STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide 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 label resident's personal care items and store them off the floor which included 2 bath basins in resident room #213 and #312 (on 2 of 4 resident hallways), failed to repair smoke prevention doors on the 200 and 400 hallways with broken and splintered laminate and wood on the lower edges of the doors (on 2 of 4 resident hallways), failed to repair doors to the main dining room and to the door of the day room/dining room on the 300 hall with broken and splintered laminate and wood on the lower edges of the doors, failed to repair bathroom doors in 7 resident rooms (room #108, #211, #213, #303, #305, #310 and #312) with broken and splintered laminate and wood on the lower edges of the doors (on 3 of 4 resident hallways), failed to repair a loose toilet with a broken bolt at the base of the toilet in the bathroom of resident room #310, failed to repair an edge guard on a wall in resident room #311 and failed to repair base molding in resident room #305 and between the therapy department and entrance to the 100 hall. The findings included: 1. a. Observations on 01/18/17 at 10:48 AM in resident room #213 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was	F 253	How will this deficiency be corrected for each resident found to be affected by the deficient practice? On 1/20/17, the Director of Nursing removed and disposed of the bath basins from resident rooms #213 and #312 that were stored on the floor and were not labeled. They were disposed of in housekeeping garbage for discard. On 2/2/17, The Director of Maintenance placed an order for a contract vendor to replace the smoke prevention doors on the 200 and 400 hallways, doors to the main dining room, the door of the dayroom/dining room on the 300 hall, and resident bathroom doors in resident rooms #108, #211, #213, #303, #305, #310 and #312. They will be replaced and installed by 3/21/17. The Director of Maintenance repaired the loose toilet with the broken bolt at the base of the toilet and related grout in the bathroom of resident room #310 on 1/20/17. The Director of Maintenance replaced the edge guard on the wall in resident room	3/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2017

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F 253	Continued From page 1 no resident name visible on the basin. Observations on 01/19/17 at 9:00 AM in resident room #213 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was no resident name visible on the basin. Observations on 01/20/17 at 11:18 AM in resident room #213 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was no resident name visible on the basin. b. Observations on 01/18/17 at 10:27 AM in resident room #312 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was no resident name visible on the basin. Observations on 01/19/17 at 3:09 PM in resident room #312 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was no resident name visible on the basin. Observations on 01/20/17 at 11:26 AM in resident room #312 revealed a bath basin was sitting on the floor under a sink in the room. The bath basin was not in a plastic bag and there was no resident name visible on the basin. During a tour and interview on 01/20/17 at 11:49 with the Director of Nursing (DON) she explained resident care equipment was supposed to be labeled with the residents name with included bath basins. She stated bath basins were not supposed to be stored on the floor in resident rooms but should be stored in the resident's closet. During the tour the DON verified the bath basins in resident room #213 and #312 had no resident name on them and she was not sure why staff had not labeled them and they should not	F 253	#311 on 1/20/17. The Director of Maintenance replaced the base molding in resident room #305 on 1/20/17 and the base molding between the therapy department and entrance to the 100 hall on 2/2/17. How will this deficiency be corrected for each resident who would be affected by the deficient practice in the future? The Minimum Data Set (MDS) Coordinators, The Discharge Planning Nurse, Staff Development Coordinator and Health Information Management Director conducted a 100% audit of resident rooms for proper labeling and storage of resident personal care items on 1/20/17, and no other bath basins or personal care items were unlabeled or improperly stored. The Director of Maintenance reviewed all smoke prevention doors, and non-smoke prevention doors, including resident bathroom doors, for disrepair on 1/23/17, and any/or all identified doors were repaired by 2/17/17 or were ordered for replacement and installation no later than 3/21/17. The Maintenance Director will review all the toilets in the facility to ensure there are no loose or cracked bolts or grout, all edge guards on the walls in resident rooms and base molding in resident rooms by 2/17/17 to ensure that there are	

