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	345450	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

(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 000	INITIAL COMMENTS The statement of deficiencies was amended on 1/24/2017. Tag F329 was deleted per management recommedations.	F 000		
F 159 SS=B	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do	F 159		2/3/17

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

Electronically Signed | 02/01/2017

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F 159	Continued From page 1 not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide residents ready access to their personal funds for 6 of 6 residents (Residents #7, #17, #33, #39, #43, and #69) reviewed with personal fund	F 159	F159 1. Residents #7, 17, 33, 39, 43, and 69 were interviewed regarding personal funds request and any funds requested were given to resident as requested by	

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F 159	Continued From page 2 accounts. The findings included: During the initial tour of the faciliy on 1/4/17 at 10:45 AM a sign was observed in the facility lobby that indicated banking hours for resident trust funds were Monday through Friday from 9:30 AM to 4:30 PM with the exception of holidays. 1. Resident #7 was initially admitted to the facility on 5/28/10 and most recently readmitted on 1/12/13. The annual Minimum Data Set (MDS) assessment dated 11/28/16 indicated her cognition was intact. An interview was conducted with Resident #7 on 1/4/17 at 11:15 AM. She indicated she had a personal fund account with the facility. An interview was conducted with the Business Office Manager (BOM) on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #7 had a personal fund account. She additionally confirmed Resident #7 independently requested money from her personal fund account. The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday through Friday. She reported the facility had	F 159	the business office manager on 1-27-17. 2. The Executive Director held a resident council meeting to discuss the availability of resident funds during the weekend and how to access them on 1-20-17. All licensed nursing staff, including weekend and as needed staff were in-serviced on how the resident funds could be accessed on 1-19-17. The business office manager or Executive Director interviewed all alert and oriented residents that have a resident trust fund account regarding personal fund request on 1-30-17. Any funds requested were distributed by the business office manager. 3. The Executive Director re-educated the Business Office Manager on posting weekend banking hours and funds available for residents when requested on 1-16-17. The business office manager to provide petty cash box for nursing supervisor on weekends and after hours for personal funds request of residents. The Executive Director will perform quality improvement monitoring on the petty cash box weekly for 12 weeks then monthly to ensure personal funds available. The results of this monitoring will be documented on the quality improvement monitoring tool. Follow up based on Quality Monitor findings. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance improvement (QAPI) Committee by the Executive Director for review by Interdisciplinary team members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.

2. Resident #17 was initially admitted to the facility on 12/14/14 and most recently readmitted on 6/4/15. The quarterly MDS assessment dated 10/20/16 indicated her cognition was intact. 1/4/17 8:59 AM

An interview was conducted with Resident # 17 on 1/4/17 at 8:59 AM. She indicated she had a personal fund account with the facility.

An interview was conducted with the BOM on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #17 had a personal fund account. She additionally confirmed Resident #17 independently requested money from her personal fund account.

The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday

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through Friday. She reported the facility had banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.

3. Resident #33 was admitted to the facility on 12/5/08 and most recently readmitted on 9/18/15. The quarterly MDS assessment dated 10/10/16 indicated her cognition was intact.

An interview was conducted with Resident # 33 on 1/4/17 at 11:19 AM. She indicated she had a personal fund account with the facility.

An interview was conducted with the BOM on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #33 had a personal fund account. She additionally confirmed Resident #33 independently requested money from her personal fund account.

The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday

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through Friday. She reported the facility had banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.

4. Resident #39 was initially admitted to the facility on 2/11/15 and most recently readmitted on 12/1/16. The annual MDS assessment dated 10/18/16 indicated his cognition was intact.

An interview was conducted with Resident # 39 on 1/3/17 at 4:54 PM. He indicated he had a personal fund account with the facility.

An interview was conducted with the BOM on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #39 had a personal fund account. She additionally confirmed Resident #39 independently requested money from his personal fund account.

The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday

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through Friday. She reported the facility had banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.

5. Resident #43 was admitted to the facility on 4/17/15. The quarterly MDS assessment dated 12/16/16 indicated his cognition was moderately impaired.

An interview was conducted with Resident #43 on 1/3/17 at 2:47 PM. He indicated he had a personal fund account with the facility.

An interview was conducted with the BOM on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #43 had a personal fund account. She additionally confirmed Resident #43 independently requested money from his personal fund account.

The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday

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through Friday. She reported the facility had banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.

6. Resident #69 was initially admitted to the facility on 1/2/14 and most recently readmitted on 12/22/14. The annual MDS assessment dated 10/13/16 indicated his cognition was intact.

An interview was conducted with Resident #69 on 1/3/17 at 3:04 PM. He indicated he had a personal fund account with the facility.

An interview was conducted with the BOM on 1/5/17 at 4:35 PM. She reported she was responsible for managing resident personal fund accounts. She reviewed her records and verified that 46 residents had personal fund accounts with the facility. The BOM further reviewed her records and indicated that out of the 46 residents who had personal fund accounts there were 16 residents who independently requested money from their personal fund account. She confirmed Resident #69 had a personal fund account. She additionally confirmed Resident #69 independently requested money from his personal fund account.

The interview with the BOM continued. The BOM stated she was the only employee who had access to the monies that were distributed at resident ' s request from their personal fund account. She indicated she worked Monday

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F 159	Continued From page 8 through Friday. She reported the facility had banking hours on Monday through Friday from 9:30 AM to 4:30 PM. The BOM stated that residents who had personal fund accounts were able to request and receive money during these banking hours only. She revealed there was no system in place for residents to access their personal fund accounts outside of the Monday through Friday 9:30 AM to 4:30 PM time frame.	F 159		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units free of visible dust and debris in 13 of 16 rooms (rooms 110, 111, 112, 114, 115, 116, 117, 118, 119, 123, 125, 131, and 136). The air filter was missing from PTAC units in 2 out of 16 rooms (rooms 110 and 120). The facility also failed to maintain the removable air filters in the portable oxygen concentrators. The portable oxygen concentrators had visible dust and debris on the removable air filters for 4 of 6 residents (Residents # 64, # 67, #90 and #43). The removable air filter was missing from the portable oxygen concentrator for 1 of 6 residents (resident #33). The findings included: 1. a. An observation on 1/3/2017 at 12:40 PM revealed visible dust on the air filter for the PTAC unit in room 111.	F 253	F253 - 1. The Maintenance Director cleaned the air filters in the Packaged Terminal Air Conditioner(PTAC) unit in rooms. 110, 111, 112, 114, 115, 116, 117, 118, 119, 123, 125, 131 and 136 on 1-6-17. An air filter was placed in room 110 and 120 by the maintenance director on 1-27-17. The air filters on the portable oxygen concentrators for residents #64, 67, 90, and 43 was cleaned by the central supply manager on 1-6-17. An air filter was placed on the portable oxygen concentrator for resident #33 by the central supply manager on 1-6-17. 2. The maintenance director completed a complete review of PTAC units on 1-27-17 to ensure filters clean and present. After the review all rooms identified that needed servicing, filters were clean and or replaced. The central supply manager	2/3/17

