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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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and staff interviews, the facility failed to maintain the survey results in the posted location where it was accessible to all residents and families 3 of 4 days of the survey. The findings included: On 09/13/16 at 5:45 PM, observations revealed the survey results could not be located by the survey team in the front lobby. During the interview with the resident council president (Resident #26) on 09/14/16 at 11:35 AM, Resident #26 stated she did not know where to locate the survey results. On 09/14/16 at 11:51 AM review of the facility's informational postings revealed the survey results were located in a black notebook in the lobby. At this time, no black notebook or survey results were observed in the lobby.	F 167	1) On 9/15/16, the Executive Director (ED) updated and posted a readily accessible copy of the facility□s most recent State or Federal survey and any plan of correction in a labeled binder located in the front lobby. 2) The ED will maintain a current, accessible copy of the facility□s most recent State or Federal survey results and any plan of correction for resident and family examination. 3) On 9/19/16, the Regional Director of Clinical Services (RDCS) reeducated the ED on regulation 483.10(g)(1) regarding a residents right to examine the results of the most recent State or Federal survey and any plan of correction in effect with respect to the resident and family. The ED will ensure a current, accessible copy of the facility□s most recent State or Federal survey results and any plan of	10/14/16

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

Electronically Signed | 10/07/2016

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F 167	Continued From page 1 The survey results could not be found in the lobby during observations made on 09/14/16 at 5:14 PM and on 09/15/16 at 8:00 AM. During an interview with the Administrator on 09/15/16 at 9:30 AM, the Administrator stated he was responsible for ensuring the survey results were located in the front lobby. He stated that he checked for the placement of the survey results "periodically". He stated the binder was normally at the front table where the visitor sign in book was located. He further stated that there was a specific resident who liked "to acquire them."	F 167	correction are posted for resident and family examination. The Director of Clinical Services (DCS) or Licensed Nurse designee will monitor/observe for the accessible posting of the facility□s most recent State or Federal survey results and any plan of correction; 3 times weekly for 4 weeks, 1 time weekly for 8 week then, quarterly for 9 months. 4) The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring/ observation tools for maintaining substantial compliance, and make changes to the corrective plan as necessary.	
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 reviews, resident and staff interviews the facility compromised the dignity of 2 of 3 sampled residents (Resident #8 and Resident #48) by failing to respond to requests for toileting assistance resulting in incontinence and feelings of embarrassment.	F 241	1) On 9/16/16, the Executive Director (ED) obtained an additional sit-to-stand lift. Resident #8 and #48 will continue to receive timely staff assistance for toileting to promote dignity and respect of individuality.	10/14/16

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F 241	Continued From page 2 The findings included: 1. Resident #8 was readmitted to facility 03/21/16 with diagnosis including cerebral vascular accident with left hemiparesis, right elbow fracture, diabetes mellitus and seizure disorder. According to Resident #8's quarterly Minimum Data Set (MDS) dated 08/03/16 he was cognitively intact with no memory problems and was able to make his needs known. Resident #8 also required extensive assistance and two persons assist with transfers and toilet use. The MDS revealed him to be occasionally incontinent of urine and frequently incontinent of bowel. An undated care plan for Resident #8 named problem of altered bladder elimination (incontinence). Goal stated resident will not experience complication related to incontinence with a target date of 11/30/16. Interventions included personalized toileting schedule before and after meals, at bedtime and whenever necessary. The facility provided an undated Kardex Information sheet for Resident #8 which had sit-to-stand checked for transfer assistance. On 09/14/16 at 11:20 AM an interview with Resident #8 was conducted. Resident indicated there had been two separate occurrences where he had to wait so long to be toileted that he soiled himself. He stated it was about two and three weeks earlier. He further added the one that happened three weeks ago was a forty minute wait. He stated that was embarrassing. During an interview on 09/15/16 at 12:00 PM,	F 241	2) On 9/28/16, the Director of Clinical Services (DCS) completed a quality monitoring of residents requiring the assistance of mechanical transfer devices for toileting. On 3) 9/19/16, the ED ordered an additional mechanical lift (Hoyer) to ensure that each unit had appropriate equipment necessary to provide incontinence care. On 9/19/16, the ED was reeducated by the Regional Director of Clinical Services (RDCS) on regulation 483.15(a) on promoting care for residents in a manner and environment that enhances and maintains resident□s dignity and respect to include; maintaining an adequate supply of mechanical transfer devices on each unit to meet residents care needs. By 10/10/16, the ED and DCS/Licensed Nurse reeducated direct patient care staff on the use and availability of mechanical transfer devices and providing incontinence care to needs while maintaining residents dignity. Adequate mechanical transfer devices will be available for each unit to aide in incontinence care needs while promoting residents dignity per regulation 483.15(a). 4) The Director of Clinical Services (DCS) or Licensed Nurse designee will monitor/observe transfers for 3 random residents requiring mechanical transfer devices for toileting 3 times weekly for 4 weeks, 1 time weekly for 8 weeks then, quarterly for 9 months. The DCS/licensed nurse designee will report monitoring results monthly to the	

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F 241	Continued From page 3 Nurse Aide (NA) #1 stated the facility only had one sit-to-stand and one total lift to be used on all the residents that required them. NA #1 added it caused problems for the residents because the NAs had to share the lifts between the halls. She also stated it was not uncommon for the residents to be incontinent on themselves before they could get to them with the lifts. She reported about three weeks earlier Resident #8 had to wait so long for the sit-to-stand lift he soiled himself before she could get to him. During an interview with the Director of Nursing (DON) on 09/15/16 at 5:40 PM she admitted she became aware of the problem of not having enough lifts in the August (2016) staff meeting. The DON stated she advised the staff to put the lifts in the hall after they transferred residents so they would be visible to be used by the other staff. She further added it was her expectation the residents not have to wait longer than twenty minutes to be toileted and it was not acceptable for residents to be incontinent while waiting for the lift. 2. Resident #48 was admitted to facility on 10/30/15 with diagnosis including cardiopulmonary disease, venous insufficiency and congestive heart failure. Review of the quarterly Minimum Data Sets (MDS) dated 07/15/16 Resident #48 was found to be cognitively intact with no memory problems and able to make his needs known. The quarterly MDS noted Resident #48 required extensive assistance and two persons assist with transfers and extensive assistance and two persons assist with toilet use. He was also noted to be frequently incontinent of bladder and bowel.	F 241	Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring/ observation tools for maintaining substantial compliance, and make changes to the corrective plan as necessary.	

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An undated care plan revealed Resident #48 had a problem with altered bladder elimination. The goal was to have decreased episodes of incontinence. Interventions included establishing voiding patterns, personalize toileting schedule to before and after meals, at bedtime and whenever necessary.

The facility provided an undated Kardex Information sheet for Resident #48, which had sit-to-stand checked for transfer assistance.

During an interview on 09/13/16 at 10:30 AM Resident #48 reported he had to take a fluid pill every day which caused him to urinate frequently. He stated he could not use the urinal so he had to depend on the staff to toilet him. Since he needed the sit-to-stand lift to transfer he would wet himself almost every day because he had to wait for up to thirty minutes (he pointed to the clock) or longer before he was able to toilet causing him to be incontinent on himself. He added he had considered refusing the fluid pill because he did not like being wet.

On 09/13/16 at 4:00 PM an interview was conducted with Nurse Aide (NA) #4 who stated the facility had one sit-to-stand and one total lift to be used for the entire facility. She explained the residents would often have to wait a while to be toileted because the lilts would be on the other hall being used. NA #4 admitted some residents had incontinent episodes before she could get the lifts for them.

