STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 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 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	F 159		3/9/17

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

Electronically Signed | 02/24/2017

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F 159	Continued From page 1 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 record review, resident interview and staff interview, the facility failed to provide residents ready access to their personal funds for 4 of 9 residents reviewed with personal funds (Resident #33, #75, #100, and #180). The findings included: 1. Resident #33 was admitted to the facility on 11/9/12 with multiple diagnoses that included Diabetes Mellitus, hypertension, and dementia. The annual Minimum Data Set (MDS)	F 159	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provisions of the Federal & State Law. F159 Business Office Manager met with	

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F 159	Continued From page 2 assessment dated 10/18/16 indicated her cognition was intact. An interview was conducted with Resident #33 on 2/6/17 at 4:19 PM. She indicated she had a personal fund account with the facility. She stated banking hours were Monday through Friday and she was unable to access her funds over the weekend. An interview was conducted with the Business Office Manager (BOM) on 2/9/17 at 10:08 AM. She reported she was responsible for managing resident personal fund accounts. She confirmed Resident #33 had a personal fund account. The BOM stated that residents were able to access their funds by coming to the business office between 9:00 AM and 5:00 PM on Monday through Friday. She revealed the facility had no process in place for residents to access their personal fund accounts over the weekend. She indicated the facility had previously utilized a petty cash system that allowed the weekend charge nurse to access and disburse personal funds to residents if requested. The BOM stated this petty cash system ceased being used at least 4 months ago. An interview was conducted with the Administrator on 2/9/17 at 5:00 PM. She indicated she expected residents to have access to their personal fund accounts as required. She reported she was unaware the petty cash system that was previously utilized over the weekend had been discontinued prior to her employment at the facility. 2. Resident #75 was admitted to the facility on 3/13/10 with multiple diagnoses that included	F 159	resident #33, #75, #100, and #180, on 2/24/17, and informed them of the banking hours for the weekend. Business Office Manager met with the resident council 2/28/17, to inform them of the weekend banking hours. A sign is posted at the front office with weekend banking hours. Nursing Supervisor will be responsible for distribution of resident funds on the weekend. Weekend banking hours has been established (10a-5p) Sat & Sun. The Nursing Supervisor has been re-educated by the Business Office Manager on the process for distribution of monies and documentation. Administrator and/or Business Office Manager will complete weekly observation and interview residents to verify that funds are available on the weekends, this will include monthly meetings with the Resident Council. Administrator and/or Business Office Manager will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee monthly for 6 months to ensure a trend of compliance is evident.	

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F 159	Continued From page 3	F 159		

intracranial injury and history of cerebrovascular accident (CVA). The quarterly MDS assessment dated 10/3/16 indicated his cognition was intact.

An interview was conducted with Resident #75 on 2/6/17 at 3:23 PM. He indicated he had a personal fund account with the facility. He stated banking hours were Monday through Friday and he was unable to access his funds over the weekend.

An interview was conducted with the BOM on 2/9/17 at 10:08 AM. She reported she was responsible for managing resident personal fund accounts. She confirmed Resident #75 had a personal fund account. The BOM stated that residents were able to access their funds by coming to the business office between 9:00 AM and 5:00 PM on Monday through Friday. She revealed the facility had no process in place for residents to access their personal fund accounts over the weekend. She indicated the facility had previously utilized a petty cash system that allowed the weekend charge nurse to access and disburse personal funds to residents if requested. The BOM stated this petty cash system ceased being used at least 4 months ago.

An interview was conducted with the Administrator on 2/9/17 at 5:00 PM. She indicated she expected residents to have access to their personal fund accounts as required. She reported she was unaware the petty cash system that was previously utilized over the weekend had been discontinued prior to her employment at the facility.

3. Resident #100 was admitted to the facility on 3/22/10 with multiple diagnoses that included

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F 159	Continued From page 4	F 159		

dementia. The quarterly MDS assessment dated 12/6/16 indicated his cognition was moderately impaired.

An interview was conducted with Resident #100 on 2/6/17 at 10:59 AM. He indicated he had a personal fund account with the facility. He stated banking hours were Monday through Friday and he was unable to access his funds over the weekend.

An interview was conducted with the BOM on 2/9/17 at 10:08 AM. She reported she was responsible for managing resident personal fund accounts. She confirmed Resident #100 had a personal fund account. The BOM stated that residents were able to access their funds by coming to the business office between 9:00 AM and 5:00 PM on Monday through Friday. She revealed the facility had no process in place for residents to access their personal fund accounts over the weekend. She indicated the facility had previously utilized a petty cash system that allowed the weekend charge nurse to access and disburse personal funds to residents if requested. The BOM stated this petty cash system ceased being used at least 4 months ago.

An interview was conducted with the Administrator on 2/9/17 at 5:00 PM. She indicated she expected residents to have access to their personal fund accounts as required. She reported she was unaware the petty cash system that was previously utilized over the weekend had been discontinued prior to her employment at the facility.

4. Resident #180 was admitted to the facility on 8/5/16 with multiple diagnoses that included

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F 159	Continued From page 5 cancer. The quarterly MDS assessment dated 11/22/16 indicated his cognition was intact. An interview was conducted with Resident #180 on 2/6/17 at 10:59 AM. He indicated he had a personal fund account with the facility. He stated banking hours were Monday through Friday and he was unable to access his funds over the weekend. An interview was conducted with the BOM on 2/9/17 at 10:08 AM. She reported she was responsible for managing resident personal fund accounts. She confirmed Resident #180 had a personal fund account. The BOM stated that residents were able to access their funds by coming to the business office between 9:00 AM and 5:00 PM on Monday through Friday. She revealed the facility had no process in place for residents to access their personal fund accounts over the weekend. She indicated the facility had previously utilized a petty cash system that allowed the weekend charge nurse to access and disburse personal funds to residents if requested. The BOM stated this petty cash system ceased being used at least 4 months ago. An interview was conducted with the Administrator on 2/9/17 at 5:00 PM. She indicated she expected residents to have access to their personal fund accounts as required. She reported she was unaware the petty cash system that was previously utilized over the weekend had been discontinued prior to her employment at the facility.	F 159		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		3/9/17

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F 242	Continued From page 6 (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to honor resident's choice in bathing for two of two sampled residents reviewed for choices (Resident #75 and #58). The findings included: 1. Resident #75 was admitted to the facility 10/5/12. Cumulative diagnoses included history of cerebrovascular accident with left hemiparesis (paralysis). A Quarterly Minimum Data Set dated 10/3/16 indicated Resident #75 was cognitively intact. A Quarterly MDS dated 1/3/17 indicated Resident #75 had clear speech, was able to make himself understood and understood others. Resident #75 required extensive assistance of one person for personal hygiene and total assistance with bathing. A care plan dated 5/2/16 and last reviewed	F 242	F242 Resident #75 and #58 were assessed 2/26/17 by the Director of Nursing and/or Administrative Nurses to identify their individual resident care needs and choice related to, bathing. Resident care guide, and care plan updated by the Director of Nursing and/or Administrative Nurses on 3/2/17. Resident #75 and #58 bathing will be in the morning on Tuesday & Friday. They are receiving showers based on their choices. Director of Nursing and Administrative Nurses have reassessed all current residents to identify individual care needs and choices related to bathing. Resident Care Guides have been updated to reflect individual care needs & choice on or before 3/9/17.	

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F 242	Continued From page 7 1/17/17 stated Resident #75 required staff assistance and intervention for completion of ADL's (activities of daily living). Nursing staff were to provide care and encourage active participation in tasks. On 2/7/17 at 3:12PM, an interview was conducted with Resident #75 who stated he got his shower today and was supposed to get 2 showers a week on Tuesdays and Fridays. He said there had been many times he did not get 2 showers a week. Resident #75 said it was on Tuesday that many of his showers were not done and he felt that he should receive his showers as scheduled. A review of the shower schedule from December 2016 through February 7, 2017 revealed Resident #75 was supposed to receive a shower on Tuesday and Friday on the day shift (7:00AM-3:00PM). The following was noted: 12/9/16-nothing documented 12/13/16--shower given 12/16/16--shower given 12/20/16--shower given 12/27/16--shower refused 12/30/16--shower given 1/3/17-nothing documented 1/6/17--shower given 1/10/17--nothing documented 1/13/17--nothing documented 1/17/17-- shower given 1/20/17--nothing documented 1/24/17--nothing documented 1/27/17--nothing documented 1/31/17--nothing documented 2/3/17--nothing documented 2/7/17-- shower given On 2/9/17 at 8:45 AM, an interview was	F 242	Director of Nursing and/or Administrative Nurses will complete re-training with current nursing staff related to F242, providing resident individual care needs and choices on or before 3/9/17. The Director of Nursing and/or Administrative Nurses will complete walking rounds, daily 5 days weekly to ensure that nursing staff are providing bathing needs. QI tool will be used to record results of these rounds including interviews and observations of 5 resident/day. Walking rounds will continue, randomly twice daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee monthly for 6 months to ensure a trend of compliance is evident.	

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conducted with NA#1. She stated she had provided care for Resident #75 for about eight months. NA#1 stated he had only refused a shower for her one time and that was in early January. She said she might have forgotten to record that Resident #75 received a shower on 1/10/17, 1/20/17, 1/24/17 and 2/3/17.

On 2/9/17 at 11:30AM, an interview was conducted with the Director of Nursing who stated residents should receive their showers as per the shower schedule or as requested by the resident.

2. Resident # 58 was admitted to the facility on 12/8/09 with multiple diagnoses including Parkinson's disease and Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 11/22/16 indicated that Resident #58's cognition was intact. The assessment also indicated that Resident #58 was dependent on the staff with bathing and she had no behavior problems.

The care plan dated 11/22/16 was reviewed. One of the care plan problems was" the resident requires staff assistance and intervention for completion of activities of daily living (ADL) needs and she requires extensive to total care utilizing two staff members." The goal was "resident will have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function." The approaches included to gather and provide needed supplies and to encourage active participation in tasks.

The facility's shower schedule was reviewed. The shower schedule indicated that Resident #58 was scheduled to have a shower every Tuesday

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and Friday on 2nd shift.

The daily shower sheets for Resident #58 were reviewed for December 2016 and January and February 2017. The shower sheets revealed that Resident #58 was provided a shower 4 times in December (December 9, 20, 27, & 30), 2 times in January (January 17 & 20) and none in February. The sheets also revealed that Resident #58 had refused showers on December 6 and January 13.

On 2/6/17 at 1:35 PM, Resident #58 was interviewed. She reported that she had concerns of not receiving showers due to short staff. She stated that her shower days were Tuesday and Friday on the evening shift. She indicated that there was one nursing assistant (NA) assigned on the hall on 3-11 shift.

On 2/7/17 at 4:45 PM, Resident #58 was again interviewed. She stated that it was her shower day and nobody would give her a shower because there was only one NA assigned on the hall. She added that she had never refused a shower because her shower was very important to her.

On 2/7/17 at 4:50 PM, NA #8 was interviewed. She stated that she worked on 3-11 shift and was assigned to Resident #58. She revealed that the normal staffing on the hall where Resident #58 resided was 4 NAs but only 3 NAs assigned most of the time. With 3 NAs on the hall, she was assigned to 20 residents. NA #8 stated that "I do the best I can" for the 20 residents. She revealed that she didn't have the time to give showers.