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F 253	Continued From page 2 have been left on the floor. 2. a. Observations on 01/17/17 at 12:06 PM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/18/17 at 10:50 AM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/20/17 at 11:15 AM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. b. Observations on 01/17/17 at 12:09 PM revealed the smoke prevention doors on the 400 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/18/17 at 10:55 AM revealed the smoke prevention doors on the 400 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/20/17 at 11:30 AM revealed the smoke prevention doors on the 400 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. 3. a. Observations on 01/18/17 at 11:16 AM revealed 2 doors to the main dining room with broken and splintered laminate on the edges of the lower half of the doors that were rough to touch.	F 253	no further identified issues noted. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The Director of Nursing, Staff Development Coordinator or designee completed educated from 2/7/17 - 2/17/17 with all housekeeping staff, therapy staff and nursing staff on proper labeling and storage of residents' personal care items. Any associates not educated by 2/17/17 will not work until this education is received and new staff will be trained during orientation. The Director of Nursing or designee will conduct an inspection of 5 random resident rooms weekly to observe for proper labeling and storage of personal items. Any items found to be out of compliance will be corrected at that time. The Director of Maintenance or designee will educate all facility staff on the work order process by 2/17/17. Any associates not educated by 2/17/17 will receive this training before returning to work. New associates in those departments will receive this education during orientation. The Director of Maintenance or designee will conduct an inspection of all smoke prevention doors, 5 random non-smoke prevention doors, 5 toilets, 5 edge guards and 5 base molding areas in the facility weekly. As needed repairs are identified,	

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F 253	Continued From page 3 Observations on 01/19/17 at 11:35 AM revealed 2 doors to the main dining room had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/20/17 at 11:40 AM revealed 2 doors to the main dining room had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. b. Observations on 01/17/17 at 12:02 PM revealed the day room/dining door and the dining room door on the 300 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/19/17 at 11:45 AM revealed the day room/dining door and the dining room door on the 300 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 01/20/17 at 11:22 AM revealed day room/dining door and the dining room door on the 300 hall had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. 4. a. Observations on 01/17/17 at 12:37 PM revealed the bathroom door in resident room #108 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/18/17 at 10:28 AM revealed the bathroom door in resident room #108 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/19/17 at 12:32 PM revealed the bathroom door in resident room #108 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the	F 253	they will be prioritized and scheduled. A copy of the completed work order will be given to the Executive Director weekly for 3 months to ensure findings have been corrected or a plan is in place for correction. How will the facility monitor the measures to make sure that solutions are sustained? The Director of Maintenance and Director of Nursing will present all findings to the Performance Improvement Committee monthly for 3 consecutive months. The Performance Improvement Committee consisting of, but not limited to, the Executive Director, Medical Director, Director of Nursing, Business Office Manager, Health Information Management Director, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Food Services, Infection Control Nurse, and Staff Development Coordinator will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. If any member of the Performance Improvement Committee is not present, findings will be reviewed upon return to work.	

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door.
Observations on 01/20/17 at 11:12 AM revealed the bathroom door in resident room #108 had broken and splintered laminate that were rough to the touch on the edges of the lower half of the door.

b. Observations on 01/17/17 at 3:10 PM revealed the bathroom door in resident room #211 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/19/17 at 9:20 AM revealed the bathroom door in resident room #211 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/20/17 at 11:18 AM revealed the bathroom door in resident room #211 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.

c. Observations on 01/18/17 at 10:47 AM revealed the bathroom door in resident room #213 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/19/17 at 9:24 AM revealed the bathroom door in resident room #213 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/20/17 at 11:19 AM revealed the bathroom door in resident room #213 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.

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F 253	Continued From page 5 d. Observations on 01/18/17 at 9:59 AM revealed the bathroom door in resident room #303 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/19/17 at 9:25 AM revealed the bathroom door in resident room #303 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/20/17 at 11:23 AM revealed the bathroom door in resident room #303 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. e. Observations on 01/18/17 at 9:45 AM revealed the bathroom door in resident room #305 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/19/17 at 9:30 AM revealed the bathroom door in resident room #305 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/20/17 at 11:24 AM revealed the bathroom door in resident room #305 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. f. Observations on 01/17/17 at 2:35 PM revealed the bathroom door in resident room #310 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door. Observations on 01/18/17 at 9:56 AM revealed the bathroom door in resident room #310 had	F 253		

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broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/20/17 at 11:28 AM revealed the bathroom door in resident room #310 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.

g. Observations on 01/18/17 at 10:27 AM revealed the bathroom door in resident room #312 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/19/17 at 9:37 AM revealed the bathroom door in resident room #312 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.
Observations on 01/20/17 at 11:26 AM revealed the bathroom door in resident room #312 had broken and splintered laminate that was rough to the touch on the edges of the lower half of the door.

