STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 10/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 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, resident and staff interviews the facility failed to prevent a resident ' s exposure as observed from the hallway for 1 of 5 residents (Resident #159) reviewed for dignity. The findings included: Resident #159 was admitted to the facility on 10/4/16 with the diagnosis of frequent falls, dementia and pulmonary emboli. The nursing admission data collection form dated 10/4/16 revealed that Resident #159 had short term memory loss and required partial to moderate assistance with mobility. The initial care plan dated 10/13/16 revealed that Resident #159 had an activity of daily living (ADL) deficit related to dementia and required total assistance for completion of ADL task. An observation was made from the hallway into Resident #159 ' s room (103-A) on 10/13/16 at 5:53 AM and Resident #159 was observed to be lying on his back near the doorway (Bed A), the door was opened and the privacy curtain was not pulled. Resident #159 had no clothing and his briefs were pulled down to his knees. The blanket was at the foot of his bed and his entire body was uncovered exposing the front of his entire body. A continuous observation was made from the hallway on 10/13/16 from 5:53 AM to 6:11 AM. At 5:55 AM Nurse Aide (NA) #1 walked past Resident #159 ' s room and went to the 300 Hall.	F 241	F241 Immediate correction for the alleged deficient practice was achieved on 10/13/16 when C.N.A #1 provided care for Resident # 159 and ensured that he was gowned and covered. Resident #159 is no longer a resident of this facility. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. A review was conducted by the Director of Nursing (DON) on 11/2/16 to determine other residents that were prone to exposure. Any resident identified as potential will have interventions implemented to ensure personal privacy and dignity. Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. Inservice education provided to all nursing staff regarding resident exposure and ensuring that personal dignity is maintained. Education will be completed	11/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2016

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F 241	Continued From page 1 An observation was made on 10/13/16 at 6:02 AM revealed Resident #159 to be without any clothes and his entire body was uncovered, Resident #159 was trying to reach his call light which was touching the floor and out of reach. Resident #159 stated " I don ' t like it " when asked how he felt about being without clothes and uncovered. At 6:11 AM on 10/13/16 NA#1 went down 100 hall and noticed Resident #159 and went into room and closed the door. At 6:26 AM on 10/13/16 Resident #159 was observed to be dressed in a gown and covered with bed sheets and a bedspread and his call light in reach. An interview with the Director of Nurses (DON) on 10/13/16 at 4:30 PM revealed that Unit A (100,200,300 halls) had a resident census of 40 and was staffed with 1 nurse and 1 NA which was not preferable but was manageable. The normal staffing on 3rd shift was 1 nurse and 2 NA ' s for the unit. The NA that called in was to find her own coverage and the DON was not notified that the NA was not replaced.	F 241	by the DON/ADON by 11/9/16. This education will be provided to all newly hired employees during orientation period. 2. Beginning 11/3/16 the DON, ADON, Unit Managers and resident ambassador will conduct periodic rounds to observe for resident exposure/dignity. Identified concerns will be addressed immediately to ensure dignity is maintained. 3. Care plans will be initiated by 11/9/16 for any resident identified as an exposure risk to include preferences and interventions to decrease the risk of exposure. Monitoring implemented to ensure the alleged deficiency does not recur includes: The DON will present a report during the monthly QAPI regarding resident exposures that may have been identified during periodic rounds. This will be monitored monthly for 3 months or until substantial compliance is achieved. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		11/10/16

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F 278	Continued From page 2 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 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set to reflect weight loss for 1 of 5 sampled residents (Resident #49) reviewed for weight loss. Findings included:	F 278	F278 To immediately correct the alleged deficient practice the Resident Care Management Director completed a modification MDS for Resident #49 to reflect that the resident is not on a	

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F 278	Continued From page 3 Resident #49 was originally admitted to the facility on 10/17/12 and re-admitted on 3/11/16 with diagnoses which included: advanced dementia, diabetes mellitus, and anemia. Review of the quarterly MDS (minimum data set) dated 9/22/16 indicated Resident #49 was severely, cognitively impaired and was on a prescribed weight loss program. The Care Plan revealed on 9/21/16 the resident had a weight loss in the last thirty days. The Approach to this weight loss was for the resident to continue receiving supplements. During an interview on 10/13/16 at 11:23am, the MDS Director indicated the assessment data revealed Resident #49 had weight loss; but, was not on a weight loss program. She acknowledged there was a coding error on the quarterly MDS and that a modification of this MDS would be transmitted to the State Agency with the correction.	F 278	planned weight loss program on 10/13/16. To identify other residents who may be affected by the alleged deficient practice, the DON completed an audit of MDS completed in the last 30 days to ensure the accurate coding of weight loss. This was completed on 11/3/16. No other assessments were noted to have inaccurate coding. Measures implemented to ensure the alleged deficient practice does not recur includes: 1. Director of Care Management conducted re-education with RCMD regarding accurate completion of the MDS regarding weight loss K0300 on 11/3/16. 2. Inservice education provided by the RCMD to the dietary manager regarding section K coding accuracy for weight loss completed by 11/3/16. 3. DON or Designee will review 5 assessments weekly for four weeks and then monthly for 3 months to validate accurate coding for weight loss. Opportunities will be corrected as identified. To ensure the alleged deficient practice does not recur the DON will summarize the results of weekly monitoring and present a report to the QAPI committee monthly for 3 months or until substantial compliance is achieved. "Preparation and/or execution of this plan	

