "refrigeration" or "temperatures between 36 degrees Fahrenheit (F) and 46 degrees Fahrenheit (F) are kept in a refrigerator with a thermometer." And outdated, contaminated, and deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. 1) During medication storage observations on 05/05/16 at 6:45 AM the 200 hall medication (med) cart revealed 2 insulin pens (one pen of	F 431	F 431 All identified open, unlabeled, not refrigerated or expired medications (insulin pens, TB serum, bacteriostatic agent, lidocaine and a bottle of nitroglycerin) were returned to pharmacy or destroyed. The medication carts were checked for proper storage of medication and cleaned. No other items on the carts were found to be unlabeled, expired or required refrigeration. This was completed by the cart nurse and the Unit Managers on 5/6/16. All nurses were reeducated on the proper storage and labeling of medication on the medication carts. Identification of potentially affected residents and corrective actions taken: All residents have the potential to be affected by the deficient practice. On 5/6/16 all medications in the medication carts were inspected for opened unlabeled or expired medications by the cart nurses and Unit Managers. No additional expired medication or storage issues were identified.	

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F 431	Continued From page 80 Novolog and one pen of Lantus) unopened with a dispensed date from pharmacy of 05/02/16 that was unrefrigerated as per the affixed label on the pens. The pharmacy label read in part "refrigerate insulin pen until opened." An interview was conducted with Nurse #7 on 05/05/16 at 6:52 AM. Nurse #7 stated she was unable to recall if she had placed the insulin pens in the medication cart when the pharmacy had delivered the medications on Monday night 05/02/16. Nurse #7 confirmed the 2 insulin pens should have been stored in the medication refrigerator prior to opening instead of being placed in the medication cart. An interview was conducted with the Director of Nursing (DON) on 05/06/16 at 4:50 PM. She stated she would have expected the insulin to have been refrigerated prior to opening. 2) During an observation on 05/05/16 at 1:55 PM of the 300 and 400 rehab 1 medication cart revealed an insulin pen of Novolog unopened with a dispensed date from pharmacy on 05/02/16 that was unrefrigerated as per the affixed label on the pens. The pharmacy label read in part "refrigerate insulin pen until opened." During an observation on 05/05/16 at 2:00 PM of the 300 and 400 rehab 1 medication (med) cart also revealed an insulin pen of Humalog that was dated as being opened on 04/06/16. Further observations of the same med cart revealed an opened pen of Humalog insulin that contained no date as to indicate when it had been opened. Further observations on 05/05/16 at 2:05 PM of	F 431	Systemic Change: All Nurses, RNs and LPNs (full, part time and PRN) were in- serviced on the need to date and label all open multi-use medications. This education was provided by an Education Training Packet on Medication Storage. All in-house RN or LPN will receive in-service training on Medication Storage as of May 18, 2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Pharmacy Consultant will check medication carts monthly for cleanliness and expired medications also to ensure open medications are dated, labeled and stored correctly. The 11 to 7 cart nurse will check carts daily for proper storage of all medications. This will be done weekly for one month and then monthly for at least three months. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance. Identified issues will be reported immediately to DON or ADON for appropriate action. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team	

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F 431	Continued From page 81 the 300 and 400 rehab 1 med cart revealed an opened vial of tuberculin purified protein (TB serum) that contained no date as to indicate when it had been opened. Continued observations on 05/05/16 at 2:07 PM of the med cart revealed an opened vial of bacteriostatic agent (used to stop bacteria from reproducing) that contained no date as to indicate when it had been opened. Also was observed an opened vial of 1% lidocaine (numbing medication) that contained no date as to indicate when it had been opened. An observation on 05/05/16 at 2:10 PM of the same med cart revealed an opened bottle of nitroglycerin pills (used for chest pain) that contained no date as to indicate when the bottle had been opened. An interview was conducted on 05/05/16 at 2:15 PM with Nurse #8. She stated the expectation of the nursing staff was for unopened insulin pens to be stored in the refrigerator. Nurse #8 further stated that nursing staff was expected to date the medications when they open them. Nurse #8 confirmed that Humalog insulin should be discarded 28 days after opening. An interview was conducted on 05/05/16 at 2:30 PM with the Unit Nurse Supervisor (NS). The NS stated it was her expectation for all medications to have an opened date noted on them when they were opened by the staff nurse. She further stated when an insulin medication was received from the pharmacy it was supposed to be refrigerated until opened. The NS indicated it was her expectation for insulin medications to be	F 431	and Department Heads until resolved. Date of Completion: June 3, 2016	