On 09/14/16 at 8:30 AM, NA #5 reported it was an almost every day occurrence when she worked with Resident #48, for him to be incontinent on

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F 241	Continued From page 5 himself before she could get the sit-to-stand lift to him. During an interview with the Director of Nursing (DON) on 09/15/16 at 5:40 PM she stated she became aware of the problem of not having enough lifts for the residents in the August (2016) staff meeting. The DON stated she advised the staff to put the lifts in the hall after they transferred residents so the lifts would be visible to be used by the other staff. She further added it was her expectation the residents not have to wait longer than twenty minutes to be toileted and it was not acceptable for residents to be incontinent while waiting for the lift.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interviews and staff interviews, the facility failed to provide 2 of 2 sampled residents assessed as safe smokers the choice to smoke whenever they wanted to smoke (Residents #49 and #90). The findings included: The facility's smoking policy, with an effective	F 242	1) Resident #49 and #90 were reassessed as Safe Smokers and care plans updated by a Licensed Nurse on 10/10/16 to reflect residents choice to smoke whenever they choose. 2) On 9/28/16, the DCS reassessed residents ability to smoke safely and updated care plan accordingly. Residents	10/14/16

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F 242	Continued From page 6 date of 11/30/14 and revised on 01/22/15, included the following procedures: "1. Residents will be evaluated for eligibility regarding smoking privileges upon admission, quarterly, an in change of condition... 3. The facility shall establish and post designated resident smoking times. 4. Resident smoking times will be clearly posted in assigned areas within the facility. The designated smoking areas will be determined by the facility... 6. No fire igniting materials (matches/lighters) will be in the resident's possession at any time and is strictly prohibited. 7. Designated staff will supervise residents during assigned smoking times." The Designated Resident Smoking Times included Monday - Sunday at 9:00 AM, 1:00 PM, 4:00 PM and 7:00 PM. 1. Resident #49 was admitted to the facility originally on 11/21/14 and most recently readmitted to the facility on 12/27/15. His diagnoses included end stage renal disease, transient ischemic attack, cerebral infarction without residual deficits, and right eye blindness. The medical record revealed he was his own responsible party and signed his admission papers. Review of the Readmission Data Collection dated 12/27/15 revealed Resident #49 was observed as able to communicate why oxygen must always be shut off prior to lighting cigarettes; was able to communicate the risks associated with smoking; was able to light the cigarette safely with a lighter; smoked safely; utilized the ashtray safely and properly and was able to extinguish the cigarette	F 242	identified as Safe Smokers will have the choice to smoke whenever they choose. 3) By 10/14/16, the ED and Licensed Nurse reeducated staff on honoring residents choice to smoke whenever they choose if assessed to be a "safe smoker". Residents who smoke will be assessed upon admission, readmission, quarterly and with significant change in condition to determine their ability to safely smoke and their care plan will be updated accordingly. Unsafe smokers will be supervised by staff in a designated smoking area at designated times. Residents deemed safe to smoke will be given the choice to smoke whenever they choose. 4) The ED/licensed designee will monitor "safe smokers" for choice to smoke ad lib is being honored; 3 times weekly for 4 weeks, 1 time weekly for 8 weeks then, quarterly for 9 months. The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring/ observation tools for maintaining substantial compliance, and make changes to the corrective plan as necessary.	

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safely and completely when finished smoking. The boxes to mark where he was a safe or unsafe smoker were not checked.

Review of the safe smoking evaluation for Resident #49 dated 03/10/16 revealed no negatives related to his cognitive patterns, communication, hearing or vision, physical ability or during observations of smoking. The form checked him as being a "safe smoker" and supervision needed while smoking was checked as "none." The narrative stated "Resident was able to smoke (light cigarette, etc) per self (symbol for without) diff (difficulty).

Review of the Quarterly Data Collection form dated 03/17/16 revealed Resident #49 was observed without any negative findings on the safe smoking evaluation section and marked as a "safe smoker."

The activity care plan was updated on 04/01/16 which identified Resident #49 as an independent smoker and refusing most out of room activities.

The quarterly Minimum Data Set (MDS) dated 04/25/16 coded him with intact cognition, having no behaviors, being nonambulatory, and requiring supervision for all activities of daily living skills.

Review of the Quarterly Data Collection form dated 06/30/16 revealed Resident #49 was observed without any negative findings on the safe smoking evaluation section and marked as a "safe smoker."

The quarterly MDS dated 07/26/16 coded him with intact cognition, having no behaviors, being nonambulatory, and requiring supervision for all

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activities of daily living skills.

The safety care plan with an initiation start date of 11/23/15 and last updated 07/28/16 included the goal for the resident to comply with facility smoking protocols. Interventions included to provide scheduled staff supervised smoking times and redirect resident during non-smoking times.

Review of the Safe Smoking Evaluation completed 09/13/16 revealed he was assessed with no cognitive issues and during the observation of his smoking, he had no negative findings. The form stated the resident was determined to be a "safe smoker" and the supervision needed while smoking included two options (none and constant) which were left unchecked. The narrative noted the resident was evaluated to be a safe smoker and all smoking supplies were to be kept in the possession of staff until assigned smoking times.

On 09/13/16 at 3:56 PM observations were made of residents smoking in the courtyard. Resident #49 was among the residents smoking. He was observed using the ashtray appropriately. All residents were being supervised the Human Resources Coordinator and the Activity Director.

The Activity Director was interviewed on 09/13/16 at 4:01 PM. She stated that there were 9 residents in the facility who currently smoked. She reiterated the posted smoking times. She also stated residents were permitted to smoke 2 cigarettes each within 15 minutes during each of the 4 designated smoking times. The Activity Director further stated each resident was assessed for smoking safety and that there was a

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corporate form that each resdient filled out to which they agreed to be supervised. She said if the resident did not agree to be supervised then they had to leave the facility property to smoke.

On 09/14/16 at 8:18 AM, Resident #49 was interviewed regarding smoking. Resident #49 stated within the last week or two, the facility stated "the state" said residents could not smoke unsupervised. He stated until that time he was permitted to smoke unsupervised and any time up until 11:00 PM. Resident #49 stated he kept his smoking materials in a locked box in his night stand. He stated that now he was not allowed to smoke unsupervised or whenever he desired and his smoking materials were kept by staff. He said the staff gave him his lighter and cigarettes to take to dialysis with him and he returned them to staff when he returned to the facility. Resident #49 stated he was willing to follow the rules but felt that he was being "punished" for those residents who did not smoke safely by following the rules and who needed to be supervised.

The facility provided a form signed by Resident #49 (undated) named Designated Resident Smoking Times which listed the 4 daily smoking times. The form stated "The purpose of this smoking schedule is not to restrict a resident's privilege, but to promote safety for all persons within the facility. Unsupervised smoking is not permitted. You must be supervised by staff from the facility. Family member and friends are not considered staff....Residents who fail to adhere to the smoking policy will be re-educated and may results (sic) in possible discharge from the facility."

On 09/14/16 at 11:15 AM the Activity Director

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stated that around August, the smoking policy changed. She said that there were residents who were permitted to smoke independently, however, the corporation changed the smoking policy to ensure every resident who smoked was supervised and smoked only at the designated times. She stated Resident #49 had been considered a safe smoker and had complained about the new policy as he enjoyed smoking and socializing with some of the other residents who smoked independently. She further stated she never observed unsafe smoking practices by Resident #49, however, nursing staff assessed for safe smoking abilities.

The Administrator was interviewed about the smoking policy and procedure on 09/14/16 at 3:49 PM. The Administrator stated that there was a recent change in the smoking policy. He stated that about 6 to 8 months ago, residents assessed as safe to smoke independently were allowed to keep their own smoking materials in a locked box provided to them. These residents were permitted to smoke anytime they wanted to in the designated areas. The Administrator further stated that a corporate nurse, name unknown, sent a memo which directed all smoking to be supervised. He stated that the facility changed the implementation of the policy to have staff maintain all smoking materials and about two weeks ago he reviewed the memo/policy with residents who smoked and had the residents sign a form (Designated Resident Smoking Times as above) agreeing that their smoking would be supervised during the designated times. He further stated all residents who smoked were then reevaluated for their safe smoking abilities which established the need for devices such as smoking aprons. The Administrator stated that

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Resident #49, although assessed as being safe to smoke independently, was not permitted to smoke unsupervised and had to smoke during the designated times only. He stated that this was a corporate decision.

2. Resident #90 was admitted to facility 05/11/16 with diagnosis including cerebral vascular accident with hemiparesis and insomnia.

The facility provided a form signed by Resident #90 (undated) named Designated Resident Smoking Times which listed the four daily smoking times. The form stated "The purpose of this smoking schedule is not to restrict a resident's privilege, but to promote safety for all persons within the facility. Unsupervised smoking is not permitted. You must be supervised by staff from the facility. Family member and friends are not considered staff ...Residents who fail to adhere to the smoking policy will be re-educated and may results (sic) in possible discharge from the facility".

Review of the quarterly Minimum Data Set (MDS) dated 08/18/16 revealed Resident #90 had no problems with memory recall or skills for daily decision making, exhibited no negative behaviors and he participated in his own assessment. Functional limitations revealed limited range of motion in his shoulder.

Review of the Safe Smoking Evaluation for Resident #90 dated 09/07 (with no year noted on document) revealed a handwritten statement concluding Resident #90 was determined to be a safe smoker.

An undated Safety care plan for Resident #90

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revealed a goal that resident will not sustain serious injury giving example of burns through next target date of 11/30/16. Interventions include safe smoking assessment on admission and quarterly, instruct resident on safe protocol, keeping smoking materials locked, provide designated smoking areas and monitor for continued safe smoking. A handwritten statement dated 8/11/16 read Care Plan reviewed with Interdisciplinary Team to continue with Plan of Care.