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F 278	Continued From page 4	F 278	of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interview, the facility failed to follow-up with the Physician concerning the dialysis center's recommendation to change the nutritional supplement for 1 of 1 sampled resident (Resident #127) reviewed for dialysis. Findings included: Resident #127 was admitted on 9/12/16 with diagnoses which included: end-stage renal disease, abscess of the liver, and anemia. The Admission MDS (Minimum Data Set) dated 9/19/16 indicated Resident #127 was cognitively intact; was independent with eating; had a height of 66 inches and weight of 135 pounds; and was receiving dialysis treatments. The Care Plan dated 9/19/16 revealed Resident	F 281	F 281 Immediate correction was achieved for the alleged deficient practice by the Unit Manager notifying the Physician Assistant of the recommendation from Dialysis to change the nutritional supplement for Resident #127on 10/13/16. No new orders were received as Resident #127 was discharged from the facility. The facility recognizes that all residents receiving Dialysis have the potential to be affected by the alleged deficient practice. On 11/5/16 the DON completed a review of 30 days of Dialysis communication records to ensure that all recommendations had been followed. No other residents were identified to have been affected.	11/10/16

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F 281	Continued From page 5 #127 had the potential for nutritional problems related to several dislikes, dialysis, and abscess on his liver for which he was receiving intravenous antibiotics. One of the approaches to the potential nutritional problem included: provide and serve supplements as ordered. Review of a Physician's Order dated10/6/16 revealed Resident #127 was to receive 120 milliliters medpass (nutritional supplement) twice each day between meals. The review of the Dialysis Communication Record dated 10/10/16 included the dialysis center's following recommendations for Resident #127: stop medpass supplement; give health shakes (nutritional supplements) twice each day, with meals. Review of the Physician's Communication Book, Physician's telephone orders, and the Physician's Progress Notes indicated the facility did not follow up with the Physician concerning the dialysis center's recommendations. During an observation and interview on 10/12/16 at 12:26pm, Resident #127 was observed sitting in his wheelchair, in his room eating a meal. The resident was served a renal, no added salt diet. There was no nutritional supplement on his meal tray. The resident revealed that he received a boost drink (nutritional supplement) before every lunch and supper. During an interview on 10/13/16 at 2:35pm, the DON (Director of Nursing) acknowledged the dialysis center's recommendation for the change in Resident #127's nutritional supplement was not followed-up by the facility's nurse. The DON	F 281	Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. Inservice education was provided by the DON/ADON for all licensed nurses regarding review of the Dialysis communication record upon return and expectations for follow up on any recommendations. This education was completed on 11/5/16. This education will be provided to newly hired nurses during the orientation period. 2. Beginning 11/2/16 Unit Managers will review the Dialysis communication records daily for 4 weeks then weekly for 3 months to ensure that recommendations are processed in a timely manner by the attending nurse. 3. Beginning 11/7/16 the DON/ADON will randomly review the dialysis communication record monthly to validate that recommendations have been processed in a timely manner. Monitoring to ensure that the alleged deficient practice does not recur includes the DON summarizing the results of daily monitoring by the Unit Managers and presenting to QAPI monthly for 3 months or until substantial compliance is achieved. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	

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F 281	Continued From page 6 revealed her expectation was for the facility's attending nurse communicate the dialysis center's recommendation with the Physician and a telephone order be written on the same day the resident returned from dialysis with the recommendation.	F 281	conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure a therapy evaluation was conducted for use of knee splints to treat contractures for one of three residents with contractures. Resident #49. The findings included: Resident #49 was admitted to the facility on 3/11/16 with diagnoses including Alzheimer ' s dementia, diabetes and contractures. The " Rehab to Restorative Transition Record " dated 4/9/16 indicated Resident #49 was to receive restorative nursing for gentle passive range of motion to bilateral hips and knees and apply/remove knee braces to the bilateral lower extremities up to 6 hours.	F 318	F318 Immediate correction was achieved for the alleged deficient practice by referring Resident #49 to therapy for evaluation of lower extremities regarding proper splint placement and contracture management on 10/14/16. The facility recognizes that all residents who utilize splints have the potential to be affected by the alleged deficient practice. Physical Therapy and Occupational Therapy screened all residents identified to utilize splints to ensure proper use. Any resident identified with on going splinting needs were placed on therapy caseload. This was completed on	11/10/16