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F 431	Continued From page 82 discarded after 28 days of being opened or expired. A telephone interview was conducted on 05/05/16 at 4:35 PM with the pharmacist. He stated the Novolog insulin was supposed to be refrigerated until it was opened. He further stated the Humalog insulin was good for 28 days after opening. An interview was conducted with the Director of Nursing (DON) on 05/06/16 at 4:50 PM. She stated she would have expected the insulin to have been refrigerated prior to opening and insulin pens were to be dated when opened. The DON further stated she expected all medications to have a date on them as to indicate when the medication was opened.	F 431		
F 441 SS=E	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	F 441		6/3/16

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F 441	Continued From page 83 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to post signage with instructions for contact isolation precautions and failed to follow infection control procedures during cleaning and mopping of resident rooms for a resident with physician orders for contact isolation and then went directly into another resident's room who was not on isolation precautions and mopped and cleaned without changing the mop water, the cleaning rag or gloves to prevent cross contamination for 1 of 3 residents sampled with orders for contact isolation (Resident # 62). The findings included: Resident # 62 was admitted to the facility on 07/03/14 with diagnoses of chronic kidney	F 441	F441 Resident #62 was diagnosed on 5/5/16 after seeing the eye doctor in the facility with conjunctivitis. The signage was applied to the door along with the isolation cart after this visit. On 5/6/16 the surveyor documents at 10:08am the sign was present along with the isolation cart. The housekeeping supervisor was made aware of this deficient cleaning practice for isolation room of resident #62 and the employee was properly educated at that time according to the facilities infection control policy on daily cleaning of precaution rooms along with the procedure on isolation room cleaning from	

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F 441	Continued From page 84 disease, type II diabetes and heart disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/28/16 revealed Resident # 62 was cognitively intact for daily decision making and required extensive assistance with hygiene, bathing and toileting. A review of a physician's order dated 05/05/16 indicated TobraDex Suspension 0.3-0.1 % (Tobramycin-Dexamethasone) antibiotic eye drops and instill 1 drop in both eyes four times a day for conjunctivitis (redness and drainage of the eyelids) for 7 Days. The orders also indicated contact precautions for conjunctivitis. During an observation on 05/06/16 at 10:08 AM the door of Resident #62's room was open and a red sign was posted on the door frame which indicated Stop See Nurse. A clear plastic storage unit was sitting on the floor inside the door which contained gowns, gloves and masks. Housekeeper #1 parked a cleaning cart in front of the door of Resident #62's room and entered the room with a pair of gloves on and swept the floors, wiped down surfaces of the sink and furniture with a cleaning rag and mopped the bathroom floor. Housekeeper #1 then walked out of Resident #62's room and entered another resident's room who was not on isolation precautions with the same gloves on and used the same cleaning rag to wipe down the sink and furniture and mopped the bathroom floor with the same mop and mop water. During an interview on 05/06/16 at 10:30 AM Housekeeper #1 stated she had only worked in the facility for 2 days. She explained she had been instructed to wipe everything with a cleaning	F 441	the housekeeping department Stanton environmental services. Identification of potentially affected residents and corrective actions taken: All residents who require isolation precautions have the potential to be affected by the deficient practice. On 5-6-16, the RN Unit Nurse Managers reviewed all patients to ensure that those who require isolation precautions had signs to notify staff. The Housekeeping Supervisor was made aware of this deficient cleaning practice for isolation room of resident #62. On 5/18/16, all Contracted Environmental Service employees were reeducated on the facilities infection control policy and the daily cleaning of precaution rooms, along with the procedures on isolation room cleaning. Systemic Changes: On 5/18/16, all Contracted Environmental Service employees were reeducated by the Housekeeping Supervisor on the facilities infection control policy and the daily cleaning of precaution rooms, along with the procedures on isolation room cleaning. All nurses and the unit managers were also in-serviced by the Director of Nursing that all patients who require isolation must have signs posted to notify staff of the requirement. This education is to be completed by June 3, 2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 441	Continued From page 85 rag, clean the bathroom, sweep and mop and empty the trash. She stated she was unaware of what the sign Stop See Nurse that was posted on the door frame meant and stated she had no idea what the plastic storage container inside the door of Resident #62's room was for and had not heard anything about contact precautions. During an interview on 05/06/16 at 10:53 AM with the long term care Unit Manager/ Assistant Director of Nursing she explained they posted the sign on the door frame of Resident #62's room to Stop See Nurse because they did not want to advertise what the isolation was for. She stated visitors and staff were expected to go to the nurse when they saw the sign for instructions regarding which isolation supplies they should use. She explained Resident #62 was on contact isolation precautions for conjunctivitis and the clear plastic storage unit inside Resident #62's door contained isolation supplies. She further explained staff should wear gloves while they were in the resident's room but she was not sure what routine the housekeeper should follow when cleaning Resident #62's room. During an interview on 05/06/16 at 3:45 PM the Director of Environmental Services explained housekeepers were expected to clean resident rooms in the long term care units of the facility on a daily basis and that should include cleaning of the bathroom, dusting and mopping. He stated if a resident had a Stop See Nurse sign on their door it was the usual routine for housekeepers to ask the nurse what the housekeeper should wear while cleaning the room. He stated changing of mop water depended on what the precaution was but most of the time they used disinfectant in the mop water and that kept the room clean. He	F 441	all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The director of environmental services will monitor that proper procedure for cleaning of isolation room is in compliance daily. Additionally the DON will review 5 new admits and 5 charts with recent lab results to ensure that isolation signs have been posted when appropriate. This will be done weekly for one month then monthly for at least three months. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting to ensure compliance by the director of environmental services. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the quarterly QA Meeting by the director of environmental services. The quarterly QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads until resolved. Date of Completion: June 3, 2016	