On 09/12/16 4:09 PM observations were made of residents smoking on the side porch. Resident #90 was among the residents smoking. All residents were being supervised by the Human Resources Coordinator and the Activity Director.

Interview with the Activity Director on 09/13/16 at 4:01 PM revealed there were nine residents in the facility who currently smoked. She stated the current smoking times were 9:00 AM, 1:00 PM, 4:00 PM and 7:00 PM and residents were permitted to smoke two cigarettes each within fifteen minutes during each of the four designated smoking times. She further stated residents were assessed for smoking safety and there was a corporate form each resident filled out to which they agreed to be supervised. She added if the resident did not agree to be supervised they had to leave the facility property to smoke.

The Administrator was interviewed on 09/14/16 at 3:49 PM about the smoking policy and procedure. He stated about six or eight months ago residents assessed as safe to smoke independently were allowed to keep their smoking materials in a locked box provided for them. These residents were allowed to smoke anytime they wanted to in

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F 242	Continued From page 13 the designated areas. The Administrator further stated that a corporate nurse, name unknown, sent a memo which directed all smoking to be supervised. He stated the facility changed the implementation of the smoking policy to have staff maintain all smoking materials and about two weeks ago he reviewed the smoking policy with residents who smoked and had them sign a form (Designated Resident Smoking Times as above) agreeing their smoking times would be supervised during the designated times. He further stated all residents who smoke were then reevaluated for their safe smoking abilities which established the need for devices such as smoking aprons. The Administrator stated that Resident #90 although assessed to smoke independently, was not permitted to smoke unsupervised and had to smoke during the designated times only. He stated this was a corporate decision. On 09/15/16 8:44 AM Resident #90 was interviewed regarding smoking. He stated that when he was admitted to the facility he was allowed to smoke anytime he wanted to and was able to keep his own cigarettes and lighter. He stated this stopped about two weeks ago and now he had to smoke at the times the facility would let him and he could no longer keep his cigarettes and lighter with him. Resident #90 further stated he did not like this change and would like to be able to smoke when he wanted to as long as he could do it safely.	F 242		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		10/14/16

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F 272	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 272	1) On 10/3/16-10/5/16, the MDS	

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F 272	Continued From page 15 facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for the areas of cognitive loss/dementia, psychotropic drug use, urinary incontinence, activities of daily living skills for 5 of 18 residents reviewed for comprehensive assessments (Residents #52, #17, #3, #11, and #51). The findings included: 1. Resident #52 was admitted to the facility on 05/25/16 with diagnoses including dementia and depression. The admission Minimum Data Set (MDS) dated 06/07/16 coded her with severely impaired cognition, having no behaviors, no mood indicators, and having received antidepressants 7 days in the previous 7 days. a. The Care Area Assessment (CAA) dated 06/10/16 for Cognitive Loss/Dementia stated Resident #52 had an alteration in cognition related to severely impaired decision making and memory problems evidenced by her inability to recall 3 items after a 3 minute span. The CAA did not analyze how her severely impaired cognition impacted her day to day function and routines. Interview on 09/15/16 at 10:46 AM with the Social Worker who completed the cognition CAA revealed once hired, she received a couple days of training from staff from a sister facility. She stated that she was taught to put in the resident's decision making ability, risk factors and interventions. She further stated she was not taught to describe the individual resident in the CAA.	F 272	Coordinator modified Care Area Assessments (CAAs) to the identified Minimum Data Set (MDS) Comprehensive Assessments to address the underlying causes and contributing factors as follows: a) resident #52- for 6/7/16 MDS-cognitive loss/ dementia, urinary incontinence and psychotropic drug use; b) resident #17- for 1/18/16 MDS-cognitive loss/ dementia, ADLs and urinary incontinence; c) resident #3- for 8/3/16 MDS-cognitive loss/ dementia and psychotropic drug use; d) resident #11- for 4/18/16 MDS-cognitive loss/ dementia e) resident #51- for 5/8/16 MDS-cognitive loss/ dementia 2) On 9/26/16, the MDS Coordinator quality monitored the most recent MDS Comprehensive Assessment for residents whose CAAs triggered in the area of cognitive loss/ dementia, urinary incontinence, psychotropic drug use and ADLs. No resident harm resulted. 3) On 9/19/16, the RDCS reeducated the MDS Coordinators, Social Services and DCS on regulation 483.20(b)(1) and requirements to complete Comprehensive Assessments and corresponding triggered CAAs that address the underlying causes and contributing	

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F 272	Continued From page 16 b. The CAA dated 07/25/16 related to Urinary Incontinence stated Resident #52 required extensive assistance with toileting and 1 nurse aide. She was noted as always being continent of bowel and bladder. This CAA failed to analyze how her need for extensive assistance impacted her day to day function and routines relating to her continence. Interview with the MDS Coordinator #2 on 09/15/15 at 4:48 PM revealed the incontinence CAA was completed by MDS Coordinator #1 who was no longer employed at the facility. MDS Coordinator #2 stated the CAA lacked needed information and that the MDS Coordinator #1 did not have much experience in writing CAAs. c. The CAA dated 07/25/16 related to Psychotropic Drug use stated Resident #52 took Zoloft every day for a diagnoses of depression. She was also noted as having dementia. The CAA further stated the Zoloft keeps her depression under control and this contributed to and enhanced her quality of life. The CAA did not analyze how her depression affected her day to day routines or functions or how the medication improved her day to day functions. Interview with the MDS Coordinator #2 on 09/15/15 at 4:48 PM revealed the psychotropic drug use CAA was completed by MDS Coordinator #1 who was no longer employed at the facility. MDS Coordinator #2 stated the CAA lacked needed information and that the MDS Coordinator #1 did not have much experience in writing CAAs. 2. Resident #17 was admitted to the facility on	F 272	factors. By 10/4/16, the MDS Coordinator (newly hired 9/6/16 and RAC-CT recertified 8/2016) provided additional training to the Dietary Manager, Activities Director and part-time MDS Coordinator on completing comprehensive CAAs per the Resident Assessment Instrument (RAI) manual. The MDS Coordinator will complete and review, in collaboration with the MDS IDT, Comprehensive Assessments and triggered CAAs to ensure the underlying causes and contributing factors are completed to comprehensively address the residents condition. 4) The DCS/licensed nurse designee will monitor residents triggered CAAs for cognitive loss/dementia, urinary incontinence, psychotropic drug use and ADLs for admission, annual and significant change Comprehensive MDS Assessments prior to submission 3 times weekly for 4 weeks, 5 random residents 1 time weekly for 8 weeks then, 5 random residents quarterly for 9 months to validate accuracy and completeness. The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring/ observation tools for maintaining substantial compliance, and make changes to the corrective plan as necessary.	

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06/20/13. His diagnoses included Parkinson's Disease and dementia.

The annual Minimum Data Set (MDS) dated 01/15/16 coded him with severely impaired cognitive impairments, ambulating with supervision, requiring supervision with assistance of one and being frequently incontinent of bladder.

a. The Care Area Assessment dated 01/18/16 for Cognitive Loss/Dementia stated the Resident #17 had an alteration in cognition related to having moderately impaired decision making and memory problems evidenced by his inability to recall 3 items after 3 minutes related to dementia. The CAA did not analyze how his impaired cognition impacted his day to day function and routines.

Interview on 09/15/16 at 10:46 AM with the Social Worker who completed the cognition CAA revealed once hired, she received a couple days of training from staff from a sister facility. She stated that she was taught to put in the resident's decision making ability, risk factors and interventions. She further stated she was not taught to describe the individual resident in the CAA.

b. The Activities of Daily Living (ADL) skills CAA dated 01/27/16 stated this resident had been evaluated by occupational therapy and physical therapy and has impaired ADL performance, coordination, functional, activity tolerance and impaired safety with ambulation. The CAA did not identify how his deficits affected his day to day function and routines.

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Interview with MDS Coordinator #2 on 09/15/16 at 4:48 PM revealed she completed the CAA relating to ADLs. She stated that she did not have the necessary information related to the CAA and that normally she would have described what abilities he was delinquent in. She agreed there was no description of the problem.

c. The CAA related to Urinary Incontinence dated 01/27/16 stated that he had a history of arthritis, osteoporosis, Parkinson's Disease, depression and anxiety and had frequent incontinence per the bowel and bladder record. He was noted with impaired mobility and was at risk for pressure and urinary tract infections. The CAA stated he was alert and able to make his needs known but did have concentrating problems per dementia. The CAA failed to describe how these issues affected his ability to remain continent.

Interview with MDS Coordinator #2 on 09/15/16 at 4:48 PM revealed she completed the CAA relating to incontinence. She stated that she did not have the necessary information related to the CAA and stated she only put in the resident's age and diagnoses and no description of the problem.