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F 318	Continued From page 7 Review of an " In-House Communicator " dated 6/16/16 revealed the licensed physical therapy assistant hand recommended positioning of Resident #49 with a red bolster between the knees when sitting in the Broda chair. The Quarterly Minimum Data Set (MDS) dated 6/29/16 indicated Resident #49 had severe impairment with short and long term memory, required extensive physical assistance with bed mobility, dressing and hygiene. Resident #49 did not walk and required physical assistance of one staff for mobility in her chair on and off the unit. The Quarterly MDS assessed Resident #49 with functional limitation of bilateral upper and lower extremities. This MDS had no documented occupational or physical therapy that had been provided in the last 7 days. There was no documented restorative therapy in the last 7 days. (6/23/16 to 6/29/16). The care plan dated 7/22/16 for a restorative nursing plan indicated Resident #49 had a problem of weakness at bilateral upper extremities and required active range of motion to be provided. There was not a care plan for maintenance of contractures of the bilateral lower extremities. Review of the July 2016 " Rehabilitation/Restorative Service Delivery Record " revealed Active range of motion (AROM), grooming, passive range of motion (PROM) and splints were to be provided by restorative nursing. The documentation included initials for the two types of range of motion and grooming. The knee splints had " D/c ' d " (discontinue) and no date was provided. This	F 318	10/13/16. Measures implemented to ensure that the alleged deficient practice does not recur include: 1. Inservice education provided for nursing staff by the DON/Rehab Director regarding splint application will be completed by 11/9/16. 2. Restorative Nursing will apply splint according to wear schedule as recommended by therapy beginning 11/1/16. 3. Beginning 11/1/16 the Rehab tech will validate placement of splints daily Monday-Friday and the weekend supervisor will validate placement Saturday and Sunday. 4. Beginning 11/7/16 the Restorative Nurse, restorative nursing assistant and Rehab Manager will meet weekly to review the current residents on the splinting program. 5. The RCMD will review the care plans of all residents who have splinting schedules to ensure that interventions are in place for the maintenance of contractures by 11/9/16. Monitoring to ensure that the alleged deficient practice does not recur includes the DON/ADON will review validation by the rehab tech of splint placement and the restorative meeting weekly. A summary	

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F 318	Continued From page 8 form included a " Summary Note " dated 7/22/16 the bilateral knee splints not currently in use due to therapy re-evaluating at present. Review of the current monthly orders for October 2016 included bilateral knee splints were to be applied daily up to 6 hours. Observations on 10/10/16 at 12:09 PM revealed Resident #49 was seated in a Broda chair with no splint devices in place. A positioning device of a red bolster was present between her knees. Interview with Restorative Nursing Assistant (RNA) #1 on 10/13/16 at 10:31 AM revealed Resident #49 received AROM to upper extremities, and PROM to lower extremities. RNA #1 explained the resident had a boot, but it was discontinued due to a wound on her foot. Interview with the treatment nurse on 10/13/16 at 10:47 AM revealed Resident #49 had a wound on her right plantar foot as of 7/1/16. The wound resolved on 7/21/16. The resident had a wound on her left foot as of 8/4/16 and it resolved on 9/14/16. Interview with MDS nurse #1 on 10/13/2016 at 10:48 AM revealed he was the nurse manager for restorative. On 7/22/16 he had written in his meeting notes the splints were discontinued and a referral to therapy to evaluate the resident was requested. The MDS nurse #1 explained he did not write orders for restorative, and a communication form was completed by RNA #1 for the evaluation. He further explained they did not have to write orders for restorative since it was a nursing plan of treatment.	F 318	of this review will be presented to QAPI monthly for 3 months or until substantial compliance is achieved. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 318	Continued From page 9 Interview with Physical Therapist (PT) #1 on 10/13/16 at 10:57 AM revealed Resident #49 was seen from 3/16 to 6/16 by PT due to wounds. Thinks the AFO (Ankle Foot Orthotic) was not recommended due to the wounds. He explained the process for referrals included use of an in-house communication form, and sometimes verbally. He would do the referral when informed. Continued interview revealed if it (referral) was not done, he was not informed of the referral. The last time Resident #49 was treated by PT was 6/16. The PT #1 observed Resident #49 with the wedge positioning device between her knees, but was not aware who provided it. Interview with the MDS nurse #1on 10/13/16 at 11:11 AM revealed the RNA did the referral and they were looking for the communication form. The communication form was provided on 10/13/2016 at 11:29 AM which requested the AFO to be discontinued and PT to evaluate and assess the resident. Interview with RNA #1on 10/13/2016 at 12:46 PM revealed one knee splint was missing for about 2 weeks. She explained she told therapy using an in house form for therapy referral. She further explained both splints have to be applied, and not just one. Interview with MDS nurse #1 and the Director of Nursing on 10/13/16 at 2:06 PM revealed there had been a failure to communicate between the therapy and nursing. They thought they were referring her back to therapy, but that was not done.	F 318		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		11/10/16

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F 328	Continued From page 10 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure enteral feedings were administered as ordered, positioning to prevent aspiration was maintained and medications were administered as ordered for two of two residents with gastrostomy feeding tubes. Residents #115 and 103. The findings included: Review of the policy and procedure for medications via a gastrostomy tube, dated 2012 included "...6. Elevate head of bed to Fowler's position, as tolerated...8. Remove plug at the end of the tube and attach syringe. 9. Release clamp from tube, if present, and instill approximately 10 ml (milliliters) of water into the tube through the syringe to check for patency....11. Just before the syringe empties of water, add medicaiton in accordance with physician order..." 1. Resident admitted to the facility on 4/7/16 with diagnosis including dysphagia, dementia, Parkinson's disease and diabetes type 2. Admission Minimum Data Set (MDS) dated	F 328	F328 Immediate correction was achieved for the alleged deficient practice as follows: Resident #115 was reviewed by the Registered Dietitian on 10/12/16 with no new recommendations; on 10/6/16 the order to flush the G-tube was clarified to 50cc per hour. Resident #103 orders were received from the physician on 10/14/16 to administer Osmolite 1.5 via G-tube every 6 hours. Registered Dietitian reviewed Resident #103 on 10/31/16 with no recommended changes. Nurse #4 is no longer employed by this facility. The facility recognizes that all residents who receive medications or feeding via	