On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. The DON stated that

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F 242	Continued From page 10 she expected the NAs to provide showers to residents as scheduled.	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a reclining chair to accommodate a physician order dated 10/27/16 for Resident #205 to be up out of bed twice weekly for 1 of 1 resident reviewed for accommodation of needs. Findings included: Resident #205 was admitted 8/20/15 with a diagnosis of traumatic brain injury (TBI). The most recent quarterly MDS dated 1/8/17 coded Resident #205 as comatose and requiring total assistance for all her activities of daily living (ADLs). A review of Resident #205 last revised ADL care plan on 10/7/16 included an intervention dated 10/25/16 that she was to be up out of the bed twice weekly on her shower days. A review of Resident #205 ' s physician orders read on 10/27/16 she was to be up out of bed twice weekly on shower days. In an observation on 2/5/17 at 5:00 PM, Resident #205 was lying in bed. In an observation on 2/6/17 at 9:00 AM, Resident #205 was lying in bed.	F 246	F246 Resident #205 has been re- assessed by the Director of Nursing and Physical Therapy on 2/23/17, to identify individual accommodation of needs, related to seating. Resident # 205 currently has a reclining chair provided as MD ordered. Director of Nursing and Administrative Nurses have reviewed current physician orders to identify individual needs related to implementation of current physician orders, including Specialty chairs and mobile devices. Any resident indentified with a need of a speciality chair and/or mobile devices will be provided equipment through our medical supply vendor as needed to promote quality of life as of 3/9/17. Director of Nursing and/or Administrative Nurses will complete re-training by 3/9/17, with current nursing staff, including PRN and weekend staff, on MD Order procedure, process and implementation related to F242, providing reasonable	3/9/17

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F 246	Continued From page 11 In an observation on 2/7/16 at 2:50 PM, Resident #205 was lying in bed In an observation on 2/8/16 at 10:00 AM, Resident #205 was lying in bed. In an observation on 2/8/17 at 4:40 PM, Resident #205 was lying in bed. In an observation on 2/9/17 at 8:15 AM, Resident #205 way lying in bed. In an interview on 2/9/17 at 8:20 AM, nursing assistant (NA) #5 stated she had worked at the facility for ten years and usually was assigned Resident #205. She stated she was not aware that Resident #205 was to be left up out of bed in a reclining chair on her showers days. NA #5 stated she had never seen Resident #205 up in a reclining chair and the facility only had three of four reclining chairs for the whole building. She stated that was not enough to accommodate all the residents who should be gotten out of the bed. In an interview on 2/9/17 at 8:22 AM, Restorative Aide (RA) #1 stated she had never observed Resident #205 sitting in a reclining chair except one time last spring when her responsible party (RP) stayed in town for a week to visit her. She recalled the RP taking Resident #205 outside in a reclining chair. RA #1 stated she thought the facility only had a few reclining chairs and there was not enough for everyone who needed them. She stated staff were always borrowing from station three (700 hall) because they had two on that end for two specific residents. In an interview on 2/9/17 at 9:02 AM, NA #12 stated she was not aware that Resident #205 was to be left up in a reclining chair on her shower days. She stated she had never seen resident	F 246	accommodations to promote quality of life, including providing appropriate chair or mobility devise to promote quality of life. DON and/or Adm nurses will monitor MD orders by reviewing 6 physician orders weekly x 4 weeks; then, monthly x 3 months to ensure MD orders are processed and implemented timely. Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee monthly for 6 months to ensure a trend of compliance is evident.	

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F 246	Continued From page 12 #205 in a reclining chair since she was admitted. In an observation and interview on 2/9/17 at 2:15 PM, NA #5 stated she gave Resident #205 a shower and borrowed a reclining chair from station three (700 hall) to sit her in at the nursing station. Resident #205 was clean, well groomed and appeared comfortable and engaged in activities going on around her. In a tour of the facility on 2/9/17 at 2:20 PM, there was only two observed reclining chairs in the facility, one on 700 hall and the other one observed was in use by Resident #205. In an interview on 2/9/17 at 2:30 PM, NA #13 working on 700 hall stated she only knew of two reclining chairs and one of those was borrowed by NA #5 earlier. In an interview on 2/9/17 at 5:00 PM, the Administrator stated at one time, the facility was trying to do away with reclining chairs because they could be considered a restraint if not used properly. The Administrator and Director of Nursing stated it was their expectation the facility provide a reclining chair to accommodate the order for Resident #205 to be up out of bed twice weekly.	F 246		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 248		3/9/17

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F 248	Continued From page 13 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provided one to one (1:1) activities for 1 (Resident #205) of 3 residents reviewed for activities. Findings included: Resident #205 was admitted 8/20/15 with a diagnosis of traumatic brain injury (TBI). The most recent quarterly MDS dated 1/8/17 coded Resident #205 as comatose and requiring total assistance for all her activities of daily living (ADLs). A review of Resident #205 Activity Assessment History last completed 8/26/15 with the assistance of the responsible party indicated the following activities were of interest to her: watching television, movies, listening to rhythm and blues music, reading, plants and religious services on occasion and past interest of being outdoors. The summary read Resident #205 was confined to bed and would receive 1:1 visits two to three times weekly. A quarterly activity note dated 7/7/2016 read Resident #205 had no changes in her cognitive or physical abilities and she would continue to receive 1:1 visits two to three times weekly. Another quarterly activity note dated 10/7/2016 read Resident #205 continued to receive 1:1 intervention from activity department and family visits. The note read to continue with the plan of care for three more months.	F 248	F248 Resident #205 was re-assessed by the Activities Director, to determine activity needs. Resident care plan was updated, by Activities Director, to included 1:1 activities on 2/24/17. Resident #205 is now receiving 1:1 activities to accommodate her individual activity needs. Activities Director and/or assistants have completed an activities assessment on all current residents, as of 3/3/17, to identify activity needs, including but not limited to 1:1 activities. Resident care plan has been updated, by the Activities Director, with current activity individual needs as of 3/9/17. The Administrator has completed re-training with the activities director, 2/23/17 related to, F 248 including completing activities assessment, development of individualized care planning goals to reflect information gathered from assessment, and providing and documentation of 1:1 activities for residents. New admissions, Activities Director and/or assistant will complete an activity	

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F 248	Continued From page 14 A review of Resident #205 last care plan revised on 10/7/16 did not include an activities care plan regarding her 1:1 visits two to three times weekly. A review of the Record of One-To-One Activities logs from 12/19/16 to 2/9/17 included only one in room visit per week from 12/21/16 through 1/18/17: 12/21/16-put lotion on arms and talked about television 12/30/16-talked 1/4/17-read 1/11/17- put lotion on her arms 1/18/17-music and lotion 1/23/17-soft yarn 1/25/17 -showed her dancing animals on window seal 1/30/17-season pictures and cards 2/1/17-sang The last activity note was completed on 1/6/2017 and read there was no changes in her activity interest or participation. The activity department was to continue with current plan of care for three months. In an observation on 2/7/16 at 2:50 PM, Resident #205 was lying in bed with her window blinds closed and the television playing. Resident #205 tube feeding was stopped and head of her bed was elevated approximately 30 degrees with her head turned toward the right slight and tilted downward. There was a towel placed on her chest to keep her gown dry from salvia. When asked if she liked to look outside, Resident #205 nodded her head up and down as if saying "yes". In an interview on 2/7/17 at 4:50 PM, the activity	F 248	assessment for new admissions, according to the RAI guidelines, to identify individual resident activity needs, including need for 1:1 activity. Each resident identified to have a need for 1:1 activities will have daily documentation completed by the Activities Director and/or assistant in the resident medical record. Activities director will monitor 1:1 activities for residents to ensure that implementation and documentation for each resident by observation and record review randomly twice daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months. QI monitoring tool will be use by the Activities director to record monitoring of 1:1 activities. Activities Director will compile a summary of monitoring efforts and present to the facility Quality Assurance & Performance Improvement committee monthly for 6 months to ensure a trend of compliance.	

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F 248	Continued From page 15 director (AD) Resident #205 was receiving 1:1 visits by someone from the activities department but was unsure of the frequency of the visits. In another interview on 2/9/17 at 8:00 AM, the AD stated someone from her department should be visiting Resident #205 at least twice weekly and an Activity Assessment should have done completed annually with Resident #205 ' s responsible party. In an interview on 2/9/17 at 8:20 AM, nursing assistant (NA) #5 stated she had worked the facility for ten years and worked most days with Resident #205. She stated Resident #205 was able to communicate her like and dislikes if she was asked yes or no questions. In an interview on 2/9/17 at 5:00 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #205 be assessed annually for activity preference and receive in-room 1:1 visits at a minimum of twice weekly.	F 248		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 272		3/9/17

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F 272	Continued From page 16 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to completely assess residents on the Minimum Data Set (MDS) assessment for 13	F 272	F272 Medical record for residents #27, #33, #73, #146, #149, #215, #241, #82, #97,	

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F 272	Continued From page 17 of 35 sampled residents (Residents #27, #33, #73, #146, #149, #215, #241, #82, #97, #205, #199, #75, and #151). The findings included: 1. Resident #27 was admitted to the facility on 4/9/10 with multiple diagnoses that included heart failure, dementia, and schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated 12/29/16 indicated Resident #27 had clear speech, was able to make himself understood, and he understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #27. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #27. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #27. Questions Q0100 through Q0600 were not assessed. An interview was conducted with the Social Worker (SW) on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was	F 272	#205, #252, 199, #75, and #151 were reviewed, District Director of Care Management for, accuracy and completion on 2/22/17. Significant corrections of prior assessments will be completed for those residents on or before 3/9/17 to accurately reflect the residents' current status, District Director of Care Management reviewed current residents OBRA assessments with assessment reference dates between 1/24/17 -2/28/17,to ensure that assessments are complete. This review will include that all triggered CAAs are complete. Any resident identified during this time, with an incomplete assessment or CAA, will have a significant correction completed per RAI guidelines on or before 3/9/17. District Director of Care Management provided education, on 2/22/17, with the MDS department, Social Services, and Activity Director regarding complete assessments, complete CAAs, the use of dashes, and the significant correction of prior assessment process. Residents' assessments are scheduled per RAI manual requirements. A calendar is created by the MDS Supervisor to communicate assessment reference dates to the interdisciplinary team. If at any time a member of the team is not able to complete their section(s) of the MDS, it will be reported to the MDS Supervisor immediately so that timely/complete assessments will be achieved.	

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F 272	Continued From page 18 not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the Assessment Reference Date (ARD) so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th. An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed. 2. Resident #33 was admitted to the facility on 11/9/12 with multiple diagnoses that included Diabetes Mellitus, hypertension, and dementia. The quarterly MDS assessment dated 1/18/17 indicated Resident #33 had clear speech, was able to make herself understood, and she understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #33. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for	F 272	The ADON/IDT will review progress of completion of resident MDS sections daily in the morning team meeting by pulling the “MDS in Progress” report. Each member of the IDT team will validate timely completion of their sections by initialing the print out of the “in progress” report which will serve as an audit tool. Failure to maintain compliance will result in disciplinary action. MDS Supervisor will complete a summary report of status of completion/accuracy monthly to the QAPI committee for 6 months or until a trend of compliance is evident.	

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Resident #33. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #33. Questions Q0100 through Q0600 were not assessed.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully

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completed.

3. Resident #73 was admitted to the facility on 1/9/15 with multiple diagnoses that included schizophrenia and dementia.

The annual MDS assessment dated 1/17/17 indicated Resident #73 had clear speech, was usually able to make herself understood, and she sometimes understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #73. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #73. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #73. Questions Q0100 through Q0600 were not assessed.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the

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facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

4. Resident #146 was admitted to the facility on 6/7/15 with multiple diagnoses that included multiple sclerosis.

The annual MDS assessment dated 12/28/16 indicated Resident #146 had clear speech, was able to make herself understood, and she understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #146. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #146. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the

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Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #146. Questions Q0100 through Q0600 were not assessed.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

5. Resident #149 was admitted to the facility on

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RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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7/11/16 with multiple diagnoses that included prostate cancer.

The quarterly MDS assessment dated 1/17/17 indicated Resident #149 had clear speech, was able to make himself understood, and he understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #149. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #149. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #149. Questions Q0100 through Q0600 were not assessed.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that

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sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

6. Resident #215 was admitted to the facility on 9/30/15 with multiple diagnoses included bipolar disorder.

The quarterly MDS assessment dated 12/30/16 indicated Resident #215 had clear speech, was usually able to make herself understood, and she usually understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #215. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #215. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #215.

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F 272	Continued From page 25 Questions Q0100 through Q0600 were not assessed. An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th. An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed. 7. Resident #241 was admitted to the facility on 3/17/16 with multiple diagnoses that Alzheimer ' s and atrial fibrillation.	F 272		

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The quarterly MDS assessment dated 12/25/16 indicated Resident #241 had clear speech, was sometimes able to make himself understood, and he sometimes understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #241. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500, were not assessed. Section D, the Mood section, was not fully completed for Resident #241. Question D0100 indicated the resident mood interview was not assessed. The remaining resident interview questions in the Mood section, questions D0200 through D0300, were not assessed. Section Q, the Participation in Assessment and Goal Setting section, was not completed for Resident #241. Questions Q0100 through Q0600 were not assessed.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she

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was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

8. Resident #97 was admitted to the facility on 10/23/14 with multiple diagnoses including Dementia without behavioral disturbances. His cognitive patterns section (C), mood section (D) and participation in assessment and goal setting section (Q) were blank on the quarterly Minimum Data Set (MDS) assessment dated 1/19/17.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D, and Q). She reported she was just unable to complete the assessments within the ARD so she

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had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

9. Resident #252 was admitted to the facility on 10/17/16 with multiple diagnoses including Seizures. His cognitive patterns section (C), mood section (D) and participation in assessment and goal setting section (Q) were blank on the quarterly Minimum Data Set (MDS) assessment dated 1/10/17.