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F 253	Continued From page 9 An observation on 1/3/2017 at 2:58 PM revealed visible dust on the air filter for the PTAC unit in room 115. An observation on 1/3/2017 at 4:57 PM revealed visible dust on the air filter for the PTAC unit in room 114. An observation on 1/4/2017 at 2:39 PM revealed visible dust on the air filter for the PTAC unit in room 114. An observation on 1/3/2017 at 4:59 PM revealed visible dust on the air filter for the PTAC unit in room 112. An observation on 1/4/2017 at 2:34 PM revealed visible dust on the air filter for the PTAC unit in room 111. An observation on 1/4/2017 at 2:41 PM revealed visible dust on the air filter for the PTAC unit in room 116. An observation on 1/4/2017 at 2:47 PM revealed visible dust on the air filter for the PTAC unit in room 117. An observation on 1/4/2017 at 2:48 PM revealed visible dust on the air filter for the PTAC unit in room 118. An observation on 1/4/2017 at 2:49 PM revealed visible dust on the air filter for the PTAC unit in room 119. An observation on 1/4/2017 at 2:51 PM revealed visible dust on the air filter for the PTAC unit in room 123. An observation on 1/4/2017 at 2:54 PM revealed visible dust on the air filter for the PTAC unit in room 131. An observation on 1/4/2017 at 2:55 PM revealed visible dust on the air filter for the PTAC unit in room 136. b. An observation on 1/4/2017 at 2:34 PM revealed that the PTAC unit in room 111 was missing one of the two air filters. An observation on 1/4/2017 at 2:50 PM revealed	F 253	completed a complete review of portable oxygen concentrators to ensure filters clean and present on 1-9-17. After the review all rooms identified that needed servicing of O2 concentrators were clean and or replaced. 3. The Executive Director to re-educate Maintenance Director on cleaning and ensuring filters are present on the PTAC unit by 1-11-17. The Executive Director to re-educate Central Supply Manager on cleaning and ensuring filters present on portable oxygen concentrators by 1-11-17. The Executive Director to complete 5 random observations of PTAC units weekly for 12 weeks then monthly to ensure filters clean and present. The Executive Director will complete 5 random observations weekly for 12 weeks then monthly of portable oxygen concentrators to ensure filters clean and present. The results of this monitoring will be documented on the quality improvement monitoring tool. Follow up based on Quality Monitoring findings. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement Committee by Executive Director for review by the interdiciplinary Team (IDT) each month. The QAPI Committee will evaluate effectiveness and amend as needed.	

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that the PTAC unit in room 117 was missing both air filters.

An interview with the Maintenance Director on 1/4/2017 at 3:13 PM revealed that the routine cleaning of the air filters on the PTAC units was the responsibility of the housekeeping department.

An interview with the interim Housekeeping Director on 1/4/2017 at 3:20 PM revealed that the housekeeping department was responsible for cleaning the removable filters in the PTAC units. The interim Housekeeping Director stated that the removable filters should be checked every day by the housekeeping staff that was assigned to the hall. Further clarification was provided that there was no log for cleaning the removable air filters on the PTAC units.

A random inspection of the removable air filters in the PTAC unit with the Maintenance Director and the interim Housekeeping Director conducted on 1/4/2017 at 3:25 PM revealed visible dust on the removable air filter in rooms 117, 123, and room 125. There was no removable air filter in the PTAC unit in room 120.

An interview conducted with the administrator on 1/4/2017 at 3:59 PM revealed that it was the administrator ' s expectation that the removable air filters on the PTAC units be clean.

2. a. An observation on 1/3/2017 at 12:44 PM revealed visible dust on the air filter for the portable oxygen concentrator for resident # 67. An observation on 1/4/2017 at 2:35 PM revealed visible dust on the air filter for the portable oxygen concentrator for resident # 67.

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An observation on 1/4/2017 at 2:41 PM revealed visible dust on the air filter for the portable oxygen concentrator unit for resident # 64.
An observation on 1/4/2017 at 2:55 PM revealed visible dust on the air filter for the portable oxygen concentrator unit for resident # 90.
An observation on 1/4/2017 at 2:57 PM revealed visible dust on the air filter for the portable oxygen concentrator for resident # 39.
b. An observation on 1/4/2017 at 2:42 PM revealed no filter on the portable oxygen concentrator unit for resident # 33.

An interview was conducted with the Director of Nursing (DON) on 1/4/2017 3:35 PM revealed that the person responsible for cleaning and maintaining the removable filters on the portable oxygen concentrator units was the Central Supply Coordinator (CSC). The DON provided further information that the CSC was responsible for checking the filters every Thursday when the oxygen tubing was changed.

An interview was conducted with the CSC on 1/4/2017 at 3:40 PM. The CSC stated that she replaced the filters if they needed to be replaced. If the filters were dirty, she would rinse them, dry them off, and then would return them to the oxygen concentrator. If the filter was missing, she stated that she would replace the filter with a replacement filter that she kept in stock. If a resident was on Hospice, then the Hospice company would come in and check their own oxygen concentrator and filter.