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F 328	Continued From page 11 4/14/16 indicated Resident #115 had long and short term memory impairment, eating required extensive assistance of one person, toileting 3/3, hygiene 3/2. No weight loss was indicated on the admission assessment with nutrition provided by a feeding tube for 51% or greater of nutritional needs met by the feeding. No weight was documented on the admission assessment. Review of the Care Area Assessment (CAA) dated 4/20/16 for nutrition and hydration indicated Resident #115 had a problem of chewing and swallowing, at risk for fluid deficit, a gastrostomy tube (G tube) and received Glucerna 60 milliliters (ml) an hour with 100 ml per hour of water flushes. A decision to proceed to care planning was made by the care plan team. Quarterly MDS dated 7/6/16 indicated weight was 126 pounds and no weight loss had occurred. Total assistance was required for eating with 51% or greater of his nutritional needs being met by the tube feeding. The initial care plan dated 4/13/16, with an update of 7/16/16 for problems of enteral nutrition and fluid deficit related to impaired swallowing and use of a G tube. Approaches included to flush the tube as ordered, tube feeding as ordered, head of bed elevated except at short intervals to provide care and check placement and residuals as ordered. Review of the hospital discharge orders dated included water flushes to be provided every four hours. Admission orders dated 4/12/16 included tube feeding with Glucerna at 60 milliliters per hour	F 328	g-tube have the potential to be affected by the alleged deficient practice. An audit of tube feeding orders was completed by the Unit Managers on 11/4/16 to validate accuracy of the orders. Measures implemented to ensure the alleged deficient practice does not recur includes: 1. Beginning 11/1/16 the Dietary Manager will provide a list of all residents in the facility receiving tube feedings to the Registered Dietitian. Residents receiving g-tube feedings will be reviewed monthly by the RD. 2. Inservice education was provided by the DON/ADON for Licensed Nurses regarding accuracy of tube feeding orders and flushes, proper positioning and ensuring the feeding pump is on as prescribed by the physician. Education completed by 11/9/16. 3. The DON/ADON/UM will complete skills validations for licensed nurses to ensure understanding of medication administration technique via g-tube, proper resident positioning and appropriate technique for checking placement of g-tube. This skills validation will be completed by 11/10/16, any nurse who is not scheduled (PRN) will have skills validation completed prior to working their next shift. 4. The DON/ADON/UM will continue to complete 4 skills validations monthly for 3	

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F 328	Continued From page 12 continuous via feeding pump. Water flushes were 100 ml//hour continuous via pump. The same admission orders included "Enteral Feeding: Glucerna 1.5 @ 40ml/ho with H2O at 30ml/hour. Current orders dated 9/8/16 included tube feeding of Glucerna 1.5 per G-tube (gastrostomy) via pump rate of 60mlhr. Current orders included "hydration: Bolus with 100mls H2O (water) q (every) 1 hrs (hours) for Hydration." Review of the Admission Medication Administration Record for 4/8/16 revealed water flushes were started at 100 ml/hour continuous via pump beginning on 3rd shift 10 p to 6 a. on 4/8/16. .Review of the electronic chart beginning with July 6, 2016 through 10/12/16 revealed no documentation by a registered dietician available for review. Observations on 10/10/16 from 3:18 PM to 3:54 PM revealed Resident # 115 ' s feeding pump had been off with a beeping alarm alert of " hold error. " The resident had not received the tube feeding or water by the G tube during the continuous observation. Interview with the evening hall nurse #5 on 10/10/16 at 4:10 pm revealed she was not aware the pump had been put on hold. She had not held the feeding and restarted the feeding. Interview with Unit B Manager, who also signed the admission assessment, was conducted on 10/12/2016 11:20 AM. The discharge orders from the hospital dated 4/7/16 included Tube	F 328	months to validate the licensed nurses have clear understanding of the proper technique of administering g-tube feeding and medication. Newly hired nurses will be educated, to include skills validation, during the orientation period. Monitoring initiated to ensure the alleged deficient practice does not recur includes the DON or Designee summarizing the results of skills validation and presenting a report monthly to the QAPI committee. Monitoring will continue monthly for 3 months or until substantial compliance is achieved. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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feedings with Diabetisource AC full strength at 60ml/hour with free water flushes 100cc every 4 hours. The discrepancies in the orders was questioned with the nurse manager. She explained the 40cc/hour was her handwriting. She explained the orders did not match and did not know what had occurred. After reviewing the chart, she explained the rate at 40cc was in error. The other nurse had the order correct. The water was a transcription error, on self- audit it was fixed on 6/18/16 with telephone clarification for 100ml/hour. The unit B Manager was asked who determined the amount of water flush required, she explained either the physician or the dietician decided how much water to administer and how often.