5. Observations on 01/17/17 at 02:35 PM in the bathroom of resident room #310 revealed a large white vinyl base plate for the toilet had shifted partially out from under the base of the toilet and a bolt at the base of the toilet was broken and the grout around the base of the toilet was cracked.
Observations on 01/18/17 at 9:56 AM in the bathroom of resident room #310 revealed a large white vinyl base plate for the toilet had shifted partially out from under the base of the toilet and a bolt at the base of the toilet was broken and the grout around the base of the toilet was cracked.
Observations on 01/19/17 at 9:36 AM in the bathroom of resident room #310 revealed a large

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white vinyl base plate for the toilet had shifted partially out from under the base of the toilet and a bolt at the base of the toilet was broken and the grout around the base of the toilet was cracked.
Observations on 01/20/17 at 11:28 AM in the bathroom of resident room #310 revealed a large white vinyl base plate for the toilet had shifted partially out from under the base of the toilet and a bolt at the base of the toilet was broken and the grout around the base of the toilet was cracked.

6. Observations on 01/18/17 at 1:40 PM in resident room #311 revealed a clear guard to protect edges of a wall from damage was located on the edge of a corner wall at the bathroom but was broken off from the top partially down the wall with rough edges to the touch.
Observations on 01/19/17 at 9:38 AM in resident room #311 revealed a clear guard to protect edges of a wall from damage was located on the edge of a corner wall at the bathroom but was broken off from the top partially down the wall with rough edges to the touch.
Observations on 01/20/17 at 11:25 AM in resident room #311 revealed a clear guard to protect edges of a wall from damage was located on the edge of a corner wall at the bathroom but was broken off from the top partially down the wall with rough edges to the touch.

7. a. Observations on 01/18/17 at 9:45 AM revealed in resident room #305 a section of base molding was missing at a corner next to the bathroom.
Observations on 01/19/17 at 9:30 AM revealed in resident room #305 a section of base molding was missing at a corner next to the bathroom.
Observations on 01/20/17 at 11:24 AM revealed in resident room #305 a section of base molding

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F 253	Continued From page 8 was missing at a corner next to the bathroom. b. Observations on 01/18/17 at 10:49 AM between the therapy department and the entrance to the 100 hall the vinyl molding at the floor on a corner was pulled apart from the wall and was slit open. Observations on 01/19/17 at 9:40 AM between the therapy department and the entrance to the 100 hall the vinyl molding at the floor on a corner was pulled apart from the wall and was slit open. Observations on 01/20/17 at 11:11 AM between the therapy department and the entrance to the 100 hall the vinyl molding at the floor on a corner was pulled apart from the wall and was slit open. During an interview and environmental tour on 01/20/17 at 11:59 AM with the Maintenance Director he explained the facility utilized a work order system and there was a clipboard in between the nurse's stations to write things down that needed repair. He stated he had an assistant to help him and they checked the clipboard several times a day and they checked items off when the repair was completed. He further stated he or his assistant were on call for 24 hours a day, 7 days a week and he expected for staff to report everything that needed repair. He explained he did orientation with new employees and oriented them to the work order system and showed them where the work order clipboard was located. He stated they had replaced all resident room doors within the last year but were not doing anything at the present time with repairs to other doors in the facility. He confirmed the smoke prevention doors on the 200 and 400 halls, doors in resident bathrooms and dining room doors had been damaged and needed repair. He explained the missing base	F 253		

