STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING ______ B. WING ______	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 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 record review, observation, resident and staff interview, the facility failed to have the water pitcher within reach for one of three sampled residents reviewed for choices (Resident # 102). The findings included: Resident #102 was readmitted to the facility on 12/11/15. Cumulative diagnoses included, in part, dementia anxiety and history of urinary tract infections. An Annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #102 was moderately impaired in cognition. She required supervision with set up help only with eating. Resident #102 was non-ambulatory and required extensive assistance for transfers. On 11/29/16 at 10:32 AM, an interview was conducted with Resident #102. Resident #102's water pitcher was observed and was placed across the room by the sink. Resident #102 stated nursing staff always left her water pitcher over there so she couldn't get it. She stated she had not told them to put it over there and wished she could have it where she could get water when	F 242	Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings	12/29/16

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

Electronically Signed — 12/16/2016

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

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F 242	Continued From page 1 she wanted to. At the time of the interview, Resident #102's call bell was not accessible and was noted to be lying on the floor between the bed and wall. A review of physician orders revealed Resident #102 was not on fluid restriction or on thickened liquids. On 11/29/16 at 12:20 PM, Resident #102 was observed sitting in her wheelchair eating lunch. She was consuming fluids independently. Her water pitcher remained beside the sink and unavailable for resident to use. On 11/30/16 at 8:30AM, an observation revealed Resident #102's water pitcher was over by the sink. Resident #102 was sitting up in bed with her overbed table in front of her. She had completed her breakfast and was drinking fluids that had been on her breakfast tray. On 11/30/16 at 11:05AM, an interview was conducted with NA (nursing assistant) #1. Resident #102's water pitcher was observed sitting by the sink. NA #1 stated she did not know why it was over there and should be on Resident #102's overbed table. An observation of Resident #102's water pitcher on 11/30/16 at 12:30PM revealed the water pitcher was over by the sink and not accessible to resident. Resident was up in her wheelchair with her overbed table in front of her. On 11/30/16 at 4:44 PM, Resident #102 was observed lying in bed. Her overbed table was beside the bed and her water pitcher was observed sitting by the sink.	F 242	F242 1) Water pitcher was placed by the nursing assistant (NA) within resident #102's reach 12/1/16. 2) All water pitcher placement for 100% of residents without fluid or dietary restrictions were checked by the Director of nursing (DON) 12/16/16 and all pitchers were within resident's reach. 3) Appropriate placement of water pitchers will be checked each shift by the hall nurse as he/she make their rounds and will be placed within resident reach for those residents who are without fluid/dietary restrictions. The check will be documented on the 24 hour report sheet for 6 weeks by the hall nurse. All nurses and persons, including weekend and PRN nursing staff, responsible for passing water/ice will be in-serviced on appropriate placement of pitchers. The in-service will be conducted by the DON, assistant director of nursing (ADON), nurse supervisor, and/or a corporate consultant. In-service was initiated 12/15/16, to be completed by 12/29/16. 4) An audit of water pitcher placement for 10 random residents per week throughout the entire facility will be conducted by the DON, ADON, nurse supervisor, and/or a corporate consultant x 6 weeks to ensure pitchers are in the appropriate place using the Choices/ADL's/Fall interventions Audit Tool. Afterward 5 residents per hall will be audited by the DON, ADON, nurse supervisor, and/or a corporate consultant weekly x 6 weeks. Initiated 12/22/16. 5) Findings will be presented by the administrator or DON to the monthly	

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F 242	Continued From page 2 On 11/30/16 at 4:45PM, an interview was conducted with NA#2. She stated water pitchers were usually kept on the bedside stand or overbed table. She stated she refilled and checked the water pitchers before the end of her shift at 11:00PM. NA #2 said it was her first day on 100 hall and she wasn't "in a routine just yet". She observed Resident #102's water pitcher over by the sink and said the water pitcher should be on the overbed table. NA #2 moved the water pitcher to the overbed table so Resident #102 could obtain water from the pitcher. On 11/30/16 at 5:00PM, an interview was conducted with Nurse #1. She stated the water pitcher should be on the bedside table or stand so residents could have the water accessible to them unless there was a reason such as they only could have thickened liquids or was on a fluid restriction. On 12/01/2016 at 8:39 AM, an observation revealed Resident #102's water pitcher was on her overbed table and accessible to resident. On 12/1/16 at 12:30PM, an interview was conducted with the Director of Nursing who stated her expectation was for the water pitchers to be accessible to the resident. She said Resident #102 should have her water pitcher on the bedside table or overbed table.	F 242	Quality Improvement (QI) Committee (administrator, DON, ADON, treatment nurse, minimum data set (MDS) nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator) for review and recommendations. Survey was reviewed in QA committee 12/14/16.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		12/29/16

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F 272	Continued From page 3 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 review and staff interview, the facility failed to completely assess residents on	F 272	F272 1) On 12/16/16 the Social Worker (SW)	

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F 272	Continued From page 4 the Minimum Data Set (MDS) assessment in the areas of mental status and mood for 2 of 21 sampled residents reviewed (Residents #28 and #106). The findings included: 1a. Resident #28 was admitted to the facility on 10/11/16 with multiple diagnoses that included cancer, cardiovascular disease, and dementia. A significant change in status Minimum Data Set (MDS) assessment dated 11/8/16 indicated Resident #28 had clear speech, was able to make herself understood, and understood others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 required an answer that indicated if a Brief Interview for Mental Status (BIMS) was conducted with Resident #28. This question was coded with a dash that indicated the question was not answered. The remaining questions in the BIMS section, questions C0200 through C0500, were also coded with dashes that indicated the questions were not answered. An interview was conducted with MDS Nurse #1 on 11/30/16 at 4:50 PM. Section C of the significant change MDS dated 11/8/16 for Resident #28 was reviewed with MDS Nurse #1. She indicated the Social Worker (SW) completed Section C of Resident #28's 11/8/16 MDS. MDS Nurse #1 reported she was responsible for the review of Section C for completeness and accuracy. She revealed the BIMS should have been attempted with Resident #28. An interview was conducted with the SW on 12/1/16 at 10:37 AM. She indicated she was responsible for the completion of Section C of Resident #28's MDS dated 11/8/16. She revealed she had not completed the BIMS with	F 272	completed an assessment for residents #28 and #106 related to cognition including a brief interview for mental status (BIMS) score and moods. On 12/16/16 the SW completed a detailed general care plan progress note for residents #28 and #106 related to the cognitive and mood assessment. The documentation is detailed related to the resident's cognitive status to include BIMS scores and moods. The documentation includes an analysis of the findings supporting the decision to proceed or not to care plan. 2) On 12/19/16, the minimum data set (MDS) nurse began auditing each resident last comprehensive assessment to ensure that section C (cognitive patterns) and section D (moods) were completed accurately. A detailed general care plan progress note was completed by the SW for each resident where a concern was noted. The audit was completed on 12/22/16. All residents were assessed and any missing assessments immediately corrected with a full assessment in a detailed general care plan note. 3) On 12/19/16 the MDS corporate consultant completed an in-service with the MDS Coordinator, MDS nurse, and on 12/20/16 with SW related to accurately completing sections C and D per the Resident Assessment Instrument (RAI) manual. On 12/27/16 the director of nursing (DON) began auditing sections C and D of the MDS assessment for completeness and accuracy using the Assessment Accuracy	

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F 272	Continued From page 5 Resident #28 because she had been informed the MDS was due after the Assessment Reference Date (ARD). An interview was conducted with the Director of Nursing on 12/2/16 at 3:25 PM. She indicated her expectation was for the MDS to be fully completed. 1b. Resident #28 was admitted to the facility on 10/11/16 with multiple diagnoses that included cancer, cardiovascular disease, and dementia. A significant change MDS assessment dated 11/8/16 indicated Resident #28 had clear speech, was able to make herself understood, and understood others. Section D, the Mood section, was not fully completed for Resident #28. Question D0100 required an answer that indicated if a Resident Mood Interview was conducted with Resident #28. This question was coded with a dash that indicated the question was not answered. The remaining questions in the Resident Mood Interview section, questions D0200 through D0300, were also coded with dashes that indicated the questions were not answered. An interview was conducted with MDS Nurse #1 on 11/30/16 at 4:50 PM. Section D of the significant change MDS dated 11/8/16 for Resident #28 was reviewed with MDS Nurse #1. She indicated the Social Worker (SW) completed Section D of Resident #28's 11/8/16 MDS. MDS Nurse #1 reported she was responsible for the review of Section D for completeness and accuracy. She revealed the Resident Mood Interview should have been attempted with Resident #28.	F 272	Audit Tool. This audit will be completed for 10 residents weekly x four weeks, then 10 residents biweekly x eight weeks, then 10 residents monthly x 3 months by the DON, assistant director of nursing (ADON), and/or corporate consultant. 4)The DON or assistant director of nursing (ADON) will present the results of the Assessment Accuracy Audit Tool to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, SW, admissions coordinator, dietary manager, environmental services manager, maintenance director)for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. 5) The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.	

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F 272	Continued From page 6	F 272		

An interview was conducted with the SW on 12/1/16 at 10:37 AM. She indicated she was responsible for the completion of Section D of Resident #28's MDS dated 11/8/16. She revealed she had not completed the Resident Mood Interview with Resident #28 because she had been informed it was due after the Assessment Reference Date (ARD).

An interview was conducted with the Director of Nursing on 12/2/16 at 3:25 PM. She indicated her expectation was for the MDS to be fully completed.

2. Resident #106 was admitted to the facility 10/14/14. Cumulative diagnoses included: anxiety, major depressive disorder and dementia without behavioral disturbance.

A Quarterly Minimum Data Set (MDS) dated 9/16/16 was reviewed. Section C for cognitive patterns and Section D for mood was not comprehensively assessed for Resident #106. Question C0100 indicated "not assessed" . The brief interview for mental status C0200 through C0500 was not conducted and stated "not assessed" . Section C0600 for the staff assessment for cognitive patterns was not conducted and stated "not assessed" . Section C1300 for Delirium signs and symptoms also stated "not assessed" . C1600 acute onset mental status change indicated "not assessed/ no information" . D0100 for the resident mood interview indicated "not assessed" .

