STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

(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 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		7/28/16

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

Electronically Signed | 07/22/2016

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

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 6 of 21 sampled residents (Residents #14, #22, #61, #75, #81, and #95). The findings included: 1. Resident #22 was most recently admitted to the facility on 12/26/12. Her diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, Alzheimer's disease, and dementia. The annual Minimum Data Set (MDS) dated 05/03/16 coded Resident #22 with impaired vision (seeing large print but not newspapers or books), wearing no glasses, having severely impaired cognitive skills, and being edentulous. a. The Care Area Assessment (CAA) dated 05/05/16 related to vision stated she had impaired vision without glasses. This CAA did not described the underlying causes, contributing factors or risk factors specifically as to how they related to and affected Resident #22's day to day function and abilities. Interview with the Social Service Coordinator (SSC) #1 on 06/30/16 at 4:20 PM revealed SSC #2 trained her in completing the CAA and she was unaware that she should describe and analyze Resident #22's abilities and describe how her vision affected her day to day activities.	F 272	(A)The vision and dental CAA's written 5/5/16 for Resident #22 were revised to describe the underlying causes, contributing factors, and risk factors specifically as to how they relate to and affect the daily function and abilities of the resident by 7/28/16. The vision CAA written 2/12/16 for Resident #61 was revised to describe the underlying causes, contributing factors, and risk factors specifically as to how they relate to and affect the daily function and abilities of the resident by 7/28/16. The psychotropic medication use CAA's written 2/11/16 for Residents #75 and #14 were revised to describe the underlying causes, contributing factors, and risk factors specifically as to how they relate to and affect the daily function and abilities of each resident on by 7/28/16. The nutritional CAA written 3/25/16 for Resident #81 was revised to describe the underlying causes, contributing factors, and risk factors specifically as to how they relate to and affect the daily function and abilities of the resident by 7/28/16. The psychotropic medication use CAA written 3/4/16 for Resident #95 was revised to describe the underlying causes, contributing factors, and risk factors specifically as to how they relate to and affect the daily function and abilities of the	

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F 272	Continued From page 2 b. The Care Area Assessment (CAA) dated 05/05/16 related to dental revealed she was edentulous and will care plan for analysis of findings. This CAA did not described the underlying causes, contributing factors or risk factors specifically as to how they related to and affected Resident #22's day to day function and abilities. Interview with the Food Service Director (FSD) on 06/30/16 at 3:58 PM revealed she was responsible for completing the dental CAA on residents. The FSD stated that she was not aware of what information to include in a dental CAA and did not know she should analyze Resident #22's abilities and describe how being edentulous affected her day to day activities. 2. Resident #61 was admitted to the facility on 04/18/14. Her diagnoses included congestive heart failure, Alzheimer's Disease, dysphagia and dementia. Her annual Minimum Data Set (MDS) dated 02/11/16 coded her with severely impaired cognitive skills, and impaired vision with no corrective lenses. The Care Area Assessment (CAA) related to vision dated 2/12/16 stated Resident #61 had impaired vision without glasses and no referral was needed at this time. This CAA did not described the underlying causes, contributing factors or risk factors specifically as to how they related to and affected Resident #61's day to day function and abilities. Interview with the Social Service Coordinator (SSC) #1 on 06/30/16 at 4:26 PM revealed she	F 272	resident by 7/28/16. (B)As of 7/28/16, all comprehensive MDS' for current residents with an assessment reference date of 2/11/16 and after had the CAA's for vision, dental, psychotropic medication use, and nutrition reviewed to determine if each included a description of the underlying causes, contributing factors, and risk factors. Any noted with missing detailed information was immediately corrected. (C)The Minimum Data Set Policy/Procedure was revised to include directions that CAA's require detailed information noting the underlying causes, contributing factors, and risk factors for areas of concern. The interdisciplinary care plan team members (MDS Coordinators, FSD, Activities Director, and Social Services Coordinators) were in-serviced by the DON and Administrator on this policy revision as well as CAA procedures using Chapter 4 and Appendix C of the RAI Manual (2015) and the AANAC Care Area Assessments Training Module 7/25/16. Both MDS Coordinators will also attend the next available NC DHSR CAA training when scheduled and will return to share this training with the remaining members of the interdisciplinary care plan team. During weekly Care Plan team meetings beginning the week of 7/25/16, all CAA's for scheduled review will be discussed in detail by the interdisciplinary team to ensure all triggered areas include	