An interview was conducted with the SW on 2/8/17 at 10:45AM. She stated she completed Sections C, D, and Q of the MDS. She reported she had worked at the facility for about 3 years. She indicated she was unsure of the number of questions that were required to be completed before ceasing the resident interviews. The SW was informed of multiple MDS assessments that were identified as not assessed for sections C, D, and Q. She revealed this was not a surprise to her. She stated she was the only SW at the facility at that time and she had gotten behind on her portion of the assessments (sections C, D,

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and Q). She reported she was just unable to complete the assessments within the ARD so she had to put "Not Assessed". The SW revealed that sections C, D, and Q should have been assessed. She stated that, as of 1/25/17, she was now up to date on the MDS assessments. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up the assessments and get back on track. She also reported another SW had been hired and she was scheduled to start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

10. Resident #205 was admitted 8/20/15 with a diagnosis of traumatic brain injury (TBI). The annual Minimum Data Set (MDS) dated 4/7/16 indicated Resident #205 was comatose (section B) thereby blocking out the activities section (section F) of the annual MDS. There was no Care Area Assessment triggered for activities due to the incorrect coding of Resident #205 as in a persistent vegetative state. The quarterly Minimum Data Set (MDS) dated 7/8/17 indicated she was comatose (section B) but the quarterly MDS dated 10/8/16 did not indicated Resident #205 was comatose (section B) allowing for the completion of sections C and D. The most recent quarterly MDS dated 1/8/17 was again coded as Resident #205 was comatose (section B) and requiring total assistance for all her activities of daily living (ADLs).

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In an interview on 2/8/17 at 12:30 PM the Activity Director (AD) stated she completed section F of the annual and significant change MDS assessments. She stated she did not know why Resident #205 ' s RP was not called and interviewed about her activity preference last April.

In an interview on 2/8/17 at 4:50 PM, MDS #2 stated when Resident #205 was coded as comatose in section B on 4/7/16, it removed the option for activities to be assessed. MDS nurse #2 was unable to provide documentation that Resident #205 was considered comatose. MDS nurse #2 stated it was a coding error.

In an interview on 2/9/17 at 5:00 PM, the Administrator and the Director of Nursing stated it was their expectation that the MDS be fully completed.

11. Resident #199 was admitted 1/13/17 with cumulative diagnoses of chronic obstructive pulmonary disease (COPD) and hypertension. The 5 day MDS dated 1/20/17 indicated section C and section Q were not assessed.

In an interview on 2/8/17 at 10:45 AM, the SW stated she completed sections, C, D and Q of the MDS. She stated she had worked at the facility for three years. The SW was informed of multiple MDS assessments identified as missing completion of section C, D and Q. She stated she was not surprised because she was the only SW at the facility and she had gotten behind on her portion of the MDS assessment within the ARD so she had to put "Not Assessed." She stated she

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be caught up as off 1/25/17 and now up to date of her portion of the MDS assessment. She stated the facility recently hired a Case Manager who was assisting her and the facility had hired another SW who was scheduled to start on 2/28/17.

In an interview on 2/9/17 at 5:00 PM, the Administrator and the Director of Nursing stated it was their expectation that the MDS be fully completed.

12. Resident #75 was admitted to the facility 10/5/12. Cumulative diagnoses included intracranial injury and history of cerebrovascular accident (CVA) with left hemiparesis (paralysis).

A Quarterly Minimum Data Set (MDS) dated 1/3/17 indicated Resident #75 had clear speech, was able to make himself understood and understood others. Section C, the Cognitive Patterns section, was not fully completed for Resident #75. Question C0100 indicated a Brief Interview for Mental Status (BIMS) was not assessed. The remaining resident interview questions in the BIMS section, questions C0200 through C0500 were not assessed. The staff assessment for mental status indicated Resident #75 had adequate short term and long term memory and was independent with daily decision-making. Section D for mood revealed D0100 -D300 was documented as not assessed. Section Q0100 through Q0600 was blank and not assessed.

On 2/8/17 at 10:45AM, an interview was conducted with the Social Worker. She stated she completed Section C, D, and Q. She had worked at the facility for about 3 years. She said

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she was unsure of the number of questions that were required to be completed before ceasing the resident interview. When it was reported to her there were a number of assessments identified that were not assessed for C, D, and Q. She indicated this was not a surprise to her. She stated she was the only Social Worker here at that time and she had gotten behind on the assessments. She stated she was just unable to complete all of the assessments within the ARD (Assessment Reference Date) so she had to put Not Assessed. She indicated they should have been attempted. She stated that, as of 1/25/17, she was now up to date. She indicated the facility hired a Case Manager who was assisting her and this was how she was able to catch up on get back on track. She also reported another Social Worker had been hired and she would start on Feb 28th.

An interview was conducted with the Administrator and Director of Nursing (DON) on 2/9/17 at 5:00 PM. The Administrator and DON both indicated they expected the MDS to be fully completed.

13. Resident #151 was admitted to the facility 3/1/13. Cumulative diagnoses included: chronic kidney disease, diabetes and hypertensive heart disease with heart failure.

A Modified Annual Minimum Data Set (MDS) dated 11/12/16 indicated Resident #151 was moderately impaired in cognition. She required extensive assistance for personal hygiene. Section L0200 for Dental indicated that Resident #151 had obvious or likely cavity or broken natural teeth.

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F 272	Continued From page 33 A Care Area Assessment (CAA) was reviewed and revealed that there was no information documented on the CAA and the area had not been completed. On 2/8/17 at 10:00AM, an interview was conducted with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated she did not know why the CAA had not been completed. MDS Nurse #2 stated she had completed the modified MDS dated 11/12/16 and the modification had included the change in the dental section. She stated she did not know why the CAA was not completed and it should have been completed with the modified assessment. On 02/09/2017 at 5:16PM, an interview was conducted with the Administrator and Director of Nursing. She stated a second social worker had been hired and the facility had also hired a case manager who completed all the MDS assessments for short stay residents. Both the Adminsitrator and Director of Nursing stated they expected the MDS to be fully completed.	F 272		
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	F 278		3/9/17

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F 278	Continued From page 34 the assessment is completed. (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 code the Minimum Data Set (MDS) assessment accurately in the areas of Preadmission Screening and Resident Review (PASRR) level II (Residents #27, #73, #115, and #215), behaviors (Resident #151), and discharge status (Resident #147) for 6 of 35 sampled residents reviewed. The findings included: 1. Resident #27 was admitted to the facility on 4/9/10 with multiple diagnoses included schizoaffective disorder, depression, and anxiety. Record review indicated Resident #27 had a level	F 278	F278 The referenced MDS of residents #27, #73, #115, #215, #151 and #147 was reviewed by the District Director of Care Management, on 2/22/17, related to PASRR, behaviors, and discharge status. Modifications to the referenced MDS assessments will be completed on or by 3/9/17 to accurately reflect the residents' PASRR status, behaviors, and discharge status. District Director of Care Management will complete an audit on 3/2/17 of current	

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F 278	Continued From page 35 II PASRR. The annual MDS assessment dated 4/9/16 indicated a "No" to question A1500 which asked if Resident #27 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 2/8/17 at 10:45 AM. She reported she was involved in maintaining a list of residents who had level II PASRRs. She stated the MDS Nurses completed Section A of the MDS. She revealed she was not sure how the MDS Nurses were kept informed of residents who had level II PASRRs. An interview was conducted with MDS Nurse #2 on 2/8/17 at 5:15 PM. She stated the MDS Nurses were responsible for the completion of Section A of the MDS. Question A1500 which asked if a resident had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she checked with the SW to answer question A1500 for verification of residents who had level II PASRRs. A follow up interview was conducted with the SW on 2/8/17 at 5:40 PM. She confirmed Resident #27 was a level II PASRR and that the 4/9/16 annual MDS was coded inaccurately. An interview was conducted with the Director of Nursing (DON) on 2/9/17 at 5:00 PM. She indicated her expectation was for the MDS to be completed accurately.	F 278	comprehensive assessments and cross reference their medical record to ensure MDS coding is accurate for Section A PASRR. PASRR – District Director of Care Management completed re-education on 2/22/17, with the MDS Department, Social Services Department, Admissions, Business Office and Activities regarding PASRR Level. Admission and Social Services Director will complete an audit of current residents to ensure that each resident has a PASRR number available and has been entered into facility electronic medical records. This list will be updated weekly to include any new resident(s). This will ensure that information is available to MDS staff at all times so that accurate coding of PASRR status will be achieved. The District Case mix Specialist will audit all comprehensive MDSs completed weekly x 4 weeks to ensure that PASRR status is accurately reflected in section A of the MDS. After 4 weeks, the District Case mix Specialist will audit a minimum of 10 Comprehensive MDSs monthly x 3 months to ensure PASRR status is accurately reflected in section A of the MDS. The ADON will report the results of all monitoring efforts and present findings at the monthly QAPI meeting for 3 months than quarterly thereafter. The Quality Assurance Performance Improvement committee will review monitoring	

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F 278	Continued From page 36 2. Resident #73 was admitted to the facility on 1/9/15 with multiple diagnoses included schizophrenia. Record review indicated Resident #73 had a level II PASRR. The annual MDS assessment dated 1/7/17 indicated a "No" to question A1500 which asked if Resident #73 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 SW on 2/8/17 at 10:45 AM. She reported she was involved in maintaining a list of residents who had level II PASRRs. She stated the MDS Nurses completed Section A of the MDS. She revealed she was not sure how the MDS Nurses were kept informed of residents who had level II PASRRs. An interview was conducted with MDS Nurse #2 on 2/8/17 at 5:15 PM. She stated the MDS Nurses were responsible for the completion of Section A of the MDS. Question A1500 which asked if a resident had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she checked with the SW to answer question A1500 for verification of residents who had level II PASRRs. A follow up interview was conducted with the SW on 2/8/17 at 5:40 PM. She confirmed Resident #73 was a level II PASRR and that the 1/7/17	F 278	outcomes and make recommendations to ensure continued compliance is sustained and determine the need if any changes are necessary to ensure continued compliance. Behaviors - District Director of Care Management completed re-education on 2/22/17, with MDS department, Social Services, and Activities Director regarding behaviors. Social Services directors will run the “Behavior Report” from our EMR daily and review the finding in the morning clinical meeting. The behaviors identified from this report will be followed up by the social services department to verify accuracy and complete further documentation. The behavior report will be maintained in a binder by the Social Services Department with notations made on the report to reflect the accuracy of the behavior. A progress note will be made in the EMR by the social services department to reflect the accurate behavior. Behaviors will be discussed in the morning team meeting. This will ensure clear communication to the IDT regarding behaviors so that accurate coding on the MDS will be achieved. Social Service Directors will report the monitoring efforts and present findings r/t behaviors at the monthly QAPI meeting for 3 months, then quarterly thereafter. The QAPI committee will review monitoring outcomes and make recommendations to ensure continued compliance is sustained and determine	

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F 278	Continued From page 37 annual MDS was coded inaccurately. An interview was conducted with the Director of Nursing (DON) on 2/9/17 at 5:00 PM. She indicated her expectation was for the MDS to be completed accurately. 3. Resident #115 was admitted to the facility on 6/1/11 with multiple diagnoses included schizophrenia and bipolar disorder. Record review indicated Resident #115 had a level II PASRR. The annual MDS assessment dated 3/2/16 indicated a "No" to question A1500 which asked if Resident #115 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 SW on 2/8/17 at 10:45 AM. She reported she was involved in maintaining a list of residents who had level II PASRRs. She stated the MDS Nurses completed Section A of the MDS. She revealed she was not sure how the MDS Nurses were kept informed of residents who had level II PASRRs. An interview was conducted with MDS Nurse #2 on 2/8/17 at 5:15 PM. She stated the MDS Nurses were responsible for the completion of Section A of the MDS. Question A1500 which asked if a resident had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she checked with	F 278	the need if any changes are necessary to ensure continued compliance.	

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the SW to answer question A1500 for verification of residents who had level II PASRRs.

A follow up interview was conducted with the SW on 2/8/17 at 5:40 PM. She confirmed Resident #115 was a level II PASRR and that the 3/2/16 annual MDS was coded inaccurately.

An interview was conducted with the Director of Nursing (DON) on 2/9/17 at 5:00 PM. She indicated her expectation was for the MDS to be completed accurately.

4. Resident #215 was admitted to the facility on 9/30/15 with multiple diagnoses included bipolar disorder.

Record review indicated Resident #215 had a level II PASRR.

The annual MDS assessment dated 9/30/16 indicated a "No" to question A1500 which asked if Resident #215 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 SW on 2/8/17 at 10:45 AM. She reported she was involved in maintaining a list of residents who had level II PASRRs. She stated the MDS Nurses completed Section A of the MDS. She revealed she was not sure how the MDS Nurses were kept informed of residents who had level II PASRRs.

An interview was conducted with MDS Nurse #2 on 2/8/17 at 5:15 PM. She stated the MDS Nurses were responsible for the completion of Section A of the MDS. Question A1500 which

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asked if a resident had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she checked with the SW to answer question A1500 for verification of residents who had level II PASRRs.

A follow up interview was conducted with the SW on 2/8/17 at 5:40 PM. She confirmed Resident #215 was a level II PASRR and that the 9/30/16 annual MDS was coded inaccurately.

An interview was conducted with the Director of Nursing (DON) on 2/9/17 at 5:00 PM. She indicated her expectation was for the MDS to be completed accurately.