3. Resident #3 was admitted on 07/27/16 with diagnosis including dementia, anxiety disorder, depression, and psychotic disorder.

Review of the admission Minimum Data Set (MDS) dated 08/03/16 revealed Resident #3 had severely impaired cognition and there were no behaviors noted. During the mood interview Resident #3 reported feeling feeling down or depressed, having trouble concentrating, and trouble falling or staying asleep. The admission MDS noted Resident #3 received antidepressant

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and antipsychotic medications daily during the 7 day assessment period.

a. Review of the Care Area Assessment (CAA) Summary for Cognitive Loss/Dementia dated 08/05/16 revealed Resident #3 had an alteration in cognition related to severely impaired decision making and memory problems evidenced by her inability to recall 3 items after a 3 minute span. The CAA Summary did not include an analysis of the findings which stated a description of the problem, contributing factors, or risk areas related to the care area. The CAA Summary did not describe how Resident #3's severely impaired cognition impacted his day to day function and routines.

An interview was conducted with Social Worker (SW) on 09/15/16 at 10:46 AM. The SW reviewed Resident #3's admission MDS dated 08/03/16 and confirmed she had completed to CAA Summary for Cognitive Loss/Dementia. The SW stated after she was hired she received a couple of days of MDS training from staff from a sister facility. The SW explained she was taught to include the resident's decision making ability, risk factors and interventions in the CAA Summary. The interview further revealed the SW was not taught to describe the individual resident in the CAA Summary.

b. Review of the Care Area Assessment (CAA) for Psychotropic Drug Use dated 08/10/16 revealed Resident #3 had a hx of psychosis, anxiety, and depression and listed the medications prescribed for these diagnoses. It was noted Resident #3 was at risk for adverse medication side effects including falls. The CAA Summary did not include an analysis of the

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findings which stated a description of the problem, contributing factors, or risk areas related to the care area. The CAA Summary did not indicate if there had been any behavior monitoring, adverse drug reactions, or describe his day to day function in light of his diagnoses and prescribed medications. The CAA Summary did not indicate if a referral had been made for psychological services.

An interview was conducted with MDS Coordinator #2 on 09/15/16 at 5:15 PM. MDS Coordinator #2 stated the facility had not had a full time MDS Coordinator for a couple of months and she had been coming to the facility 2 to 3 times a week to help with MDS assessments. MDS Coordinator #2 reviewed Resident #3's admission MDS dated 08/03/16 and confirmed she had completed to CAA Summary for Psychotropic Drug Use. The interview further revealed MDS Coordinator #2 reviewed physician's notes, the history and physical, and medication orders when completing the assessment for psychotropic drug use. MDS Coordinator #2 stated she should include more resident specific details in the CAA Summary.

4. Resident #11 was admitted to the facility on 03/15/13 with diagnoses including intellectual disability and depression.

Review of the annual Minimum Data Set (MDS) dated 04/18/16 revealed Resident #11 was severely cognitively impaired with no mood indicators or behaviors. The MDS further revealed Resident #11 received antidepressants 7 days in the previous 7 day look back period.

Review of the Care Area Assessment (CAA)

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dated 04/22/16 for Cognitive Loss/Dementia stated Resident #11 had an alteration in cognition and memory evidenced by her inability to recall 3 items (blue, sock and bed) after a 3 minute time span related to intellectual disability. The CAA did not analyze how her severely impaired cognition and intellectual disability impacted her day to day function and routines.

An interview conducted on 09/15/16 at 10:46 AM with the Social Worker (SW) revealed she completed the cognition CAA for Resident #11. She stated she was taught, by corporate, to put in the resident's decision making ability, risk factors and interventions for the analysis of findings for the cognition CAA. The SW further stated she was not instructed to describe the individual resident and their strengths and weaknesses for the CAA.

5. Resident #51 was admitted to the facility on 04/21/16 with diagnoses including dementia, anxiety, depression and psychotic disorder.

Review of the significant change Minimum Data Set (MDS) dated 05/08/16 revealed Resident #51 was severely cognitively impaired with no mood indicators or behaviors. The MDS further revealed Resident #51 received antidepressants and antipsychotics 7 days in the previous 7 day look back period.

Review of the Care Area Assessment dated 05/12/16 for Cognitive Loss/Dementia stated Resident #51 had an alteration in cognition related to severely impaired decision making and memory problems as evidenced by her inability to recall current year, month and day of the week related to dementia. The CAA did not analyze

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F 272	Continued From page 22 how her severely impaired cognition impacted her day to day function and routines. An interview conducted on 09/15/16 at 10:46 AM with the Social Worker (SW) revealed she completed the cognition CAA for Resident #51. She stated she was taught, by corporate, to put in the resident's decision making ability, risk factors and interventions for the analysis of findings for the cognition CAA. The SW further stated she was not instructed to describe the individual resident and their strengths and weaknesses for the CAA.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the comprehensive assessments related to the triggered areas of incontinence, falls and psychotropic medications within 14 days after admission for 1 of 18 residents sampled for review of comprehensive assessments (Resident #52). The findings included:	F 273	1) On 10/3/16, the MDS Coordinator modified the 6/7/16 Minimum Data Set (MDS) Comprehensive Assessment for Resident #52 to accurately identify and address the underlying causes and contributing factors for triggered Care Area Assessments (CAAs) of urinary incontinence, falls and psychotropic drug use.	10/14/16

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F 273	Continued From page 23 Resident #52 was admitted to the facility on 05/25/16. Her diagnoses included dementia, depression, and arthrosclerotic heart disease. The admission Minimum Data Set (MDS) dated 06/07/16 coded Resident #52 as being able to be understood, being able to understand, having severely impaired cognition, requiring extensive assistance with bed mobility, transfers and toileting, always being continent of bowel and bladder, requiring staff assistance to stabilize when moving on and off the toilet and receiving antidepressants in the previous 7 days. The MDS also noted Resident #52 had a fall within a month of the admission and falls in the previous 2-6 months prior to admission, but no falls since admission. Review of the Care Area Assessments revealed: *the area of urinary continence was not completed until 07/25/16; *the area of falls was not completed until 07/25/16; and *the area of psychotropic medications was not completed until 07/25/26. These CAAs were completed by MDS Coordinator #1 (no longer working in the facility). On 09/15/16 at 2:39 PM, the Director of Nursing stated the facility has experienced turn over in the MDS positions. She stated that MDS Coordinator #1 was here just a few months and was terminated as she did not seem to be catching onto the position expectations. An interview was conducted with MDS Coordinator #2, a part time fill in nurse on 09/15/16 at 4:48 PM. MDS Coordinator #2 stated	F 273	2) On 9/26/16, the MDS Coordinator quality monitored admission MDS Comprehensive Assessment for residents admitted 8/19/16-9/19/16 for timely completion of the Comprehensive MDS Assessment and CAAs triggering in the area of urinary incontinence, falls and psychotropic drug use. No discrepancies were identified. 3) On 9/19/16, the RDCS reeducated the MDS Coordinators on regulation 483.20(b)(2)(i) and requirements to complete admission Comprehensive MDS Assessments and corresponding triggered CAAs within 14 days of admission. The MDS Coordinator will update the MDS Calendar after resident admissions to identify and track residents admission Comprehensive MDS Assessments and corresponding triggered CAAs to ensure timely completion within 14 days of admission. 4) The DCS/licensed nurse designee will monitor residents admission Comprehensive MDS Assessments and corresponding triggered CAAs for urinary incontinence, falls and psychotropic drug use prior to submission; 3 times weekly for 4 weeks, 1 time weekly for 8 weeks then, 5 random residents quarterly for 9 months to validate timely completion within 14 days of admission. The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to	

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F 273	Continued From page 24 that she assisted in completing MDSs when the MDS position was vacant and as needed. Per MDS Coordinator #2, the MDS coordinator #1 who completed Resident #52's CAAs dated 07/25/16 did not have much experience and got overloaded with the workload. She confirmed the CAAs were late being completed.	F 273	evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective plan as necessary.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change comprehensive assessment for 1 of 3 sampled residents reviewed with significant changes. Resident #17 experienced significant changes in the areas of transfers, dressing, toileting, hygiene, continence, ambulation, and in his ability to stabilize himself which were not assessed. The findings included:	F 274	1) On 10/6/16, the MDS Coordinator completed a significant change Minimum MDS Comprehensive Assessment for Resident #17 to accurately reflect the residents current physical and mental condition. 2) On 9/29/16, the MDS Coordinator held a meeting with the MDS Interdisciplinary Team (IDT) to discuss residents current	10/14/16