On 12/01/2016 at 10:37 AM, an interview was conducted with the social worker. She stated she was the person who completed sections C and D and those sections were documented as " not assessed " because it was past the ARD

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F 272	Continued From page 7 (assessment reference date) when she completed the assessment for Resident #106. She said she had been instructed by the MDS consultant that the information had to be documented on the MDS by the ARD date or that section had to be documented as " not assessed " . The social worker stated there had been a change in MDS personnel and the prior MDS person would leave her a note to remind her that an assessment was due for that day. She stated she was told about the assessment for Resident #106 late and sections C and D were completed on 9/20/16. On 12/01/2016 at 3:32 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be fully completed.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		12/29/16

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F 278	Continued From page 8 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the scheduled Minimum Data Set (MDS) assessment in the areas of urinary catheters (Resident #91), prognosis (Resident #91), medications (Resident #72 and Resident #130), pressures ulcers (Resident #143) and diagnoses (Resident #134 & #72) for 5 of 21 sampled residents reviewed for MDS accuracy. Findings included: 1a. Resident #91 was originally admitted on 10/13/11 and was readmitted on 7/15/16 with cumulative diagnoses of aspiration pneumonia, brain cancer, cerebral vascular accident and urinary retention. A review of the physician's orders indicated Resident #91 had a urinary catheter inserted on 7/17/16 for urinary retention. The significant change MDS dated 7/23/16 indicated Resident #91 was cognitively intact, no behaviors, and extensive to total assistance with her activities of daily living (ADLs). Resident #91 was coded as having a urinary catheter.	F 278	F278 1) On 12/12/16 resident # 91 quarterly assessment dated 10/25/2016 was modified to accurately code use of urinary catheter by the minimum data set (MDS) nurse. On 12/12/16 resident #91s significant change assessment dated 7/23/16 and quarterly assessment dated 10/25/16 were modified to accurately code resident with a life expectancy of less than 6 months by the MDS nurse. On 12/12/16 resident # 143 significant change assessment with date of 9/9/16 was modified to accurately code resident as being admitted with a pressure ulcer by the MDS nurse. On 12/12/16 resident #134 quarterly assessment dated 10/31/16 was modified to accurately code resident diagnosis of depression and anxiety by the MDS nurse. On 12/12/16 resident #72 significant change assessment dated 10/26/16 was modified to accurately code resident diagnosis of depression and anxiety by the MDS nurse. On 12/12/16 resident # 72 significant change in status assessment	

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F 278	Continued From page 9 A nursing note dated 8/12/16 indicated Resident #91 removed her indwelling urinary catheter and orders were given for the urinary catheter to remain out. The quarterly MDS dated 10/25/16 indicated Resident #91 had moderate cognitive impairment, no behaviors and extensive to total assistance with her ADLs. Resident #91 was coded as having a urinary catheter. In an interview on 11/30/16 at 4:50 PM, the MDS coordinator stated the quarterly MDS dated 10/25/16 should not have been coded for a urinary catheter for Resident #91 since the urinary catheter was discontinued on 8/12/1/6. The MDS Coordinator stated about five months ago, there had been some MDS staffing changes and the MDS assistant was still learning how to accurately complete MDS assessments. In an interview on 12/1/16 at 3:23 PM, the Director of Nursing stated it was her expectation that Resident #91 significant change MDS dated 7/23/16 and her quarterly MDS dated 10/25/16 be coded to accurately capture the care needs. b. Resident #91 was originally admitted on 10/13/11 and was readmitted on 7/15/16 with cumulative diagnoses of aspiration pneumonia, brain cancer, cerebral vascular accident and urinary retention. Resident #91 was readmitted 7/15/16 with orders for hospice services. A review of the medical record revealed a Certification of Terminal Illness signed by the physician on 7/28/16 certifying the Resident #91 had a life expectancy of 6 months or less.	F 278	dated 10/26/2016 was modified to accurately code resident had received a diuretic medication in the last 7 days of the assessment period by the MDS nurse. On 12/12/16 resident # 130 admission assessment dated 3/3/16 and quarterly assessment dated 9/16/16 were modified to accurately code resident had received a diuretic medication and an anticoagulant in the last 7 days of the assessment period by the MDS nurse On 12/12/16 the modified assessment was accepted by the National Repository. 2) On 12/21/16, the director of nursing (DON)/staff facilitator (SF) began auditing all in progress and export ready MDS assessments completed for accuracy of active diagnosis coding, urinary catheters, medications, life expectancy of less than 6 months, and pressure ulcers. The audit will be completed by 12/27/16. Four assessments have been corrected for accuracy of active diagnosis coding, urinary catheters, life expectancy of less than 6 months, pressure ulcers, and medications as necessary. All modified assessments should be received by the National Repository by 12/28/16. 3) On 12/19 the MDS coordinator and MDS nurse received an in-service by the MDS Corporate Consultant related to accurately coding the MDS assessment including the coding of diagnosis codes, medications, pressure ulcers, life expectancy of less than 6 months, and urinary catheters. 4) On 12/28/16 the DON, Staff Facilitator, and/or corporate consultant will begin auditing MDS assessments for correct	

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F 278

Continued From page 10

The significant change MDS dated 7/23/16 indicated Resident #91 was cognitively intact, no behaviors, and extensive to total assistance with her activities of daily living (ADLs). Resident #91 was coded for hospice services but not coded for a prognosis of less than 6 months to live.

A review of the medical record revealed a Certification of Terminal Illness signed by the physician on 10/10/16 certifying the Resident #91 had a life expectancy of 6 months or less.

The quarterly MDS dated 10/25/16 indicated Resident #91 had moderate cognitive impairment, no behaviors and extensive to total assistance with her ADLs. Resident #91 was coded for hospice services. But the MDS was not coded for a prognosis of less than 6 months to live.

In an interview on 11/30/16 at 4:50 PM, the MDS coordinator stated when Resident #91 was admitted to hospice services, the significant change MDS dated 7/23/16 should have indicated a prognosis of less than 6 months The MDS coordinator also stated the quarterly MDS dated 10/25/16 should have also been coded for less than 6 months to live prognosis since Resident #91 remained on hospice services. The MDS Coordinator stated about five months ago, there had been some MDS staffing changes and the MDS assistant was still learning how to accurately complete MDS assessments.

In an interview on 12/1/16 at 3:23 PM, the Director of Nursing stated it was her expectation that Resident #91 significant change MDS dated 7/23/16 and her quarterly MDS dated 10/25/16 be

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active diagnosis codes, pressure ulcers, medications, life expectancy of less than 6 months, and urinary catheters using the Accuracy Audit Tool. 25% of completed assessments will be audited weekly x 4 weeks, then 25% of completed assessment biweekly x 8 weeks, then 25% of completed assessments monthly x 3months.
5) The monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator) will review the results of the Accuracy Audit Tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly quality assurance (QA) committee for further recommendations and oversight. Plan was reviewed in QA Committee 12/14/16.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	**33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002**

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F 278	Continued From page 11 coded to accurately capture the care needs. 2. Resident # 143 was admitted to the facility on 6/28/16 with multiple diagnoses including Diabetes Mellitus. The significant change in status Minimum Data Set (MDS) assessment dated 9/9/16 indicated that Resident #143's cognition was intact and she had a stage IV pressure ulcer that was not present on admission. The admission nursing assessment dated 6/28/16 was reviewed. The assessment revealed that Resident #143 was admitted with an unstageable pressure ulcer on her left heel. On 12/1/16 at 10:40 AM, MDS Nurse #1 was interviewed. She stated that she was aware that Resident #143 was admitted with a pressure ulcer on her left heel but she missed to code the MDS assessment to indicate that the pressure ulcer was present on admission. On 12/1/16 at 3:24 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 3. Resident # 134 was admitted to the facility on 3/25/16 with multiple diagnoses including depression and anxiety state. The quarterly Minimum Data Set (MDS) assessment dated 10/31/16 indicated that Resident #134 had severe cognitive impairment and had received an antidepressant and antianxiety drugs. The assessment did not indicate that the resident had diagnoses of depression and anxiety. Review of the physician' orders for Resident #134 revealed that the resident was on Xanax and Buspar for anxiety and Lexapro for depression On 12/1/16 at 10:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse stated that she	F 278		

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missed to code the MDS assessment to indicate that Resident #134 had diagnoses of depression and anxiety.
On 12/1/16 at 3:24 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

4 a. Resident # 72 was admitted to the facility on 8/25/14 with multiple diagnoses including depression and anxiety. The significant change in status Minimum Data Set (MDS) assessment dated 10/26/16 indicated that the resident had severe cognitive impairment and had received antidepressant and antianxiety medications. The assessment did not indicate that the resident had diagnoses of depression and anxiety

Review of the physician' orders for Resident #72 revealed that the resident was on Ativan for anxiety and Paxil for depression
On 12/1/16 at 10:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse stated that she missed to code the MDS assessment to indicate that Resident #72 had diagnoses of depression and anxiety.
On 12/1/16 at 3:24 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

b. Resident # 72 was admitted to the facility on 8/25/14 with multiple diagnoses including hypertension. The significant change in status Minimum Data Set (MDS) assessment dated 10/26/16 indicated that the resident had severe cognitive impairment and had not received a

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diuretic medication.

Review of the physician' orders for Resident #72 revealed that the resident was on Lasix (a diuretic drug) for hypertension
On 12/1/16 at 10:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse stated that she missed to code the MDS assessment to indicate that Resident #72 had received a diuretic drug in the last 7 days of the assessment period.
On 12/1/16 at 3:24 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.
5 a. Resident #130 was admitted to the facility 2/25/16. Cumulative diagnoses included diabetes and cerebral infarction (type of stroke).

An Admission Minimum Data Set (MDS) dated 3/3/16 indicated Resident #130 was cognitively intact. Medications administered during the seven day look back period indicated Resident #130 received seven (7) days of injections and seven (7) days of insulin injections. No other medications were noted.

Physician orders were reviewed and revealed the following orders: Spironolactone (diuretic medication) 25 milligrams by mouth daily, HCTZ (hydrochlorothiazide-diuretic medication) 25 milligrams by mouth daily and Eliquis (anticoagulant medication) 5 milligrams by mouth twice a day.

The Medication Administration Record (MAR) for February 26th through March 3. 2016 (the seven day look back period) revealed Resident #130 received Eliquis 5 milligrams by mouth seven (7) days. Resident #130 also received

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Hydrochlorothiazide 25 milligrams and Spironolactone 25 milligrams by mouth seven (7) days.

On 12/01/2016 at 10:11AM, an interview was conducted with MDS Nurse #1 who stated she was aware that HCTZ and spironolactone were diuretic medications and Eliquis was an anticoagulant medication. She said she documented the medications administered during the look back period from the MAR's. MDS Nurse #1 reviewed the MAR's for the look back period of 2/26/16 through 3/3/16 and said she should have coded diuretic medications and anticoagulant medications for seven (7) days.

On 12/1/16 at 3:26 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.

b. Resident #130 was admitted to the facility 2/25/16. Cumulative diagnoses included diabetes and cerebral infarction.

A Quarterly MDS dated 9/14/16 indicated resident #130 was cognitively intact. Medications administered during the seven day look back period indicated Resident #130 received seven days of injections, insulin, antidepressant medication and antianxiety medication. Diuretic medication and anticoagulant medication was not indicated as having been received

A review of the MAR for the seven day look back period of September 7-14, 2016 revealed Resident #130 received Eliquis 5 milligrams by mouth seven (7) days. Resident #130 also received Hydrochlorothiazide 25 milligrams and

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F 278	Continued From page 15 Spironolactone 25 milligrams by mouth seven (7) days. On 12/01/2016 at 10:11AM, an interview was conducted with MDS Nurse #1 who stated she was aware that HCTZ and spironolactone were diuretic medications and Eliquis was an anticoagulant medication. She said she documented the medications administered during the look back period from the MAR's. MDS Nurse #1 reviewed the MAR's for the look back period of 9/7/16 through 9/14/16 and said she should have coded diuretic medications and anticoagulant medications for seven (7) days. On 12/1/16 at 3:26 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		12/29/16