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F 272	Continued From page 3 was trained by the SSC #2 and neither were instructed to give more than the description of the vision problem for the resident. 3. Resident #75 was admitted to the facility most recently on 09/28/14. Her diagnoses included trauma with subarachnoid hemorrhage, confusion, Alzheimer's Disease, depressive disorder and schizophrenia. The annual Minimum Data Set (MDS) dated 02/09/16 coded her with severely impaired cognitive skills and having no moods, no behaviors or delirium or hallucinations in the look back period. She was coded as receiving antipsychotics and antidepressants 7 days in the previous 7 days. The Care Area Assessment (CAA) dated 02/11/16 only stated that the resident triggered for assessment due to the use of antipsychotic and antidepressant medications. There was no analysis describing the underlying causes, contributing factors or risk factors specifically as to how they related to and affected Resident #75's day to day function and abilities. Interview with the MDS Coordinator #1 on 06/30/16 at 2:57 PM revealed she completed the medication section and CAAs for Resident #75. MDS Coordinator #1 stated she normally just listed the medications received and explained why the resident received those medications. She further stated she was unaware of the need to write a descriptive summary specific to how they related to and affected Resident #75's day to day function and abilities.	F 272	underlying causes, contributing factors, and risk factors as to how they related to and affect the daily function and abilities of the resident(s). Any additions or revisions will be made to any CAA at that time as needed. (D)The DON will audit 3 comprehensive assessments from the weekly care plan schedule following the interdisciplinary team meeting to review all CAA's to ensure all triggered areas include underlying causes, contributing factors, and risk factors as to how they related to and affect the daily function and abilities of the resident(s). Any concerns or issues identified from these audits will be immediately corrected by the specific discipline involved with additional coaching/training/disciplinary action provided. This audit will be conducted weekly X 4 weeks followed by every other week X 4 weeks and finally monthly X 4 months beginning on 7/28/16. The Administrator will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning on 7/28/16.	

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4. Resident #14 was admitted on 01/26/16 with diagnoses including Alzheimer's disease, dementia, anxiety disorder, and manic depression (bipolar disease).

Review of the admission Minimum Data Set (MDS) dated 02/08/16 revealed Resident #14 had moderately impaired cognition and was able to make her needs known. The admission MDS indicated she had no negative responses to the mood interview and there were no behaviors noted. The admission MDS further revealed Resident #14 was administered antipsychotic, antidepressant, and antianxiety medications daily during the 7 day look-back period.

Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 02/11/16 revealed Resident #14 triggered due to Klonopin 2.0 mg (milligrams) at bedtime for anxiety, Prozac daily for depression, and Risperdal 0.5mg every morning for bipolar disease. There was no documentation in the summary/analysis of contributing factors, description of the problem, or risk factors related to the care area. The CAA did not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health services had seen Resident #14.

An interview was conducted with MDS Coordinator #1 on 06/30/16 at 2:54 PM. MDS Coordinator #1 confirmed she had completed the Medications section and CAA Summary for Psychotic Drug Use for Resident #14's admission MDS dated 02/08/16. MDS Coordinator #1

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stated she normally just listed the medications received and explained why the resident received those medications when completing the CAA Summary. The interview further revealed she was unaware of the need to write a descriptive summary specific to how the medications related to and affected Resident #14's day to day function and abilities.

5. Resident #81 was admitted on 03/14/16 with diagnoses including diabetes mellitus, hypertension, and history of transient ischemic attack.

Review of physician's orders dated 03/14/16 revealed Resident #81 was ordered a regular consistency 2 gram sodium and no concentrated sweets diet.

Review of the admission Minimum Data Set (MDS) dated 03/21/16 revealed Resident #81 received a therapeutic diet.