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F 274	Continued From page 25 Resident #17 was admitted to the facility on 06;/20/13. His diagnoses included dementia, hypertension, hyperlipidemia, Parkinson's disease and depression. Review of the annual Minimum Data Set (MDS) dated 01/15/16 coded Resident #17 with severely impaired cognition, requiring supervision for transfers, dressing, toileting, and hygiene. He was coded as being independent with ambulation and not being steady during transitions but able to stabilize himself. He was also coded as being frequently incontinent of bladder and occasionally incontinent of bowel. The MDS coded him with no range of motion impairments. The next MDS, a quarterly dated 04/15/16, coded him as requiring extensive assistance with transfers, dressing, toileting and hygiene. He was coded as not ambulating during the assessment period in the hall or in his room and was only able to stabilize himself with human assistance. In addition the MDS coded him as always being incontinent of bowel and bladder and having range of motion impairment on one side. The quarterly MDS dated 07/16/16 revealed he still required extensive assistance with transfers, dressing and toileting, still needed assistance to stabilize himself during transitions, and still being always incontinent of bladder. He ambulated less than 2 times in his room during the assessment period and not in the hall. This MDS showed improvement in that he was now frequently incontinent of bowel, had no range of motion impairments and did walk but only 1 to 2 times during the assessment period.	F 274	physical and mental condition in comparison to their last Comprehensive MDS Assessment. The MDS IDT consists of the MDS Coordinator, DCS, Social Services, Dietary Manager and Activities Director. Residents identified with a significant change in condition per the Resident Assessment Instrument (RAI) guidelines, had a significant change MDS Comprehensive completed within 14 days of finding, as appropriate. 3) On 9/19/16, the RDCS reeducated the MDS Coordinators on regulation 483.20(b)(2)(ii) requirements and RAI criteria to complete a significant change Comprehensive MDS Assessments within 14 days of change. The MDS IDT will discuss residents with physical and/or mental changes in condition weekdays and weekly during Care Plan Meeting to identify residents meeting the RAI manual criteria for a significant change Comprehensive MDS Assessment. The MDS Coordinator will maintain a Significant Change Watch List to document and aide in the tracking of resident changes and complete significant change MDS Comprehensive Assessments within 14 days. 4) The DCS/licensed nurse designee will monitor 3 random residents for significant changes in physical and/or mental condition; 3 times weekly for 4 weeks, 1 time weekly for 8 weeks then, quarterly for 9 months to validate timely completion of significant change MDS Comprehensive Assessments within 14 days, as	

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F 274	Continued From page 26 An interview with a nurse aide #1 on 09/14/16 at 9:57 AM revealed Resident #17 was totally incontinent of bladder, required total assistance with pericare, and required total assistance with dressing Interview with MDS Coordinator #2 on 09/15/16 at 4:48 PM an agency staff member completed the 04/15/16 MDS and a corporate staff member completed the MDS dated 07/16/16. MDS Coordinator #2 stated that a significant change assessment should have been completed in April 2016.	F 274	appropriate. The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective plan as necessary.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		10/14/16

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F 278	Continued From page 27 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 observations, record reviews and staff interviews the facility failed to code a significant change Minimum Data Set (MDS) accurately regarding dental status and an admission MDS for falls for 2 of 18 sampled residents (Residents #31 and #52). The findings including: 1. Resident #31 was admitted on 06/07/12 with diagnoses including dementia. Review of the significant change MDS dated 07/23/16 revealed Resident #31 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. Resident #31 was coded in the dental status section as not having any dental problems during the 7-day look-back period. Possible options for coding in the dental status section included no natural teeth or tooth fragment(s) (edentulous). Observations of Resident #31 on 09/12/16 at 2:35 PM revealed she was resting in bed with her eyes closed and her mouth open. There were no natural teeth noted. During an interview on 09/15/16 at 4:04 PM Nurse #3 stated Resident #31 was edentulous and could not recall a time when Resident #31	F 278	1) On 9/27/16, the MDS Coordinator made a significant correction to the 7/23/16 significant change MDS Comprehensive Assessment for Resident #31 to accurately reflect the residents edentulous status. On 10/1/16, the MDS Coordinator modified the 6/7/16 MDS Comprehensive Assessment and triggered fall CAA for Resident #52 to accurately reflect the underlying causes contributing factors and fall history. 2) By 10/10/16, the MDS Coordinator quality monitored active residents most recent MDS Comprehensive Assessment for accuracy of dental status and fall coding, as well as, corresponding triggered CAAs as appropriate. Modifications and/or significant corrections were completed by the MDS Coordinator as appropriate. 3) On 9/19/16, the RDCS reeducated the MDS IDT on regulation 483.20(g)-(j) and guidelines to complete accurate Comprehensive MDS Assessments and corresponding triggered CAAs upon admission, quarterly, annually and with significant change in resident condition.	

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F 278	Continued From page 28 had any natural teeth. An interview was conducted with MDS Coordinator #2 on 09/15/16 at 5:12 PM. MDS Coordinator #2 stated Resident #31's significant change MDS was completed by a part-time MDS Nurse who was utilized on an as needed basis. MDS Coordinator #2 reviewed the dental status section of Resident #31's significant change MDS dated 07/23/16 and confirmed it should have been coded "edentulous" because Resident #31 had no natural teeth at the time of the assessment. 2. Resident #52 was admitted to the facility on 05/25/16. Her diagnoses included dementia, depression, and artherosclerotic heart disease. The admission Minimum Data Set (MDS) dated 06/07/16 coded Resident #52 as having severely impaired cognition, requiring extensive assistance with transfers and toileting, and ambulating in her room under supervision with one assist. She was also coded as needing human assistance to stabilize herself during transitions on and off the toilet. The MDS also noted Resident #52 had a fall within a month of the admission and falls in the previous 2-6 months prior to admission, but no falls since admission. Review of the incident reports revealed Resident #52 was found on the floor in her bathroom on 05/28/16 at 2:45 PM when she was transferring from the commode. The Care Area Assessment (CAA) completed for the triggered area of falls was completed on 07/25/16 (late) by MDS Coordinator #1. This CAA did not identify or mention any falls	F 278	The MDS coordinator will be responsible for the accuracy of residents dental status and fall coding on the admission, quarterly, annual and significant change in condition Comprehensive MDS Assessments and corresponding triggered CAAs. 4) The DCS/licensed nurse designee will monitor residents Comprehensive MDS Assessments and corresponding triggered CAAs for accurate dental status and fall history; 3 times weekly for 4 weeks, 1 time weekly for 8 weeks then, 5 random residents quarterly for 9 months. The DCS/licensed nurse designee will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective plan as necessary.	

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F 278	Continued From page 29 experienced by Resident #52 since admission but referred to a history of falls. Review of the incident reports revealed that between her admission and the completion of this CAA, Resident #52 experienced additional falls on 06/07/16, 06/23/16, 07/01/16, 07/08/16, 07/10/16 and 07/17/16. During an interview with the Director of Nursing on 09/15/2016 at 2:39 PM, she stated the facility had experienced turn overs with MDS staff. She further stated that MDS Coordinator #1 was terminated after several months as she was unable to perform the job expectations. Interview with MDS Coordinator #2 on 09/15/16 at 4:48 PM revealed she filled in part time and the admission MDS for Resident #52 was completed by MDS Coordinator #1 who was no longer working in the facility. MDS coordinator stated that the 06/07/16 MDS was inaccurately coded for falls since admission. She further stated MDS Coordinator #1 had little experience in completing MDS and CAAs.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		10/14/16