A round was conducted on 1/4/2017 at 3:43 PM with the CSC to inspect the removable filter in the portable oxygen concentrators. Resident # 67 ' s oxygen concentrator had visible dust and debris

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F 253	Continued From page 12 on it and the CSC stated that the filter looked like it could use some cleaning. She also stated that the filter was clean when she changed the tubing on 1/2/2017. Resident # 33 had no removable filter on her portable oxygen concentrator. The CSC stated that the filter on the portable oxygen concentrator for resident # 64 looked clean. Resident # 90 ' s removable filter on the portable oxygen concentrator was dirty according to the CSC. Resident # 90 was a Hospice resident. Resident # 69 ' s removable filter was clean on his portable oxygen concentrator. Resident # 43 ' s removable filter on the portable oxygen concentrator had a thick layer of dust and debris on it. The dust on the filter was thick enough to be able to scratch it off with a finger and the filter was almost white in color. The CSC stated that the filter was dirty. The filter was shown to the facility administrator who had joined the inspection at resident # 43 ' s room. The administrator stated that it was his expectation to keep the removable filters for the portable oxygen concentrators clean.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278		2/3/17

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F 278	Continued From page 13 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 2 residents (Residents #45 and #108) reviewed with level II Preadmission Screening and Resident Review (PASRR). The findings included: 1. Resident #45 was initially admitted to the facility on 9/3/09 and most recently readmitted on 2/10/16 with multiple diagnoses that included moderate intellectual disabilities. Record review indicated Resident #45 was a level II PASRR. Resident #45 received a level II PASRR with no expiration date on 3/19/15.	F 278	F278 1. The comprehensive annual Minimum Data Set (MDS) for Resident #45 dated 12-19-16 was corrected on 1-5-17 by the MDS Coordinator to accurately reflect level II Pre-Admission Screening and Resident Review (PASSR). The admission MDS for Resident #108 dated 12-26-16 was corrected on 1-5-17 by the MDS Coordinator to accurately reflect level II PASRR. 2. The MDS Coordinator, Director of Clinical Services and Assistant Director of Clinical Services will complete a review of Residents section A preadmission screening and resident review (PASSR)	

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F 278	Continued From page 14 The annual Minimum Data Set (MDS) assessment dated 12/19/16 indicated a "No" to question A1500 which asked if Resident #45 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. An interview was conducted with the Social Worker (SW) on 1/5/17 at 3:10 PM. She indicated she was responsible for maintaining of list of residents who were level II PASRRs. She stated Resident #45 was not a level II PASRR. The level II PASRR determination notification for Resident #45 dated 3/19/15 with no expiration date was reviewed with the SW. The SW revealed she had not seen this determination notification before and had not known Resident #45 had a level II PASRR with no expiration date. She reported that there had been some changes with how PASRR level II's were identified which caused some confusion as to whether or not a resident was a level II PASRR. An interview was conducted with the MDS Coordinator on 1/5/17 at 3:15 PM. She reported she completed Section A of the MDS. She stated she relied on the SW to inform her of residents who had level II PASRRs. She reported she kept a hand written list based on the information provided to her by the SW of the level II PASRR residents that resided in the facility and Resident #45 was not her list. The level II PASRR determination notification for Resident #45 dated 3/19/15 with no expiration date was reviewed with the MDS Coordinator. The annual MDS dated 12/19/16 that indicated Resident #45 had not been evaluated by level II PASRR (question A1500) was reviewed with the MDS Coordinator. The MDS Coordinator explained that the SW	F 278	to validate the most recent MDS assessment have been coded accurately to reflect the status of the resident. This review was completed on 1-20-17. This review validated the most recent MDS assessment of all residents had been coded accurately to reflect the status of the resident. 3. The Regional MDS Coordinator re-educated the MDS Coordinator on 1-13 -17 on the accurate completion of sections A on the MDS. The Social Services Director will randomly review 5 completed MDS assessments weekly for 12 weeks then monthly to verify accurate completion, the results of this monitoring to be documented on the quality improvement monitoring tool. The Social Services Director will utilize the FL-2 upon admission to determine the resident□s PASSR level. This PASSR level will be provided to the MDS coordinator either verbally or electronically. Follow up based on findings by Social Services Director as identified during these quality monitoring. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) by the Social Services for review by the Interdisciplinary Team (IDT) members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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informed her of residents that had level II PASRRs. She indicated Resident #45's previous comprehensive MDS assessments indicated he had a level II PASRR. She reported when she completed the most recent comprehensive assessment (12/19/16) she spoke with the SW and was informed Resident #45 no longer had a level II PASRR. The MDS Coordinator stated she was not aware Resident #45's level II PASRR had no expiration date.

A follow up interview was conducted with the MDS Coordinator on 1/5/17 at 3:15 PM. She revealed she spoke with the SW and verified Resident #45 had a level II PASRR. She confirmed the 12/19/16 MDS for Resident #45 was coded inaccurately and she was going to complete a modification.

An interview was conducted with Director of Nursing (DON) on 1/6/17 at 10:35 AM. She indicated her expectation was for the MDS to be coded accurately.

2. Resident #108 was admitted to the facility on 12/19/16 with multiple diagnoses that included depression.

Record review indicated Resident #108 was a level II PASRR.

The admission MDS dated 12/26/16 indicated a "No" to question A1500 which asked if Resident #45 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition.

An interview was conducted with the MDS Coordinator on 1/5/17 at 10:15 AM. She reported

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F 278	Continued From page 16 she completed Section A of the MDS. She stated she relied on the SW to inform her of residents who had level II PASRRs. She reported she kept a hand written list based on the information provided to her by the SW of the level II PASRR residents that resided in the facility and Resident #108 was not her list. The admission MDS dated 12/26/16 that indicated Resident #108 had not been evaluated by level II PASRR (question A1500) was reviewed with the MDS Coordinator. The MDS Coordinator revealed the SW had not informed her that Resident #108 had a level II PASRR. An interview was conducted with the SW on 1/5/17 at 10:15 AM. The SW verified Resident #108 was a level II PASRR. She reported that there had been some changes with how PASRR level II's were identified which caused some confusion as to whether or not a resident was a level II PASRR. The SW revealed that she was unable to recall if she had informed the MDS Coordinator of Resident #108's PASRR level II. A follow up interview was conducted with the MDS Coordinator on 1/5/17 at 10:25 AM. Resident #108's PASRR level II was confirmed with the MDS Coordinator. She revealed the MDS was coded inaccurately and she was going to make a modification. An interview was conducted with Director of Nursing (DON) on 1/6/17 at 10:35 AM. She indicated her expectation was for the MDS to be coded accurately.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		2/3/17

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F 280	Continued From page 17 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