Review of the Care Area Assessment (CAA) Summary for Nutritional Status dated 03/25/16 revealed the analysis of findings stated Resident #81 needed a therapeutic diet. There was no documentation in the summary/analysis of contributing factors, a description of the problem, or risk factors related to the care area.

An interview was conducted with the Food Service Director (FSD) on 06/30/16 at 2:24 PM. The FSD confirmed she had completed the Swallowing/Nutritional Status section and CAA Summary for Nutritional Status Resident #81's admission MDS dated 03/21/16. The FSD stated she was responsible for the Swallowing/Nutritional Status and Oral/Dental

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Status sections of the MDS and the CAA Summary for Nutritional Status. The FSD indicated she reviewed the medical record and talked with staff to complete her portions of the MDS. The interview further revealed the FSD was not taught to write any details in the analysis of findings when completing a CAA Summary.

6. Resident #95 was admitted on 08/01/12 with diagnoses including Alzheimer's disease and anxiety disorder.

Review of the annual Minimum Data Set (MDS) dated 03/02/16 revealed Resident #95 had severely impaired cognition and was able to make her needs known. The annual MDS indicated she had no negative responses to the mood interview and there were no behaviors noted. The admission MDS further revealed Resident #95 was administered an antianxiety medication daily during the 7 day look-back period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 03/04/16 revealed Resident #95 had diagnoses of anxiety, obsessive compulsive disorder, and Alzheimer's disease and received Xanax for anxiety twice a day. The CAA Summary referred to a progress note dated 02/11/16 and also instructed the reader to review several disciplines documentation and Medication Administration Records. The analysis of findings also noted there was no change in mood or behavior and no adverse behaviors noted but did not describe what this meant for Resident #95. There was no documentation in the summary/analysis of contributing factors, description of the problem, or risk factors related to the care area. The CAA did

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F 272	Continued From page 7 not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health services had seen Resident #95. An interview was conducted with MDS Coordinator #2 on 06/30/16 at 3:17 PM. MDS Coordinator #2 confirmed she had completed the Medications section and CAA Summary for Psychotic Drug Use for Resident #95's annual MDS dated 03/02/16. MDS Coordinator #2 stated she based her CAA Summary on the indicators that triggered on the MDS, review of the medical record, and progress notes. MDS Coordinator #2 further stated she needed to include more resident specific details when completing the CAA Summary for Psychotropic Drug Use.	F 272		
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		7/28/16

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F 278	Continued From page 8 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code an admission Minimum Data Set (MDS) correctly to reflect a resident had been evaluated by Level II PASSR (Preadmission Screening and Review) and failed to code a significant change MDS accurately to reflect dental status for 2 of 21 sampled residents (Residents #12 and #14). The findings included: 1. Resident #14 was admitted on 01/26/16 with diagnoses including manic depression (bipolar disease). Review of a document dated 02/01/16, which included Resident #14's PASSR history, noted her Level II PASSR number was 2016032247F and it expired on 05/01/16. The admission MDS dated 02/08/16 indicated Resident #14 had not been evaluated by Level II PASSR to determine if she had serious mental illness.	F 278	(A)The comprehensive MDS assessment dated 2/8/16 for Res. #14 was corrected by 7/28/16 by the MDS Coordinator to accurately reflect that the Level II PASRR was done on admission. The comprehensive MDS assessment dated 6/16/16 for Res. #12 was corrected by 7/28/16 by the MDS Coordinator to accurately reflect that the resident is edentulous. (B)Per NC MUST reviews, there have been no other residents admitted since 2/8/16 with a Level II PASRR for coding under Section A of a comprehensive MDS assessment. The dental status of all residents was assessed by the FSD together with a licensed nurse and then the FSD compared assessments to the most recent comprehensive MDS assessments —Section L for proper coding of	