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F 279	Continued From page 16 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan for the use of psychoactive medications and behaviors for one of five sampled residents reviewed for unnecessary medications (Resident #130). The findings included: 1 a. Resident #130 was admitted to the facility 2/25/16. Cumulative diagnoses included: diabetes and cerebral infarction (stroke). An Admission Minimum Data Set (MDS) dated 3/3/16 indicated Resident #130 was cognitively intact. Resident interview for mood indicated Resident #130 had mood indicators of feeling down, depressed, trouble falling asleep or staying asleep/ sleeping too much. No behaviors were noted. A physician's progress note dated 3/23/16 stated Resident #130 was seen at the request of nursing staff for increased depressed mood. A referral was ordered for psychiatric services to see Resident #130 for adjustment placement in the facility. A review of the medical record revealed a psychology evaluation dated 4/22/16. A primary diagnosis of obsessive compulsive disorder was noted at that time. A physician's order dated 4/28/16 indicated	F 279	F279 1)A Care Plan was developed 12/12/16 by the minimum data set (MDS) nurse for Resident # 130 for the use of psychoactive medications that addresses the use of antianxiety and antidepressant medications and for behaviors including resistive to care, yelling, resistive to care, cursing, and refusals. 2)A 100% review will be completed by the MDS coordinator on 12/22/16 for all residents who receive an antianxiety or antidepressant medication to ensure they have a care plan in place for the use of psychoactive medications. A 100% review will be completed by the MDS coordinator on 12/22/16 for all residents with behaviors to ensure they have the appropriate behavior care plan in place to include interventions. Four resident care plans have been corrected. 3)The MDS nurses will be in-serviced by the MDS corporate consultant on 12/22/16 to ensure that all residents receiving antianxiety or antidepressant medications are care planned for the use of psychoactive medications and that residents must have behaviors care planned appropriately with interventions. 4) The director of nursing (DON), assistant director of nursing (ADON), nurse supervisor, and/or corporate	

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F 279	Continued From page 17 Cymbalta (antidepressant medication) 60 milligrams by mouth daily. A psychology progress note dated 5/6/16 stated Resident #130 continued to accumulate items in her room as if she hoarded them bit there was not an opportunity to discuss the nature of her belongings. A physician's order dated 5/20/16 indicated Buspar (anti-anxiety medication) 7.5 milligrams by mouth twice daily for anxiety/ mood. A psychology note dated 6/2/16 stated Resident #130 was seen for follow up and psychiatric medication management. Resident #130 had increased behaviors, anxiety and depressed mood. Nursing staff had reported Resident #130 had episodes of yelling, hoarding and crying behaviors. She had refused to talk with the psychiatric nurse practitioner previously. Cymbalta (antidepressant medication) had been ordered 4/25/16 with continued anxious and irritable mood. She had refused care and medications at times. Current psychiatric medications included: Buspar (anti-anxiety medication) 5 milligrams by mouth twice a day (ordered 5/19/16) and Cymbalta 60 milligrams daily for depression/ anxiety. A psychiatric note dated 7/20/16 included the following diagnoses: anxiety, depression, hoarding behavior; Medications included: Buspar 7.5 milligrams twice a day (increased on 5/20/16) and Cymbalta 60 milligrams daily. A Quarterly MDS dated 9/14/16 indicated Resident #130 was cognitively intact. Mood indicators were noted as Resident #130 feeling	F 279	consultant will complete a 10% sample audit of the care plans for use of psychoactive medications and behaviors to ensure there is a care plan bi-monthly for three months beginning 12/28/16. 5)The administrator will review the completed audits with the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator)monthly for 6 months for follow up and recommendations or continuation as indicated. Plan reviewed in QA Committee meeting 12/14/16.	

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F 279	Continued From page 18 down and depressed. Behaviors during the assessment period were noted as other behavioral symptoms not directed towards others occurred 1-3 days. A review of the care plan for Resident #130 revealed an initial comprehensive care plan dated 3/14/16. The care plan for Resident #130 was last reviewed and revised on 9/19/16. There was not a care plan for the use of psychoactive medications. On 11/29/16 at 11:48AM, Resident #130 declined to be interviewed. On 12/01/2016 at 10:18 AM, an interview was conducted with MDS Nurse #1. She stated she always initiated a care plan for residents who received psychoactive medications. She reviewed the care plan for Resident #130 and stated she did not know why there was not a care plan that addressed the use of antianxiety and antidepressant medications. On 12/1/16 at 3:32 PM, an interview was conducted with the Director of Nursing. She stated she expected a care plan to be developed when a resident had psychoactive medications ordered. b. Resident #130 was admitted to the facility 2/25/16. Cumulative diagnoses included: diabetes and cerebral infarction (stroke). A nursing note dated 3/2/16 stated Resident #130 was difficult with med passes. She cried/ yelled and stated she couldn't talk to herself while the nurse talked to her and she had to look at things.	F 279		

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F 279	Continued From page 19 She also refused to rotate sites for blood sugar checks and insulin administration. An Admission Minimum Data Set (MDS) dated 3/3/16 indicated Resident #130 was cognitively intact. Resident interview for mood indicated Resident #130 had mood indicators of feeling down, depressed, trouble falling asleep or staying asleep/ sleeping too much. No behaviors were noted. A nursing note dated 3/5/16 stated Resident #130 refused staff assistance with ADL's (activates of daily living) and showers. She also refused to change wet clothing. A physician's progress note dated 3/23/16 stated Resident #130 was seen at the request of nursing staff for increased depressed mood. A referral was ordered for psychiatric services to see Resident #130 for adjustment placement in the facility. A nursing note dated 3/25/16 stated Resident #130 had been noted to yell and scream at staff members (office staff, therapy and CNA's (nursing assistants)). On 3/29/16 at 1:30PM, a nursing note stated Resident #130 refused Accucheck blood sugar check. Crying and yelling and stated it (blood sugar) was high because she had just finished breakfast. A nursing note dated 4/4/16 at 3:44 PM stated Resident #130 refused to let CNA give her a shower x 4. She finally let CNA give her a partial bath at the end of the shift. She was yelling, screaming, crying, swearing and slamming her	F 279		

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room door at intervals.

A nursing note dated 4/13/16 at 5:10PM stated Resident #130 was non-compliant with wound care and became upset and yelled at staff when they tried to explain the importance of being compliant with wound care, elevating her legs and dietary compliance.

A nursing note dated 4/17/16 at 9:00AM stated Resident #130 refused to have her heart rate and blood pressure taken. She refused to get washed or change clothes per CNA. Resident #130 was malodorous and had been in same clothes x 5 days.

A review of the medical record revealed a psychology evaluation dated 4/22/16. A primary diagnosis of obsessive compulsive disorder was noted at that time.

A physician's order dated 4/28/16 indicated Cymbalta (antidepressant medication) 60 milligrams by mouth daily.

A nursing note dated 4/30/16 at 12:48 PM indicated Resident #130 refused all morning meds except insulin, agitated, yelling that she just wanted to sleep.

A psychology progress note dated 5/6/16 stated Resident #130 continued to accumulate items in her room as if she hoarded them bit there was not an opportunity to discuss the nature of her belongings.

A physician's order dated 5/20/16 indicated Buspar (anti-anxiety medication) 7.5 milligrams by mouth twice daily for anxiety/ mood.

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A psychology note dated 6/2/16 stated Resident #130 was seen for follow up and psychiatric medication management. Resident #130 had increased behaviors, anxiety and depressed mood. Nursing staff had reported Resident #130 had episodes of yelling, hoarding and crying behaviors. She had refused to talk with the psychiatric nurse practitioner previously. Cymbalta (antidepressant medication) had been ordered 4/25/16 with continued anxious and irritable mood. She had refused care and medications at times. Current psychiatric medications included: Buspar (anti-anxiety medication) 5 milligrams by mouth twice a day (ordered 5/19/16) and Cymbalta 60 milligrams daily for depression/ anxiety.

A nursing note dated 6/19/16 stated Resident #130 hollered at staff, cussing staff at times, smelled of body odor and refused bath.

A psychiatric note dated 7/20/16 included the following diagnoses: anxiety, depression, hoarding behavior; Medications included: Buspar 7.5 milligrams twice a day (increased on 5/20/16) and Cymbalta 60 milligrams daily.

A nursing note dated 8/10/16 said Resident #130 refused weight this morning. She was yelling and screaming at staff.

A nursing note dated 9/9/16 stated the medication aide refused to take her medication. The medication aide reported that the resident snatched the medication cup, crushed pills in cup with her hand and hid the cup of pills under her blanket. She refused to give the medications back to the medication aide and then took the

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F 279	Continued From page 22 meds in the bathroom with her. A Quarterly MDS dated 9/14/16 indicated Resident #130 was cognitively intact. Mood indicators were noted as Resident #130 feeling down and depressed. Behaviors during the assessment period were noted as other behavioral symptoms not directed towards others occurred 1-3 days. A nursing note dated 11/8/16 at 7:30AM stated Resident 130 ' s behavior was out of control yelling and screaming at the nursing assistant. A review of the care plan for Resident #130 revealed an initial comprehensive care plan dated 3/14/16. The care plan for Resident #130 was last reviewed and revised on 9/19/16. There was not a care plan for behaviors until 11/29/16 when a care plan was developed for problematic behavior which was characterized by inappropriate behavior. Care related to resistive to treatment, care (refused to take baths, refused ADL (activity of daily living) care, skin treatments. Interventions dated 11/29/16 included, in part: allow for flexibility in ADL routine to accommodate resident's mood. Document care being resisted per facility protocol and notify physician of patterns of behavior. Discuss with resident implications of not complying with therapeutic regime. Inform resident of ADL that is required ahead of time and give two options of times to be done give resident choice and allow for flexibility in routines. If resident refuses care, leave resident and return in 5--10 minutes. Psychiatric consult as indicated. On 11/29/16 at 11:48AM, Resident #130 declined to be interviewed.	F 279		

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On 11/30/16 at 10:15AM, an interview was conducted with NA#1 who stated Resident #130 usually refused all care. She would just say she didn't want to. NA#1 said she offered many times but the answer was usually the same. She said Resident #130 refused to bathe, refused to change wet briefs and refused to change her clothes.

On 11/30/2016 at 12:21 PM, an interview was conducted with Nurse #3. She said Resident #130 was verbally abusive to the nursing assistants, would sometimes refuse her medications. She said the resident wanted them to leave the medications with her and nursing staff have continued to explain to her that they cannot leave the medications at bedside.

On 12/01/2016 at 10:18 AM, an interview was conducted with MDS Nurse #1. She stated she really thought Resident #130 had a care plan for behaviors. She stated there should have been a care plan in place for her behaviors of depression, anxiety and hoarding, resisting/ refusing care when Resident #130 first exhibited the behaviors. The care plan should have been in place prior to 11/29/16.

On 12/1/16 at 3:32 PM, an interview was conducted with the Director of Nursing. She stated she expected a care plan to be developed for behaviors at the time behaviors occurred.