Based on medical record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in 6 out of 35 residents reviewed (Resident #147).

Findings included:
Resident #147 was admitted to the facility on 12/14/16 from the hospital into the facility for therapy and rehabilitation. The Resident completed therapy and was discharged to home with family on 1/6/17. The MDS dated 1/6/17 documented Resident #147 was discharged to an acute hospital.

Record review revealed the Nurse Practitioner ' s order dated 1/5/17 discharged Resident #147 to

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F 278	Continued From page 40 home . On 1/9/17 at 11:33 am the MDS Nurse #2 was interviewed regarding Resident #147 ' s discharge and the coding of the MDS. The MDS Nurse #2 stated that the resident was discharged home and the MDS was incorrect. On 1/9/17 at 6:03 pm an interview was conducted with the Administrator and Director of Nursing, and both stated they expected staff to accurately code the MDS. 6. Resident #151 was admitted to the facility 3/1/13. Cumulative diagnoses included Alzheimer's disease. A modified Annual Minimum Data Set (MDS) dated 11/12/16 indicated Resident #151 was moderately impaired in cognition. E0900 for behaviors indicated wandering was a behavior that occurred 1-3 days during the assessment period. E1000 documented that the wandering placed resident at significant risk of getting to a potentially dangerous place. It was also noted that wandering significantly intruded on the privacy or activity of others. A Care Area Assessment (CAA) for behavioral symptoms stated Resident #151 had a diagnosis of Alzheimer ' s disease. She was alert and oriented in some areas. Episodic confusion was noted and she was unable to state the day, date or year. She assisted with activities of daily living and was able to make her needs known. We will care plan behavior. There was no documentation regarding wandering behavior.	F 278		

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A review of the care plan for Resident #151 last revised 11/28/16 revealed no care plan for behaviors and/or wandering behavior.

A review of the nursing notes for the seven day look-back period revealed no nursing notes regarding wandering behavior.

A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documentation of wandering behavior for Resident #151.

On 2/8/17 at 9:00AM, an interview was conducted with the Social Worker. She stated she was responsible for completing section E. The Social Worker indicated the nursing assistants had an area on their kiosk where behaviors were documented and this automatically was entered in the behavior area on the MDS. A copy of the nursing assistant documentation revealed the nursing assistant had documented wandering behavior on 11/6/16 at 3:26AM and stated she had not asked the nursing assistant if that information was correct. The Social Worker said Resident #151 usually sat in her room. She stated if wandering behavior occurred, she would err on the side of caution and would also indicate that the wandering placed the resident at significant risk of getting to a potentially dangerous place.

On 2/8/17 at 10:30AM, an interview was conducted with MDS Nurse #1. She stated she would have completed the CAA at that time and, from what she understood, the wandering behavior was a one-time episode. MDS Nurse #1 said she was not aware that the wandering

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F 278	Continued From page 42 behavior had occurred and she had never seen Resident #151 wandering about the facility or trying to get out of the facility. She said Resident #151 liked to stay in her room and usually sat in her room most of the time. On 2/8/17 at 2:29PM, a telephone interview was conducted with NA#3. She said she worked the 11:00PM-7:00AM shift and Resident #151 was part of her usual assignment. She stated Resident #151 usually slept throughout the night. NA#3 stated Resident #151 could not get u by herself and nursing staff would have to assist her with getting out of bed. When asked regarding the documentation of the wandering behavior on 11/6/16, she stated that was a mistake and was incorrect.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279		3/9/17

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and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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F 279	Continued From page 44 section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to care plan Residents #205 for one to one (1:1) activities for 1 of 3 resident reviewed for activities Findings included: Resident #205 was admitted 8/20/15 with a diagnosis of traumatic brain injury (TBI). The annual Minimum Data Set (MDS) dated 4/7/16 indicated Resident #205 was comatose (section B) thereby blocking out the activities section (section F) of the annual MDS. There was no Care Area Assessment triggered for activities due to the incorrect coding of Resident #205 as in a persistent vegetative state. The most recent quarterly MDS dated 1/8/17 coded Resident #205 as comatose and requiring total assistance for all her activities of daily living (ADLs). A review of the Activity assessment History dated 8/26/15 indicated 1:1 visits would be made two to three times weekly. A review of the care plan last revised on 10/7/16 did not address any activity needs or the recommended 1:1 visits two to three times weekly. In an interview on 2/8/17 at 12:30 PM the Activity Director (AD) stated she care planned the residents who would have triggered for activity needs or required an individualized activity program such as 1:1 activities. She stated since Resident #205 ' s annual MDS dated 4/7/16 was coded incorrectly, the computer removed activities as part of her assessment needs therefore, it was not care planned.	F 279	F279 Resident #205 was re-assessed by the Activities Director, to determine activity needs. Resident care plan was updated, by Activities Director, to included 1:1 activities on 2/24/17. Resident #205 is now receiving 1:1 activities to accommodate her individual activity needs. Activities Director and/or assistants have completed an activities assessment on all current residents, as of 3/3/17, to identify activity needs, including but not limited to 1:1 activities. Resident care plan has been updated, by the Activities Director, with current activity individual needs as of 3/9/17. The Administrator has completed re-training with the activities director on 2/23/17, F 279 including, development of individualized care planning goals to reflect resident individualized care plan goals, including but not limited to activities programs. At the time of admission, Activities Director and/or assistant will complete an activity assessment to identify individual resident activity needs, including need for 1:1 activity. Each resident identified to have a need for 1:1 activities will have daily documentation completed by the Activities Director and/or assistant in the resident medical record.	

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F 279	Continued From page 45 In an interview on 2/9/17 at 5:00 PM, the Administrator and the Director of Nursing stated it was their expectation Resident #205 would have been care planned for 1:1 activities.	F 279	Resident care plans will be reviewed at the morning clinical meeting daily to ensure resident individual plans are current. Activities Director and MDS Supervisor will compile a summary of monitoring efforts and present to the facility Quality Assurance & Performance Improvement committee monthly for 6 months to ensure a trend of compliance.	
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 observation, record review, and staff interview, the facility failed to follow the care planned interventions to monitor a wanderguard (Resident #176) and to obtain a psychiatric consultation (Resident #287) for 2 of 4 residents reviewed for accidents. The findings included: 1. Resident #174 was initially admitted to the facility on 7/1/16 and readmitted on 9/19/16 with multiple diagnoses that included aphasia (loss of ability to understand or express speech) following nontraumatic intracerebral hemorrhage (bleeding of the brain), insomnia, and a history of falls.	F 282	F282 Resident #174 was reassessed by the Director of Nursing, wander guard was removed and care plan updated on 2/9/17. Resident #287 received psychological consultation and no interventions were recommended 2/24/17. Director of Nursing and Administrative Nurses have reviewed current physician orders to identify individual needs related to implementation of current physician orders, including	3/9/17

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The admission Minimum Data Set (MDS) assessment dated 9/26/16 indicated Resident #174 had significant cognitive impairment. He was indicated to have wandering behaviors that placed him at significant risk of getting to a dangerous place on 1 to 3 days during the 7 day MDS review period.

The Care Area Assessment (CAA) related to behaviors for the 9/26/16 MDS for Resident #174 indicated he manifested the behavior of wandering. Staff were to monitor his whereabouts and were to answer door alarms as soon as possible.

Resident #174's plan of care was reviewed. The plan of care included the focus area, "[Resident #174] had manifested behaviors of wandering during the assessment period ...he has the ability to propel his wheelchair. He's on wanderguard to alert staff of attempts to get out of facility unattended." The interventions included, in part, check for safety devices for proper function and evaluate resident for placement of safety device. The plan of care was initiated on 9/30/16 and most recently reviewed on 1/17/17.

A review of the Treatment Administration Record (TAR) from 9/30/16 through 2/9/17 revealed Resident #174 had no monitoring conducted of a wanderguard for function and/or placement.

An observation was conducted of Resident #174 on 2/9/17 at 12:47 PM. He was in his wheelchair self-propelling in the facility hallway. Resident #174 had a wanderguard on his left wrist.

An interview was conducted with Nurse #1 on 2/9/17 at 12:49 PM. Nurse #1 indicated Resident

Psychological consults and wandering behavior 3/9/17.

Director of Nursing and/or Administrative Nurses, MDS Coordinator and IDT team will review physician orders at the morning clinical team meeting, to ensure that new orders have been implemented timely. Resident care plans and care guides will be updated by Director of Nursing and/or Administrative Nurses, at the morning clinical team meeting with updates of changes to current resident care and treatment.

Resident care guides will be updated and reviewed with nursing staff, including certified nursing assistants and licensed nurses, through huddles, by the Administrative Nurses each day to ensure they are aware of any changes to the current resident care and treatment plans.

Director of Nursing and/or Administrative Nurses will complete re-training by 3/9/17, with current nursing staff, including licensed and unlicensed staff PRN, weekend and agency, on F282, providing care and treatment based on the resident care plans, development of individualized care planning goals to reflect resident individualized care plan goals, including showers/bathing, nail care, activities and physician orders. Licensed and unlicensed nursing staff will receive training prior to working next scheduled shift.

The Director of Nursing and/or

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RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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F 282	Continued From page 47 #174 had no wanderguard. She reported if Resident #174 had a wanderguard it would have been documented on the TAR. Nurse #1 reviewed the TAR and confirmed Resident #174 had no monitoring done for function or placement of a wanderguard. An interview was conducted with the Nurse Unit Manager (UM) on 2/9/17 at 12:50 PM. She indicated Resident #174 had no wanderguard. The plan of care for Resident #174 that indicated he had a wanderguard was reviewed with the Nurse UM. She stated she not known Resident #174 had a care plan for a wanderguard. The Nurse UM then observed Resident #174 in his wheelchair in the hallway with a wanderguard on his left hand. She revealed she had not known Resident #174 had a wanderguard. She reported she needed to follow up on why Resident #174 was wearing a wanderguard. A nursing note dated 2/9/17 at 1:11 PM indicated an elopement risk assessment was completed today (2/9/17) and indicated Resident #174 was not at risk for elopement, the physician was notified, and his wanderguard was removed. A follow up interview was conducted with the Nurse UM on 2/9/17 at 2:40 PM. She stated that Resident #174 was assessed with the need for the wanderguard, had the wanderguard placed on him, and had it added to his plan of care on 9/30/16. She indicated the nurse who completed the assessment and placed the wanderguard on Resident #174 should have obtained a physician's order, added him to the wanderguard book, and included the monitoring for function and placement on his TAR. The Nurse UM revealed Resident #174 never had a physician's	F 282	Administrative Nurses will complete walking rounds daily 5 days weekly to ensure that nursing staff are providing showers/bathing & nail care. QI tool will be used to record results of these rounds including interviews and observations of 5 resident/day. Walking rounds will continue, randomly twice daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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order for a wanderguard, he was never included in the wanderguard book, and the wanderguard had never been monitored for function and placement. She indicated she was unable to verify who initially placed the wanderguard on Resident #174.

The interview with the Nurse UM continued. She indicated she completed a new elopement risk assessment today (2/9/17) and determined Resident #174 no longer required the use of a wanderguard. She reported that she spoke with the physician who recommended the discontinuation of the wanderguard for Resident #174. The Nurse UM stated the wanderguard had been removed from Resident #174.

An interview was conducted with Director of Nursing on 2/9/17 at 5:00 PM. She indicated her expectation was for the care plan interventions to be followed.

2. Resident #287 was admitted 1/10/17 with cumulative diagnoses of encephalopathy, disorientation, chronic kidney disease (CKD) and, cirrhosis. His admission Minimum Data Set dated 1/17/17 indicated he had severe cognitive impairment, trouble concentrating, trouble sleeping and wandering behaviors.

A review of Resident #287 ' s orders included the following:
*1/10/17 May be seen and treated by a Psychiatrist
*1/16/17 psychological consult

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Resident #287 was care planned for his psychotropic medications and wandering on 1/23/17. He was also on care planned for physical resistance, anxiety and wandering again on 2/5/17. His interventions included of a psychological consult as needed.