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F 278	Continued From page 9 An interview was conducted with Social Services Coordinator (SSC) #1 on 06/30/16 at 3:59 PM. SSC #1 stated she was aware Resident #14 met Level II PASSR conditions at the time of her admission because Resident #14's admission was delayed until she could be evaluated by a physician. SSC #1 reviewed Resident #14's admission MDS dated 02/08/16 and confirmed she had completed Section A which included if a resident had been evaluated by Level II PASSR. SSC #1 could not explain why she had not coded the admission MDS accurately to reflect Resident #14's evaluation for Level II PASSR. 2. Resident #12 was admitted to the facility on 07/29/15. Her diagnoses included hypertension, dementia, anemia and vitamin deficiency. Review of the significant change Minimum Data Set (MDS) dated 06/16/16 revealed Resident #12 had severely impaired cognitive skills, and having no problems with her oral or dental status. Observation on 06/28/16 at 8:34 AM revealed Resident #12 had no teeth or dentures in her mouth. On 06/30/16 at 10:12 AM the Hospice nurse stated Resident #12 had no natural teeth. On 06/30/16 at 3:51 PM the Food Service Director (FSD) was interviewed and stated she was responsible for the MDS dental section. She further stated she had received no training related to how to assess a resident's dental status and did not look inside a resident's mouth when completing this portion of the MDS. The FSD stated she incorrectly marked the MDS and	F 278	oral/dental status. Any coding errors oral/dental status on the comprehensive assessments noted from these audits were corrected by the MDS Coordinator to accurately reflect the status of each resident. (C) As of 7/25/16, the MDS Coordinator(s) will be responsible for the assessment and coding or oral/dental health and the completion of Section L (oral/dental status) as licensed nurses. The interdisciplinary care plan team members (MDS Coordinators, FSD, Activities Director, and Social Services Coordinators) were in-serviced on 7/25/16 by the DON and Administrator on this change as well as accurately assessing each resident for coding Level II PASRR in MDS Section A and oral/dental status in MDS Section L using the coding guidelines/definitions in Chapter 3 of the RAI Manual (2015) as well as webinar training videos created by CMS on PASRR information, oral assessment, and SNF/MDS 3.0 Update. (D)The ADON/SDC will audit 3 comprehensive MDS assessments from the weekly schedule to ensure accurate coding of Level II PASRR and oral/dental status. The MDS Coordinator will immediately correct any concerns or issues identified from these audits--additional coaching/training/disciplinary action will be provided to the person who initially coded inaccurately. This audit will be conducted weekly X 4 weeks followed by every other	

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F 278	Continued From page 10 should have marked that Resident #12 was edentulous.	F 278	week X 4 weeks and finally monthly X 4 months beginning on 7/28/16. The DON will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning on 7/28/16.	
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 review, and family and staff interviews the facility failed to remove facial hairs for 1 of 4 dependent resident reviewed for activities of daily living (Resident #160). The findings included: Resident # 160 was admitted on 05/18/16 with diagnoses including Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) dated 05/25/16 revealed Resident #160 had severely	F 312	(A)Facial hairs were removed from the face of Res. #160 on 6/30/16 by assigned nursing staff. (B)An audit of all residents was completed on 7/22/16 by the 1st and 2nd shift Nursing Supervisors for any facial hairs on residents in need of removal—all identified concerns were addressed immediately and any residents who do not desire to be shaved (male or female) were properly care planned for this choice. (C)The Bathing policy and the Nursing	7/28/16