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F 253	Continued From page 9 molding in resident room #305 had not been reported to him and he had not noticed the damage to the cove molding between the therapy department and the entrance to the 100 hall. He further explained he had not been made aware of the damage to the corner guard on the edge of the bathroom wall in resident room #311. He stated the toilet in the bathroom of resident room #310 looked as if it had been kicked loose and confirmed the base plate that was supposed to be under the base of the toilet was partially out from under the toilet and bolt flange was broken on the base on the right side of toilet and the toilet was loose at the floor and had not been reported to him. During an interview and tour on 01/20/17 at 12:38 PM with the Administrator she stated maintenance staff had started using a maintenance request log for staff to document anytime they saw something that needed repair. She explained maintenance staff checked the log each day and then they brought requests to her for approval if expenses were involved. She stated it was her expectation for staff to report repairs which included damage to doors, toilets, edge guards on walls and base molding to the maintenance staff and she expected for maintenance staff to complete the repairs.	F 253		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		2/17/17

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F 431	Continued From page 10 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to remove 10 expired antiemetic suppositories (promethazine) from 1 of 2 medication storage refrigerators. Findings included: A review of the facility policy entitled A Guide to Medication Utilization Expiration Dates and was	F 431	How will this deficiency be corrected for each resident found to be affected by the deficient practice? The Director of Nursing disposed of the 10 expired anti-emetic suppositories (promethazine) from the medication refrigerator on 1/20/17.	

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F 431	Continued From page 11 revised on 06/21/06 indicated drugs including those in the medication carts as well as those in the medication room were to be checked monthly for an expiration date by nursing personnel. If the drug was outdated, it would be disposed of as per state and federal laws. On 01/20/2017 at 08:27 AM 5 Promethazine 12.5 mg (milligram) suppositories with an expiration date of 07/2016 and 5 Promethazine 12.5 mg suppositories with an expiration date of 10/2016 were observed in 1 of 2 medication refrigerators in a clear plastic zip lock bag with an expiration date written on the outside of the bag as 12/2017. On 01/20/16 at 8:30 AM an interview was conducted with Nurse #1 who verified 5 Promethazine 12.5 mg suppositories had expired on 07/2016 and 5 Promethazine 12.5 mg suppositories had expired on 10/2016 and were in the medication refrigerator ready for resident use. Nurse #1 immediately removed the 10 expired Promethazine suppositories from the medication refrigerator. On 01/20/2017 at 9:01 AM an interview was conducted with the Director of Nursing (DON) who verified that 5 Promethazine 12.5 mg suppositories were expired on 07/2016 and 5 Promethazine 12.5 mg suppositories were expired on 10/2016 and were in the medication refrigerator ready for resident use. The DON stated it was the responsibility of the treatment nurse to check the medication refrigerator 3 days a month and it was her expectation that the treatment nurse would have removed the expired Promethazine suppositories from the medication refrigerator. The DON stated it was her expectation that the nursing staff would check for	F 431	How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? The Director of Nursing and the RN Supervisor completed a 100% audit on 1/20/17 to identify any other potentially expired or improperly stored medications. No other areas of deficiency were identified. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The Director of Nursing or designee will educate all licensed nurses on the medication storage and security in the facility policy to ensure expired medications are immediately removed from and are not stored in medication refrigerators by 2/17/17. All licensed nurses who have not received this training by 2/17/17 will not be allowed to work until such training is received. All new associates will be given this education during orientation. Effective 1/20/17, the Director of Nursing or designee will audit the medication refrigerator daily for 12 weeks. Any expired or improperly stored items will be immediately removed from stock, locked in the medication room in a segregated area, and disposed of according to procedure for medication destruction and re-ordered from the pharmacy if a current	