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F 280	Continued From page 18 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 19 Based on observation, record review, facility policy review and staff interview, the facility failed to revise the care plan for one of three residents with a pattern of wandering behaviors to a potentially dangerous place to include the use of a Wander guard bracelet (Resident #21). A Wander guard bracelet is a bracelet placed on a resident to alert staff when the resident attempts to leave the building and sets off an alarm when the resident tries to exit the building. The findings included: A facility policy titled Elopement Risk with effective date of 11/30/2014 stated, in part, "It is policy of the company that on admission and quarterly, all residents will be assessed for elopement risk. If the resident is identified as an elopement risk based on the assessment, the care plan will reflect the interventions (i.e. Wander guard or Code Alert) and desired outcomes. Review and/or revise care plan following attempt to leave the facility." Resident #21 was admitted to the facility 7/20/13. Cumulative diagnoses included: late onset Alzheimer's disease, anxiety and major depressive disorder with psychotic symptoms. An Elopement risk evaluation for Resident #21 dated 5/23/16 indicated she was at risk for elopement. It was noted on the evaluation that Resident #21 had a Wander guard bracelet. An Elopement risk evaluation for Resident #21 dated 9/12/16 indicated she was at risk for elopement. It was noted on the evaluation that Resident #21 had a Wander guard bracelet. A Significant Change Minimum Data Set (MDS)	F 280	F280 1. A Safety Care Plan reflecting resident use and monitoring of a wander guard was initiated for Resident #21 by the Minimum Data Set (MDS) Coordinator on 1-9-17. 2. The MDS Coordinator, Director of Clinical Services and Assistant Director of Clinical Services to complete a review of Residents elopement risk evaluation to validate a Care Plan is in place that reflects wander guard use. This review was completed on 1-30-17. All resident□s utilizing a wander guard has a care plan that reflects its use. 3. The Interdisciplinary Team (IDT) which includes the Director of Clinical Services, Unit Manager, MDS Coordinator, Activities Director, Dietary Manager and Social Services Director, re-educated by the Regional MDS Coordinator by 2-1-17 related to the development of Comprehensive Care Plans, including the requirement for Care Planning use of wander guards. Care plans will be initiated and completed for residents utilizing a wander guard by the MDS Coordinator via communication with the Director of Clinical Services and through visualization of doctor□s orders reflecting that a wander guard has been ordered. The Director of Clinical Services or Assistant Director of Clinical Services will randomly review 4 Resident Care Plans weekly for 12 weeks then monthly to validate care plans are in place for residents with wander guards as required, the results of this monitoring will be documented on the quality improvement	

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F 280	Continued From page 20 dated 11/30/16 indicated Resident #21 was moderately impaired in cognition. Rejection of care was noted for 1-3 days during the assessment period. No wandering occurred during the assessment period. A Care Area Assessment (CAA) for psychotropic drug use stated, in part, that Resident #21 was alert with periods of confusion and disorientation. She had a history of exit seeking behavior that required the use of a Wander guard bracelet. Will be addressed in care plan. A nursing note dated 12/2/16 at 2:00PM stated Resident #21 was very agitated. She continued to scream obscenities and refused medications and breakfast. She began to attempt to exit the facility and became very aggressive with staff. Staff attempted to redirect resident without success. A nursing note dated 12/4/16 at 5:40PM stated Resident #21 was up in the wheelchair attempting to leave facility. She continued to scream and punch the front lobby door. Attempted to redirect multiple times by staff members. Resident #21 was being monitored by staff members 1:1 for safety at that time. A nursing note dated 12/5/16 11:00PM--7:00AM stated Resident #21 was up in wheelchair in common area very agitated talking about going home. She called out racial names, refused care and refused to go to bed. Resident #21 was placed on 1:1 care. A nurse practitioner progress note dated 12/5/16 stated a monthly visit was done for evaluation and management of mood disorder, Alzheimer's	F 280	monitoring tool. Follow up based on findings by the Director of Clinical Services or Assistant Director of Clinical Services as identified during these quality monitoring. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the MDS Coordinator for review by IDT members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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dementia, major depressive disorder and follow up on altered mental status from last visit. The note indicated on 12/2/16, Resident #21 became upset about having a new roommate, became combative and made attempts at elopement. Facility staff were with Resident #21 outside of the building attempting to call and reason with her to get her back in the facility.

An Elopement risk evaluation for Resident #21 dated 12/6/16 indicated she was at risk for elopement. It was noted on the evaluation that Resident #21 had a Wander guard bracelet.

A care plan dated 12/13/16 indicated Resident #21 had a history of wandering, exit-seeking behavior. Approaches and interventions included monitoring for exit-seeking behavior. There was no indication that Resident #21 had a Wander guard bracelet.

A review of physician orders for December 2016 and January 2017 revealed there was not an order for a Wander guard bracelet.

A review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) from September 2016 through January 2017 revealed no documentation that Resident #21 had a Wander guard bracelet or that one had been monitored or checked for function.

On 1/4/17 at 4:37PM, an interview was conducted with Nurse #2. She stated she was the nurse who provided care for Resident #21 on 12/2/16 and on 12/4/16. She said Resident #21 got a new roommate and she had expressed sometimes she did not like African Americans.

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Resident #21 was upset about the roommate and Nurse #2 said she took Resident #21 with her during her medication administration pass. Resident #21 continued to be agitated and displayed aggressive behaviors. She said Resident #21 was at the front door trying to exit the building and the Administrator, Director of Nursing and Assistant Director of Nursing were with her at that time. Nurse #2 said Resident #21 had a Wander guard bracelet on but she did not recall if the bracelet was in place on 12/2/16. She said she remembered seeing the Wander guard bracelet in place over the past 3-4 months and knew that it worked because resident #21 has gone to the door in the past and tried to go out the door and the door won't let her out.

On 1/5/17 at 10:15AM, an interview was conducted with the Director of Nursing who stated she would expect a resident who had a Wander guard bracelet in place to have a physician's order and have the bracelet on the MAR so staff could monitor and check for placement and function.

On 1/5/17 at 10:55AM, an interview was conducted with the MDS Coordinator who stated she did not know that Resident #21 had a Wander guard bracelet. She said she checked the chart and would have noted the use of the Wander guard bracelet on the care plan if she had seen a physician's order and/or seen it noted on the medication administration record.

On 1/5/17 at 11:11AM, the Director of Nursing stated the nursing staff transported the resident to the door to check for function of the bracelet. She just found out yesterday that they have a box that checks for function of the placement.