A review of Resident #287 ' s behavior monitoring completed by the nursing assistants (NAs) indicated the following behaviors observed:

1/11/17 at 8:51 AM-wandering
1/12/17 at 9:06 AM-wandering
1/12/17 at 6:34 PM-wandering
1/16/17 at 5:06 PM-wandering
1/17/17 at 8:54 AM-wandering
1/18/17 at 4:20 PM-wandering
1/19/17 at 5:28 AM-repetitive movement
1/20/17 at 5:57 AM-repetitive movement
1/20/17 at 5:57 AM-wandering
1/21/17 at 10:15 AM-wandering
1/21/17at 6:36 PM-wandering
1/22/17 at 4:22 AM-repetitive movement
1/23/17 at 6:50 AM-repetitive movement
1/23/17 at 9:54 AM-wandering
1/24/17 at 6:59 AM-repetitive movement
1/24/17 at 6:59 AM-wandering
1/24/17 at 4; 22 PM-repetitive movement
1/28/17 at 5:48 PM- wandering
1/29/17 at 4:07 PM-wandering
1/30/17at 6:59 AM-repetitive movement
1/30/17 at 6:59 AM-wandering
1/30/17 at 6:59 AM-sexually inappropriate
1/30/17 at 8:33 AM- wandering
1/31/17 at 1:08 AM-repetitive movement
1/31/17 at 12:50 PM- wandering
1/31/17 at 9:08 PM- wandering
2/1/17 at 1:31 AM- wandering

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F 282	Continued From page 50 2/2/17 at 12:52 PM- wandering 2/2/17 at 3:44 PM- wandering 2/3/17 at 4:09 AM- wandering 2/3/17 at 4:09 AM-sexually inappropriate 2/3/17 at 5:25 PM- wandering 2/4/17 at 11:00 AM- wandering 2/5/17 8:00 AM- wandering 2/6/17 at 4:03 PM-wandering 2/7/17 at 4:09 PM- wandering 2/8/17 at 10:30 AM-wandering In an interview on 2/8/17 at 4:50 PM, MDS Nurse #2 stated nursing completed the care plan for Resident #287 ' s psychotropic medications on 1/23/17and the SW care planned the behaviors on 2/5/17. A psychological consult was ordered as needed on admission 1/10/17 and again on 1/16/17. MDS #2 stated it was the responsibility of the SW to set up the psychological referrals but nursing should communicate to the SW when the order was written on 1/16/17. In an interview on 2/9/17 at 2:10 PM, the SW stated she completed the care plan for behaviors on 2/5/17 and it was her responsibility to set up all the psychological consults. She stated Resident #287 was not referred out for a psychological consult when the order was written on 1/16/17 but was to be seen 2/10/17. The SW stated it was definitely an oversight on her part. In an interview on 2/9/17 at 5:00 PM, the Administrator and the Director of Nursing stated it was their expectation that the care planned interventions be followed.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		3/9/17

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F 309	Continued From page 51 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to arrange and provide a psychological consult as ordered resulting in a delay of treatment (Resident #287) and failed to obtain a topical ointment as ordered (Resident #75) for 2 of 29 residents reviewed for well-being. The findings included: 1. Resident #287 was admitted 1/10/17 with cumulative diagnoses of encephalopathy, disorientation, chronic kidney disease (CKD) and, cirrhosis. His admission Minimum Data Set dated 1/17/17 indicated he had severe cognitive	F 309	F309 Resident #287 received psychological consult and no interventions were recommended 2/24/17 Resident #75 is now receiving correct topical ointment per MD order beginning 2/9/17. DON /Adm. Nurses have reviewed current MD orders to identify individual needs related to processing and implementation of current MD orders, including psy	

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F 309	Continued From page 52 impairment, trouble concentrating, trouble sleeping and wandering behaviors. A review of Resident #287 ' s orders included the following: 1. Haldol 1 milligrams (mg) by mouth every 4 hours as needed for agitation ordered 1/10/17 2. Ativan 0.5 mg by mouth every 8 hours as needed for anxiety or agitation ordered 1/16/17 On 1/16/17, the physician also ordered an ammonia level and a psychological consult. 3. Ativan 1 mg by mouth every 8 hours as needed for anxiety or agitation ordered 1/18/17 4. Ativan 1 mg topically every 6 hours as needed for anxiety of agitation ordered 1/19/17 5. Atarax 50mg by mouth a bedtime for anxiety ordered 1/23/17 Resident #287 was care planned for psychotropic medications and wandering on 1/23/17. His interventions included of a psychological consult as needed. A review of Resident #287 ' s behavior monitoring completed by the nursing assistants (NAs) indicated the following behaviors observed: 1/11/17 at 8:51 AM-wandering 1/12/17 at 9:06 AM-wandering 1/12/17 at 6:34 PM-wandering 1/16/17 at 5:06 PM-wandering 1/17/17 at 8:54 AM-wandering 1/18/17 at 4:20 PM-wandering 1/19/17 at 5:28 AM-repetitive movement 1/20/17 at 5:57 AM-repetitive movement 1/20/17 at 5:57 AM-wandering	F 309	consults and treatment orders 3/9/17. Staff Development and/or Administrative Nurses provided education to licensed nurse staff, including PRN, weekends, and agency, on MD order procedure and timely implementation of MD orders. Licensed nurses will received education prior to working their scheduled shift of work 3/9/17. The Director of Nursing and/or Administrative Nurses will complete walking rounds, daily 5 days weekly to ensure that nursing staff are providing treatments as ordered. QI tool will be used to record results of these rounds including interviews and observations of 5 resident/day. Walking rounds will continue, randomly daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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1/21/17 at 10:15 AM-wandering
1/21/17at 6:36 PM-wandering
1/22/17 at 4:22 AM-repetitive movement
1/23/17 at 6:50 AM-repetitive movement
1/23/17 at 9:54 AM-wandering
1/24/17 at 6:59 AM-repetitive movement
1/24/17 at 6:59 AM-wandering
1/24/17 at 4; 22 PM-repetitive movement
1/28/17 at 5:48 PM- wandering
1/29/17 at 4:07 PM-wandering
1/30/17at 6:59 AM-repetitive movement
1/30/17 at 6:59 AM-wandering
1/30/17 at 6:59 AM-sexually inappropriate
1/30/17 at 8:33 AM- wandering
1/31/17 at 1:08 AM-repetitive movement
1/31/17 at 12:50 PM- wandering
1/31/17 at 9:08 PM- wandering
2/1/17 at 1:31 AM- wandering
2/2/17 at 12:52 PM- wandering
2/2/17 at 3:44 PM- wandering
2/3/17 at 4:09 AM- wandering
2/3/17 at 4:09 AM-sexually inappropriate
2/3/17 at 5:25 PM- wandering
2/4/17 at 11:00 AM- wandering
2/5/17 8:00 AM- wandering
2/6/17 at 4:03 PM-wandering
2/7/17 at 4:09 PM- wandering
2/8/17 at 10:30 AM-wandering

A review of Resident #287 ' s medical record indicated on 2/2/17 the social worker (SW) made a referral to the in-house psychological services provider regarding the original order written on 1/16/17.

In an interview on 2/9/17 at 12:20 PM, the Administrator stated she received an email 2/9/17 from the in-house psychological consult provider

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regarding the referral for Resident #287 sent on 2/2/17. The email read this provider denied to see Resident #287 due to his payer source. The Administrator stated nobody from the facility had followed up on the referral dated 2/2/17 until 2/9/17.

In an observation on 2/9/17 at 12:30 PM, Resident #287 was observed lying in his bed sleeping.

In an interview on 2/9/17 at 12:30 PM, the Unit Manager (UM) stated Resident #287 had several falls right after his admission because he was very impulsive The UM stated Resident #287 was doing better at present and she was unaware if he was being seen by psychological services or of any orders for a psychological consult.

In an interview on 2/9/17 at 12:40 PM, the speech therapist (ST) stated when Resident #287 was first admitted, she was unable to evaluate him due to his mental status and inability to follow instructions. The ST stated there were some improvements in his cognition but he still was not fully engaged in his treatments.

In an interview on 2/9/17 at 12:50 PM, NA #11 stated Resident #287 was still having verbal behaviors, not sleeping, unsteady when walking and wandering.

In an interview on 2/9/17 at 1:00 PM, Nurse Practitioner (NP) #2 stated there was an order for Resident #287 to be evaluated by psychological services on 1/16/17 and she was not aware that he had not been seen. NP #2 stated it was especially important for psychological service to be in working with Resident #287 due his

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cirrhosis and with his antipsychotic medications prescribed. She stated the last ammonia level done on 1/16/17 was 70 which was at an acceptable level. NP #2 stated it was her expectation that the psychological consult ordered on 1/16/17 for Resident #287 would have happened no later than one to two weeks after the date of the order. NP #2 stated when the facility found out the in-house psychological services provider was not able to treat Resident #287, arrangements should have been made to take him out to see an outside provider.

In an interview on 2/9/17 at 2:10 PM, the SW stated it was her responsibility to set up all the psychological consults. She stated Resident #287 was not referred out for a psychological consult when the order was written and it was definitely an oversight on her part. The SW stated she contacted a local psychological provider on 02/09/2017, after it was brought to her attention he had not been seen and made an appointment for Resident #287 to be seen on 2/10/17 with a staff member accompanying him.

In a second observation on 2/9/17 at 2:30 PM, Resident #287 was standing at the nursing station. He appeared pleasant but disheveled. He was cooperative but repeatedly looking around his surroundings with trouble engaging in conversation.

In an interview on 2/9/17 at 5:00 PM, the Administrator and the Director of Nursing stated it was their expectation that the SW would have made the psychological consult referral before when the order was written on 1/16/17 and that the SW would have followed up with the in-house provider prior to 2/9/17 so Resident #287 could

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have been referred out to a local psychological provider timely.

2. Resident #75 was admitted to the facility 10/5/12. Cumulative diagnoses included history of eczema and dermatitis (skin conditions where the skin becomes red and itchy).

A Quarterly Minimum Data Set dated 10/3/16 indicated Resident #75 was cognitively intact.

A Nurse Practitioner progress note dated 12/8/16 revealed Resident #75 was seen for increased inflammation on his back. He had a chronic rash on the top of his shoulders down his truck area. He had been treated with multiple creams and the area below his shoulder blades was hot, tender to touch with bright erythema (redness of the skin). Impression: Dermatitis and not responsive to topical corticosteroids (used to treat inflammation) or anti-fungal ointments. Zinc oxide topical (applied to skin) to back twice a day until healed.

A physician order dated 12/8/16 indicated to apply zinc oxide (ointment that forms a barrier on the skin to protect it from irritants) topically--apply thick layer to back twice a day until healed every day and night shift for wound care.

A Quarterly Minimum Data Set (MDS) dated 1/3/17 indicated Resident #75 had clear speech, was able to make himself understood and understood others. Resident #75 required extensive assistance of one person for personal hygiene and total assistance with bathing. Skin conditions were documented as Resident #75 having no open lesions or pressure ulcers.

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A Dermatology (skin specialist) consult dated 1/6/17 stated Resident #75 was seen for evaluation of a severe rash on the left upper back. The rash was not draining or bleeding and was quite itchy. Resident #75 had eczema and dermatitis issues in this location chronically and used a barrier cream that he applied to the affected area. Impression: nummular dermatitis (coin shaped raised areas of eczema on the skin that are scaly) with pruritus (severe itching of the skin).

A care plan dated 5/2/16 and last reviewed 1/17/17 indicated Resident #75 had actual skin impairment with treatment to macerated area as ordered. Additional information added on 10/20/16 was for treatment to his left flank and left shoulder as ordered. Approaches included, in part, to observe skin weekly and document findings as indicated. Document observation of any non-pressure related skin impairments. Wound care as ordered.

A Skin assessment dated 2/1/17 indicated resident #75 had existing rashes on upper back. Treatment was in progress for rash.

A review of the Treatment Administration Record (TAR) for January 2017 revealed the zinc oxide ointment was not applied on night shift (7:00PM-7:00AM) on 1/10/17, 1/15/17, 1/17/17, 1/19/17 and 1/22/17.

A review of the TAR for February 2017 revealed the zinc oxide ointment was not applied on 2/8/17 and was on order.

On 2/9/17 at 8:15AM, an interview was conducted

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with Resident #75. He stated he has had the rash on his back for years and it would get better, then worse. He stated they put a cream on his back last night and it felt a little better this morning but still felt raw.

On 2/9/17 at 8:30AM, the facility was asked to provide the number for the nurse who had documented the ointment was not applied in January and February. The facility stated she was an agency nurse and they would have to look for the phone number. The facility did not provide a phone number for the nurse.

On 2/9/17 at 11:30AM, an observation of the application of the ointment to the rash was observed. NA#1 bathed Resident #75 and applied an ointment that contained menthol 0.2% and zinc oxide 20% to his rash areas. She stated she had been applying this ointment on his back for about a week or so because the zinc oxide ointment was on order. The ointment that contained menthol 0.2% and zinc oxide 20% was a protective ointment usually used as a skin protectant during incontinent care.