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F 431	Continued From page 12 expired medication prior to administering any medication to the resident. The DON stated moving forward the medication refrigerator would be checked on a daily basis and individual medication stored in the refrigerator would be checked for expiration. On 01/20/2017 at 9:13 AM an interview was conducted with the Administrator who stated her expectation was that the DON or her designee would have been responsible to assure that expired medications were not available in the medication refrigerator ready for resident use. The Administrator stated moving forward that any individual medication stored in a plastic bag and labeled with an expiration date on the outside of the bag would be checked by nursing to assure the medication had not expired. On 01/20/2017 at 10:28 AM an interview was conducted with Nurse #2 who stated she was responsible to check the medication refrigerator for expired medication. Nurse #2 stated she checked the medication refrigerator this month and must have missed the expired Promethazine suppositories.	F 431	order exists. Upon completion of the 12-week daily audit, the Director of Nursing or designee will audit the medication refrigerators monthly for any expired or improperly stored items. Any expired or improperly stored items will be immediately removed from stock, locked in the medication room in a segregated area, and disposed of according to procedure for medication destruction and re-ordered from the pharmacy if a current order exists. How will the facility monitor the measures to make sure that solutions are sustained? Effective 1/20/17, the medication room refrigerator will be audited by the Director of Nursing or designee daily for 12 weeks. Results will be reported to the Performance Improvement Committee x3 months. Upon completion of the 12-week daily audit, the Director of Nursing or designee will audit the medication refrigerators monthly for any expired or improperly stored items. Any expired or improperly stored items will be immediately removed from stock, locked in the medication room in a segregated area, and disposed of according to procedure for medication destruction and re-ordered from the pharmacy if a current order exists.	
F 520	483.75(o)(1) QAA	F 520		3/21/17

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F 520 SS=E	Continued From page 13 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 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 and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for one recited deficiency which were originally cited in December of 2015 on a Recertification survey and subsequently recited on the current recertification survey. The	F 520	How will this deficiency be corrected for each resident found to be affected by the deficient practice? On 1/20/17, the Director of Nursing removed and disposed of the bath basins from resident rooms #213 and #312 that were stored on the floor and were not labeled. They were disposed of in	

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deficiency was in the area of housekeeping and maintenance services. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referred to: F 253 Housekeeping and Maintenance Services. Based on observations and staff interviews the facility failed to label resident's personal care items and store them off the floor which included 2 bath basins in resident room #213 and #312 (on 2 of 4 resident hallways), failed to repair smoke prevention doors on the 200 and 400 hallways with broken and splintered laminate and wood on the lower edges of the doors (on 2 of 4 resident hallways), failed to repair doors to the main dining room and to the door of the day room/dining room on the 300 hall with broken and splintered laminate and wood on the lower edges of the doors, failed to repair bathroom doors in 7 resident rooms (room #108, #211, #213, #303, #305, #310 and #312) with broken and splintered laminate and wood on the lower edges of the doors (on 3 of 4 resident hallways), failed to repair a loose toilet with a broken bolt at the base of the toilet in the bathroom of resident room #310, failed to repair an edge guard on a wall in resident room #311 and failed to repair base molding in resident room #305 and between the therapy department and entrance to the 100 hall.

During the recertification survey of 12/04/15 the facility was cited for failure to repair resident doors with broken and splintered laminate and wood on 13 of 59 resident doors (Resident room #101, #104, #105, #106, #108, #109, #110, #111, housekeeping garbage for discard.

On 2/2/17, The Director of Maintenance placed an order for a contract vendor to replace the smoke prevention doors on the 200 and 400 hallways, doors to the main dining room, the door of the dayroom/dining room on the 300 hall, and resident bathroom doors in resident rooms #108, #211, #213, #303, #305, #310 and #312. They will be replaced and installed by 3/21/17.

The Director of Maintenance repaired the loose toilet with the broken bolt at the base of the toilet and related grout in the bathroom of resident room #310 on 1/20/17.

The Director of Maintenance replaced the edge guard on the wall in resident room #311 on 1/20/17.

The Director of Maintenance replaced the base molding in resident room #305 on 1/20/17 and the base molding between the therapy department and entrance to the 100 hall on 2/2/17.