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F 323	Continued From page 30 Based on observations, record review, resident interviews and staff interviews, the facility failed to maintain the safety for 2 of 3 residents sampled for accidents. Resident #52 had a history of repeated falls and the facility failed to ensure that planned interventions were implemented, evaluated for effectiveness and changed to address the recurrent circumstances of the falls timely (turning off the alarms and going to the bathroom unassisted). In addition, Resident #49 was not strapped in the facility van properly during transport and staff who drove the facility van had not been trained in securing the straps after receiving a new van in January 2016. The findings included: 1. Resident #52 was admitted to the facility on 05/25/16. Her diagnoses included dementia, unsteady gait, vertigo, depression and hypertension. Occupational therapy was ordered on 05/26/16 for 5 times a week for therapeutic exercises, therapeutic activities, neuro re-education, self care training and wheelchair mobility. Review of the Occurrence Report dated 05/28/16 at 2:45 PM revealed Resident #52 was found sitting on the floor in the bathroom. She stated she was trying to stand up. The follow up written on 06/01/16 at 11:09 AM revealed Resident #52 got out of bed to the bathroom without assist and did not call for help. She was reminded to call for help and a therapy referral was made. Resident #52 began physical therapy on 05/28/16 for 5 times per week for gait training, therapeutic exercises, therapeutic activities, and neuro	F 323	1) On 10/3/16, the DCS completed a Fall Risk Assessment and updated safety care plan for resident #52 to ensure appropriate fall interventions are in implemented and safety is maintained. Resident #49 wheelchair will continue to be properly strapped and secured during van transportation to ensure safety is maintained. 2) By 10/6/16, the DCS reassessed residents at risk for falls and updated residents□ fall care plan with appropriate interventions to ensure resident safety is maintained. The facility will continue to properly secure residents during van transportation with appropriately trained drivers. 3) By 10/10/16, the DCS/licensed nurse reeducated direct care staff on the importance of ensuring fall prevention interventions are in place per the residents plan of care to maintain safety. The licensed nurse will assess residents fall risk and update safety care plan upon admission, quarterly, with significant change in condition or fall as appropriate to maintain residents□ safety. Nursing will physically observe residents safety interventions are in place per the plan of care. On 9/14/16, employees who operate the facility van completed a Motor Vehicle Safety Program, Q□Straint Wheelchair and Occupant Restraint System Training Program (company van specific) and signed acknowledgement of facility policy and procedures for safe resident transport. Van operators will be trained prior to	

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F 323	Continued From page 31 re-education. The admission Minimum Data Set (MDS) dated 06/07/16 coded Resident #52 as having severely impaired cognition, requiring extensive assistance with bed mobility, transfers, and toileting, and being able to walk in her room with supervision and one staff. The MDS coded her as unsteady and needing staff assistance to stabilize herself when moving on and off the toilet. She was coded as always continent of bowel and bladder. She was inaccurately coded as having had no falls since admission. A care plan for safety with the established date of 07/22/16 for the potential for injury due to poor safety awareness, confusion, poor communication and deconditioning, gait/balance problems, knowledge deficits, history of falls, incontinence, and dementia. The intervention of therapy referral and to remind the resident to use the call bell was noted written on the care plan as starting 05/28/16. Alarms in the wheelchair and bed were on the care plan, however, their implementation date was not identified. There was no care plan related to toileting. The Care Area Assessment regarding falls (which was completed late dated 07/25/16) stated Resident #52 had a lengthy history of falls some with serious injuries. She had poor balance, unsteady gait and constant dizziness. She had been working with therapy and used a rolling walker. She had documented falls in her medical record at (name of hospital) since 2011. The CAA continued stating that Resident #52 had dementia, mild cognitive impairment at this time, memory problems and severely impaired decision	F 323	operation and annually thereafter. 4) The DCS/licensed nurse designee will monitor/observe residents at risk for falls to ensure safety is maintained per the care plan for 3 residents three times a week for 4 weeks, 1 time a week for 8 weeks, then quarterly for 9 months. The ED/licensed designee will monitor/observe residents for safe vehicle transport three times a week for 4 weeks, 1 time a week for 8 weeks, then quarterly for 9 months. The ED/DCS will report findings monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective plan as necessary.	

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making skills and safety awareness.

Resident #52 continued to have falls per the Occurrence Reports and the interventions added to the care plan and the Director of Nursing's review were as follows:
*06/07/16 at 11:45 PM resident was found sitting on her buttocks with legs bent at the knees, sitting between the bed and the wheelchair. She was assisted to the bathroom. The resident stated her wheelchair moved. The immediate intervention of an alarm and gripper socks was implemented per this report. The follow up intervention of gripper socks was added to the care plan. Interview with the Director of Nursing (DON) on 09/15/16 at 2:30 PM revealed that the alarm in place was changed from a tab type to a pressure alarm in bed and an alarm was initiated in the wheelchair.
*06/30/16 at 9:30 PM the nurse aide took her to the bathroom and the resident lost her balance when she stood up and started to turn, sitting on the floor. The brakes were not locked on the wheelchair. The immediate intervention was instruction given to the nurse aide not to leave Resident #52 in the bathroom alone and to lock the brakes of the wheelchair. The care plan was updated on 06/30/16 to remind the resident to lock her wheelchair brakes, however, nothing was added about staying with Resident #52 when she used the bathroom. Interview with the DON on 09/15/16 at 2:30 PM revealed that staff should be staying with the resident when she was in the bathroom but stated that intervention was not specific in the care plan.
*07/01/16 at 11:00 AM Resident #52 was found on the floor next to the bed. The resident stated she was sitting on the bed, bent over to pick something up and tumbled off the bed. Fall mats

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by bed were implemented on a trial basis on 07/01/16. The documentation did not address any alarms sounding. Interview with the DON on 09/15/16 at 2:30 PM revealed that any trials i.e. the floor mat would be tried for at least 24 hours and reassessed.

*07/08/16 at 1:00 PM, Resident #52 was found sitting on the floor in front of the toilet. She sustained small bruises on her left knee with a small scratch noted. The resident stated she sat down on the floor trying to transfer to the wheelchair. The immediate intervention was for a chair pad alarm and a medication evaluation. The care plan was updated with this chair pad alarm, medication review and the discontinuation of the fall mat noting the mats were further trip hazards. Interview with the DON on 09/15/16 at 2:30 PM revealed the intervention was a chair pad alarm.

*07/10/16 at 7:30 PM Resident #52 was found on the bathroom floor with one brake on the wheelchair locked and the alarm turned off. She and sustained a 1 centimeter (cm) by 1 cm skin tear to her elbow. Immediate interventions were to turn on alarms. The care plan was updated on 07/10/16 with the addition of an alarming self release seat belt. Interview with the Director of Nursing on 09/15/16 at 2:30 PM revealed the resident got out of bed and took herself to the bathroom. The DON could not explain why an alarm did not sound or why the intervention of an alarming self release seat belt was added if the resident got out of bed independently alarms were not sounding.

*0717/16 at 3:00 PM staff found Resident #52 on the floor on her back. At first the resident stated she did not know how she fell then stated she was trying to get into her wheelchair which slid out from under her. There was nothing related to

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a bed alarm sounding. The intervention was for the physician to review medications. Interview with the DON on 09/15/16 at 2:30 PM revealed that she would expect documentation that the alarm was not sounding and if the report did not mention the alarm, she assumed it was on and working.

Occupational Therapy Follow-Up Recommendations dated 07/25/16 included instructions for Resdient #52 to be transferred to the toilet every 2 hours daily. She required care giver assistance to toilet and care giver assistance with hygiene and clothing management. She required assistance due to safety and being unsteady with balance. She required cues to lock the brakes on the wheelchair and put shoes on her feet.

Review of physician notes dated 07/27/16 revealed Resident #52's orthostatic blood pressures and vital signs were obtained last week and no concerns were noted. He noted that she stated she fell when she tried to sit on the toilet. He ordered no medication changes and to continue to monitor her.

Resident #52 was discharged from physical therapy on 08/01/16.

Resident #52 continued to fall per the Occurrence Reports with care planned interventions and the DON's review of the falls as follows:
*08/08/16 at 9:45 AM Resident #52 was found on the floor in the bathroom. The report was silent to any alarms sounding. The intervention added to the care plan on 08/08/16 was a sensor motion detector at her headboard for a trial period. Review of the care plan revealed an addition

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dated 08/08/16 that stated she was started on an antipsychotic for paranoid delusions, and she had been getting up every 15 minutes unassisted to void. An urinalysis was ordered. This was found to be negative per lab results. Interview with the DON on 09/15/16 at 2:30 PM revealed that she assumed the alarm worked since it was not mentioned in the report. She further stated they tried the sensor alarm for 24 hours but staff could not get out of the way after setting it fast enough and the alarm kept activating immediately. She further stated after 24 hours, the intervention returned to the bed pad alarm.

Resident #52 was discharged from occupational therapy on 08/11/16. Discharge recommendations included the functional maintenance program indicated the use of "safety/laser alarm when available."

Falls continued as per the Occurrence Reports and care plans:
*08/19/16 at 9:45 AM Resident #52 was found sitting on the floor and no alarm was activated as it was not turned on. The resident stated she was attempting to go to the bathroom when she fell to the floor and landed on her buttocks. This was also witnessed by the roommate. The follow up dated 08/24/16 noted the sensor alarm was unsuccessful and the resident continued to turn the alarm off. Intervention per the occurrence report was for anti-tippers to the wheelchair. Interview with the DON on 09/15/16 at 2:30 PM revealed she learned from staff that Resident #52 turned her alarm off. DON stated the resident unplugged the alarm cord from the box. When asked what was done to prevent the resident from turning off the alarm, the DON stated nothing other than to follow the care plan.