F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		12/29/16

The resident has the right, unless adjudged incompetent or otherwise found to be

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F 280	Continued From page 24 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to review and revise plans of care in the areas of behaviors (Resident #49), psychotropic medications (Resident #12), and falls (Resident #31) for 3 of 8 sampled residents reviewed. The findings included: 1. Resident #49 was initially admitted to the facility on 3/23/12 and most recently readmitted on 5/7/13 with multiple diagnoses that included Alzheimer's, psychotic disorder with delusions, schizophrenia, and dementia. The annual Minimum Data Set (MDS) assessment dated 10/14/16 indicated Resident #49 had significant cognitive impairment. She	F 280	F280 1)Care Plan related to behaviors including suicidal ideations for resident # 49 was revised to including resolving the intervention of removal of call light and use of call bell on 12/12/16 by MDS Coordinaotr. Care plan related to use of psychotropic medications for resident #12 was revised to take use of antidepressant medication out of focus area on 12/12/16 by MDS Coordinator. Care plan related to falls for resident #31 was revised including updating interventions on 12/12/16 by MDS Coordinator. 2) A 100% audit was completed by the MDS Coordinator on 12/22/16 for all residents with a care plan in place for use	

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F 280	Continued From page 25 was indicated to have no behaviors during the 10/14/16 MDS review period. The comprehensive plan of care for Resident #49 included a focus area related to problematic behaviors and ineffective coping that was initiated on 10/16/15 and last revised on 10/24/16. The focus area read, in part, "Problematic behavior in which [Resident #49] acts characterized by ineffective coping; suicidal behavior related to: verbal threats." The interventions included the use of a cow bell and the removal of Resident #49's call light with cord. This intervention was initiated on 10/16/15 and had not been revised. An observation was conducted on 11/29/16 at 5:34 PM of Resident #49's room. Resident #49's call bell with an attached cord was located on her bed. Resident #49 was not present in her room at the time of observation. An observation was conducted on 11/30/16 at 7:55 AM of Resident #49 in her bed in her room. The call bell with an attached cord was located on her bed within her reach. An interview was conducted on 11/30/16 at 7:57 AM with Nurse #4. Nurse #4 reported she was familiar with Resident #49 as she was a long term resident at the facility. She indicated Resident #49 used her call light infrequently. She reported that in the past, Resident #49 had made passive suicidal statements such as, "I just wish I were dead". Nurse #4 indicated when Resident #49 made suicidal statements her call light with cord was removed from her room and was replaced with a cow bell. She revealed this was a temporary intervention for Resident #49's safety. Nurse #4 indicated Resident #49 was currently at	F 280	of psychotropic medications to ensure antidepressant medication were not inaccurately included in the care plan. A 100% audit was completed by the MDS Coordinator on 12/22/16 for all residents with suicidal ideations to ensure they have the appropriate revision to their behavior care plan in place to include interventions. A 100% audit was completed on 12/22/16 by the MDS Coordinator for all residents with falls in the past 30 days to ensure their care plans have been revised including interventions as appropriate. 3)The MDS nurses were in-serviced by the MDS Corporate Consultant on 12/19/16 related to the accurate revision of care plans including falls, behaviors, and use of psychotropic medications. 4)The DON or licensed nurse designee will complete a 10% sample audit of the Care Plans for use of psychoactive medications, falls, and behaviors to ensure there is a Care Plan bi-monthly for three months. 5)The Administrator will review the completed audits with the completed audits will review the completed audits with the QI Committee monthly for 6 months for follow up and recommendations or continuation as indicated. Survey reviewed in QI Committee meeting 12/14/16.	

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her baseline and the call light with cord was permitted in her room.

An interview was conducted on 11/30/16 at 4:05 PM with the Director of Nursing (DON). She indicated she expected plans of care to be accurate and revised as needed. The plan of care related to suicidal behaviors for Resident #49 that indicated the intervention of the removal of call light with cord was reviewed with the DON. The DON revealed this intervention should have been revised as it was a temporary intervention. She indicated Resident #49's call light with cord had been returned to her room.

An interview was conducted on 11/30/16 at 4:45 PM with MDS Nurse #1. She reported she and MDS Nurse #2 were responsible for revising plans of care. She explained that MDS Nurse #2 was new to the position as she began working as an MDS Nurse about 5 months ago. MDS Nurse #1 revealed there had been some mistakes made as MDS Nurse #2 was learning the MDS and care plan processes.

2. Resident #12 was initially admitted to the facility on 5/29/09 and most recently readmitted on 1/15/16 with diagnoses that included anxiety, depression, psychotic disorder, schizophrenia, mood disorder and impulse disorder.

The annual MDS dated 9/28/16 indicated his cognition was significantly impaired. Resident #12 was indicated to have been administered antipsychotic medication and antianxiety medication on 7 of 7 days during the MDS review period.

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F 280	Continued From page 27 The comprehensive plan of care for Resident #12 included a focus area related to psychotropic medications that was initiated on 9/30/10 and most recently revised on 11/4/16. The focus area read, in part, " Continues on antipsychotic, antidepressant, and antianxiety [medications]. " A psychiatric consultation note dated 10/19/16 indicated Resident #49 was ordered antipsychotic medication and antianxiety medication. Resident #12 was not ordered antidepressant medication. A review of Resident #12's November 2016 physician's orders and Medication Administration Record (MAR) revealed Resident #12 had not been ordered an antidepressant medication and had not been administered an antidepressant medication. An interview was conducted on 11/30/16 at 4:05 PM with the Director of Nursing (DON). She indicated she expected plans of care to be accurate and revised as needed. An interview was conducted on 11/30/16 at 4:45 PM with MDS Nurse #1. She reported she and MDS Nurse #2 were responsible for revising plans of care. She explained that MDS Nurse #2 was new to the position as she began working as an MDS Nurse about 5 months ago. MDS Nurse #1 revealed there had been some mistakes made as MDS Nurse #2 was learning the MDS and care plan processes. An interview was conducted with MDS Nurse #2 on 12/1/16 at 1:00 PM. The plan of care for Resident #12 related to psychotropic medications that indicated he received antidepressant medication was reviewed with MDS Nurse #2.	F 280		

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The physician's orders and the MARs for Resident #12 that indicated he was not ordered or administered an antidepressant medication were reviewed with MDS Nurse #2. She indicated she had revised this plan of care for Resident #12 on 11/4/16 to indicate he received antipsychotic medication, antianxiety medication, and antidepressant medication. She reported this was an error and the plan of care needed to be revised as Resident #12 had not been ordered or administered antidepressant medication.
3. Resident #31 was admitted to the facility on 2/27/14. Cumulative diagnoses included, in part, dementia without behavioral disturbance, Alzheimer's disease and chronic pain

A Quarterly Minimum Data Set (MDS) dated 10/12/16 indicated Resident #31 was severely impaired in cognition. He required supervision with transfers and ambulation in the room and corridor. Balance was noted as not steady but able to stabilize without staff assistance. No impairment in functional range of motion was indicated.

Medical record review revealed a nursing note dated 11/12/16 at 3:35 AM when Resident #31 was found sitting on the floor beside his roommate's bed. He had an abrasion to the right knee and a skin tear to the left wrist. Resident #31 stated he slid out of chair. He denied hitting his head but there was a raided bruise on the left side of his forehead. Neurological checks were within normal limits. Vital signs were: temperature 97.9, pulse-64, respirations-18 and blood pressure 126/74.

A Quality Improvement (QI) falls review note dated 11/14/16 stated Resident #31 had an

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unobserved fall on 11/12/16 on 3rd shift. A referral was filled out for physical therapy and occupational therapy.

A nursing note dated 11/19/16 at 1:51 AM stated at 11:30 PM, Resident #31 was noted on the floor between the beds with blood on the floor. He was holding his forehead with both hands and blood was noted on his tee-shirt. Resident #31 said he did not know what happened or if he hit his head. Vital signs were temperature-97.9 pulse -66, respirations-18 and blood pressure 116/72. The laceration on his forehead was cleaned and a dressing was applied.

A QI falls review note dated 11/21/16 stated Resident #31 had an unobserved fall on 11/19/16 on 3rd shift with laceration to forehead. Physical therapy to evaluate.

A care plan dated 3/12/14 and last revised on 11/30/16 indicated Resident #31 was at risk for falls. The last revision dated 11/30/16 noted a fall of 11/12 when Resident #31 was found sitting on the floor with an abrasion to his right knee, skin tear to his left wrist and a bruise to the left side of his forehead. On 11/16. Found on floor between the beds. No injuries noted. Interventions included: assist during transfer and mobility. Assist resident to negotiate barriers as necessary. Resident to wear proper and nonslip footwear. Bed in lowest position (not on floor). Rehab therapy referral. Ensure environment free of clutter. Monitor and intervene for factors causing falls. Monitor routinely for needs. All of the interventions were dated 3/12/14 with no revisions or changes to the care plan noted since Resident #31's fall on 11/12/16.

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F 280	Continued From page 30 On 12/01/2016 at 10:04 AM, an interview was conducted with MDS Nurse #1. She stated Resident #31 received restorative nursing for ambulation until `0.14.16 when he was discharged from the program. She said he was ambulating independently and safe with ambulation at that time. MDS Nurse #1 said she updated the problem of falls on 11/30/16 but failed to update the interventions when she reviewed the care plan on 11/30/16. On 12/1/16 at 3:30 PM, an interview was conducted with the Director of Nursing. She stated they had a meeting every morning to discuss falls/ incidents. The Director of Nursing stated the MDS Coordinator was in those meetings so she could revise the care plans as needed. She said she expected interventions that were discussed during those meetings regarding falls to be included in the care plan within 24 hours.	F 280		
F 281 SS=E	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 record review and staff interview, the facility failed to follow doctor's order for four months for 1 (Resident #134) of 5 sampled residents reviewed for unnecessary drugs. Finding s included: Resident # 134 was admitted to the facility on 3/25/16 with multiple diagnoses including	F 281	F281 1) Omission of medication was reported to the prescribing practitioner by the nursing supervisor on 12/1/16. Order was discontinued 12/1/16 as a dose reduction per the nurse practitioner (NP). Nurse was counseled regarding the omission by the Director of Nursing. 12/16/16	12/29/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 31 dementia with behaviors and psychosis. The quarterly Minimum Data Set (MDS) assessment dated 10/31/16 indicated that Resident #134 had severe cognitive impairment and had received an antipsychotic drug. The assessment also indicated that the resident had behaviors. The physician's orders for Resident #134 were reviewed. The orders included Risperdal (antipsychotic drug) 0.5 milligrams (mgs) at 2 PM and 1 mg. twice a day for psychosis which was started on 5/4/16. On 7/13/16, there was an order to change the Risperdal to 0.5 mgs in AM and at 2 PM and 1 mg. at bedtime. The Medication Administration Records (MARs) were reviewed. The MARs indicated that Resident #134 had received Risperdal 0.5 mgs at 2 PM and 1 mg at bedtime from 7/13/16 to 11/30/16. The nurse's notes were reviewed. The notes revealed that Resident #134 continued to have behaviors of yelling out loud and refused medications. On 11/30/16 at 4:05 PM, the Director of Nursing (DON) was interviewed. The DON stated Nurse #5 was the nurse who transcribed the order for Risperdal to the MAR. She indicated that Nurse #5 failed to transcribe the order correctly to the MAR. Risperdal 0.5 mgs was ordered to be given twice a day in AM and at 2 PM and she transcribed it once a day at 2 PM instead. The DON further stated that she expected the doctor's order to be transcribed correctly and be followed.	F 281	2) All residents with psychoactive medication orders were reviewed by the director of nursing (DON) to ensure that orders had been carried out properly and any corrections needed were made 12/19/16. No other issues were found. 3) All nursing staff including weekend and PRN staff were in-serviced by the DON on transcription of medical orders beginning 12/15/16 to be completed by 12/29/16. Triple check process put into place when orders are received including new order form completed when order received and reviewed by transcribing nurse, from and order then reviewed by another licensed nurse, and lastly reviewed by a third shift nurse. Order also sent to pharmacy for review. Medication administration records (MAR) are reviewed monthly thereafter with orders being reviewed by two different nurses and a final check by a third shift nurse beginning 12/29/16. 4) The DON, assistant director of nursing (ADON), nurse supervisor, and/or corporate consultant will conduct a 20% random audit of new orders weekly x 6 weeks, followed by a 10% audit x 6 weeks. Initiated by 12/29/16. 5) The administrator or DON will report the audit results in the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator) meeting. Survey reviewed in QA Committee meeting 12/14/16.	