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F 312	Continued From page 11 impaired cognition and was able to make her needs known. The admission MDS noted Resident #160 required extensive assistance with personal hygiene. No rejection of care was noted on the admission MDS. Review of a care plan dated 05/27/16 revealed Resident #160 required assistance with activities of daily living (ADL). The goal was for Resident #160 to have an increased level of function with ADL to her fullest ability over next next review on 08/27/16. Interventions included: to assist with all personal hygiene tasks, encourage to do as much as possible, and also noted Resident #160 required one person assistance with ADL and care. Review of the shower schedule revealed Resident #160 was scheduled for showers on Tuesday and Saturday during the 3:00 PM to 11:00 PM shift. Observations during a family interview conducted on 06/27/16 at 11:54 AM revealed Resident #160 had white facial hairs covering her chin which were approximately 1/8 to 1/4 of an inch long. The family member stated a staff member had shaved Resident #160's facial hairs when she was first admitted and she needed to be shaved again. The interview further revealed Resident #160 used to shave her facial hairs herself when she was living independently. Subsequent observations of Resident #160 on 06/28/16 at 10:36 AM and 06/29/16 at 10:07 AM revealed Resident #160 had white facial hairs covering her chin which were approximately 1/8 to 1/4 of an inch long.	F 312	Assistant Duties policy were both revised to include the removal of all facial hairs unless otherwise indicated by resident/family choice at least twice weekly with bathing/showering as needed on other days as well as reporting by the nursing assistant to the assigned nurse of any resident refusals for the purposes of nursing documentation noting such. It was also noted in the Bathing policy that the facility Beautician will also assist in removing facial hair (male and female) during scheduled appointments. The removal of facial hairs with bathing/showering as well as refusal of such with reporting to the nurse unless otherwise care planned per resident choice was added to the electronic documentation (Smart Charting) to be completed by the assigned nursing assistant with each bath/shower. The removal of facial hairs on an as needed basis as well as refusal of such with reporting to the nurse unless otherwise care planned per resident choice was also added as a separate area in the electronic documentation (Smart Charting) for documentation purposes. An in-service for all nursing staff on the Bathing policy and the Nursing Assistant Duties policy as well as the new nursing documentation needs for the removal of facial hair was conducted by the ADON/SDC between 7/25/16 - 7/28/16. (D) A Nursing Manager on both 1st and 2nd shifts will audit bath/shower records	

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F 312	Continued From page 12 During an interview on 06/29/16 at 1:37 PM Nurse Aide (NA) #2 confirmed he cared for Resident #160 on 06/28/16 (Tuesday) during the 3:00 PM to 11:00 PM shift. NA #2 stated he removed female residents facial hairs as needed and always asked them first because this was a dignity issue. NA #2 further stated Resident #160 did not want a shower on 06/28/16 and just wanted her face washed off before she went to bed. NA #2 indicated he did not notice the length of Resident #160's facial hairs on 06/28/16 because he did not turn on the overhead light in the room. An interview was conducted with the Director of Nursing (DON) on 06/29/16 at 4:30 PM. The DON stated men were shaved daily or as requested and women's chin hairs were removed as needed. The DON observed Resident #160 after the interview and stated he would have expected staff to remove her facial hairs and he would take care of this.	F 312	for 6 residents (2 from each unit) on each of his/her separate shifts for proper documentation of the removal of facial hairs and will then assess each of those residents to ensure action was taken to either remove any facial hairs as documented or to report refusals to the nurse for further assistance or documentation in the clinical record. Any concerns or issues identified from these audits will be immediately corrected by the 1st shift Nursing Supervisor and 2nd shift Nurse In Charge--additional coaching/training/disciplinary action will be provided to the person who failed to follow the policy as written. This audit will be conducted weekly X 4 weeks followed by every other week X 4 weeks and finally monthly X 4 months beginning on 7/28/16. The Risk Management Coordinator will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning on 7/28/16.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328		7/28/16

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F 328	Continued From page 13 Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to administer oxygen at the physician ordered liters per minute rate for 1 of 1 sampled resident receiving continuous oxygen (Resident #22). The findings included: Resident #22 was admitted to the facility most recently on 12/26/12. Her diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, atrial fibrillation, congestive heart failure, Alzheimer's disease and dementia. Review of physician orders revealed Resident #22 was ordered continuous oxygen via nasal cannula at the rate of 2 liters per minute since her admission on 12/26/12. Observations made throughout the survey revealed Resident #22's oxygen rate was different than the physician orders as follows: *On 06/28/16 at 3:36 PM, as she rested in bed, her oxygen concentrator was set and administering oxygen at 5 liters per minute. *On 06/29/16 at 8:33 AM, as she was in her wheelchair in the dining room, her portable oxygen tank located on the back of her wheelchair, was set and administering oxygen at 1.5 liters per minute.	F 328	(A)Res. #22's respiratory status was assessed on 6/30/16 by the Licensed Nurse and oxygen was set at 2 liters per minute via nasal cannula as ordered by the physician. No respiratory distress was noted for Res. #22 at that time. (B)An audit of all residents receiving oxygen was completed by 7/25/16 by the Director of Nursing to ensure all were receiving oxygen therapy as ordered by the physician—all identified concerns were addressed immediately. The MDS Coordinator met with nurses and nursing assistants on all units by 7/28/16 to determine which, if any resident(s) were known to "play" with oxygen concentrators and tanks including dismantling them. Any identified residents were care planned immediately for this behavior so that increased monitoring/staff awareness could occur. (C)The Oxygen Administration policy and procedure was revised to include: •Nursing staff will notify the MDS Coordinator when there is another resident who has been known to interfere with the oxygen delivery of another	