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F 280	Continued From page 23 On 1/5/17 at 12:27PM, an interview was conducted with Nurse #1. She stated Resident #21 had a Wander guard bracelet on one of her ankles. She said she checked to make sure the bracelet was in place. She did not check to make sure it was working.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 and staff interview, the facility failed to consistently implement the care planned interventions to provide ongoing 15 minute safety checks as ordered by the physician for a resident who had a history of wandering, exit seeking, and falls for 1 of 3 residents (Resident #72) reviewed for accidents. The findings included: Resident #72 was initially admitted to the facility 8/15/16 and readmitted on 8/25/16 with multiple diagnoses that included right hip fracture, lumbar compression fracture, dementia, and anxiety. A significant change Minimum Data Set (MDS) assessment dated 9/1/16 indicated Resident #72 had significant cognitive impairment. He was assessed with physical behaviors directed toward	F 282	F282 1. Resident #72 no longer resides at the facility. 2. The Minimum Data Set (MDS) Coordinator, Director of Clinical Services and Assistant Director of Clinical Services completed a review of resident□s safety care plans to ensure 15 minute checks are implemented as ordered and placed on Kardex on 1-31-17. All 15 minute checks were implemented as ordered and placed on kardex. 3. The Director of Clinical Services, Assistant Director of Clinical Services re-educated licensed nursing staff on 1-19 -17 on following the resident□s care plans for safety to ensure 15 minutes checks implemented as ordered. The Director of	2/3/17

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F 282	Continued From page 24 others on 1-3 days during the review period. The physical behaviors were noted to significantly interfere with Resident #72's care and social interactions and put others at significant risk of injury. Resident #72 had rejected care on 1-3 days during the review period. He additionally had wandering behaviors 1-3 days during the review period. The wandering behaviors were noted to place Resident #72 at significant risk of getting to a potentially dangerous place. He received antianxiety medication on 5 of 7 days during the review period. Resident #72 was assessed as not steady on his feet and was only able to stabilize with staff assistance. He required extensive assistance with bed mobility and transfers and supervision with locomotion on and off the unit. He utilized a wheelchair. Resident #72 had a fall in the month prior to admission, a fall in the last 2-6 months prior to admission, and 2 or more falls with no injury since admission. The Care Area Assessment (CAA) for falls from the 9/1/16 MDS indicated Resident #72 had very poor safety awareness, utilized a wheelchair, and was non-ambulatory since his readmission (8/25/16). He was hard of hearing and had hearing aids he sometimes refused to wear. His cognition and hearing problems affected his ability to understand. Resident #72 was noted to have had problems with standing and sitting balance and a history of falls resulting in a right hip fracture and lumbar compression fracture. Resident #72 also had a history of wandering/exit seeking and had a wanderguard. Resident #72 had 3 falls noted since admission (8/21/16, 8/27/16, and 8/31/16). The significant change assessment was indicated to be completed for a decline in Activities of Daily Living (ADLs) and	F 282	Clinical Services or Assistant Director of Clinical Services to randomly observe 5 residents and review their completed care plans weekly for 12 weeks then monthly to validate care plans are being followed and interventions for safety checks and implemented as ordered.. The results of this monitoring will be documented on the quality improvement monitoring tool. Follow up based on findings by the Director of Clinical Services as identified during these quality monitoring. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Director of Clinical Services for review by Interdisciplinary Team (IDT) members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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ambulation abilities, an increase in behaviors, and an increase in falls.

The CAA for psychotropic medications from the 9/1/16 MDS indicated Resident #72 had a history of exit seeking behaviors and had a wanderguard in place since 8/16/16. On 9/6/16 safety checks every 15 minutes were initiated for Resident #72 and were indicated to continue until further notice.

The comprehensive plan of care dated 9/2/16 for Resident #72 included the focus category of safety. Resident #72 had the potential for injury related, in part, to problems with standing balance, history of falls, wandering, exit seeking, anxiety, poor safety awareness, confusion, poor communication comprehension, and the use of psychoactive medication. The interventions included a wanderguard as ordered by the physician, monitor for exit seeking, and safety checks every 15 minutes as ordered by the physician.

A physician's order dated 9/6/16 indicated safety checks were to be completed every 15 minutes for Resident #72 and recorded on the safety form to monitor for attempts to elope. The physician's order additionally indicated to "continue [15 minute checks] until further notice".

A review of Resident #72's medical record revealed no documentation of the ongoing 15 minute safety checks that were ordered by the physician on 9/6/16. Additionally, there was no physician's order in the medical record that discontinued the safety checks every 15 minutes for Resident #72.

An interview was conducted with the Director of

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Nursing (DON) on 1/5/17 at 1:07 PM. The physician's order dated 9/6/16 for Resident #72 that indicated safety checks were to be conducted every 15 minutes and documented on the safety form until further notice was reviewed with the DON as well as the medical record that contained no documentation of safety checks every 15 minutes for Resident #72. The DON indicated the safety forms may not have been filed in Resident #72's medical record. She stated she was going to look for Resident #72's safety form to verify the safety checks were conducted every 15 minutes and were documented.

A follow up interview was conducted with the DON on 1/5/17 at 2:27 PM. The DON provided a safety form for Resident #72 that had 15 minute safety checks documented for a 24 hour period from 9/6/16 at 7:00 AM through 9/7/16 at 7:00 AM. The physician's order dated 9/6/16 for Resident #72 that indicated safety checks were to be conducted every 15 minutes and documented until further notice was again reviewed with the DON as well as the medical record that contained no physician's order to discontinue the safety checks every 15 minutes for Resident #72. Additionally, the plan of care related to safety that indicated safety checks were to be completed every 15 minutes as ordered by the physician was reviewed with the DON. She explained that the physician's order should have indicated a specific length of time the safety checks every 15 minutes were to be conducted. She stated that normally the safety checks every 15 minutes were conducted for a 24 hour period. She reported for Resident #72 the 15 minute safety checks were conducted for a 24 hour period only. The DON revealed that according to the plan of

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F 282	Continued From page 27 care related to safety and the phrasing of the 9/6/16 physician's order the safety checks every 15 minutes for Resident #72 should have been ongoing until a physician's order discontinued them.	F 282		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to consistently implement the physician's orders and care planned interventions	F 323	F323 1. Resident #72 no longer resides at the facility.	2/3/17