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F 281	Continued From page 32 On 11/30/16 at 4:39 PM, Nurse #5 was interviewed. She acknowledged that she was the one who transcribed the order for Risperdal. Nurse #5 stated that she missed to transcribe the Risperdal to twice a day as ordered on the MAR.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow the care plan for accident (Resident # 72), restorative nursing (Resident #143), nutrition (Resident #28) and behaviors (Resident #49) for 4 of 9 sampled resident reviewed. Findings included: 1. Resident #72 was admitted to the facility on 8/25/14 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 10/26/16 indicated that Resident #72 had severe cognitive impairment and had falls. The incident reports and nurse's notes for the last 3 months were reviewed. Resident #72 had falls on the 9/11/16 at 6:41 AM, 9/24/16 at 5:41 PM, 10/6/16 at 7:19 AM, 11/1/16 at 12:37 PM, 11/3/16 at 7:00 PM, 11/16/16 at 7:46 AM and on 11/21/16 at 10:02 AM.	F 282	F282 1) On 12/14/16 Resident #72s care plan for accidents and care guide were reviewed and updated by the Minimum Data Set Nurse (MDS) to be accurate and up to date. The resident care plan includes risk for falls focus with personal alarm to the chair as an intervention. On 12/14/16 resident #143s restorative nursing care plan was reviewed and updated by the MDS nurse to include the restorative nursing care plan interventions. On 12/16/16 Resident #28s nutrition care plan was reviewed by the dietary manager and updated by the MDS nurse to include nutritional interventions. On 12/14/16 Resident #49s behaviors care plan was reviewed and updated by the MDS nurse to include suicidal behavior and appropriate interventions. 2) On 12/20/16, the MDS nurse reviewed 100% of the care plans and care guides	12/29/16

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F 282	Continued From page 33 The care plan for Resident #72 was reviewed. One of the care plan problems dated 11/17/16 was at risk for falls characterized by history of falls related to impaired cognition. The goal was for the resident to have no fall related injury. The approaches included to assist the resident during transfer and mobility as needed, and rehabilitation therapy referral as ordered. On 11/29/16, a personal alarm (wireless) to the chair was added to the approaches. Resident #72 was observed on 11/29/16 at 4:35 PM and on 11/30/16 at 9:20 AM, 11:25 AM, 11:55 AM and 4:20 PM. The resident was up in wheelchair with no wireless chair alarm observed. The resident was observed standing up on several occasions. On 11/30/16 at 4:22 PM, the two nurse's aides (NA #3 & NA #5) assigned on the hall where Resident #72 resided were interviewed. The two NAs stated that they have not seen Resident #72 having a chair alarm for a long time. On 11/30/16 at 4:22 PM, Nurse #1 assigned to Resident #72 was interviewed. She stated that she had not seen Resident #72 having a chair alarm for a long time. On 12/1/16 at 3:34 PM, the Director of Nursing (DON) was interviewed. The DON stated the incident reports were reviewed during the QI meeting every day. The action to prevent further falls was decided during the meeting. The DON indicated that the wireless alarm was decided after the 11/21/16 fall. She expected the action to be entered in the care plan and be followed within 24 hours after the meeting.	F 282	for all residents identified through the MDS process with suicidal behaviors, fall risk, and restorative nursing ensuring resident care plans and care guides are up to date including appropriate interventions. On 12/22/16 the dietary manager reviewed 100% of the care plans related to nutrition ensuring resident care plans and care guides are up to date including appropriate interventions. Corrections were made immediately to ensure that care plans and guides are accurate. 3) Beginning on 12/15/16, the director of nursing (DON) and staff facilitator (SF) in-serviced all nurses and nursing assistants including weekend and PRN staff related to following resident care plans to ensure each resident is provided quality care and safety is maintained . In-service will be completed by 12/29/16. During orientation of new employees nurses and nursing assistants will continue to be in-serviced on the importance of following a resident's care plan and care guide and locations of each form. 4)The administrative nurses, DON, SF, and/or MDS nurse will begin 12/23/16 utilizing the audit tool Following Resident Care Plans to ensure care plans are being followed to include interventions required to assist with management of residents identified with behaviors, restorative services, fall risk interventions, and nutritional interventions. Random audit of care plans throughout the entire facility will be conducted by the DON, assistant director of nursing, staff facilitator, nurse	

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F 282	Continued From page 34 2. Resident # 143 was admitted to the facility on 6/28/16 with multiple diagnoses including cerebral infarction. The significant change in status Minimum Data Set (MDS) assessment dated 9/9/16 indicated that Resident #143's cognition was intact and she had limitation in range of motion on one side of both upper and lower extremities. Resident #143's care plan dated 9/27/16 was reviewed. One of the problems was resident was at risk for limitation in range of motion on both upper extremities. The goal was to maintain mobility, function/strength/flexibility to upper extremity with no complain of pain. The approaches included restorative nursing program. The restorative nursing evaluation and treatment plan for Resident #143 dated 9/27/16 was reviewed. The restorative nursing goal was to prevent worsening of LUE contracture, mange LUE splint and maintain RUE strength and functional use. The treatment plan was to apply the left hand splint for 3 hours 6-7 times per week, and to monitor the skin integrity under the splint/brace daily. If the resident did not participate in splint/brace program, document reason. On 11/30/16 at 9:45 AM, 12:25 PM and 5:30 PM, and on 12/1/16 at 9:05 AM, Resident #143 was observed. The resident was not wearing a splint on her LUE. The daily restorative nursing program documentation forms for November 2016 were reviewed. The forms revealed that Resident #143 did not receive restorative on 11/3, 11/5, 11/6, 11/7, 11/8, 11/9, 11/12, 11/13, 11/17, 11/18, 11/21, 11/22, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/29 and 11/30.	F 282	supervisor, and/or corporate consultant of 10% of residents bimonthly x 3 months and reviewed by the DON. 5)The DON or SF will review the audit results at the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator)for any trends, actions taken and determine the need for and /or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendation to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. Survey was reviewed with the QA committee on 12/14/16.	

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On 11/30/16 at 5:10 PM, MDS Nurse #1 was interviewed. The MDS Nurse stated that she was in charge of the restorative nursing program. She indicated that the restorative aide had been sick since Monday (11/28). She indicated that the Staffing Coordinator had assigned a backup nurse aide to do restorative in case the restorative aide was out. The MDS Nurse further indicated that she was not aware that there was no backup NA assigned to do restorative. She added that this had been a concern that was brought to the attention of the DON and administrator.
On 12/1/16 at 3:00 PM, the Staffing Coordinator was interviewed. She indicated that the staffing was so low, that the nurse aides could not help restorative because they were needed to work on the floor.

On 12/1/16 at 3:27 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the care plan for restorative nursing program to be followed.

3. Resident #28 was admitted to the facility on 10/11/6 with multiple diagnoses that included cancer, cardiovascular disease and dementia.

The admission MDS dated 10/18/16 indicated Resident #28 had significant cognitive impairment. Her weight was assessed as 128 pounds. Resident #28's Care Area Assessment (CAA) for nutrition indicated she was at risk for weight loss and altered nutritional status related to her cognitive impairment. The plan included monitoring and recording Resident 28's meal intake percentages. The goal was for Resident #28 to increase oral intake and stabilize her weight to 123 to 133 pounds through the next

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review.

The comprehensive plan of care for Resident #28 included the focus area of nutrition. Resident #28 was indicated to have had weight loss, inadequate intake, and decreased appetite. The interventions included the monitoring and recording of Resident #28's percentage of meal intake. This plan of care was initiated on 10/20/16 and had not been revised.

Resident #28's recorded percentages of meal intake from 10/12/16 through 11/29/16 (49 total days) was reviewed. Resident #28's percentage of meal intake was recorded on 98 out of 147 meals. There were 49 meals throughout the 49 day timeframe that Resident #28's percentage of meal intake was not recorded.

An interview was conducted with Director of Nursing (DON) on 11/30/16 at 4:05 PM. She indicated her expectation was for the plan of care to be followed. The plan of care related to nutrition for Resident #28 that indicated her percentage of meal intake was to be monitored and recorded was reviewed with the DON. The recorded percentages of meal intake for Resident #28 from 10/12/16 through 11/29/16 were reviewed with the DON. She stated her expectation was for the percentage of meal intake to be monitored and recorded for every meal. She revealed the monitoring and recording of Resident #28's percentage of meal intake was not completed consistently.

4. Resident #49 was initially admitted to the facility on 3/23/12 and most recently readmitted

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on 5/7/13 with multiple diagnoses that included Alzheimer's, psychotic disorder with delusions, schizophrenia, and dementia.

The annual Minimum Data Set (MDS) assessment dated 10/14/16 indicated Resident #49 had significant cognitive impairment. She was indicated to have no behaviors during the 10/14/16 MDS review period.

The comprehensive plan of care for Resident #49 included a focus area related to problematic behaviors and ineffective coping that was initiated on 10/16/15 and last revised on 10/24/16. The focus area read, in part, "Problematic behavior in which [Resident #49] acts characterized by ineffective coping; suicidal behavior related to: verbal threats" The interventions included the documentation of 15 minute checks for [Resident #49's] safety. This intervention was initiated on 10/16/15 and had not been revised.

A review of Resident #49's medical record revealed no documentation of 15 minute checks from January 2016 through June 2016. Resident #49's July 2016 Medication Administration Record (MAR) had 15 minute checks documented for all three shifts (7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM) as per the plan of care. Resident #49's August 2016 MAR had no documentation of 15 minutes checks from 8/1/16 through 8/15/16 as well as on 8/17/16. Resident #49's August 2016 MAR had 15 minute checks documented on the first shift only (7:00 AM to 3:00 PM) on 8/16/16 and 8/18/16 through 8/31/16. Resident #49's September 2016, October 2016, and November 2016 MARs had 15 minute checks documented for all three shifts as per the plan of care.

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F 282	Continued From page 38 An interview was conducted on 11/30/16 at 7:57 AM with Nurse #4. Nurse #4 reported she was familiar with Resident #49 as she was a long term resident at the facility. She indicated Resident #49 used her call light infrequently. She reported that in the past, Resident #49 had made passive suicidal statements such as, "I just wish I were dead". Nurse #4 indicated when Resident #49 made suicidal statements an intervention was implemented for 15 minute checks to be completed be by nursing staff. She reported the nurse on duty had to observe Resident #49 at least once every 15 minutes and then document the observation on the MAR. Nurse #4 reported this intervention was currently in place. She indicated the 15 minute checks were to continue until Resident #49 had been assessed as at her baseline with no safety concerns. Nurse #4 indicated she was not sure when the 15 minute checks were implemented. An interview was conducted on 11/30/16 at 4:05 PM with the Director of Nursing (DON). She indicated she expected plans of care to be accurate, followed, and revised as needed. The plan of care related to suicidal behaviors for Resident #49 that indicated the intervention for 15 minute checks with documentation for Resident #49. The MARs from January 2016 through August 2016 for Resident #49 that revealed incomplete documentation of 15 minute checks as indicated in the plan of care was reviewed with the DON. The MARs from September 2016 through November 2016 for Resident #49 that had 15 minute checks documented as indicated in the plan of care was reviewed with the DON. The DON stated if the intervention was in the plan of care she expected it to be followed. She was	F 282		