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*08/21/16 at 2:00 PM Resident #52 was lying outside the doorway sitting in the floor. She complained of rib pain was her rib x-rays were negative. The resident stated she was coming from the bathroom and tipped her wheelchair over. The immediate intervention per the occurrence report was to check on getting an alarm for the bathroom door. The alarm was sounding. The care plan was updated to include anti-tippers on the wheelchair and to place a scoop mattress to the bed. Interview with the DON on 09/15/16 at 2:30 PM revealed that because the roommate used the bathroom, she felt an alarm on the bathroom door would be too distracting. DON stated she never discussed the bathroom alarm with the roommate.
*08/24/16 at 10:20 PM A nurse aide found Resident #52 sitting on her buttocks on the floor in front of her wheelchair and the alarm was not sounding. The resident stated she was going to the bathroom. Per the follow up note a toileting program was initiated. The immediate intervention was to order hipsters and move the alarm. These were added to the care plan as well as the attempt for he motion sensor. Interview with the DON on 09/15/16 at 2:30 PM revealed the alarm box on the bed was on the right side of the bed and was moved to the left side. She further stated all such changes were passed to staff during daily report.
*09/02/16 at 3:30 PM the alarm sounded and although nurse aide was in the room with the roommate, she could not get to Resident #52 before she sat on the floor missing her wheelchair.
*09/04/16 at 8:15 PM Resident #52 was found sting on the he floor in front of her wheelchair. The bed alarm was not sounding. It was noted she turned off alarm. The resident stated she was

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going to the bathroom. The immediate intervention was to move the alarm out of her reach and an urinalysis was ordered and found negative for infection. The care plan was updated with an urology consult. Interview with the DON on 09/15/16 at 2:30 PM revealed at this point it became clear Resident #52 kept going to the bathroom and the DON wanted to see why, hence a urinalysis and possible urology consult. *09/09/16 at 5:00 PM Resident #52 was found on the bathroom floor. She stated she was trying to get back into the wheelchair and it slid out from under her. The intervention was to instruct staff to make sure bed and chair alarm were always turned on as the alarm did not sound. The care plan was updated to change the alarm to the other side of the bed. Interview with the DON on 09/15/16 at 2:30 PM revealed when asked about anti-roll back device for the wheelchair due to the wheelchair slipping away from her, the facility did not have a wheelchair that was appropriate and fit an anti-roll back device. DON offered no explanation as to why during the survey the alarms were no turned on or working as follows.

Resident #52 was observed on 09/14/16 at 8:14 AM sitting on the side of her bed feeding herself breakfast. Although she was sitting on a pressure alarm in bed, the alarm which was located at mattress height on the left side was in the middle of the bed was turned off. Then on 09/14/16 at 9:46 AM she was in bed with the pressure alarm still turned off. Her wheelchair was across the room by the sink. At this time she asked the surveyor to push the wheelchair closer to her.

On 09/14/16 at 11:15 AM, Resident #52 was observed sitting in her wheelchair with the alarmed seat belt not connected at the buckle

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which would cause the alarm to sound. She was able to release the velcro but no alarm sounded.

On 09/14/16 at 11:27 AM an interview was conducted with the restorative aide. The restorative aide stated she assisted Resident #52 from bed and into the wheelchair. She stated she did not turn the bed alarm off nor did the alarm sound when she transferred the resident to the wheelchair. The restorative aide stated she connected the seat belt and made sure the alarm was activated. At this time, the surveyor and restorative aide observed Resident #52 together and found the seat belt unattached, not around her and not sounding. The restorative aide showed how she connected it and was able to engage the alarm in front of the surveyor which then worked.

On 09/14/16 at 2:18 PM Nurse Aide (NA) #7 stated during interview she would sometimes leave Resident #52 in the bathroom for privacy and expected her to ring for assistance when she was ready.

On 09/14/16 at 2:42 PM NA #9 stated during interview that she has seen Resident #52 turn the alarm off in bed. She further stated she did not think the resident could turn the seat belt alarm off. NA #9 further stated she had not seen the alarm in the bed anywhere else but on the left side at mattress height in the middle of the bed for the past 2 months.

On 09/14/16 at 5:33 PM Restorative Nurse was interviewed. She stated she was just starting the restorative program up after being off three months and started a restorative program for Resident #52 this date due to her numerous falls.

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Resident #52 was observed in her wheelchair in the hall on 09/14/16 at 5:37 PM. Resident #52 was observed in the wheelchair with the seat belt attached but the alarm was not on. Once the belt was released, the alarm did not activate. Restorative nurse present at this observation pushed the cord in and out of the box several times in order to get the alarm to work.

Interview with the Director of Nursing on 09/15/16 at 2:30 PM revealed that the nurse on duty at the time of a fall will put in initial interventions and try to determine the root cause of the fall. During the next morning meeting, the interdisciplinary team would discuss the fall and interventions placed by the nurse. Any formal ongoing changes after the interdisciplinary team meets would be added to the care plan.

Interview with the Occupational Therapist on 09/15/16 at 4:39 PM revealed that a laser for the bathroom was provided but maintenance stated the resident kept setting it off by rolling around the room and it was not working effectively.

On 09/15/16 at 6:37 PM, the DON stated there was no evidence that a formal toileting program was implemented to determine toileting patterns or provide scheduled toileting to attempt to prevent Resdient #52 from taking herself to the bathroom unassisted. In addition she stated that she was able to find a wheelchair for Resdient #52 that fit her and was equipped with an anti-roll back device.

2. Resident #49 was admitted to the facility on 12/27/16 with diagnoses which included hypertension, bilateral below the knee

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amputation, end stage renal disease and diabetes.

Review of the quarterly Minimum Data Set (MDS) dated 07/26/16 revealed Resident #49 was cognitively intact with no memory impairment, mood indicators or behaviors. The MDS further revealed Resident #49 received dialysis. Review of the admission MDS dated 03/23/16 revealed Resident #4 was cognitively intact with no mood indicators or behaviors and received dialysis.

During an interview conducted on 09/14/16 at 8:20 AM Resident #49 stated he went to dialysis every Monday, Wednesday and Friday. Resident #49 stated the facility bus provided his transportation to and from dialysis, leaving the facility around 10:30 AM and returning to the facility around 3:30 to 4:00 PM. He stated at the beginning of the summer the Administrator filled in for the usual facility transporter and took him and Resident #4 to dialysis and picked them up about 45 minutes to an hour late at dialysis that afternoon. He stated when the Administrator put him in the bus he did not secure the safety tie down straps on his wheelchair and when they started moving his wheelchair started to move. Resident #49 stated he grabbed the safety strap on the side of the van and held onto it during the ride back to the facility and that kept him from turning over. He further stated Resident #4 saw him moving up and back in the bus. Resident #49 stated neither he nor Resident #4 told the Administrator he wasn't strapped down until they returned to the facility and he was getting him out of the bus. He stated the Administrator stated he didn't believe he had not strapped him down and accused him of undoing the straps himself. Resident #49 stated he could not reach the back

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straps to undo them even if he tried.

An interview was conducted on 09/14/16 at 11:19 AM with Resident #4. Resident #4 stated the Administrator took her and Resident #49 to dialysis in the spring and picked them up. She stated the Administrator put her in the bus first on the right side and then put Resident #49 on the left side behind her. She stated when they started moving she heard something behind her and when she turned around Resident #49 was behind her holding on to a black strap and his wheelchair was moving up and back. She stated she did not tell the Administrator because she thought he would hear the wheelchair moving or see it in the rearview mirror. Resident #4 stated the Administrator never noticed the wheelchair moving and when they got back to the facility Resident #49 told him he wasn't strapped in the Administrator didn't believe him. Resident #4 stated the Administrator asked her if Resident #49's wheelchair had been moving and she told him yes. She stated she told the Facility Transporter about the incident the next day.

An interview conducted on 09/14/16 at 2:08 PM with the Facility Transporter revealed if she had to be pulled to the floor to work, was double booked, was out sick or on vacation the Administrator drove the bus for transports. She stated she was pulled to the floor to work on 04/04/16 and the Administrator did the transports that day. The Transporter stated when she came into work the next day Resident #49 and Resident #4 both told her that the Administrator had failed to tie down Resident #49's wheelchair in the bus and he had moved from side to side and held onto the strap on the side of the van to keep from turning over. The Transporter stated Resident #49 had been

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able to undo the tie downs in the old van but he couldn't reach the back tie downs in the new bus to undo them. She stated she didn't file an incident report because she assumed the Administrator had filed one. The Transporter stated she was trained on how to use the tie downs to secure the wheelchair in the old van when she started transporting in 01/24/13 by the Maintenance Director. She further stated they got a new bus in 01/2016 and she did not have any training on the tie down system in the bus and she had not had any updated training since 01/2013.