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F 441	Continued From page 86	F 441		

further stated housekeepers should remove their gloves before they left the resident's room and they should put on clean gloves before they cleaned the next resident's room. He further explained Housekeeper #1 had only worked in the facility for 2 days and they had to speed up her orientation process because they had a housekeeper who was out of work. He confirmed Housekeeper #1 was paired up with an experienced housekeeper on 05/05/16 and received the hands on portion of training but had not received the blood borne pathogen training that usually occurred over several days in orientation.

During an interview on 05/06/16 at 5:08 PM the Director of Nursing confirmed she had taken charge of the infection control program in January 2016 and had been revising the program for the facility. She explained it was her expectation for nursing staff to inform families and visitors regarding isolation precautions the resident required. She stated she trained nursing staff in infection control procedures but housekeepers were trained in infection control by the Environmental Services Director. She stated it was her expectation for housekeepers to follow infection control procedures for cleaning of isolation rooms and it was her expectation when housekeepers had finished cleaning in a resident's room with isolation precautions they should change the mop, change the mop water, throw the cleaning rag away, change gloves and wash their hands before they entered the next resident's room. She further stated housekeepers should not wear the same gloves from one resident's room to the next to prevent cross contamination.

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F 520	Continued From page 87	F 520		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify 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 and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in October, 2015. This was for recited deficiencies which were originally cited during a recertification survey completed on 10/02/15, a complaint	F 520	F520 Corrective Action for Resident Affected: No specific residents were mentioned in the 2567. Corrective Action for Resident Potentially Affected:	6/3/16