Further clarification provided by the Unit B Manager on 10/12/16 at 12:48 PM indicated the water flush order was changed to 50ml/hour on 10/6/16. Review of the October MAR revealed the order had been changed in the electronic chart.

Interview with Registered Dietician on 10/12/2016 at 11:32AM revealed the resident was not on her list for review of residents receiving tube feeding. She had been a consultant since June for the facility. Further interview revealed she had not made any recommendations for water flush amounts for Resident #115.

Interview with the primary physician was conducted on 10/12/2016 at 4:27 PM. The physician explained the initial hospital discharge orders would be followed. The facility dietician would make recommendations and be reviewed by the physician for tube feedings and water flushes.

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Observations on 10/13/16 at 5:35 AM to 6:630 AM revealed Resident #115 ' s tube feeding was empty and the pump had been turned off. Nurse #4 hung a new bottle of feeding and water flush via the pump at 6:40 AM. Interview with nurse #4 at the time the new bottle of feeding was hung revealed she was not aware the feeding had run out or the pump was turned off. The feeding was started again at 6:45 AM.

2. Resident #103 was admitted to the facility on 10/8/15 with diagnoses including diabetes, dysphagia and stroke.
The Minimum Data Set (MDS) dated 8/17/16 indicated Resident #103 had no problems with short or long term memory, received nutrition and hydration by enteral feedings, had no behaviors or rejection of care during the assessment timeframe.
The care plan dated 6/15/16 for a problem of received enteral nutrition related to impaired swallowing. The approaches included for the nurse to provide flush as ordered, additional fluids with medication pass and as ordered, check placement and check residuals as ordered, and elevate head of bed.

The current monthly orders for September 2016 included enteral feedings of Osmolite 1.5 at 75/milliliters (ml) per hour for 10 hours. The water flush order indicated 70 ml per hour for 10 hours was to be administered. An order to elevate the head of the bed 30-45 degrees (semi-fowler ' s position) during feedings and at least 1 hour after feeding to prevent aspiration/pneumonia. The monthly orders indicated the G -tube placement was to be checked for proper placement by visual

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inspection of aspirated stomach content prior to instilling medication, initiating a feeding or when there was an interruption of feeding, or at least every shift for continuous feeding.
Observations of nurse #4 and Resident #103 were made on 10/13/16 beginning at 5:45 AM and ending at 6:08 AM. The head of the bed was elevated, and the resident had slid down in the bed. Resident #103 was positioned in bed with his head near the bend in the head of the bed. Nurse #4 did not reposition the resident, or request he re-position himself prior to administration of the water flush and medications. Observations of nurse #4 revealed she placed the end of the G-tube in a cup of water to check for placement. Continuous observations revealed the crushed Vitamin D and Aspirin were administered directly into the G-tube without water dilution. After the medications were administered, nurse #1 administered a bolus feeding of 240 milliliters of Osomolite 1.5 by gravity. The continuous feeding was not administered by nurse #4.
Interview on 10/13/16 at 6:38 AM with nurse #4 revealed powder residue remained in the medication cup on the sides and on the bottom of the cup. Nurse #4 explained she should have diluted the Vitamin D and Aspirin prior to administration. Further interview revealed she checked for placement by submerging the end of the G-tube in the cup of water. The continuous feeding was not administered due to the resident had refused the feeding prior on her shift. She explained she administered a bolus of one can at 11:00 PM and again at 5:00 AM since he refused the continuous feeding. Nurse #4 explained she had administered a bolus feeding on other nights when she worked.

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F 328	Continued From page 16 Interview with the Director of Nursing (DON) on 10/13/16 at 2:00 PM revealed her expectation for administering medications through a G-tube would be to dilute the medications prior to administration. She explained she was not aware the nurse was administering a bolus feeding and there was not an order for a bolus when the continuous feeding was to be administered. The resident should have been repositioned before the water and medications were given.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to administer medications with a 5% or less medication error rate as evidenced by four errors were made in 26 opportunities with an error rate of 15.38%. (Resident #103) The findings included: Resident #103 was admitted to the facility on 10/8/15 with diagnoses including diabetes and stroke. Review of the September 2016 monthly orders for Resident #103 included the following orders: Folic Acid Tablet 1 milligram give 1 tablet via G-Tube one time a day for supplement at 5:00 AM; Vitamin D3 tablet 1000 unit give 1 tablet via G-Tube one time a day for supplement at 5:00 AM and Aspirin Tablet chewable 81 milligrams give 1 tablet via G-Tube one time a day for heart	F 332	F332 Immediate correction of this alleged deficient practice was achieved for Resident #103 on 10/14/16 by the Unit Manager notifying the PA of the medication errors on 10/13/16 to include improper administration technique, partial does of multivitamin and the omission of Miralax. No new orders were received. The facility recognizes that all residents with medications to be given by g-tube have the potential to be affected by the alleged deficient practice. Measures implemented to ensure that the alleged deficient practice does not recur	11/10/16