The Executive Director (ED) will educate the Performance Improvement (PI) Committee on the facility Performance Improvement Program Policy, and the requirement for this committee to ensure substantial compliance with federal regulations to include maintaining implemented procedures and monitor these interventions that the committee puts into place. The policy includes the

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F 520	Continued From page 15 #114, #208, #404, #406 and #415); failed to repair bathroom doors with broken and splintered laminate and wood in 3 of 59 resident rooms (Room #108, #114 and #403); failed to repair broken and splintered laminate and wood on 4 of 4 central bath doors on 100, 200, 300 and 400 halls; failed to label and cover personal care equipment in 2 resident bathrooms (Resident rooms 310 and 313) on 300 hall and 2 resident bathrooms on 400 hall (Resident rooms 401 and 402) and failed to keep 2 resident wheelchairs clean on 400 hall (Residents #126 and #156). During an interview with the Administrator on 01/20/16 at 4:30 PM she explained after the last recertification survey the plan of correction for environmental and maintenance issues was developed to roll out a little at a time and more work needed to be done. She stated they did incorporate the environmental and maintenance concerns last year in the Quality Assurance and Assessment process but focused on damage to resident room doors and corrected them. She explained they had developed the maintenance work order system and she expected for staff to report damage to doors or other damage on a work order and she expected for maintenance to do repairs. She stated she did not feel there had been a failure to communicate but it was more of a timing issue and they had not been able to get all of the environmental and maintenance problems fixed before the survey was conducted.	F 520	committee's responsibility to monitor, evaluate and ensure appropriate follow-up action. This will occur by 2/17/17. The committee which consists of, but is not limited to, the Executive Director, Medical Director, Director of Nursing, Business Office Manager, Health Information Management Director, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Food Services, Infection Control Nurse, and Staff Development Coordinator will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. If any member of the Performance Improvement Committee is not present, findings will be reviewed upon return to work. How will this deficiency be corrected for each resident who would be affected by the deficient practice in the future? The Minimum Data Set (MDS) Coordinators, The Discharge Planning Nurse, Staff Development Coordinator and Health Information Management Director conducted a 100% audit of resident rooms for proper labeling and storage of resident personal care items on 1/20/17, and no other bath basins or personal care items were unlabeled or improperly stored. The Director of Maintenance reviewed all	

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smoke prevention doors, and non-smoke prevention doors, including resident bathroom doors, for disrepair on 1/23/17, and any/or all identified doors were repaired by 2/17/17 or were ordered for replacement and installation no later than 3/21/17.

The Maintenance Director will review all the toilets in the facility to ensure there are no loose or cracked bolts or grout, all edge guards on the walls in resident rooms and base molding in resident rooms by 2/17/17 to ensure that there are no further identified issues noted.

What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future?

The Director of Nursing, Staff Development Coordinator or designee completed educated from 2/7/17 - 2/17/17 with all housekeeping staff, therapy staff and nursing staff on proper labeling and storage of residents' personal care items. Any associates not educated by 2/17/17 will not work until this education is received and new staff will be trained during orientation.

The Director of Nursing or designee will conduct an inspection of 5 random resident rooms weekly to observe for proper labeling and storage of personal items. Any items found to be out of compliance will be corrected at that time.

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F 520	Continued From page 17	F 520	The Director of Maintenance or designee will educate all facility staff on the work order process by 2/17/17. Any associates not educated by 2/17/17 will receive this training before returning to work. New associates in those departments will receive this education during orientation. The Director of Maintenance or designee will conduct an inspection of all smoke prevention doors, 5 random non-smoke prevention doors, 5 toilets, 5 edge guards and 5 base molding areas in the facility weekly. As needed repairs are identified, they will be prioritized and scheduled. A copy of the completed work order will be given to the Executive Director weekly for 3 months to ensure findings have been corrected or a plan is in place for correction. The Performance Improvement (PI) Committee will review the results of the audits and education will be provided for all survey findings bi-monthly for 3 months to ensure substantial compliance is met. How will the facility monitor the measures to make sure that solutions are sustained? The Director of Maintenance and Director of Nursing will present all findings to the Performance Improvement Committee monthly for 3 consecutive months. The Performance Improvement Committee consisting of, but not limited to, the Executive Director, Medical Director,	

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F 520	Continued From page 18	F 520	Director of Nursing, Business Office Manager, Health Information Management Director, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Food Services, Infection Control Nurse, and Staff Development Coordinator will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. If any member of the Performance Improvement Committee is not present, findings will be reviewed upon return to work.	