On 2/9/17 at 11:30AM, an interview was conducted with the Director of Nursing. She stated the zinc oxide ointment was available over the counter and Central Supply might have the item as a stock item. After checking with the person in Central Supply, she stated it was a stock item but there was none available at this time and she had a staff member go to the outside pharmacy to obtain the zinc oxide ointment

On 2/9/17 at 12:30PM, an interview was conducted with the person who worked in Central

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F 309	Continued From page 59 supply. She stated that zinc oxide ointment is a stock item. When zinc oxide was ordered for a resident, nursing staff would inform her of the order and she would order the ointment one day and receive it the next day. She said she had previously ordered zinc oxide for another resident but had not ordered any for Resident #75. She stated she ordered supplies twice a week and had ordered 5 jars of zinc oxide that should come in this week. The ointment that contained menthol 0.2% and zinc oxide 20% was a stock item and readily available for staff use. On 2/9/17 at 12:25PM, an interview was conducted with Nurse Practitioner #1. She stated the nursing staff should have applied the zinc oxide ointment as ordered and should not have applied the ointment that contained menthol 0.2% and zinc oxide 20% as that could have caused more irritation to the rash areas.	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide personal hygiene, including shower and nail care, for 5 (Residents #75, #82, #205, #87, #58) of 7 sampled residents who were dependent on staff or needed extensive assistance with personal hygiene and bathing. The findings included: 1. Resident #82 was admitted to the facility on	F 312	F312 Resident #75, #82, #205, #87, and #58 were re-assessed by the Administrative Nurse and their resident care needs related to personal hygiene, including showers & nail care, was identified and care guide and care plan by the Director of Nursing and/or Administrative Nurses 2/21/17.	3/9/17

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F 312	Continued From page 60 3/27/12. Cumulative diagnoses included contractures of both hands. An Annual Minimum Data Set (MDS) dated 12/18/16 indicated Resident #82 was severely impaired in cognition. He required total dependence for personal hygiene. A review of Resident #82 ' s care plan last reviewed on 1/1/17 revealed he required assistance with ADL ' s related to cognitive status and limited mobility. Approaches included provide assistance as required for completion of ADL tasks. On 2/7/17 at 10:56AM, Resident #82 was observed to have contractures of all fingers with the fingers contracted inward toward the palm area. He had elongated fingernails approximately 1 inch in length on all fingers. Brown/ black material was noted under all the fingernails. The fingernails were jagged in appearance. On 2/7/17 at 3:00PM, Resident #82 was observed. He had elongated fingernails approximately 1 inch in length on all fingers. Brown/ black material was noted under all the fingernails. On 2/8/17 at 10:00AM, Resident #82 was observed. He had elongated fingernails approximately 1 inch in length on all fingers. Brown/ black material was noted under all the fingernails. On 2/8/17 at 11:25AM, morning care was observed with NA #10. She stated night shift gave Resident #82 his bath and personal care. When asked to observe his fingernails, NA#10	F 312	Resident #75,#82, #205, #87, #58 are receiving showers based from their choices of day and time. Resident #82 nails were trimmed. 2/21/17. Director of Nursing and Administrative Nurses have re-assessed all current residents to identify individual choices & care needs related to personal hygiene, including showers & nail care. Resident care guides and care plans have been updated, by Director of Nursing and/or Administrative Nurses, on 3/9/17 to reflect individual choices and care needs. Director of Nursing and/or Administrative Nurses will complete re-training with current nursing staff, licensed and unlicensed staff, including PRN, weekend and agency, related to F312, providing ADL services, including providing personal hygiene, showers, and nail care. Licensed and unlicensed staff will receive education prior to working their scheduled shift 3/9/17. The Director of Nursing and/or Administrative Nurses will complete walking rounds daily 5 days weekly to ensure that nursing staff are responsive to resident needs including, showers/bathing and nail care. QI tool will be used to record results of these rounds including interviews and observations of 5 resident/day. Walking rounds will continue, randomly daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months	

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F 312	Continued From page 61 stated they needed to be cleaned and trimmed. She said another nursing assistant told her that he resisted having his nails cut and kept pulling his hands away. A review of the nursing notes from December 2016 through present revealed the only behavior documented was attempts by Resident #82 to pull out his stomach tube. On 2/8/17 at 12:10PM, an interview was conducted with the Director of Nursing. She observed Resident #82 ' s fingernails which were still elongated with brown/ black material under every nail and stated the fingernails should have been trimmed and cleaned during personal care. 2. Resident #75 was admitted to the facility 10/5/12. Cumulative diagnoses included a history of cerebrovascular accident with left hemiparesis (paralysis). A Quarterly Minimum Data Set (MDS) dated 10/3/16 indicated Resident #75 was cognitively intact. A Quarterly MDS dated 1/3/17 indicated Resident #75 had clear speech, was able to make himself understood and understood others. He was independent with daily decision-making. Resident #75 required extensive assistance of one person for personal hygiene and total assistance with bathing. A Care plan dated 5/2/16 and last reviewed 1/17/17 stated Resident #75 required staff assistance and intervention for completion of ADL (activities of daily living) needs. Approaches	F 312	Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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included to encourage active participation in tasks and provide cueing with tasks as needed.

On 2/7/17 3:12PM during interview, Resident #75 stated he was supposed to get 2 showers a week on Tuesday and Friday. He said there were many times he did not get 2 showers a week and, most of the time, missed the Tuesday shower. Resident #75 stated he felt he should get his 2 showers a week.

A review of the shower schedule from December 2016 through February 7, 2017 revealed Resident #75 was supposed to receive a shower on Tuesday and Friday on the day shift (7:00AM-3:00PM). The following was noted:
12/9/16-nothing documented
12/13/16-shower given
12/16/16-shower given
12/20/16--shower given
12/27/16-shower refused
12/30/16-shower given
1/3/17-nothing documented
1/6/17-shower given
1/10/17-nothing documented
1/13/17-nothing documented
1/17/17-shower given
1/20/17-nothing documented
1/24/17-nothing documented
1/27/17-nothing documented
1/31/17-nothing documented
2/3/17-nothing documented
2/7/17-shower given

On 2/9/17 at 8:45 AM, an interview was conducted with NA#1. She stated she had provided care for Resident #75 for about eight months. NA#1 stated he had only refused a shower for her one time in early January. She

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said she might have forgotten to record that Resident #75 received a shower on 1/10/17, 1/20/17, 1/24/17 and 2/3/17.

On 2/9/17 at 11:30AM, an interview was conducted with the Director of Nursing who stated residents should receive their showers as per the shower schedule or as requested by the resident.
3. Resident #87 was admitted to the facility on 2/10/16 with multiple diagnoses including Alzheimer's and quadriplegia (paralysis of four limbs).

The quarterly Minimum Data Set (MDS) assessment dated 12/31/16 indicated Resident #87 was non-verbal and had significant cognitive impairment. She was assessed with no rejection of care. Resident #87 was dependent on staff for bed mobility, transfers, toileting, and personal hygiene. She was also dependent for bathing and required the physical assistance of two or more staff. Resident #87 was indicated to be unsteady with balance and was only able to stabilize with staff assistance.

The plan of care for Resident #87 was reviewed. Resident #87 had a plan of care for the focus area of Activities of Daily Living (ADLs) assistance. The interventions indicated she required total assistance with care.

The shower scheduled for Resident #87 indicated she was scheduled for showers on Wednesdays and Saturdays during the second shift (3:00 PM - 11:00 PM). A review of the shower documentation from 1/1/17 through 2/4/17 revealed Resident #87 received 1 out of 10 scheduled showers. The scheduled shower was documented on 1/25/17. There was no

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documentation of a shower for Resident #87 on 1/4, 1/7, 1/11, 1/14, 1/18, 1/21, 2/28, 2/1, and 2/4. There was no documentation of a shower refusal for Resident #87 during this time frame (1/1/17 through 2/4/17).

An interview was conducted with Resident #87's family member on 2/6/17 at 3:10 PM. He stated he visited with Resident #87 seven days per week for multiple hours at a time. He indicated Resident #87 was dependent on staff for showers. He stated her showers were scheduled twice a week on Wednesday and Saturdays during the second shift. The family member reported there were multiple occasions Resident #87 had not received her shower as scheduled. He stated Resident #87's shower had been missed so often that he, "no longer expected it get done as scheduled since it happens a lot that it isn't done". The family member reported several Nursing Assistants (NAs) had informed him they were unable to provide Resident #87's shower as scheduled due to time limitations. Resident #87's family member was unable to report the names of any specific staff members.

An interview with conducted with NA #8 on 2/7/16 at 4:50 PM. She indicated she normally worked the second shift. She stated her assignment sometimes included up to 20 residents per day. NA #8 revealed there were days when she was not able to complete the showers that were assigned to her due to time limitations. She stated she did the best she could.

An interview was conducted with NA #9 on 2/8/17 at 3:35 PM. She stated she was familiar with Resident #87. She indicated Resident #87 had not rejected care.

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An interview was conducted with NA #7 on 2/8/17 at 3:40 PM. She stated she normally worked the second shift and she was familiar with Resident #87. She indicated Resident #87 required total care and needed the physical assistance of two staff for showers. She reported Resident #87 had not rejected care. NA #7 revealed there were occasions when she was really busy and was unable to complete her assigned showers.

An interview was conducted with the Director of Nursing on 2/9/17 at 11:30 AM. She indicated her expectation was for residents to receive showers as scheduled.

An interview as conducted with the Administrator on 2/9/17 at 5:00 PM. She indicated her expectation was for residents to be offered showers as scheduled. She reported the shower schedule was one of the processes the facility had been working on. The Administrator revealed the facility was not monitoring shower completion.
4. Resident #205 was admitted 8/20/15 with a diagnosis of traumatic brain injury (TBI). The most recent quarterly MDS dated 1/8/17 coded Resident #205 as comatose and requiring total assistance for all her activities of daily living (ADLs) to include showers.
Her care plan last revised on 10/07/16 indicated Resident #205 required total staff assistance with her showers.
In an observation on 2/6/17 at 9:00 AM, 2/7/17 at 3:00 PM and again on 2/8/16 at 10:00 AM, Resident #205 was observed lying in bed. She appeared clean, well groomed, and absent of evidence of incontinence.
A review of the facility shower day assignment sheet indicated Resident #205 was to receive a

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shower on Mondays and Thursdays on first shift. A review of the facility shower sheets from 12/1/16 to 2/9/17 indicated Resident #205 received a shower on the following dates:

12/28/16-shower and washed hair
1/16/17-shower
2/2/17-shower
2/6/17-shower

A calendar review from 12/1/16 to 2/9/17 revealed Resident #205 missed 16 of her scheduled showers.

In an interview on 2/9/17 at 8:20 AM, nursing assistant (NA) #5 stated she tried her best on her days assigned to Resident #205 to give her a shower but due to staffing, she was not always able to complete her assignment. She stated she always let her charge nurse know if she was not able to complete her showers.

In an interview on 2/9/17 at 5:07 PM, the Administrator and the Director of Nursing stated it was their expectation Resident #205 receive her showers as scheduled.

5. Resident # 58 was admitted to the facility on 12/8/09 with multiple diagnoses including Parkinson's disease and Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 11/22/16 indicated that Resident #58's cognition was intact. The assessment also indicated that Resident #58 was dependent on the staff with bathing and had no behavior problems.

The care plan dated 11/22/16 was reviewed. One of the care plan problems was "the resident requires staff assistance and intervention for completion of activities of daily living (ADL) needs

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and she requires extensive to total care utilizing two staff members." The goal was "resident will have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function." The approaches included to gather and provide needed supplies and to encourage active participation in task.

The facility's shower schedule was reviewed. The shower schedule indicated that Resident #58 was scheduled to have a shower every Tuesday and Friday on 2nd shift.

The daily shower sheets for Resident #58 were reviewed for December 2016 and January and February 2017. The shower sheets revealed that Resident #58 was provided a shower 4 times in December (December 9, 20, 27, & 30), 2 times in January (January 17 & 20) and none in February. The sheets also revealed that Resident #58 had refused showers on December 6 and January 13.

On 2/6/17 at 1:35 PM, Resident #58 was interviewed. She reported that she had concerns of not receiving showers due to short staff. She stated that her shower days were Tuesday and Friday on the evening shift. She indicated that there was one nursing assistant (NA) assigned on the hall on the 3-11 PM shift.

On 2/7/17 at 4:45 PM, Resident #58 was again interviewed. She stated that it was her shower day and nobody would give her a shower because there was only one NA assigned on the hall. She added that she had never refused a shower because her shower was very important to her.