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F 328	Continued From page 14 *On 06/29/16 at 10:04 AM, as she participated in a music activity in her wheelchair, her portable oxygen tank located on the back of her wheelchair was set and administering oxygen at 1.5 liters per minute. *On 06/29/16 at 11:20 AM, as she was lying in bed receiving a ulcer treatment on her foot, she was receiving oxygen at 3 liters per minute via the oxygen concentrator. *On 06/29/16 at 3:22 PM, as she sat in her wheelchair with the portable oxygen tank on the back, the oxygen was set and administering at 1.5 liters per minute. An interview was conducted with Nurse #1 on 06/29/16 at 3:23 PM. Nurse #1 verified the oxygen orders for Resident #22 was 2 liters per minute. Nurse #1 stated that it was the nurses responsibility to adjust and set the rate of oxygen. Together, Nurse #1 and the surveyor went to the resident's room to observe the rate of oxygen. Observations on 06/29/16 at 3:29 PM revealed the oxygen concentrator was set at 3 liters per minute and the portable oxygen tank was set at 1.5 liters per minute. Nurse #1 stated that the nurse aides were permitted to turn on the oxygen concentrator as it should have been set at 2 liters per minute but not adjust the flow rate of oxygen. Nurse #1 stated the nurses were instructed to check the oxygen flow rate periodically and at least every shift for accuracy. Both Nurse #1 and Nurse Aide (NA) #1 at this time stated that although Resident #22 was not known to play with the oxygen tank or concentrator, another resident on the secured unit was known to play with oxygen concentrators and tanks including dismantling them. Interview with the Director of Nursing (DON) on	F 328	resident (Ex: “plays” with the flow meter or dismantles the concentrator) so that the appropriate care planning can be implemented for such behaviors and interventions can be put in place for those with oxygen who may be affected. •When it is known that a resident has behaviors of “playing” with or dismantling oxygen tanks or concentrators (either their own or others), the following will occur for all on the same unit/same location as that particular resident to ensure oxygen orders are followed appropriately: 1. Concentrators will be set on the prescribed flow rate and the knob will be removed so that it cannot be altered by anyone until the knob is replaced. The knob will be placed in a sealed bag and hung on the side of the concentrator for easy access by the licensed nurse should the flow rate order be changed or the resident require increased oxygen at any point in time. 2.Tanks will be placed in zipped or sealed bags that will hang on the wheelchair so other residents do not have immediate access. 3.A safety check sheet with the prescribed oxygen flow rate will be implemented for each resident receiving oxygen which will require the CNA to check the oxygen flow rate every 2 hours during his/her shift and report to the nurse if the flow rate is different from the order. The nurse will then correct/adjust according to the physicians’ order. An in-service was conducted for all	

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F 328	Continued From page 15 06/30/16 at 1:19 PM revealed that nurses were expected to check for correct oxygen settings at least every shift and only nurses could make adjustments to the flow rate of oxygen. The DON further stated that he was unaware that there was a resident on the secured unit who had a history of playing with oxygen tanks and concentrators. He stated since becoming aware of this possibly being the reason for the variation of oxygen flow rates, the facility will search for a device that cannot be easily changed by confused residents.	F 328	nursing staff by the ADON/SDC between 7/25/16 - 7/28/16 on the Oxygen Administration policy revision. (D) The Risk Management Coordinator will audit all residents currently receiving oxygen therapy to ensure flow rates are accurate per physician orders and will verify that all steps of the Oxygen Administration policy have been followed accordingly on any specific unit if any residents have noted behaviors of interfering with the flow rate of oxygen tanks/concentrators (their own or others): •removal of the knobs from concentrators that are not accessibly by residents but accessible by a nurse if needed •tanks in zipped or sealed bags •Q2hour safety check lists for all on oxygen to verify flow rate as ordered Any concerns or issues identified from these audits will be immediately corrected by the Risk Management Coordinator--additional coaching/training/disciplinary action will be provided to the person who failed to follow the policy as written. This audit will be conducted weekly X 4 weeks followed by every other week X 4 weeks and finally monthly X 4 months beginning on 7/28/16. The DON will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure	