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F 520	Continued From page 88 investigation survey completed on 12/03/15 and on the current recertification survey. The deficiencies were in the areas of choice, accuracy of the Minimum Data Set, provision of care and services to maintain well-being, provision of assistance with activities of daily living, following menus, food palatability and food sanitation. The continued failure of the facility during three federal survey 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: 1. F 242: Based on observations, record review, resident and staff interviews, the facility failed to allow residents their choice of personal hygiene products and failed to allow residents to sit outside under a covered porch or on a patio causing the residents to feel imprisoned and irresponsible. The facility also failed to honor a resident's choice for the number of showers in a week causing the resident to feel un-clean for 4 of 7 residents sampled for choices (Residents #9, #165, #69, and #192). The facility was recited for F 242 regarding failure to provide choice regarding frequency of showers, choice of personal hygiene products and ability to sit outside on porches and patio. F 242 was originally cited in October 2015 for failure to provide choices in food preferences. 2. F 278: Based on staff interviews, physician's orders and review of the Medication Administration Record, the facility failed to assess the use of pain medication when completing a	F 520	All residents have the potential to be affected by this practice. See other plans of corrections cited for F242, F278, F309, F312, F363, F364, and F371. Systemic Changes: On May 31, 2016, the Vice President of Liberty Healthcare Clinical Services in-serviced the Administrator. Topics included: The need to continue all plan of correction quality assurance monitors until full compliance is sustained for 3 months. Once sustained for 3 months the survey monitor will be completed quarterly until after the next survey cycle to ensure compliance on the next survey. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Quality Assurance Audit tools identified in this plan of correction will be reviewed monthly to ensure that audits are completed until compliance is sustained for 3 months. Then audits should be completed quarterly to ensure on-going compliance until the next annual survey reveals compliance. Any issues will be reported to the Administrator and the Regional Operations Manager for corrective actions.	

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F 520	Continued From page 89 Minimum Data set for 1 of 3 sampled residents reviewed for pain (Resident #87). The facility was recited for F 278 regarding failure for accuracy in the Minimum Data Set (MDS) regarding use of pain medication. F 278 was originally cited in October 2015 for failure for MDS accuracy regarding Level II PASSR residents and cognition assessment. 3. F 309: Based on staff, nurse practitioner and family member interviews, the facility failed to respond to the inability to use the right arm and increased need for assistance with ambulation for 1 of 3 residents who experienced a change in condition (Resident #47). The facility was recited for F 309 regarding failure to respond to a resident change of condition. F 309 was originally cited in December 2015 for failure to assess pain. 4. F 312: Based on observations, record review and staff and family interviews, the facility failed to remove facial hair for 1 of 6 sampled residents for Activities of Daily Living (Resident #258). The facility was recited for F 312 regarding failure to provide assistance with chin hair removal. F 312 was originally cited in October 2015 for failure to assist with nail care. 5. F 363: Based on observation, staff interviews and review of approved menus, the facility failed to serve a 4 ounce portion of mashed potatoes, vegetables, and rice according to the approved menu to 6 of 6 residents observed (Residents #141, #69, #58, #165, #98 and #169) during 1 of 1 tray line meal observations.	F 520	Date of Completion: June 3, 2016	

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F 520	Continued From page 90	F 520		

The facility was recited for F 363 regarding failure to follow the menu regarding portion size for mashed potatoes, vegetables and rice. F 363 was originally cited in October 2015 for failure to follow the menu regarding portion size for fortified pudding.

6. F 364: Based on a review of Food Committee Meeting Minutes for 4 months (April 2016, March 2016, January 2016 and December 2015), 4 of 4 resident interviews (Residents #9, #345, #329 and #54), a test tray, 1 of 1 line observations with hot foods less than 135 degrees Fahrenheit plated for 2 of 2 residents observed (Resident #204 and #49), staff interviews and a review of medical records, the facility failed to prepare food to preserve nutritional value and provide foods per resident preference for taste and temperature during 1 of 2 dining experiences observed.

The facility was recited for F 364 regarding failure to provide palatable food and food temperatures. F 364 was originally cited in October 2015 for failure to provide palatable food.

7. F 371: Based on observations, staff interviews and review of facility records, the facility failed to 1) plate hot foods that were at least 135 degrees Fahrenheit for 2 of 2 residents observed (Residents #49 and #204), 2) conduct hand hygiene between clean and dirty tasks and prior to making direct contact with resident ' s food for 6 of 6 residents observed (Residents #347, #351, #335, #220, #110 and #136) and 3) 3 staff failed to wear beard restraints during meal preparation for 1 of 1 tray lines observed.

The facility was recited for F 371 regarding failure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 520	Continued From page 91 to plate hot food at a minimum of 135 degrees Fahrenheit, hand hygiene and wear beard restraints. F 371 was originally cited in October 2015 for failure of temperatures of hot food on the steam table. Interview with the administrator on 05/06/16 at 5:19 PM revealed the facility identified deficient areas in the dietary department, developed a corrective plan and was in the process of implementation. The administrator explained the facility monitored previously identified deficient areas and the Quality Assurance committee met regularly to measure progress.	F 520		