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F 312	Continued From page 68 On 2/7/17 at 4:50 PM, NA #8 was interviewed. She stated that she worked 3-11 shift and sometimes was assigned to Resident # 58. She revealed that the normal staffing on the hall where Resident #58 resided was 4 NAs but only 3 NAs assigned most of the time. With 3 NAs on the hall, she was assigned to 20 residents. NA #8 stated that "I do the best I can" for the 20 residents. She revealed that she didn't have the time to give showers. NA #8 further indicated that during feeding time she had to leave her assignment to help feed on the other hall, leaving the nurse on the hall. On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the NAs to provide showers to residents as scheduled.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to apply the splint as ordered by the doctor for 1 (Resident #97) of 3	F 318	F318 Nurse #4 received counseling re-education by the Director of Nursing	3/9/17

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F 318	Continued From page 69 sampled residents reviewed with limitation in range of motion (ROM). Findings included: Resident #97 was admitted to the facility on 10/23/14 with multiple diagnoses including hemiplegia and hemiparesis following cerebrovascular disease, hand and elbow contracture. Review of the physician's orders for Resident #97 revealed an order dated 7/5/16 for "bilateral hand orthotics every shift related to contracture hands." The quarterly Minimum Data Set (MDS) assessment dated 1/19/17 indicated that Resident #97 had limitation in range of motion on both sides of upper extremities and on one side of lower extremity. The assessment also indicated that the resident did not receive restorative nursing program for range of motion or for splints/brace assistance. The care plan of Resident #97 dated 2/2/17 was reviewed. One of the problems was the resident was at risk for developing pressure ulcer secondary to limited mobility, incontinence, usage of bilateral hand orthotics. The goal was the resident's skin would remain intact without signs of breakdown by the next review and resident would not manifest ROM decline. The approaches included to monitor for signs and symptoms of impending skin breakdown and skin checks weekly per facility protocol. On 2/7/17 at 4:35 PM and on 2/8/17 at 10:43 AM, Resident #97 was observed. The resident was in bed with both hands contracted and there was no splint or brace observed on either hands.	F 318	3/3/2017. Resident #97 has been re-evaluated by Occupational Therapist and splint vendor on 2/16/17, to identify proper fitting splint that should be used for the treatment of this individual resident. Hand splints for resident #97 are in place as of 2/24/17. Director of Nursing and/or Administrative Nursing and Occupational Therapy Department has re-assessed, current residents to identify their needs to increase range of motion. Residents identified with a need for splinting devices have been evaluated by rehabilitation department, and treatment plan in place by either OT or PT 3/9/17. The Rehabilitation Director will deliver new restorative referrals including recommendations for splints to the Director of Nursing daily during the morning clinical meeting. Occupational Therapist and/or Director Nursing will provide training to the restorative, certified nursing assistants, and licensed nurses, including PRN, weekend, and agency on application and removal of splint devices. 3/9/17 Director of Nursing and/or Administrative Nurses will complete a review of treatment records daily to ensure that nursing staff apply splints per MD orders. QI tool will be used to record results of these rounds including interviews and observations of 5 resident/day. Walking	

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F 318	Continued From page 70 The Treatment Administration Records (TARs) for January and February 2017 were reviewed. The TARs had nurse ' s initials on 7:00 AM boxes indicating that the splint was applied on bilateral hands on 1/5/17, 1/6/17, 1/9/17, 1/10/17, 1/11/17, 1/14/17, 1/15/17, 1/16/17, 1/17/17, 1/19/17, 1/20/17, 1/22/17, 1/23/17, 1/24/17, 1/25/17, 1/27/17, 1/28/17, 1/29/17, 1/30/17, 1/31/17, 2/2/17, 2/3/17, 2/6/17 and 2/8/17 by Nurse # 4. On 2/8/17 at 11:05 AM, Nurse #4 was interviewed. Nurse #4 stated that she worked as a treatment nurse. She stated that the order for the splint application was written on the TAR. She revealed that the restorative aides were responsible for applying the splint but the restorative aides could not sign the TAR so she was the one signing for the splint every day. Nurse #4 further indicated that she was not checking if the splint was on or not before signing the TAR. On 2/8/17 at 11:25 AM, NA #11(restorative aide) was interviewed. She stated that she was assigned as restorative aide on the hall where Resident #97 resided. She indicated that she had been a restorative aide for almost 9 months and Resident #97 had never been on her work load for splint or brace application. She added that she had never seen the resident wearing a splint. On 2/8/17 at 11:30 AM, the Occupational Therapist (OT) was interviewed. He stated that Resident #97 was referred to OT on 2/6/17 for evaluation due "to increase flexor tone in all digits in both hands. Patient has splints however has not been wearing per nursing report due to ill-fitting equipment."	F 318	rounds will continue, randomly daily for 4 weeks, then weekly for 4 weeks, and then monthly for 3 months Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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F 318	Continued From page 71 On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the order for the splint to be followed. She also revealed that restorative aides were responsible for the splint application. The DON further indicated that the facility had no restorative nurse to monitor the restorative nursing program	F 318		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Nurse Practitioner interview, the facility failed to follow the Nurse Practitioner ' s order and monitor the potassium medication in 1 out of 5 residents for Resident #274.	F 329	F329 BMP for resident #274 was drawn, results were within normal range and reviewed with the physician/ NP. No change was warranted in medication and the resident	3/9/17

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F 329	Continued From page 72 Findings included: Record revealed Resident was admitted to the facility on 11/17/16 for management of her sacral decubitus ulcer. Resident had the diagnosis renal failure, hyperkalemia, hypokalemia, and atrial fibrillation. Minimum Data Set (MDS) dated 11/17/16 documented Resident was alert and oriented and had a Brief Interview for Mental Status (BIMS) score of 15. Resident ' s most recent episode of hyperkalemia was on 1/26/17, lab result 5.5 (range 3.5-5.1). On 2/3/17 Nurse Practitioner #1 ordered a stat basic metabolic profile (BMP) lab (to determine the potassium level). No lab draw or result was found in the medical record. The Resident continued on Klor-Con 20 mEq. each day, potassium supplement medication, from 2/3/17 to 2/8/17 with an elevated potassium level. On 2/8/17 at 2:05 pm interviewed Nurse #4. Nurse #4 reviewed all log books, including the Station 2 Lab Log Book. There was no requisition order for Resident ' s stat BMP, nor was a result found. Nurse #4 stated he was not responsible for the results because he did not have access to the lab ' s website. On 2/8/17 at 2:20 pm interviewed Nurse Unit Manager (UM) #5. UM #5 provided access to the lab ' s website to find the Resident ' s stat BMP blood draw and results. The lab on-line requisition indicated BMP was drawn on 2/3/17 at 4:39 pm, but not resulted to the facility. UM #5 stated that the nurse in charge on the day of draw was responsible for the result, and that included agency staff. UM #5 stated that the stat BMP was not resulted to the facility. A copy of the lab	F 329	was not at risk for harm. 2/8/17 Director of Nursing and/or Administrative Nurses completed an audit on 2/14/17, for current resident lab orders to ensure that lab orders have been completed, lab results were obtained, and any abnormal lab results were reported to physician/NP and physician/NP orders implemented. Lab book will be maintained at each nursing unit. Licensed Nurses will enter each lab order, date of lab, residents name, lab ordered with date that the lab is due to be drawn, and nurse will initial when the order if obtained for the lab. Once the lab is drawn, nurse will initial that lab was drawn and their initials; once results are received the nurse will enter the date and time of results with their initials. The nurse will complete the Log entry for the lab by documenting the results in the resident chart, date and how the physician was notified. Physician lab orders will be reviewed by the Director of Nursing and/or Administrative nurses daily to ensure lab orders were drawn and lab results are received, and attending physician notified. Any changes to resident treatment plans will be noted by the nursing staff in the resident medical record. This list will be given to the Administrative nurses to assist with the weekly audit. Staff Development Director / Administrative Nurses will provide training for the licensed nursing staff, including	

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F 329	Continued From page 73 requisition was provided. On 2/8/17 at 3:05 pm interviewed the Administrator. Administrator stated that her expectation for staff responsibility to follow through on lab draw and results was unclear; she would have to consult the policy. Administrator stated that stat labs were normally drawn by facility staff and taken to the hospital. Administrator reviewed the lab requisition that documented the stat BMP draw was collected on 2/3/2017 at 4:38 pm. Administrator commented that she would call the lab and find out what happened to the result. On 2/8/17 at 3:17 pm interviewed the Director of Nursing (DON). DON stated her expectation for staff to follow through on lab draw and results was for staff to follow the practitioner ' s order. If the lab result was not received from the lab, staff was to find out why. 2/8/17 at 3:31 pm interviewed Nurse Practitioner (NP) #1. NP #1 stated there was a stat BMP ordered on 2/3/17 for elevated potassium. NP #1 stated she was not aware that the BMP results were not obtained. NP #1 reviewed the chart and ascertained that the Klor-Con was given from 2/3/17 to 2/8/17. NP #1 stated she would order a stat BMP today and place the Klor-Con on hold until a lab result was obtained. NP #1 stated that obtaining lab results have been a problem and there was missing documentation from the chart at this facility. NP #1 further stated that there were staffing issues. Resident has a fluctuating potassium level because of renal failure. Resident has acute renal failure and atrial fibrillation, which makes her more sensitive to adverse outcome from elevated potassium. NP #1 wrote an order for a stat BMP and placed the Klor-Con on hold until a potassium level lab was	F 329	PRN, weekend and agency, on the facility lab protocol. 3/9/17 Director of Nursing and/or Administrative Nurses will be monitoring the Lab Books/process and completing a QI monitoring tool daily x 4 weeks; weekly x 4 weeks and then monthly to ensure compliance with facility lab protocol. Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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F 329	Continued From page 74 obtained (BMP). On 1/9/17 at 9:00 am medical record and lab log book had no documentation that the Resident ' s BMP was drawn or resulted. On 1/9/17 at 9:14 am interviewed Resident #274, and she stated that a blood draw was performed last evening. On 1/9/17 at 9:18 am interviewed Nurse #2. Nurse #2 had a hand-written, hand-off in her pocket that the Resident ' s BMP result was 4.4 and to resume potassium supplement. No further orders to check BMP was received. On 1/9/18 at 9:24 am medical record had an order with the BMP result and to resume Klor-Con 20 mEq each day was written.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below as evidenced by 2 errors out of 28 opportunities for error, resulting in a 7.14 % medication error rate. The facility failed to follow doctor's orders for 1 (Resident #252) of 7 residents observed during the medication pass. Findings included: 1a. On 2/8/17 at 8:00 AM, Resident #252 was	F 332	F332 Resident #252 – no longer a patient at facility Nurse #1 has received counseling and re-education by the Director of Nursing 3/3/17. Director of Nursing and Administrative Nurses completed a medication pass observation with current licensed nurses,	3/9/17

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F 332	Continued From page 75 observed during the medication pass. Resident #252 had a doctor ' s order dated 1/30/17 for "Midodrine (anti-hypotensive drug) 10 milligrams (mgs.) 1 tablet by mouth with meals - must not have medication unless consumes his meal first." On 2/8/17 at 8:05 AM, Nurse #1 was observed to prepare and to administer Resident #252's medications including Midodrine. The resident was not served breakfast at this time. On 2/8/17 at 8:10 AM, Nurse #1 was interviewed. She stated that she didn't know what time the breakfast cart was scheduled to arrive on the hall but she tried to give the medications ordered with meals close to the time the cart arrived on the hall. On 2/8/17 at 9:00 AM, NA # 6 was interviewed and she stated that breakfast cart arrived on the hall at 9:00 AM every day. The meal delivery time was reviewed and revealed that the breakfast cart was scheduled to arrive on the hall where Resident #252 resided at 8:45 AM. On 2/8/17 at 5:07 PM, the DON was interviewed. She stated that she expected the nurses to follow the doctor's orders including medications ordered with meals. b. On 2/8/17 at 8:00 AM, Resident #252 was observed during the medication pass. Resident #252 had a doctor's order dated 12/9/16 for "Senna Plus 8.6-50 mgs. 1 tablet by mouth two times a day for constipation." On 2/8/17 at 8:05 AM, Nurse #1 was observed to prepare and to administer Resident #252's	F 332	including PRN, weekend, and agency nurses on 3/9/17. Staff Development Coordinator and/or Administrative Nurses, provided education with licensed nurses, including PRN, weekend, and agency, on proper medication administration that included, avoiding medication errors, giving medications per physician orders, medication with meals, 8 rights of medication administration 3/9/17. Director of Nursing and/or Administrative Nurses will complete 1 medication pass observations, for each unit, daily for 4 weeks, then weekly for 4 weeks, then monthly for 3 month to ensure competency of licensed nurses in the administration of medications. Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident.	