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F 282	Continued From page 39 unable to explain why the intervention had not been followed as per the care plan for a period of 7 months (January 2016, February 2016, March 2016, April 2016, May 2016, June 2016, and August 2016). An interview was conducted on 11/30/16 at 4:45 PM with MDS Nurse #1. She reported she and MDS Nurse #2 were responsible for revising plans of care. She explained that MDS Nurse #2 was new to the position as she began working as an MDS Nurse about 5 months ago. MDS Nurse #1 revealed there had been some mistakes made as MDS Nurse #2 was learning the MDS and care plan processes.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, the facility failed to provide showers as scheduled for one of three sampled residents reviewed for ADL's (activities of daily living) and who was totally dependent on staff for bathing (Resident #102). The findings included: Resident #102 was readmitted to the facility on 12/11/15. Cumulative diagnoses included, in part, dementia, anxiety, tremors, and lack of coordination.	F 312	F312 1) A shower was provided to Resident #102 by a nursing assistant (NA) at the time of the Resident's choice. Resident #102's shower schedule was changed to reflect resident choices on 12/12/16 by the director of nursing (DON). 2) The shower schedule for all residents was reviewed by the DON to ensure resident preferences were reflected and showers offered and documented by the	12/29/16

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F 312	Continued From page 40 An Annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #102 was moderately impaired in cognition. No behaviors or rejection of care was noted during the assessment period. Resident interview for preferences indicated it was very important for Resident #102 to choose between a tub bath, shower, bed bath or sponge bath. Resident #102 was totally dependent on staff for bathing. The Care Area Assessment (CAA) for ADL's indicated total dependence in bathing and would address in care plan. A care plan dated 2/2/15 and last revised on 11/29/16 indicated Resident #102 required assistance to maintain maximum function of self-sufficiency for bathing. Interventions: one person, total dependence. On 11/29/16 at 10:32 AM, an interview was conducted with Resident #102. Resident #102 stated she wanted a shower at least once a week and did not receive a shower even once a week. Nursing notes were reviewed for the past three months and revealed no nursing notes that documented refusal of care, resisting care or refusal of showers. A review of the shower schedule revealed Resident #102 should receive a shower twice a week on Wednesday and Saturday evenings. Documentation of bathing completed by the nursing assistants for October and November 2016 were reviewed. On 10/22/16 and 11/9/16, it was documented that Resident #102 refused her	F 312	NA's according to the schedule 12/15/16. Any preferences noted were changed immediately by the DON. 3) All nursing staff including weekend and PRN staff were in-serviced by the DON and/or staff facilitator (SF) beginning on 12/15/16 regarding the importance of following the shower schedule and documenting any reason why a resident chose not to have a shower. NAs will document the showers on the shower schedule daily and the hall nurse on each shift will sign off on the documentation beginning 12/15/16. In-service will be completed by 12/29/16. 4) The assistant director of nursing (ADON), DON, SF, and or corporate consultant will conduct a random 20% audit of shower schedules weekly x6 weeks to ensure that residents are receiving showers as scheduled. A weekly 10% audit x 6 weeks will follow. Audits initiated 12/26/16. 5) The DON or SF will report the audit results to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, social worker, dietary manager, environmental services manager, maintenance director, admissions coordinator). The administrator or DON will report the audit results and any recommendation of the QI committee to the quarterly quality assurance (QA) Committee for further comments and recommendations. QA meeting was held 12/14/16.	

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F 312	Continued From page 41 shower. There was no documentation that Resident #102 received a shower for the months of October and November 2016. A review of the bathing record revealed no documentation for the following days: 10/5, 10/8, 10/19, 10/29, 11/2, 11/5, 11/12, 11/16, 11/23 and 11/30/16. On the following bath days, it was documented that response not required or not scheduled: 10/1, 10/12, 10/15, 10/22, 10/26, 11/19 and 11/26/16. On 12/01/2016 at 10:58 AM, an interview was conducted with Nurse #2. She stated Resident #102 was very selective over who provided care. She said Resident #102 had refused showers in the past because she said it was too cold or she did not want certain staff to give her a shower. Nurse #2 stated , based on her mood, Resident #102 would allow staff to give her a bed bath if she refused the shower. On 12/1/16 at 1:20 PM, an interview was conducted with NA#4. He stated he provided care for Resident #102 when they were "short" and there were only three nursing assistants on evenings and Resident #102 would be on his assignment at that time. He said Resident #102 was on his assignment on some shower days in November. Resident #102 refused to take a shower because he was a man and he did not ask anyone else to provide the shower. On 12/1/16 at 1:40 PM, an interview was conducted with NA #2 who stated she left early on 11/30/16 and did not give Resident #102 her shower on that day. She stated she was going to give Resident #102 her shower before supper but therapy staff wanted Resident #102 to lie down and rest for a while. She stated she told the charge nurse when she left that Resident #102	F 312		

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F 312	Continued From page 42 had not received her shower. On 12/01/2016 at 1:49 PM, an interview was conducted with NA#3. She stated she had worked at the facility about two months. NA #3 stated she usually provided care for Resident #102 at least once a week. NA#3 stated Resident #102 received a shower on Wednesday 11/23/16. She stated Resident #102 usually refused her showers and NA #3 did not offer to give her a bed bath when she refused her showers. She stated she would not inform the charge nurse that Resident #102 refused a shower and would just document the shower as refused. On 12/01/2016 at 3:35PM, an interview was conducted with the Director of Nursing. She stated she expected nursing staff to offer and give a full bed bath if Resident #102 refused a shower. She stated the nursing assistant should report the refusal of the shower to the licensed nurse on the hall so that nurse could talk with Resident #102 and encouraged her to take a shower. The Director of Nursing stated her expectation was for Resident #102 to get a shower or bed bath as scheduled. She stated she would talk with Resident #102 and switch her shower days to day shift if that was what Resident #102 wanted.	F 312		
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	F 318		12/29/16

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decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff and resident interview, the facility failed to provide the restorative nursing program consistently as care planned and as recommended by the therapist for 1 (Resident #143) of 2 sampled residents reviewed. Findings included:

Resident # 143 was admitted to the facility on 6/28/16 with multiple diagnoses including cerebral infarction. The significant change in status Minimum Data Set (MDS) assessment dated 9/9/16 indicated that Resident #143's cognition was intact and she had limitation in range of motion on one side of both upper and lower extremities. The assessment further indicated that the resident had received occupational therapy during the assessment period.
The therapy notes for Resident #143 were reviewed. The notes revealed that occupational therapist (OT) was treating the resident for left upper extremity (LUE) contracture management program and right upper extremity (RUE) strengthening program. The OT treatment started on 8/1/16 and ended on 9/15/15. On 9/15/16, Resident #143 was referred to restorative nursing program for LUE passive range of motion exercises and contracture management and RUE strengthening.
The restorative nursing referral form was reviewed. The form was signed by the OT on 9/7/16 and by the restorative aide on 9/8/16. The goal of the restorative nursing program was for LUE contracture management and RUE

F 318

F318
1) On 12/2/16, the Restorative nursing committee (restorative registered nurse (RN), therapy director, director of nursing (DON), restorative nursing assistant (NA), and administrator) reviewed the restorative nursing care plan. Since 12/2/16, Resident #143 has received care according to the updated restorative nursing care plan.

2) On 12/9/16, the Restorative Nursing Committee (restorative registered nurse (RN), therapy director, director of nursing (DON), restorative nursing assistant (NA), and administrator) completed a 100% audit of all restorative nursing care plans to ensure all residents with restorative care plans have been provided restorative program services.

3) Beginning 12/15/16, the restorative RN will complete a weekly review of all residents on a restorative nursing care plan to ensure that residents are receiving restorative care according to their care plan. A weekly Restorative Committee meeting will be held to review care plans and to ensure that care plans are being followed beginning 12/15/16.

4) The Restorative Nurse, DON, ADON, nurse supervisor, Staff facilitator, and/or

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strengthening.
Resident #143's care plan dated 9/27/16 was reviewed. One of the problems was resident was at risk for limitation in range of motion on both upper extremities. The goal was to maintain mobility, function/strength/flexibility to upper extremity with no complain of pain. The approaches included restorative nursing program.
The restorative nursing evaluation and treatment plan for Resident #143 dated 9/27/16 was reviewed. The restorative nursing goal was to prevent worsening of LUE contracture, mange LUE splint and maintain RUE strength and functional use. The treatment plan was to apply the left hand splint for 3 hours 6-7 times per week, and to monitor the skin integrity under the splint/brace daily. If the resident did not participate in splint/brace program, document reason.
On 11/30/16 at 9:45 AM, 12:25 PM and 5:30 PM, and on 12/1/16 at 9:05 AM, Resident #143 was observed. The resident was not wearing a splint on her LUE.
The daily restorative nursing program documentation forms for November 2016 were reviewed. The forms revealed that Resident #143 did not receive restorative on 11/3, 11/5, 11/6, 11/7, 11/8, 11/9, 11/12, 11/13, 11/17, 11/18, 11/21, 11/22, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/29 and 11/30.
On 11/30/16 at 3:50 PM, the Staffing Coordinator was interviewed. She stated that the facility had one full time restorative aide. The restorative aide had been sick and was not working since Monday (11/28). She had nurse's aides who were trained to do restorative nursing in case the restorative aide was out. She revealed that she had no extra aide to cover restorative all the time

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corporate consultant will conduct a weekly 100% audit of all residents receiving restorative care using the Audit for Following Care Plan Tool x 6 weeks to ensure that care is being given according to the care plan. This audit will be followed by a 50 % weekly audit x 6 weeks. Audit initiated 12/26/16.

5) The DON or restorative RN will present the results of the audits to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, SW, admissions coordinator, dietary manager, environmental services manager, maintenance director) for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.

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F 318	Continued From page 45 and she had not assigned an aide to do restorative this week. On 11/30/16 at 5:10 PM, MDS Nurse #1 was interviewed. The MDS Nurse stated that she was in charge of the restorative nursing program. She indicated that the restorative aide had been sick since Monday (11/28). She indicated that the Staffing Coordinator had assigned a backup nurse aide to do restorative in case the restorative aide was out. The MDS Nurse further indicated that she was not aware that there was no backup NA assigned to do restorative. She added that this had been a concern that was brought to the attention of the DON and administrator. On 12/1/16 at 9:05 AM, Resident #143 was interviewed. She stated that nobody had provided exercises or had applied the splint to her extremities. She could not remember the last time she had the splint on. On 12/1/16 at 3:00 PM, the Staffing Coordinator was interviewed. She indicated that the staffing was so low, that the nurse aides could not help restorative because they were needed to work on the floor. The weekly schedule was reviewed. There was no restorative aide assigned from November 27-December 1, 2016. The full time restorative aide was assigned from 11/28-11/30 but she was out sick and nobody was listed to replace her. On 12/1/16 at 3:27 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the care plan for restorative nursing program to be followed consistently.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		12/29/16

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F 323	Continued From page 46 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: Based on record review, observation and staff interview, the facility failed to have intervention to prevent repeated falls and failed to implement the intervention as care planned for falls for 1 (Resident #72) of 2 sampled residents reviewed for accidents. Findings included: Resident #72 was admitted to the facility on 8/25/14 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 10/26/16 indicated that Resident #72 had severe cognitive impairment and had falls. The assessment also indicated that the resident needed extensive assist with transfer and ambulation. The incident reports and nurse's notes for the last 3 months were reviewed. Resident #72 had falls on the following dates and time: 9/11/16 at 6:41 AM, the resident was found on the floor near the bathroom door facing toward her bed. There were multiple old bruises noted to her right lower leg. The action taken to prevent further falls were for the staff to toilet resident frequently and to redirect from room and at the nursing station for monitoring.	F 323	F323 1. The Wireless alarm was placed in the chair by the assistant director of nursing (ADON) and anti- rollback devices were added to the chair as indicated in the interventions by the maintenance staff for the resident reviewed during the survey on 12/01/16. 2. All residents with interventions for wireless alarms and anti-rollbacks were assessed by the ADON 12/20/16 to ensure that interventions were in place. All alarms and anti-rollbacks were in place. 3. The ADON, Director of Nursing (DON) Staff facilitator, nursing supervisor, and/or corporate consultant will monitor wireless alarms and anti-rollback interventions to ensure that they are in place within 48 hours of initiation at the morning quality improvement (QI)- Falls meeting. Interventions will be reviewed daily in the QI/Falls meeting beginning 12/15/16. All nursing staff including PRN and weekend staff will be in-serviced by the	