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F 328	Continued From page 16	F 328	continued compliance beginning on 7/28/16.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide sanitary conditions for distribution of food to residents in 1 of 3 areas where food was served. The resident plates were served in dining rooms for units 100 and 300 and in kitchen area for the 400 unit. The facility did not have cleaning process in place to prevent possible contamination from dust. The findings included: On 6/29/16 at 11:55 AM staff members observed serving food onto plates to be taken to individual rooms on 400 unit for lunch. A sign suspended over the steam table and a pipe located beside the steam tabled both had a layer of thick fluffy grey dust like material. The temperatures of food had been checked and were at proper levels for serving. The food was placed onto a steam table.	F 371	(A)The sign suspended over the steam table was removed/thrown away and the pipe located beside the steam table was thoroughly cleaned by the Kitchen Manager on 6/30/16 prior to lunch being served to the residents on 400 units. The fan on the wall aimed at the steam table was not in use but was removed by maintenance staff on 7/21/16. (B)All areas where food is served to all residents (kitchen area for 400 unit and dining rooms for 100/500 units) were thoroughly cleaned including all areas with the potential of being contaminated with dust by assigned dietary services staff on 7/21/16. (C)The Food Service Director revised the Kitchen Cleaning Policy/Procedure as well	7/28/16

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F 371	Continued From page 17 The steam table had a glass partition between server and staff members who placed covers over plates, put plates onto trays, and then put trays into a warming cart. The staff members reached to top shelf in order to put covers on the plates. The sign hung suspended by small link chain from ceiling to a height 10 to 12 inches above top shelf, and approximately 30 inches above food on steam table. A white pvc-type pipe was located against the side of the steam table. On 6/30/16 at 9:00 AM the chain and pipe continued to have layer of fluffy grey material. This observation was made while in the presence of the Food Service Director (FSD). A fan was observed positioned on wall aimed toward steam table, but not running during tours of kitchen area. During an interview with the FSD on 6/30/16 at 9:00 AM it was stated that cleaning had been performed by a staff member who worked 4:00 PM to 11:00 PM shift and who used a standardized schedule. A review of the cleaning schedule on 6/30/16 at 9:00 AM revealed no listing of walls, pipe, or sign were included. The records of kitchen areas cleaned were provided by the FSD for the dates 03/21/16 through 04/07/16. During interview on 6/30/16 at 9:00 AM the Kitchen Manager stated it was expected that kitchen areas would be clean and without potential for contamination of food. The Kitchen Manager also stated that the sign would be removed and the pipe added to the cleaning schedule. The FSD stated during interview on 6/30/16 at 9:15 AM that dietary staff were responsible for cleaning the kitchen. The FSD also stated that it	F 371	as the Daily/Weekly/Monthly Cleaning Schedules to include dusting of any equipment/areas with the potential of being contaminated with dust in all food service areas including walls, pipes, fans, and signage to be done at least weekly and as needed. All dietary staff was in-serviced on this policy and the revised cleaning schedule by the Kitchen Manager between 7/22/16 – 7/25/16. (D)The Kitchen Manager will conduct an audit to review all written cleaning schedules and will make visual observations to check for cleanliness of food service areas and to ensure no dust build-up is present. This audit will be conducted weekly X 4 weeks followed by every other week X 4 weeks and finally monthly X 4 months beginning on 7/28/16. The Food Service Director will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning on 7/28/16.	

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F 371	Continued From page 18 was her expectation that the area be clean and without potential contamination of food. During an interview conducted on 6/30/16 at 9:30 AM with the Director of Nursing it was stated that it was expected that staff clean the kitchen so the area would be kept free of possible contaminants to food.	F 371		