An interview conducted on 09/14/16 at 2:13 PM with the Maintenance Director revealed he was in charge of training staff that drove the bus and transported residents. He stated the Facility Transporter, the Activity Director and the Administrator were the only staff that could drive the bus. The Maintenance Director stated the training consisted of a video on how to use the tie down system for wheelchairs, a test and driving with him to park and turn around. He stated he trained the Activity Director on 10/30/12 and the Facility Transporter on 01/24/13 but did not do yearly updates. The Maintenance Director stated he thought the Administrator had watched the video but he had no documentation or paperwork for him. He further stated the facility purchased a new bus in 01/2016 and the only training he did was to make sure the Activity Director and Facility Transporter felt comfortable driving it, he did not go over the tie down system with them.

An interview conducted on 09/14/16 at 3:28 AM with the Activity Director (AD) revealed she was trained by the Maintenance Director on how to use the tie system in the old van and bus in

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F 323	Continued From page 43 10/2012 and had not had any updated training since getting the new bus in 01/2016. She stated she was told by Resident #49 that the Administrator had not secured his wheelchair in the bus the day he picked him up at dialysis. The AD stated she didn't file a grievance or an incident report because Resident #49 didn't have any injuries and did not ask her to. During an interview conducted on 09/14/16 at 3:35 PM the Administrator stated he drove the bus for resident transports once to twice a month. He stated he was trained on the tie down system by the Maintenance Director at the facility and did not recall taking a written test but thought he watched a video. The Administrator stated he expected each bus driver to have yearly in-services on the tie systems in the bus and safe driving. He stated he was not aware an in-service had not been done since the original training for the AD and Facility Transporter. The Administrator stated he had transported Resident #49 and Resident #4 to and from dialysis in the past. He stated he could not recall a time when he had not secured Resident #49's wheelchair in the bus and it moved up and back during transport. The Administrator stated he did not recall asking Resident #4 if she observed Resident #49's wheelchair move during transport. The Administrator further stated he didn't recall filing an incident report for Resident #49's unsecured wheelchair.	F 323		
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:	F 328		10/14/16

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F 328	Continued From page 44 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder during transport for 1 of 1 observation. The findings included: Review of the facility policy for Safety, Storage and Transporting of Compressed Gas, with no date, read in part: 5. all cylinders must be securely stored by utilizing racks, chains, or stands. Unsecured cylinders will not be allowed. On 09/13/16 at 2:56 PM Nurse Aide (NA) #8 was observed changing out an empty compressed oxygen cylinder (O2 cylinder) on the back of a resident's wheelchair. NA #8 picked up the empty O2 cylinder by the neck of the cylinder from the jacket on the back of the wheelchair and carried it by the neck into the oxygen storage room in front of the nurse's desk. NA #8 then picked up a full O2 cylinder by the neck and carried it from the storage room to the wheelchair outside the storage room and placed it on the floor. She then put the gauge on the O2 cylinder while it was sitting on the floor, unsecured, and picked the O2 cylinder up by the gauge and placed it back into the jacket on the back of the resident's	F 328	1) No harm resulted from handling of compressed oxygen cylinder by employee #8. 2) On 9/28/16, the DCS physically inspected compressed oxygen cylinder storage areas in the facility to ensure safe storage and observed staff for safe transporting. No deficiencies identified. 3) By 10/10/16, the DCS/licensed nurse designee reeducated nursing staff on the safe handling and transport of compressed oxygen cylinders to ensure residents receive proper treatment and care. Nursing staff will ensure oxygen cylinders are changed out by handling the trunk of the tank close to their body (not the regulator) and transporting by rolling cart and securely stored in designated area oxygen racks. 4) The DCS/licensed nurse designee will monitor/observe the proper handling, transport and storage of oxygen cylinders for 3 residents three times a week for 4	

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F 328	Continued From page 45 wheelchair. An interview conducted on 09/13/16 at 3:02 PM with NA #8 revealed she always transported the O2 cylinder by the neck when she changed them out and always placed the O2 cylinder on the floor, unsecured when putting the gauge back on. She stated she had worked at other facilities that used rolling carts to transport the O2 cylinders but they did not have those at this facility. She stated she didn't recall receiving any education on how to transport O2 cylinders when she started working at the facility in 06/2016. An interview conducted with the Director of Nursing on 09/15/16 at 8:10 AM revealed it was her expectation for O2 cylinders to be carried close to the body like a baby and never by the neck or the gauge. She further stated the O2 cylinder should be in a secured stand when the gauge was being removed or replaced.	F 328	weeks, 1 time a week for 8 weeks, then quarterly for 9 months. The DCS/licensed nurse designee will report findings monthly to the Quality Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective plan as necessary.	
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.	F 520		10/14/16

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F 520	Continued From page 46 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, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in September of 2015. This was for one recited deficiency that was originally cited in August of 2015 and subsequently cited in September of 2016 on the current recertification survey. The repeated deficiency was in the area of resident assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag was cross referred to: F 272: Comprehensive Assessment. Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for the areas of Cognitive Loss/Dementia, Psychotropic Drug Use, Urinary Incontinence,	F 520	1) On 10/3/16-10/5/16, the MDS Coordinator modified Care Area Assessments (CAAs) to the identified Minimum Data Set (MDS) Comprehensive Assessments to address the underlying causes and contributing factors as follows: a) resident #52- for 6/7/16 MDS-cognitive loss/ dementia, urinary incontinence and psychotropic drug use; b) resident #17- for 1/18/16 MDS-cognitive loss/ dementia, ADLs and urinary incontinence; c) resident #3- for 8/3/16 MDS-cognitive loss/ dementia and psychotropic drug use; d) resident #11- for 4/18/16 MDS-cognitive loss/ dementia e) resident #51- for 5/8/16 MDS-cognitive loss/ dementia 2) On 9/26/16, the MDS Coordinator quality monitored the most recent MDS Comprehensive Assessment for residents whose CAAs triggered in the area of cognitive loss/ dementia, urinary	

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F 520	Continued From page 47 and Activities of Daily Living skills for 5 of 18 residents reviewed for comprehensive assessments (Residents #52, #17, #3, #11, and #51). The facility was recited for F 272 for failing to complete Care Area Assessments (CAAs) that addressed the underlying causes and contributing factors for the areas of Cognitive loss/Dementia, Psychotropic Drug Use, Urinary Incontinence, and Activities of Daily Living (ADL) Skills for 5 residents. F 272 was originally cited during the August of 2015 recertification survey for failing to complete Care Area Assessments that addressed the underlying causes and contributing factors when completing comprehensive MDS assessments 9 residents in the following areas: ADL Functional/Rehabilitation Potential, Falls, Psychotropic Drug Use and Urinary Incontinence. An interview was conducted with the Administrator on 09/15/16 at 6:40 PM. The Administrator stated the facility was not currently auditing Minimum Data Set (MDS) Assessments or CAAs as part of the facility's Quality Assurance (QA) Program and did not recall when the last time MDS Assessments or CAAs were audited through the QA program.	F 520	incontinence, psychotropic drug use and ADLs. No resident harm resulted. 3) On 9/19/16, the RDCS reeducated the MDS Coordinators, Social Services and DCS on regulation 483.20(b)(1) and requirements to complete Comprehensive Assessments and corresponding triggered CAAs that address the underlying causes and contributing factors. By 10/4/16, the MDS Coordinator (newly hired 9/6/16 and RAC-CT recertified 8/2016) provided additional training to the Dietary Manager, Activities Director and part-time MDS Coordinator on completing comprehensive CAAs per the Resident Assessment Instrument (RAI) manual. The MDS Coordinator will complete and review, in collaboration with the MDS IDT, Comprehensive Assessments and triggered CAAs to ensure the underlying causes and contributing factors are completed to comprehensively address the residents condition. 4) The DCS/licensed nurse designee will monitor residents triggered CAAs for cognitive loss/dementia, urinary incontinence, psychotropic drug use and ADLs for admission, annual and significant change Comprehensive MDS Assessments prior to submission 3 times weekly for 4 weeks, 5 random residents 1 time weekly for 8 weeks then, 5 random residents quarterly for 9 months to validate accuracy and completeness. The DCS/licensed nurse designee will report monitoring results monthly to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 48	F 520	Assurance Performance Improvement (QAPI) Committee to evaluate the effectiveness of the monitoring/ observation tools for maintaining substantial compliance, and make changes to the corrective plan as necessary. Additionally, the Regional Director of Clinical Services and/or Regional Director of Operations will attend the facilities QAPI meeting at least quarterly to monitor the facilities adherence to their quality assurance and process improvement plan, assuring quality care is provided and substantial compliance is being maintained.	