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F 323	Continued From page 47 9/24/16 at 5:41 PM, the resident attempted to sit down in her wheelchair and fell right on her butt. Her head hit the wall and a knot was noted on the back of her head. The resident was assessed and neuro check was done. There was no action to prevent further falls documented. 10/6/16 at 7:19 AM, the resident was found sitting on the floor. A small laceration/cut was noted on the back of her head. There was no action to prevent further falls documented. 11/1/16 at 12:37 PM, the resident was found sitting on the floor in front of her wheelchair. A skin tear was noted to her right thumb and a bruise to her index finger. The action taken was the resident was getting physical therapy. 11/3/16 at 7:00 PM, the resident was noted on the floor near a table. It appeared that the resident attempted to sit in her wheelchair and missed it. A hematoma was noted to the left side back of the head. The action taken were physical therapy and to check on antiroll back (prevent the wheelchair from rolling backwards) for her wheelchair. 11/16/16 at 7:46 AM, the resident was found in room next door on the floor. There was no injury noted. The action taken was physical therapy. 11/21/16 at 10:02 AM, the resident was observed in a standing position to sliding down to her bottom. There was no injury noted. The action taken was to add a wireless chair alarm. The care plan for Resident #72 was reviewed. One of the care plan problems dated 11/17/16	F 323	director of nursing (DON), ADON, staff facilitator (SF), nurse supervisor, and/or corporate consultant on the importance of ensuring safety interventions, including wireless alarms and anti-rollback devices are in place beginning 12/15/16. In-servicing will be completed by 12/29/16. 4. A 20% weekly random audit on alarms and anti-rollbacks will be performed by the ADON , DON, SF, and or corporate consultant x 6 weeks, followed by a 10% weekly audit x 6 weeks using the using the Choices, ADL, and Fall interventions Audit Tool. Audit to be initiated 12/26/16. 5 The DON or ADON will present the results of the audits to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, SW, admissions coordinator, dietary manager, environmental services manager, maintenance director) for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.	

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was at risk for falls characterized by history of falls related to impaired cognition. The goal was for the resident to have no fall related injury. The approaches included to assist the resident during transfer and mobility as needed, and rehabilitation therapy referral as ordered. On 11/29/16,

Resident #72 was observed on 11/29/16 at 4:35 PM, 11/30/16 at 9:20 AM, 11:25 AM, 11:55 AM and 4:20 PM. The resident was up in wheelchair with no wireless chair alarm observed. The resident was observed standing up on several occasions. The staff members were observed reminding the resident to sit back down.

Resident #72 was observed on 11/29/16 at 4:35 PM and on 11/30/16 at 9:20 AM and 11:25 AM. She was up in wheelchair. Her wheelchair was observed to have no antiroll back.

On 11/30/16 at 4:22 PM, the two nurse's aides (NA #3 & NA #5) assigned on the hall where Resident #72 resided were interviewed. The two NAS stated that they have not seen Resident #72 having a chair alarm for a long time.

On 11/30/16 at 4:22 PM, Nurse #1 assigned to Resident #72 was interviewed. She stated that she had not seen Resident #72 having a chair alarm for a long time.

On 12/1/16 at 8:22 AM, the Therapy program director was interviewed. She stated that Resident #72 was on physical therapy load. She indicated that the resident was referred by nursing due to decline and multiple falls. The Director added that the resident had no safety awareness due to her mental status. The resident could not remember to lock her

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F 323	Continued From page 49 wheelchair or that she could not walk. She indicated that the resident stood up from her wheelchair and fell. The therapist tried to educate staff and had requested maintenance to put an antiroll back to her wheelchair on 11/30/16. On 12/1/16 at 10:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse indicated that she was not aware about the wireless chair alarm for Resident #72 until 11/29/16. She was informed to add the wireless chair alarm to the resident's care plan on 11/29/16. On 12/1/16 at 3:34 PM, the Director of Nursing (DON) was interviewed. The DON stated the incident reports were reviewed during the QI meeting every day. The action to prevent further falls was decided during the meeting. She expected the action to be entered in the care plan by the MDS Nurse and be followed by the staff on the floor within 24 hours after the meeting.	F 323		
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	F 334		12/29/16

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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 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.

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(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 and staff interview, the facility failed to follow their policy on pneumococcal immunization for 4 (Residents #34, #72, #143, & #133) of 5 sampled residents reviewed for influenza/pneumococcal immunization. Findings included:
The facility's policy on pneumococcal immunization dated 1/2009 was reviewed. The policy read in part " Residents will be offered the immunization upon admission, unless it is medically contraindicated or the resident has already been immunized and the resident or the resident's representative refuses after receiving appropriate education and consultation regarding the benefits of pneumococcal immunization. "
The policy also indicated that documentation of the immunization will be noted in the resident's medical record.

1. Resident #134 was admitted to the facility on 3/25/16 with multiple diagnoses including Congestive Heart Failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 10/31/16 indicated that the resident had severe cognitive impairment. The assessment also indicated that the resident's pneumococcal

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1. Immunization records indicating that pneumococcal vaccines had been given were obtained for residents #34, #72 ,#143, and #133. The documentation was reviewed and received by the nursing supervisor on 12/1/16.

2. Immunization records for all residents were reviewed by the Infection Control Nurse/assistant director of nursing (ADON) and either records were obtained or vaccines given for any residents not having the appropriate immunization documentation by 12/20/16. Twenty residents' immunizations were documented and/or received as a result of the review.

3. The infection control nurse, director of nursing (DON), assistant director of nursing (ADON) , staff facilitator, and/or corporate consultant will review all new admits beginning 12/12/16 to ensure that either immunization records are obtained or vaccine given within 7 days of

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F 334	Continued From page 52 vaccination was not up to date due to the reason that it was not offered. Resident #134's admission records were reviewed. On admission 3/25/16, the facility had offered the pneumonia vaccine and the responsible party for Resident #134 had authorized the administration of the pneumonia vaccine to the resident. Resident #134's immunization record was reviewed. There was no documentation that the resident had received the pneumonia vaccine. On 12/1/16 at 2:20 PM, the Director of Nursing (DON) was interviewed. The DON stated the the facility had no full time infection control nurse at the present time. She indicated that a staff member was designated to be responsible for the infection control program but she could not remember who the staff member was. The DON further indicated that the pneumonia vaccine was not administered because the resident was admitted from the hospital or another nursing facility and the immunization record should have been obtained upon admission. On 12/1/16 at 3:34 PM, the DON was interviewed. She stated that her expectation was if the resident was admitted from the hospital or another nursing facility, the staff member should have obtained the immunization record and document in the record the date the immunizations were provided or the reason why it was not administered. 2. Resident # 72 was admitted to the facility on 8/25/14 with multiple diagnoses including Alzheimer's Disease. The significant change in status Minimum Data Set (MDS) assessment dated 10/26/16 indicated that the resident had severe cognitive impairment. The assessment also indicated that the resident's pneumococcal	F 334	admission. In-service given to both the infection control nurse and the admissions coordinator by the director of nursing (DON) 12/16/16 regarding the importance of immunizations and appropriate documentation. 4. An audit of all new admits will be conducted weekly by the DON, ADON , staff facilitator, and/or corporate consultant for 6 weeks to ensure that immunizations are being documented and/or received. This audit will be followed by a weekly audit of 50% of new admits x 6 weeks. Audit will be initiated 12/26/16. 5. The DON or infection control nurse will present the results of the audits to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, SW, admissions coordinator, dietary manager, environmental services manager, maintenance director) for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.	

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F 334	Continued From page 53 vaccination was not up to date due to the reason that it was offered and was declined. Resident #72's admission records were reviewed. On admission 8/25/14, the facility had offered the pneumonia vaccine and the responsible party for Resident #72 had authorized the administration of the pneumonia vaccine to the resident. Resident #72's immunization record was reviewed. There was no documentation that the resident had received the pneumonia vaccine. On 12/1/16 at 2:20 PM, the Director of Nursing (DON) was interviewed. The DON stated the he facility had no full time infection control nurse at the present time. She indicated that a staff member was designated to be responsible for the infection control program but she could not remember who the staff member was. The DON further indicated that the pneumonia vaccine was not administered because the resident was admitted from the hospital or another nursing facility and the immunization record should have been obtained upon admission. On 12/1/16 at 3:34 PM, the DON was interviewed. She stated that her expectation was if the resident was admitted from the hospital or another nursing facility, the staff member should have obtained the immunization record and document in the record the date the immunizations were provided or the reason why it was not administered. 3. Resident # 143 was admitted to the facility on 6/28/16 with multiple diagnoses including Congestive Herat Failure (CHF). The significant change in status Minimum Data Set (MDS) assessment dated 9/9/16 indicated that the resident's cognition was intact. The assessment also indicated that the resident's pneumococcal	F 334		

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vaccination was not up to date due to the reason that she was not eligible due to medical condition.
Resident #143's admission records were reviewed. On admission 6/28/16, the facility had offered the pneumonia vaccine and the resident had authorized the administration of the pneumonia vaccine.
Resident #143's immunization record was reviewed. There was no documentation that the resident had received the pneumonia vaccine.
On 12/1/16 at 2:20 PM, the Director of Nursing (DON) was interviewed. The DON stated the he facility had no full time infection control nurse at the present time. She indicated that a staff member was designated to be responsible for the infection control program but she could not remember who the staff member was. The DON further indicated that the vaccine was not administered because the resident was admitted from the hospital or another nursing facility and the immunization record should have been obtained upon admission.
On 12/1/16 at 3:34 PM, the DON was interviewed. She stated that her expectation was if the resident was admitted from the hospital or another nursing facility, the staff member should have obtained the immunization record and document in the record the date the immunizations were provided or the reason why it was not administered.

4. Resident # 133 was admitted to the facility on 9/12/16 with multiple diagnoses including Alzheimer's Disease. The admission Minimum Data Set (MDS) assessment dated 9/19/16 indicated that the resident had severe cognitive impairment. The assessment also indicated that the resident's pneumococcal vaccination was not up to date due to the reason that she was not

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F 334	Continued From page 55 eligible due to medical condition. Resident #133's admission records were reviewed. On admission 9/12/16, the facility had offered the pneumonia vaccine and the responsible party had authorized the administration of the pneumonia vaccine. Resident #133's immunization record was reviewed. There was no documentation that the resident had received the pneumonia vaccine. On 12/1/16 at 2:20 PM, the Director of Nursing (DON) was interviewed. The DON stated the he facility had no full time infection control nurse at the present time. She indicated that a staff member was designated to be responsible for the infection control program but she could not remember who the staff member was. The DON further indicated that the vaccine was not administered because the resident was admitted from the hospital or another nursing facility and the immunization record should have been obtained upon admission. On 12/1/16 at 3:34 PM, the DON was interviewed. She stated that her expectation was if the resident was admitted from the hospital or another nursing facility, the staff member should have obtained the immunization record and document in the record the date the immunizations were provided or the reason why it was not administered.	F 334		
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.	F 353		12/29/16

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F 353	Continued From page 56 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing 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 and record review, the facility failed to ensure adequate staffing to provide showers as scheduled for 1 (Resident #102) of 3 residents reviewed for Activities of Daily Living (ADLs). The facility also failed to adequately staff to ensure restorative nursing was being provided as ordered for 1 (Resident #143) of 2 residents reviewed for range of motion (ROM). Findings included: This tags is cross referred to: 1. F312-Based on medical record review, resident and staff interviews, the facility failed to provide showers as scheduled for one of three sampled residents reviewed for ADL's (activities of daily living) and who was totally dependent on staff for bathing (Resident #102).	F 353	F353 1. On 12/12/16 resident #102 received a shower by a nursing assistant per the resident's choice for scheduled time. On 12/2/16 resident #143 received range of motion exercises as per care plan intervention by the restorative nursing assistant. On 12/2/16 the administrator and the Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. 2. On 12/5/16 the Administrator and the DON reviewed the current schedule of staffing to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans in the next week.	