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F 323	Continued From page 28 to provide ongoing 15 minute safety checks to minimize the potential for further accidents for a resident who had a history of wandering, exit seeking, and falls for 1 of 3 residents (Resident #72) reviewed for accidents. The findings included: Resident #72 was initially admitted to the facility 8/15/16 and readmitted on 8/25/16 with multiple diagnoses that included right hip fracture, lumbar compression fracture, dementia, and anxiety. A nursing note dated 8/26/16 indicated Resident #72 had combative behaviors, increased agitation, and wandering. Incident reports dated 8/28/16 and 8/31/16 indicated Resident #72 had one fall on each distinct day with no injuries. A social service note dated 9/1/16 indicated Resident #72 was combative, refused care, and had periods of wandering. A significant change Minimum Data Set (MDS) assessment dated 9/1/16 indicated Resident #72 had significant cognitive impairment. He was assessed with physical behaviors directed toward others on 1-3 days during the review period. The physical behaviors were noted to significantly interfere with Resident #72's care and social interactions and put others at significant risk of injury. Resident #72 had rejected care on 1-3 days during the review period. He additionally had wandering behaviors 1-3 days during the review period. The wandering behaviors were noted to place Resident #72 at significant risk of getting to a potentially dangerous place. He received antianxiety medication on 5 of 7 days	F 323	2. Incidents in the last 30 days were reviewed on 1-20-17 by the Director of Clinical Services and Assistant Director of Clinical Services to ensure appropriate interventions are implemented, interventions noted on kardex and care planned. All interventions were implemented, care planned and noted on the kardex. 3. Licensed Nursing staff including weekend and as needed team members were re-educated by the Director of Clinical Services on implementing physician□s orders and care plan interventions for incidents on 1-19-17. The Director of Clinical Services and or Assistant Director of Clinical Services to perform quality improvement monitoring on 3 residents with incidents per week for 12 weeks then monthly to ensure interventions implemented, kardex updated and interventions care planned. The Assistant Director of Clinical Services was educated on 1-19-17 by the Director of Clinical Services related to obtaining orders for safety interventions such as every 15 minute checks with a definitive discontinuation time. All licensed and unlicensed staff will be aware of the initiation of every 15 minute checks and discontinuation of every 15 minute checks via passing on in report as well as notation made on the kardex. The every 15 minute checks will be monitored to ensure they are being conducted according to physician□s orders by the Director of Clinical Services or the Assistant Director of Clinical Services on a regular basis.	

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during the review period. Resident #72 was assessed as not steady on his feet and was only able to stabilize with staff assistance. He required extensive assistance with bed mobility and transfers and supervision with locomotion on and off the unit. He utilized a wheelchair. Resident #72 had a fall in the month prior to admission, a fall in the last 2-6 months prior to admission, and 2 or more falls with no injury since admission.

The Care Area Assessment (CAA) for falls from the 9/1/16 MDS indicated Resident #72 had very poor safety awareness, utilized a wheelchair, and was non-ambulatory since his readmission (8/25/16). He was hard of hearing and had hearing aids he sometimes refused to wear. His cognition and hearing problems affected his ability to understand. Resident #72 was noted to have had problems with standing and sitting balance and a history of falls resulting in a right hip fracture and lumbar compression fracture. Resident #72 also had a history of wandering/exit seeking and had a wanderguard. Resident #72 had 3 falls noted since admission (8/21/16, 8/27/16, and 8/31/16). The significant change assessment was indicated to be completed for a decline in Activities of Daily Living (ADLs) and ambulation abilities, an increase in behaviors, and an increase in falls.

The CAA for psychotropic medications from the 9/1/16 MDS indicated Resident #72 had a history of exit seeking behaviors and had a wanderguard in place since 8/16/16. On 9/6/16 safety checks every 15 minutes were initiated for Resident #72 and were indicated to continue until further notice.

The comprehensive plan of care dated 9/2/16 for

4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary Team members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.

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Resident #72 included the focus category of safety. Resident #72 had the potential for injury related, in part, to problems with standing balance, history of falls, wandering, exit seeking, anxiety, poor safety awareness, confusion, poor communication comprehension, and the use of psychoactive medication. The interventions included a wanderguard as ordered by the physician, monitor for exit seeking, and safety checks every 15 minutes as ordered by the physician.

A physician's order dated 9/6/16 indicated safety checks were to be completed every 15 minutes for Resident #72 and recorded on the safety form to monitor for attempts to elope. The physician's order additionally indicated to "continue [15 minute checks] until further notice".

An incident report dated 9/10/16 indicated Resident #72 stood up out of his wheelchair at the nurses station and when he went to sit back down the wheelchair rolled backwards and he slid to the floor. No injuries were noted.

An incident report dated 9/11/16 indicated Resident #72 had an unobserved fall in his room. The report stated that Resident #72 attempted to get out of his bed and fell onto his buttocks on the floor. No injuries were noted.

A physician's order dated 9/12/16 indicated a bed alarm and chair alarm were implemented for Resident #72 due to multiple falls.

The plan of care related to safety was updated on 9/12/16 with the new interventions of a bed and chair alarm.

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A review of Resident #72's medical record revealed no documentation of the ongoing 15 minute safety checks that were ordered by the physician on 9/6/16. Additionally, there was no physician's order in the medical record that discontinued the safety checks every 15 minutes for Resident #72.

An interview was conducted with the Director of Nursing (DON) on 1/5/17 at 1:07 PM. The physician's order dated 9/6/16 for Resident #72 that indicated safety checks were to be conducted every 15 minutes and documented on the safety form until further notice was reviewed with the DON as well as the medical record that contained no documentation of safety checks every 15 minutes for Resident #72. The DON indicated the safety forms may not have been filed in Resident #72's medical record. She stated she was going to look for Resident #72's safety form to verify the safety checks were conducted every 15 minutes and were documented.

A follow up interview was conducted with the DON on 1/5/17 at 2:27 PM. The DON provided a safety form for Resident #72 that had 15 minute safety checks documented for a 24 hour period from 9/6/16 at 7:00 AM through 9/7/16 at 7:00 AM. The physician ' s order dated 9/6/16 for Resident #72 that indicated safety checks were to be conducted every 15 minutes and documented until further notice was again reviewed with the DON. The medical record that contained no physician's order to discontinue the safety checks every 15 minutes for Resident #72 was also reviewed with the DON. The incident reports that indicated Resident #72 had sustained two falls (9/10/16 and 9/11/16) after the 9/6/16 physician's

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F 323	Continued From page 32 order for ongoing safety checks every 15 minutes was reviewed with the DON. The DON explained that the physician's order should have indicated a specific length of time the safety checks every 15 minutes were to be conducted. She stated that normally the safety checks every 15 minutes were conducted for a 24 hour period. She reported for Resident #72 the 15 minute safety checks were conducted for a 24 hour period only. The DON revealed with the way the physician's order was written the safety checks every 15 minutes for Resident #72 should have been ongoing until a physician's order discontinued them.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of	F 371		2/3/17