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F 332	Continued From page 17 health at 5:00 AM. Observations of nurse #4 on 10/13/16 beginning at 5:45 AM and ending at 6:08 AM revealed nurse #4 administered the crushed Vitamin D and Aspirin directly into the G-tube without water dilution. Observations included the Folic Acid had been crushed and diluted with water and the contents had spilled out onto the over bed tray table. Nurse #4 was observed adding more water to the med cup with the remaining multivitamin and administering the partial dose of the multivitamin into the G-tube. Interview on 10/13/16 at 6:38 AM with nurse #4 revealed powder residue remained in the medication cup on the sides and on the bottom of the cup. Nurse #4 explained she should have put water in it (the cup with crushed medications) and said there was residual crushed med in the cup. Nurse #4 further explained she should have re-poured the folic acid due to spillage. She did not see how much medication was on tray table until wiping off table spill. Nurse #4 identified the medications that were not diluted as the Vitamin D and Aspirin. Review of the September 2016 monthly orders included Miralax Packet, give 1 packet via G-Tube (gastrostomy) one time a day for constipation mix in liquid. The time of administration was for 5:00 AM. Observations of nurse #4 on 10/13/16 at 5:52 during med pass revealed Miralax was not administered. Reconciliation of the med pass on 10/13/16 at 1:46 PM revealed the medication had been omitted. Two attempts to interview the night shift nurse #4 were made after reconciliation was completed. Interview with the Director of Nursing (DON) on 10/13/16 at 2:00 PM revealed the medication	F 332	includes: 1. The DON/ADON/UM will complete skills validations for licensed nurses to ensure understanding of medication administration technique via g-tube. This skills validation will be completed by 11/10/16, any nurse who is not scheduled (PRN) will have skills validation completed prior to working their next shift. 2. The DON/ADON/UM will continue to complete 4 skills validations monthly for 3 months to validate the licensed nurses have clear understanding of the proper technique of administering g-tube medication. 3. Inservice education conducted by the DON/ADON for licensed nurses regarding prevention of medication errors will be completed by 11/10/16. Monitoring to ensure that the alleged deficient practice does not recur includes the DON will monitor medication error identified monthly and report during QAPI. DON will also prepare a summary of the results of skills validation monitoring and present during QAPI. This monitoring will continue monthly for 3 month or until substantial compliance is achieved. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	

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F 332	Continued From page 18 should have been administered at 5:00 AM. The DON explained her expectation for administering medications through a G-tube would be to dilute the medications prior to administration. She explained the spilled medication should have been tossed and the medication re-poured for administration.	F 332	deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		11/10/16

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F 334	Continued From page 19 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide a record of	F 334	F 334	

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F 334	Continued From page 20 influenza education in 4 of 5 resident records (Resident #67, 96, 40, 95). The findings included: A review of the facility policy and procedures for Immunizations: Influenza (Flu) vaccination of Residents and Staff (revised 9/2015) revealed, in part: A. Current and newly admitted residents ... will be offered the influenza vaccine from October of each year through the end of March the following year. B. The Vaccination Information Statement (VIS) will be used to discuss the risks and benefits of the vaccine. C. Vaccination refusal and reasons why should be documented by the facility. D. Document the administration of the vaccine, including injection site, in the medical record. 1. Resident #67 was admitted to the facility on 4/25/14 and diagnoses included cerebral vascular accident and gastro-esophageal reflux disease. The most recent quarterly Minimum Data Set (MDS) assessment dated 8/31/16 assessed the resident as being cognitively intact and received the influenza vaccine 10/19/16. A review of the medical record for Resident #67 revealed there was not a VIS in the record. 2. Resident #96 was admitted to the facility on 11/2/2015 with diagnoses to include heart failure and hypertension. The most recent quarterly MDS dated 7/13/16 assessed the resident to be moderately cognitively impaired and he declined the influenza vaccine. A review of the medical records for Resident #96 revealed there was not a VIS in the record. An interview was conducted on 10/13/2016 at 6:30 PM and the resident reported he did not recall receiving education regarding the influenza vaccine.	F 334	Immediate correction was achieved for the alleged deficient practice by providing education to licensed nurses responsible for administering the current flu season vaccines regarding the requirements for documentation of influenza education for both acceptance and declination. The DON provided this education on 10/31/16. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. DON/ADON provided education to licensed nurses regarding documentation requirements of acceptance and refusal of the influenza vaccine to include education provided to the resident/responsible party. This documentation will be signed on the administration record for acceptance or in the clinical record progress notes for declination. The education was completed on 11/9/16. All newly hired nurses will receive this education during the orientation period. 2. The DON or Designee will randomly review the documentation of current residents who declined the flu vaccine to ensure that education was provided and documented as required by 11/9/16. 3. Beginning 11/7/16 the DON or Designee will review documentation of influenza vaccine education in the clinical	