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F 353	Continued From page 57 In an interview on 11/30/16 at 4:30 PM, the Administrator stated they had been having problems with aide staffing for approximately 3 months. She stated she had lost a management position who was responsible for following up on a lot of the care issues identified during the course of the recertification survey. In an interview on 12/1/16 at 3:00 PM, the scheduling coordinator stated there had been an ongoing issues with aide staff for at least one month. She stated the facility was short of aides and it was difficult to find new staff due to rural nature of the facility and the facility was unable to compete with other facility ' s aide wages. The scheduling coordinator stated the Administrator and the DON were aware of the staffing issues and the Staff Development Coordinator (SDC had been interviewing and hiring. She stated they recently hired five or six aides but only two or three of those aide have worked out and stayed. In an interview on 12/1/16 at 3:23 PM, the DON stated it was her expectation that the facility be fully staffed but it has been a struggle. She state one weekend was hard to staff and she and the scheduling coordinator had worked up to five hours on a Friday afternoon just to get that particular weekend staffed. In an interview on 12/1/16 at 4:20 PM, the SDC stated she was responsible for the aide interviewing, hiring and orienting. She stated she had been in her position since March and since she started, there was need a problem with aide staffing. The SDC stated they had been advertising in the local papers, some of the large contract staff locators and even offered aide sign on bonuses but nothing seem to be working since	F 353	On 12/5/16, the administrator met with/notified the regional vice president(RVP) of current facility staffing needs to provide nursing care to all residents in accordance with resident care plans. 3. On 12/19/16, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to monitor for sufficient staff will be made based on the staffs ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. The Administrator, DON, nursing supervisor and/or the ADON will utilize the Sufficient Staff tool five times weekly to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately. The Administrator and/or the DON will present findings from the Sufficient Staff tool at the monthly QI committee meetings for six months for further recommendations. 4. Beginning 12/19/16, the Administrator will monitor the Sufficient Staff tool to ensure proper completion of the Sufficient Staff tool. 5. The administrator or DON will present the results of the audits to the monthly quality improvement (QI) committee (administrator, DON, ADON, treatment nurse, MDS nurse, SW, admissions coordinator, dietary manager,	

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F 353	Continued From page 58 a neighboring facility was offering more money and better benefits. This tags is cross referred to: 2. F318-Based on record review, observation and staff and resident interview, the facility failed to provide the restorative nursing program consistently as care planned and as recommended by the therapist for 1 (Resident #143) of 2 sampled residents reviewed. Findings included: In an interview on 11/30/16 at 4:30 PM, the Administrator stated they had been having problems with aide staffing for approximately 3 months. She stated she had lost a management position who was responsible for following up on a lot of the care issues identified during the course of the recertification survey. In an interview on 11/30/16 at 4:50 PM, the Minimum Data Set (MDS) Coordinator stated that there had been staffing issues related the restorative program. She stated she had one main restorative aide and she had been out of work. The MDS Coordinator stated there was other aide who had been trained in restorative but they had been working on the floor and unable to assist with restorative. The MDS Coordinator state she had spoken to the Administrator and the Director of Nursing (DON) about the staffing issues. In an interview on 12/1/16 at 3:00 PM, the scheduling coordinator stated there had been an ongoing issues with aide staff for at least one month. She stated the facility was short of aides and it was difficult to find new staff due to rural	F 353	environmental services manager, maintenance director) for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.	

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F 353	Continued From page 59 nature of the facility and the facility was unable to compete with other facility ' s aide wages. The scheduling coordinator stated the Administrator and the DON were aware of the staffing issues and the Staff Development Coordinator (SDC had been interviewing and hiring. She stated they recently hired five or six aides but only two or three of those aide have worked out and stayed. She stated she had one full time restorative aide and when she was not working there were other aides trained to do restorative but because the aide staffing was so low, she had to pull those aides to help on the floor In an interview on 12/1/16 at 3:23 PM, the DON stated it was her expectation that the facility be fully staffed but it has been a struggle. She state one weekend was hard to staff and she and the scheduling coordinator had worked up to five hours on a Friday afternoon just to get that particular weekend staffed. In an interview on 12/1/16 at 4:20 PM, the SDC stated she was responsible for the aide interviewing, hiring and orienting. She stated she had been in her position since March and since she started, there was need a problem with aide staffing. The SDC stated they had been advertising in the local papers, some of the large contract staff locators and even offered aide sign on bonuses but nothing seem to be working since a neighboring facility was offering more money and better benefits.	F 353		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		12/29/16

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F 441	Continued From page 60 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility staff failed to wash hands	F 441	F441 1. On 12/19/16, the staff facilitator (SF)	

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F 441	Continued From page 61 after providing incontinent care and before changing the resident's clothes for 1 (Resident # 143) of 3 sampled residents observed during care. Findings included: Resident #143 was admitted to the facility on 6/28/16 with multiple diagnoses including Major Depressive Disorder. The significant change in status Minimum Data Set (MDS) assessment dated 9/9/16 indicated that Resident #143's cognition was intact. The assessment further indicated that the resident had an indwelling urinary catheter and was always incontinent of bowel. The assessment also revealed that the resident was totally dependent on the staff for toilet use. On 11/30/16 at 8:55 AM, Resident #143 was observed during incontinent care and catheter care. There were two nursing assistants (NAs) (NA #6 & NA # 7) providing the care. The resident had a large bowel movement. NA #6 was observed providing incontinent care. After the incontinent and catheter care, NA #6 proceeded to change the resident's clothing without washing hands. On 11/30/16 at 9:01 AM, NA #6 was interviewed. NA #6 stated that she should have removed her gloves after the incontinent care but " she got busy and forgot. " On 11/30/16 at 4:30 PM, the administrator was interviewed. She stated that the facility had no policy on glove use and incontinent care. On 12/1/16 at 11:13 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC stated that the facility had no policy on glove use and incontinent care but she expected the staff to	F 441	counseled and in-serviced the nursing assistant (NA) providing inappropriate care to resident #143 regarding proper protocol for incontinence care and gloving. 2. Beginning 12/16/16, the staff facilitator (SF) and director of nursing (DON) began in-servicing all NA's including weekend and PRN staff regarding proper protocol for incontinence care and gloving. In-servicing will be completed by 12/29/16. 3. Beginning 12/16/16, hall nurses will observe incontinence care and gloving on all shifts as they make hall rounds to ensure proper protocol is followed. Any variance from the protocol will be reported to the DON for appropriate counseling. 4. Beginning 12/26/16, the SF, DON, Assistant Director of Nursing (ADON), nursing supervisor, and/or corporate consultant will initiate random audits using the Infection Control Incontinence Care Audit Tool. Audits will consist of observing at least 8 NAs per week giving care to one resident each x6 weeks to ensure that proper protocol is being followed. Audits will be conducted throughout the facility on all units both week days and weekends. This will be followed by audits by the SF of at least four NAs per week x 6 weeks giving care to one resident each. 5. The DON or SF will present the results of the audits to the monthly quality improvement (QI) committee	

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F 441	Continued From page 62 wash hands and change their gloves after providing incontinent care and before putting clean clothes on. On 12/1/16 at 3:33 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had no policy on glove use and incontinent care but she expected the staff to change gloves after incontinent care and before putting clean clothing on.	F 441	(administrator, DON, assistant director of nursing, treatment nurse, MDS nurse, social worker, admissions coordinator, dietary manager, environmental services manager, maintenance director) for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The survey was reviewed by QA Committee 12/14/16.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		12/29/16

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F 520	Continued From page 63 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, resident and staff interviews, the facility's Quality Assessment and Assurance committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in January 2016. This was for one (1) recited deficiency which was originally cited on 1/21/16 during the recertification/ complaint investigation survey and on the current recertification/ complaint investigation survey on 12/1/16 (F278). The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. F278: Assessment accuracy: Based on staff interviews and record review, the facility failed to accurately code the scheduled Minimum Data Set (MDS) assessment in the areas of urinary catheters (Resident #91), prognosis (Resident #91), medications (Resident #72 and Resident #130), pressures ulcers (Resident #143) and diagnoses (Resident #134) for 5 of 21 sampled residents reviewed for MDS accuracy. During the recertification survey of 1/21/16, the	F 520	F520 1.On 12/14/16, the administrator and director of nursing (DON) presented survey issues to the facility quality assurance (QA)committee (medical director, administrator, DON, assistant director of nursing, staff facilitator, minimum date set nurse, treatment nurse, maintenance supervisor, housekeeping supervisor, admissions, social worker). Residents #91, #72, #130, #143, and #134 were reviewed during the meeting related to F278 including modification of assessments and the plan of correction to ensure prevention of additional coding errors. There were no additional recommendations. The Medical Director, Administrator, DON, QI Nurse, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor will attend QA Committee Meetings on an ongoing basis and will assign additional team members as appropriate. 2. On 12/14/16 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor related to the appropriate	

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F 520	Continued From page 64 facility was cited F278 for failure to accurately code activities of daily living on the Admission Minimum Data Set (MDS) and eating on the subsequent quarterly MDS for one of nineteen residents (Resident #27). On the current recertification/ complaint investigation survey of 12/1/16, the facility failed to accurately code the MDS assessment in the areas of urinary catheters (Resident #91), prognosis (Resident #91), medications (Resident #72 and Resident #130), pressures ulcers (Resident #143) and diagnoses (Resident #134) for 5 of 21 residents reviewed to MDS accuracy. On 12/01/2016 at 3:54 PM, an interview was conducted with the Director of Nursing. She stated the facility had a new licensed practical nurse (LPN) who was fairly new to the position (about 5 months) and who assisted the MDS Coordinator with the MDS. The Director of Nursing stated the LPN had not been to the state training for MDS and the training she had received was through the company consultant. She added that there had been extra duties added to the MDS Coordinator and that might account for the inaccuracy of the MDS.	F 520	functioning of the Quality Improvement (QI)/QA Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F278 Accuracy of Assessments. As of 12/23/16, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review work orders, review Point Click Care (Electronic Medical Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. 3. The Facility QA Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F 278 Accuracy of Assessments. This will be completed by 12/29/16 and will be reviewed at the 1/11/17 QI Committee meeting. 4. The QA committee will continue to meet a minimum of quarterly. The QA Committee, including the Medical Director, will review monthly compiled QI Report information, review trends, and review corrective actions taken and the	

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F 520	Continued From page 65	F 520	dates of completion. The QA Committee will validate the facility's progress in correction of deficient practices or identified concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. 5. The administrator or Director of Nursing (DON) will report back to the QA Committee at the next scheduled meeting. Survey was reviewed at the 12/14/16 QA Committee meeting.	