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F 371	Continued From page 33 foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard a head of lettuce seven days after opening, failed to label opened luncheon meat and failed to label prepared peaches with cottage cheese in the reach in refrigerator. The facility also failed to maintain clean utility carts for 2 of 2 carts used to hold plates and condiments. Finding included: On initial tour of the facility ' s kitchen 1/3/17 at 10:30 AM, an observation of the reach in refrigerator was conducted. Observed on the bottom left shelf of the reach in refrigerator was an open head of partiality used lettuce. It was in a clear plastic storage container with clear wrap covering the top. The lettuce had brown edges covering the outer layer of leaves. There was a date of 12/21/16 written on top of the clear wrap. Also observed on the second shelf from the bottom on the left side of the reach in refrigerator, was a plate of peaches surrounding a serving of cottage cheese. The plate was covered with clear wrap. There was no date reading when the peaches and cottage cheese was prepared. Lastly, on the right side of the reach in on the second shelf from the top was a plastic bag containing two slices of luncheon meat with no date as to when it was opened. In an interview on 1/3/17 at 10:33 AM, the Dietary Manager (DM) stated the facility practiced the North Carolina Food Code and any opened food items should be labeled when opened and discarded after seven days after opening unless it	F 371	F371 - 1. The Dietary Manager discarded the head of lettuce, luncheon meat and peaches with cottage cheese on 1-3-17. The utility cart was cleaned by the dietary manager on 1-3-17. 2. The dietary manager checked and discarded all unlabeled food from the walk in refrigerator on 1-6-17. The utility carts were cleaned by the dietary manager on 1-6-17. 3. The Dietary Manager re-educated dietary staff on the process for labeling, dating, storing left over and ready to eat foods by 1-16-17. The Dietary Manager re-educated the dietary staff on cleaning of utility carts by 1-16-17. The Dietary Manager to complete 5 random observations weekly for 12 weeks then monthly of walk in refrigerator to ensure all food labeled and dated appropriately. The Dietary Manager to complete 5 random observations weekly for 12 weeks then monthly of utility carts to ensure clean and free of food debris. The results of this quality monitoring will be documented on the quality improvement monitoring tool. Follow up based on findings. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Iimprovement (QAPI) Committee by Dietary Manager for review by the Interdisciplinary Team (IDT)	

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F 371	Continued From page 34 was a bulk item. The DM removed the named food items and discarded them at this time. In another observation on 1/3/17 at 10:45 AM, the utility cart used for storing plates was observed to have food debris on the upper left hand corner of the cart. Also the condiment utility cart was observed with a plastic tray of clear plastic serving bowls sitting on a shelf under the condiments. The utility cart appeared dirty with brown stains around the edges of the cart. In an interview with the DM, she stated washing the utility cart was on the weekly cleaning schedule but the carts needed to be pressure washed at this time. In an interview on 1/6/17 at 8:10 AM, the Regional DM stated it was her expectation that all food in the reach in refrigerator be labeled when opened and/or prepared and discarded after seven days. She also stated the utility carts should be clean and free of food debris at all times and expected the carts to be thoroughly cleaned as scheduled.	F 371	members each month. The QAPI Committee will evaluate effectiveness and amend as needed.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 431		2/3/17

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dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

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F 431	Continued From page 36 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instruction and staff interviews, the facility failed to follow manufacturer's instructions for storing inhalation medications in one of three medication carts (B/D cart). The findings included: 1 a. On 1/5/17 at 12:00PM, an observation of the B/D hall medication cart was conducted with Nurse #1. There were four (4) vials of ipratropium bromide/ albuterol (medication used to help control the symptoms of lung disease) outside of the foil pouch. All of the vials were undated. Manufacturer's instructions for ipratropium bromide/ albuterol inhalation medication stated, in part, "The vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week." On 1/5/17 at 12:00PM, an interview was conducted with Nurse #1. She stated the vials should have been in the foil pouch. She said she was unaware that the ipratropium bromide/ albuterol vials was only good for seven days outside of the foil pouch. On 1/5/17 at 12:23PM, an interview was conducted with the Director of Nursing. She stated she expected nursing staff to follow manufacturer's instructions regarding storage of the inhalation medications. 1 b. On 1/5/17 at 12:00PM, an observation of the B/D hall medication cart was conducted with	F 431	F431 1. 4 vials of ipratropium bromide/albuterol outside of foil pouch not dated were discarded by the Director of Clinical Services on 1-6-17. 2. A review of all medication carts and medication room was performed by the Director of Clinical Services to ensure all mediations are in date and dated when opened on 1-9-17. All medications in all of the medication carts and medication room were in date and dated when opened. 3. The Director of Clinical Services re-educated Licensed Nursing staff including weekend and as needed team members regarding expired medications to include dating of medications when opened on 1-19-17. The Director of Clinical Services or Assistant Director of Clinical Services will randomly complete quality improvement monitoring on all medication carts and the medication room 2 times per week for 12 weeks to validate no expired medications and medications required are dated when opened. Opportunities will be corrected by the Director of Clinical Services or Assistant Director of Clinical Services as identified during these quality monitoring. 4. The results of the quality monitoring will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Director of Clinical Services for review by Interdisciplinary Team (IDT) members each month. The QAPI Committee will evaluate the	

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	345450	A. BUILDING _____ B. WING _____	C 01/06/2017

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Nurse #1. There were three (3) vials of ipratropium bromide (medication used to help control the symptoms of lung diseases) outside of the foil pouch. All of the vials were undated.

Manufacturer's instructions for Ipratropium bromide inhalation medication stated, in part, "Keep the steripoules in the foil bag within the carton in order to protect the product from light and moisture."

On 1/5/17 at 12:00PM, an interview was conducted with Nurse #1. She stated the vials should have been in the foil pouch.

On 1/5/17 at 12:23PM, an interview was conducted with the Director of Nursing. She stated she expected nursing staff to follow manufacturer's instructions regarding storage of the inhalation medications.

1 c. On 1/5/17 at 12:00PM, an observation of the B/D hall medication cart was conducted with Nurse #1. There were two (2) vials of albuterol sulfate (medication used to help control the symptoms of lung diseases) outside of the foil pouch. All of the vials were undated.

Manufacturer's instructions for albuterol sulfate inhalation medication stated, in part, "After removing from pouch, use the product within one week. Do not store outside the pouch provided."

On 1/5/17 at 12:00PM, an interview was conducted with Nurse #1. She stated the vials should have been in the foil pouch.