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F 334	Continued From page 21 3. Resident #40 was admitted to the facility on 2/26/2009 with diagnoses to include hypertension and diabetes. The most recent quarterly MDS dated 9/20/16 assessed the resident to be severely cognitively impaired and received the influenza vaccine 10/19/16. A review of the medical record for Resident #40 revealed there was not a VIS in the record. 4. Resident #95 was admitted to the facility on 7/10/13 with diagnoses to include hypertension and osteoporosis. The most recent quarterly MDS dated 7/13/16 assessed him to be cognitively intact and he declined the influenza vaccine. A review of the medical record for Resident #95 revealed there was not a VIS in the record. An interview was conducted with the resident on 10/13/2016 at 6:32 PM and he reported he did not recall receiving education regarding the influenza vaccine. An interview was conducted with the Director of Nursing (DON) 10/13/16 at 6:00 pm. She reported that the VIS was used for educating the residents, but they were not given a copy of the VIS and nothing was documented in the medical record.	F 334	record of current and newly admitted residents weekly for 4 weeks and monthly for 3 months Monitoring to ensure that the alleged deficient practice does not recur includes the DON will provide a summary of weekly monitoring to the QAPI committee monthly for 3 months or until substantial compliance is achieved. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353		11/10/16

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F 353	Continued From page 22 care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to provide sufficient number of direct care staff to meet the needs of Resident #159 as evidence by leaving 1 of 5 residents reviewed for dignity to be exposed and without clothing. The findings included: Cross referenced to Tag F-241-Based on observations, resident and staff interviews the facility failed to prevent a resident ' s exposure as observed from the hallway for 1 of 5 residents (Resident #159) reviewed for dignity. A review of the resident census for Unit A on 10/13/16 revealed there were 40 residents for 100,200 and 300 halls. An interview with NA#1 on 10/13/16 at 5:44 AM reveled that she makes rounds by herself and if the residents require assistance of 2 staff then she calls on her nurse. NA #1 indicated that if she is in a room helping a resident then the nurse will help her to answer the call lights. An interview with nurse #3 on 10/13/16 at 5:45 AM revealed that the unit is normally staffed with 1 nurse and 2 NA ' s, tonight there was a call out	F 353	F 353 Immediate correction for the alleged deficient practice was achieved on 10/13/16 when C.N.A #1 provided care for Resident # 159 and ensured that he was gowned and covered. Resident #159 is no longer a resident of this facility. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. Administrator and DON completed education for direct care nursing staff regarding proper procedure in the event of an employee calling out for scheduled work assignment, completed 11/9/16. 2. Beginning 11/7/16 any employee	

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	345011	A. BUILDING _____ B. WING _____	C 10/13/2016

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F 353	Continued From page 23 and she was staffed with 1 NA. Nurse #3 indicated that she helps the NA when she has time. An observation was made from the hallway into Resident #159 ' s room (103-A) on 10/13/16 at 5:53 AM and Resident #159 was observed to be lying on his back near the doorway (Bed A), the door was opened and the privacy curtain was not pulled. Resident #159 had no clothing and his briefs were pulled down to his knees. The blanket was at the foot of his bed and his entire body was uncovered exposing the front of his entire body. A continuous observation was made from the hallway on 10/13/16 from 5:53 AM to 6:11 AM. At 5:55 AM Nurse Aide (NA) #1 walked past Resident #159 ' s room and went to the 300 Hall. An observation was made on 10/13/16 at 6:02 AM revealed Resident #159 to be without any clothes and his entire body was uncovered, Resident #159 was trying to reach his call light which was touching the floor and out of reach. Resident #159 stated " I don ' t like it " when asked how he felt about being without clothes and uncovered. At 6:11 AM on 10/13/16 NA#1 went down 100 hall and noticed Resident #159 and went into room and closed the door. At 6:26 AM on 10/13/16 Resident #159 was observed to be dressed in a gown and covered with bed sheets and a bedspread and his call light in reach. An interview with the Director of Nurses (DON) on 10/13/16 at 4:30 PM revealed that Unit A (100,200,300 halls) had a resident census of 40 and was staffed with 1 nurse and 1 NA which was not preferable but was manageable. The normal staffing on 3rd shift was 1 nurse and 2 NA ' s for the unit. The NA that called in was to find her own coverage and the DON was not notified that the	F 353	calling off from a scheduled work assignment must notify the Administrator or DON 2 hours prior to the beginning of the shift. 3. Beginning 11/7/16 the Administrator and DON will review the weekly schedule prior to the beginning of the week to ensure adequate staffing. 4. Beginning 11/7/16 employee attendance and adherence to the call out policy will be monitored weekly by the DON/ADON with appropriate disciplinary action taken according to facility policy for attendance Monitoring for the alleged deficient practice will include reviewing the staffing schedules daily with the facility scheduler. Call outs will be reviewed monthly and a summary will be reported by the DON to the QAPI committee monthly for 3 months or until substantial compliance is achieved. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 353	Continued From page 24 NA was not replaced.	F 353		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the area surrounding 1 of 1 trash dumpster was free of refuse, debris, and containers of standing water. Findings included: During an observation of the dumpster area located directly behind the facility on 10/10/16 at 10:50am, there was 1-trash dumpster and 1-cardboard dumpster on an opened, raised cemented area. The area surrounding the dumpsters contained: 2-single bed mattresses (1-propped against the cardboard dumpster and 1-lying flat behind the 2 dumpsters); 1-opened large plastic trash bin filled with standing water and large plastic bag of trash. Also, there were 3-laundry bins located directly behind the trash dumpster. There was an upturned plastic garbage bin filled with standing water resting on top of these laundry bins. During an interview on 10/10/16 at 10:58am, the DM (Dietary Manager) revealed that the trash in the dumpster was scheduled to picked up between 8:30am and 9:45am, Monday through Friday; as was done on the day of this	F 372	F 372 Immediate correction for the alleged deficient practice is that the Maintenance Director discarded the mattresses and laundry bins that were noted propped up against the dumpster. The standing water noted in the plastic bin behind the dumpster was removed. This was was completed 10/10/16. The facility recognizes that the alleged deficient practice has the potential to affect any person who has reason to be in contact with the dumpster. Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. Inservice education was provided for the facility staff by the Maintenance Director or Administrator regarding the facility expectations for safe garbage disposal. This education was completed on 11/9/16. All newly hired employees will be provided this education during the orientation period.	11/10/16