On 1/5/17 at 12:23PM, an interview was conducted with the Director of Nursing. She

effectiveness and amend as needed.

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F 431	Continued From page 38 stated she expected nursing staff to follow manufacturer's instructions regarding storage of the inhalation medications.	F 431		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of	F 520		2/3/17

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F 520	Continued From page 39 such committee with the requirements of this section. (i) Sanctions. 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 record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 1/29/15 and 1/28/16 recertification surveys for 2 recited deficiencies in the areas of housekeeping and maintenance (F253) and food procurement/storage (F371) and following the 7/7/16 complaint investigation survey for 1 recited deficiency in the area of accidents (F323). These 3 deficiencies were cited again on the current recertification survey of 1/6/17. The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F253 - Housekeeping and Maintenance: Based on observations and staff interviews the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units free of visible dust and debris in 13 of 16 rooms (rooms 110, 111, 112, 114, 115, 116, 117, 118, 119, 123, 125, 131, and 136). The air filter was missing from PTAC units in 2 out of 16 rooms (rooms 110 and 120). The facility also failed to	F 520	F 520 1. The Executive Director held a Quality Assurance Performance Improvement (QAPI) meeting on 1-31-17 with the Interdisciplinary Team (IDT) including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director, Maintenance Director, Housekeeping Director and Business Office Manager focusing on the citations of housekeeping and maintenance, accidents and food procurement/storage. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 1-31-17 the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with	

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F 520	Continued From page 40 maintain the removable air filters in the portable oxygen concentrators. The portable oxygen concentrators had visible dust and debris on the removable air filters for 4 of 6 residents (Residents # 64, # 67, #90 and #43). The removable air filter was missing from the portable oxygen concentrator for 1 of 6 residents (Resident #33). During the recertification survey of 1/29/15 the facility was cited F253 for failure to provide maintenance and cleaning services to halls and shower rooms necessary to maintain a safe, orderly, and comfortable environment. During the recertification survey of 1/28/16 the facility was cited F253 for failure to provide clean floors and walls in bathrooms and bedrooms. On the current recertification survey of 1/6/17 the facility failed to maintain the removable air filters in PTAC units free of visible dust and debris failed to have air filters in all PTAC units, and failed to maintain removable air filters in the portable oxygen concentrators. 2. F323 - Accidents: Based on record review and staff interview, the facility failed to consistently implement the physician's orders and care planned interventions to provide ongoing 15 minute safety checks to minimize the potential for further accidents for a resident who had a history of wandering, exit seeking, and falls for 1 of 3 residents (Resident #72) reviewed for accidents. During the complaint investigation of 7/7/16 the facility was cited for failure to follow the interventions of bed alarm, chair alarm, and slip resistant mat. On the current recertification survey of 1/6/17 the facility failed to consistently implement the physician's orders and care	F 520	updated interventions as required. The Regional Vice President of Operations and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. ¿ 4. The results of theses reviews will be submitted to the Quality Assurance Performance Committee by the Executive Director for review by Interdisciplinary members each month. The Quality Assurance Performance Committee will evaluate the effectiveness and amend as needed.	

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planned interventions to provide ongoing 15 minute safety checks.

3. F371 - Food Procurement/Storage: Based on observations and staff interviews, the facility failed to discard a head of lettuce seven days after opening, failed to label open luncheon meat, and failed to label prepared peaches with cottage cheese in the reach in refrigerator. The facility also failed to maintain clean utility carts for 2 of 2 carts used to hold plates and condiments.

During the recertification survey of 1/29/15 the facility was cited F371 for failure to clean and air dry dishes to prevent food borne illness, failure to label and date the dialysis snacks, and failure to keep the dialysis snacks refrigerated during transport from the facility to the dialysis center. During the recertification survey of 1/28/16 the facility was cited F371 for failure to date 6 opened foods and close 1 food item package when opened, failure to maintain clean floors and equipment, failure to maintain equipment, water faucet, walls and floor tiles in good repair, failure to correctly calibrate a food thermometer, failure to measure the temperature of the milk correctly, failure to place a thermometer in the nourishment refrigerator located on the resident unit, and failure to maintain a clean floor and clean refrigerator shelf. On the current recertification survey of 1/6/17 the facility failed to discard a head of lettuce seven days after opening, failed to label opened luncheon meat, failed to label prepared food, and failed to maintain clean utility carts.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/6/17 at 10:55 AM. The Administrator stated he

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was the head of the facility's QAA Committee. He reported the QAA Committee consisted of the DON, Assistant Director of Nursing (ADON), Social Worker, Minimum Data Set Coordinator, Medical Records Staff, Activities Director, Wound Care Nurse, a Nursing Assistant, Dietary Manager, Admissions/Marketing Director, Business Office Manager, Maintenance Director, Medical Director, and Pharmacist. He indicated the QAA Committee met monthly with the exception of the Medical Director and Pharmacist who attended quarterly.

The Administrator indicated he was aware housekeeping and maintenance (F253) was a repeat deficiency from the 1/29/15 and 1/28/16 recertification surveys. The Administrator indicated he had not worked at the facility during the 1/29/15 survey so he was unaware of the facility's action plan and he was also unaware of who was responsible for the action plan following the 1/28/16 survey. He reported that housekeeping services were ultimately responsible for the cleanliness of the rooms, but all department heads were responsible for making rounds to ensure the facility's cleanliness was maintained. The Administrator stated he felt the facility needed to do a better job monitoring and educating staff.

The Administrator indicated he was aware accidents (F323) was a repeat deficiency from the 7/7/16 complaint investigation survey. The DON stated their action plan included the use of fall audit sheets to ensure care plan interventions were in place. She reported the ADON was responsible for this action plan. She indicated the ADON was also responsible for auditing the physician's orders to ensure the ordered

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interventions were in place. The DON indicated she felt this was a repeat deficiency due to a lack of education for the ADON regarding how orders were to be written.

The Administrator indicated he was aware food procurement/storage (F371) was a repeat deficiency from the 1/29/15 and 1/28/16 recertification surveys. He stated he was unsure of the specific action plans from the past recertification surveys, but indicated the Dietary Manager was responsible for this area. The Administrator reported that he conducted an inspection of the cleanliness of the kitchen on a monthly basis. He revealed he had noticed things that were unclean during his inspections. He reported the facility continued to in-service staff and repair items that were identified to be in need of maintenance in the kitchen. He stated that this was an area where ongoing improvements were needed.