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F 372	Continued From page 25 observation. The DM noted that none of the items observed surrounding the trash dumpster area, belonged to the dietary department.	F 372	2. Beginning 11/7/16 the Maintenance Director will monitor the dumpster area twice daily fpr 1 month then weekly for 4 weeks to ensure compliance. Monitoring to ensure that the alleged deficient practice does not recur includes the Maintenance Director will summarize findings from routine monitoring and report results to QAPI monthly for 3 months or until substantial compliance is achieved. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		11/10/16

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F 431	Continued From page 26 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain medication refrigerator temperatures in the range of 36 degrees and 46 degrees for one of two med room refrigerators. The findings included: Observations on 10/13/16 at 7:30 AM, of the refrigerator temperature log dated October 2016, for halls 400, 500 and 600, indicated the refrigerator temperatures were checked in the AM and PM. The log had temperatures documented as follows: 33 degrees for am/pm and 32 degrees am/pm on two separate dates. There	F 431	F 431 Immediate correction was achieved for the alleged deficient practice by the Unit Manager adjusting the refrigerator temperature control. Within 1 hour she rechecked the temperature to ensure proper range. This was completed on 10/13/16 The facility recognizes that residents who receive medications that require refrigeration have the potential to be affected by this alleged deficient practice.	

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F 431	Continued From page 27 were no documented rechecks of the temperatures when found to be near or at freezing. The refrigerator contained Intravenous (IV) meds, insulin vials and pens. The refrigerator log instructions indicated the temperatures should be 36 degrees to 46 degrees. The temperature registered at 38 degrees on the thermometer inside the refrigerator during this observation. Review of the past three months of medication refrigerator temperatures revealed 15 days in July, 10 days in August and 11 days in September the AM temperatures were below 36 degrees. The lowest recorded was 30 degrees. Review of the past three months of medication refrigerator temperatures revealed 14 days in July, 11 days in August and 12 days in September the PM temperature was below 36 degrees. The lowest temperature was 30 degrees. Interview with nurse #1 on 10/13/16 at 1:00 PM revealed she did not check the med room refrigerator temperatures. Nurse #2 explained the night shift checked it at the end of their shift. She explained the range for the temperatures was on the log sheet on the clipboard. Further interview revealed she would notify the maintenance director if the temperatures were out of range, Interview with the Unit B Manager on 10/13/16 at 1:36 PM revealed she checked the med room refrigerator temperatures every day. She explained after reviewing the temperature log sheet, she did the check .when it was not done. Further interview revealed if the temps were staying too cold, it could be due to staff not opening it up as much. Steps she took to correct temperatures below 36 degrees included "	F 431	Measures implemented to ensure that the alleged deficient practice does not recur includes: 1. Inservice education provided by the DON/ADON for night shift licensed nurses regarding monitoring of the refrigeration temperature and measures to take if noted out of range. Adjustments may include adjusting the temperature control and rechecking the temperature with 1 hour, if that is not effective the Maintenance Director will be notified. This education was completed on 11/9/16. 2. Beginning 11/7/16 the Unit Manager will review temperature logs daily to ensure proper function and temperature ranges. 3. The DON will review temperature logs monthly for 3 months to ensure proper temperature control and provide subsequent education as needed. Monitoring implemented to ensure that the alleged deficient practice does not recur includes the DON will provide a summary regarding temperature control of the medication refrigerators and any adjustments required to the QAPI committee monthly for 3 months or until substantial compliance is achieved. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	

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F 431	Continued From page 28 usually bumps it up. " She further explained she had not written down when she re-checked the temperatures after the correction was made. When asked at what point she would notify the maintenance director, she responded " if not up after a couple of days would put it in his book and mention it to him. " The dates of 9/24/16 to 9/28/16 were reviewed with the Unit B Manager. The temperatures were 32 and 34 degrees in the AM and 31 to 36 degrees in the PM. She explained the maintenance director had not been notified of the low temperatures. Interview with the Director of Nursing on 10/13/16 at 2:15 PM revealed she would expect the nurses to bump the temperature control up initially, She explained if the temperatures continued to be out of range, maintenance would be notified.	F 431	the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	