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F 332	Continued From page 76 medications including Senna 8.5 mgs. On 2/8/17 at 8:10 AM, Nurse #1 was interviewed. She reviewed the Medication Administration Record (MAR) and acknowledged that she administered the wrong medication. She revealed that she administered Senna instead of Senna Plus as ordered. On 2/8/17 at 5:07 PM, the DON was interviewed. She stated that she expected the nurses to follow the doctor's orders. The DON also indicated that the physician of Resident #252 was informed of the medication error.	F 332		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334		3/9/17

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F 334	Continued From page 77 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 334		

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F 334	Continued From page 78 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide education to residents and/or responsible party regarding the benefits and potential side effects of the influenza and pneumococcal immunizations before offering the vaccines to 3 (Residents #82, #97 & #205) of 5 sampled residents reviewed for immunization. Findings included: The facility's policy on Pneumococcal and influenza vaccination dated 9/2015 was reviewed. Under documentation requirements, the policy read in part "prior to vaccination, communicate the Vaccination Information Statement (VIS) to the vaccine recipient, help the vaccine recipient understand the disease and the vaccine and document the following information on the resident ' s Medication Administration Record (MAR): the edition date of the VIS, date the VIS was provided, the name, title and address of the person who administer the vaccine, the date the vaccine was administered, the vaccine manufacturer and the lot number and the declination or refusal to accept the vaccination." 1. Resident #82 was admitted to the facility on 12/11/08 with multiple diagnoses including Diabetes Mellitus and Hypertension. Resident #82's immunization record indicated that influenza vaccine was administered to him on 11/17/16 and pneumococcal vaccine on 1/27/17.	F 334	F334 Residents #82, #97 and #205 were provided education on the facility Immunization program by the Director of Nursing on 2/27/17. Current Residents and/or responsible party have been educated 3/9/17 on the facility Influenza and pneumococcal Immunization program, by the Director of Nursing. Director of Nursing has completed educated 3/9/17, with the Staff Development Coordinator and Administrative Nurses related to F334, reviewing Influenza/Pneumococcal Immunization from CDC education at the time resident signs consent for immunization. At the time of admission, facility Admission Director will provide education and consent will be requested from resident and/or responsible party. Immunization status and consents will be reviewed at the morning clinical meeting. Director of Nursing and/or Administrative Nurses will be monitoring daily x 4 weeks; weekly x 4 weeks and then monthly to ensure compliance with facility immunization protocol. Staff Development Coordinator will	

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F 334	Continued From page 79 The annual Minimum Data Set (MDS) assessment dated 12/18/16 indicated that Resident #82 had memory and decision making problems. Review of the medical records of Resident #82 revealed no documentation that education regarding the benefits and potential side effects of the influenza and pneumococcal vaccine was provided to his responsible party. On 2/9/17 at 4:45 PM, Nurse # 2 was interviewed. She stated that she used to be the infection control nurse. She indicated that during the influenza season, she mailed out the VIS form and the Pneumococcal and Influenza Immunization Consent forms to the resident's responsible party. The VIS and the consent forms included information regarding the benefits and the potential side effects of the influenza and pneumococcal vaccines. Nurse #2 added that when the forms were returned to the facility and the RP consented to administer the vaccines, the vaccines were administered to the residents. She revealed that there were several forms that were not returned to the facility by the RP and some forms had returned to the facility due to wrong address. She also stated that she did not know why Residents #82 had received the immunizations without the VIS and consent forms signed by the RP. On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the infection control nurse to follow the system in mailing the VIS and the consent forms to the RP and to keep the forms in the resident's medical records. She also stated that there should be a monitoring system to track who	F 334	compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months to ensure a trend of compliance is evident	

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did not return the forms. The DON acknowledged that the facility did not have a system in place for monitoring.

2. Resident # 97 was admitted to the facility on 10/23/14 with multiple diagnoses including Congestive Heart Failure (CHF). The quarterly MDS assessment dated 10/19/16 indicated that his cognition was moderately impaired.

The immunization record of Resident #97 revealed that influenza vaccine was offered to him on 11/17/16 and was refused.

Review of the medical records of Resident #97 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine was provided to his responsible party.

On 2/9/17 at 4:45 PM, Nurse # 2 was interviewed. She stated that she used to be the infection control nurse. She indicated that during the influenza season, she mailed out the VIS form and the Pneumococcal and Influenza Immunization Consent forms to the resident's responsible party. The VIS form and the consent forms included information regarding the benefits and the potential side effects of influenza and pneumococcal vaccines. Nurse #2 added that when the forms were returned to the facility and the RP consented to administer the vaccines, the vaccines were administered to the residents. She revealed that there were several forms that were not returned to the facility by the RP and some forms had returned to the facility due to wrong address. She also stated that she did not know why Resident #97 did not have the VIS and

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consent forms signed by the RP.

On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the infection control nurse to follow the system in mailing the VIS and the consent forms to the RP and to keep the forms in the resident's medical records. She also stated that there should be a monitoring system to track who did not return the forms. The DON acknowledged that the facility did not have a system in place for monitoring.

3. Resident #205 was admitted to the facility on 9/25/15 with multiple diagnoses including Hypertension.

On the quarterly MDS assessment dated 10/8/16, he was assessed as having memory and decision making problems.

The immunization record of Resident #205 revealed that influenza vaccine was administered to him on 10/19/16.

Review of the medical records of Resident #205 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine was provided to his responsible party.

On 2/9/17 at 4:45 PM, Nurse # 2 was interviewed. She stated that she used to be the infection control nurse. She indicated that during the influenza season, she mailed out the VIS form and the Pneumococcal and Influenza Immunization Consent form to the resident s

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F 334	Continued From page 82 responsible party. The VIS form and the consent forms included information regarding the benefits and the potential side effects of influenza and pneumococcal vaccines. Nurse #2 added that when the forms were returned to the facility and the RP consented to administer the vaccines, the vaccines were administered to the residents. She revealed that there were several forms that were not returned to the facility by the RP and some forms had returned to the facility due to wrong address. She also stated that she did not know why Resident #205 did not have the VIS and consent forms signed by the RP. On 2/9/17 at 5:07 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the infection control nurse to follow the system in mailing the VIS and the consent forms to the RP and to keep the forms in the resident's medical records. She also stated that there should be a monitoring system to track who did not return the forms. The DON acknowledged that the facility did not have a system in place for monitoring.	F 334		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 353		3/9/17

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F 353	Continued From page 83 accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a sufficient number of nursing staff to meet the needs of	F 353	F353 Cross □reference F242, F312	

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F 353	Continued From page 84 residents as evidenced by failing to honor two of two residents choice in bathing (Resident #75, #58) and failing to provide showers and nail care for 5 (Residents #75, #82, #205, #87, #58) of 7 sampled residents who were totally dependent on staff or needed extensive assistance with personal hygiene and bathing. The findings included: 1. Cross reference to tag F242. Based on observation, resident and staff interviews, the facility failed to honor resident ' s choice in bathing for two of two residents reviewed for choices (Resident #75 and #58). 2. Cross reference to tag F312. Based on record review, observation and staff interview, the facility failed to provide personal hygiene including shower and nail care for 5 (Residents #75, #82, #205, #87, #58) of 7 sampled residents who were dependent or needed extensive assistance with personal hygiene and bathing. On 2/8/17 at 9:48AM, an interview was conducted with NA #2. She stated she worked day shift (7:00AM-3:00PM) and some night shifts (11:00PM-7:00AM. NA#2 stated on Saturday 2/4/17 and Sunday 2/5/17, she provided care on station 2 (300,400,500 halls) and had approximately 22 residents on her assignment for the day shift. She said there was no way she could give each resident the amount of care they needed. NA#2 said she did not get to do showers and/or give everyone a bed bath on Saturday or Sunday and just changed residents ' clothes and provided incontinent care for her residents. She stated there were only 3 nursing assistants on station 2 on Saturday and Sunday.	F 353	Director of Nursing and/or Administrative Nurses have re-assessed all current residents to identify individual care needs, including nail care, showers/bathing. Resident care guides have been updated to reflect individual care needs. Administrator met with the facility Director of Nursing and Staffing coordinator and reviewed the nursing staff schedule to ensure that sufficient numbers of staff were available to provide nursing care to current residents in accordance with residents individual care needs. Training was completed by the facility Administrator with Director of Nursing and staffing coordinator regarding scheduling the appropriate number of certified nursing assistants and licensed nurses to allow for provision of nursing care to current residents according to their individual care needs. The scheduler and/or Administrative nurses are to contact the Director of Nursing and/or on-call administrative nurse in the event staffing needs are not met. Administrator has implemented a QI monitoring tool to monitor incoming applications to ensure qualified applicants are processed timely. A flexible orientation schedule is available to accommodate timely on-boarding for new employees, including interviews after first 3 days with Director of Nursing and/or Administrative Nurse to ensure orientation	

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F 353	Continued From page 85 On 2/8/17 at 10:02AM, an interview was conducted with NA#4. She stated she worked on day shift and normally would have 12 residents on her assignment. NA#4 said she had 22 residents on her assignment on 2/4/17 and 2/5/17. NA#4 stated there were usually 5 nursing assistants scheduled for station 2 and there were only 3 nursing assistants on 2/4/17 and 2/5/17. NA#4 said she did not have enough time to get everything done for her residents and could not do baths or showers on Saturday or Sunday. She stated there were 4 nursing assistants scheduled for Sunday but one nursing assistant did not come in on 2/5/17 and there were only 3 of them for station 2 on Sunday. NA#4 stated staffing on the weekends had gotten worse over the last couple of months. On 2/9/17 at 8:45AM, an interview was conducted with NA#1 who said she worked day shift and sometimes until 7:00PM. She said her average resident care load was around 15 residents. NA#1 said showers may not get done on Saturdays but if she worked until 7:00PM, she got her showers done. On 2/9/17 at 8:20AM, an interview was conducted with NA#5 who said she worked this past weekend (2/5/17 and 2/6/17). NA#5 stated she had 15 residents on her assignment on Saturday and 21 residents on her assignment on Sunday and was unable to give showers. She stated she did the best she could to give the care and answer call bells. A review of the nursing schedule for Saturday 2/4/17 for station 2 revealed there were 3 nursing assistants scheduled and 1 nursing assistant scheduled for orientation. The actual staff	F 353	is tailored to individual qualifications of new staff. Facility will continue to advertising on web-based sites, local newspaper, and company web sites to keep an application flow of qualified nursing staff. Nursing staff, including licensed nurses & certified nursing assistant have received re-training on the expectations of care for current resident, including nail care & showers/bathing. Staff will provide person centered care based on each resident individual care needs. Staff members identified as not providing care needs in a timely manner will receive individual education and counseling regarding expectations by the Director of Nursing and/or facility Administrator. Director of Nursing and/or Administrative Nurses will monitor resident□s medical acuity and ADL direct care needs daily by reviewing resident 24 hour report and cross reference daily staffing schedule to ensure nursing staffing including certified nursing assistants and licensed nurses, are available daily, to allow for provision of nursing care to current residents according to their individual care needs. Director of Nursing and/or Administrative Nurses will complete walking rounds randomly, 2 X a day, to ensure off shifts and weekends to ensure that nursing staff are responsive to residents needs for assistance. QI monitoring tool will be used to record results of these rounds. Walking rounds will continue, randomly,	

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F 353	Continued From page 86 assignment sheets reviewed for 2/4/17 revealed the following assignments for each of the three nursing assistants for the day shift (7:00AM-3:00PM): 1. 500 odd, 301--305; 2. 500 even, 401--405; 3. 306--314 and 4. 406-414. A review of the nursing schedule for Sunday 2/5/17 for station 2 revealed there were 3 nursing assistants scheduled. The actual staff assignment sheets reviewed for 2/5/17 showed the following assignments for each of the three nursing assistants for the day shift (7:00AM-3:00PM): 1. 404-414; 2. 304-314; 3. 500 hall, 301-304A and 401-403. A review of the staff assignment sheet for 2/7/17 on evening shift revealed NA#8 had assignment 624-634. All rooms had 2 residents with a total of 22 residents on that assignment for 3:00PM-11:00PM shift. On 2/9/17 at 4:59PM, an interview was conducted with the Administrator and Director of Nursing. The Administrator stated staffing was based on the needs of their residents. She stated she had become Administrator at the facility in November 2016. Since she had become Administrator, she had focused on nursing recruitment as the facility hired agency nursing and she wanted to have all facility nursing staff. There had been 2 interim Directors of Nursing and the present Director of Nursing had only been there since Monday 2/6/17. The Administrator said they had increased the number of nursing staff for all shifts and said they had hired approximately 13 nursing assistants over the past 2 weeks. The Administrator stated no one was monitoring if showers were received and her expectation was that residents be offered and receive at least 2	F 353	2X a day 4 weeks, weekly for 4 weeks and then monthly for 3 months. Director of nursing and Administrator will review current nursing schedule, including certified nursing assistance and licensed nurses, daily at morning team meeting x 4 weeks, then weekly for 4 weeks, and then monthly for 3 months, to ensure sufficient nursing staff are available daily, to allow for provision of nursing care for all residents according to individual care needs. Director of Nursing will complete a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement committee monthly for 6 months or until a trend of compliance is evident.	

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F 353	Continued From page 87 showers a week per the shower schedule.	F 353		
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, 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.	F 431		3/9/17

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F 431	Continued From page 88 (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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, manufacturer ' s specifications, and staff interviews, the facility failed to date multi-dose vials of injectable medications after opening in 2 of 3 medication storage refrigerators. Findings include: Review of the facility ' s policy (effective 12/01/2007) for storage and expiration dating of drugs, biologicals, syringes and needles revealed the following on page 2: "The Facility should ensure that drugs and biologicals: (1) have an expired date on the label; (2) have been retained no longer than recommended by manufacturer or supplier guidelines." The manufacturer ' s specifications for storage of tuberculin and pneumovax was to discard them 30 days after vial entry. On 1/8/17 at 12:15 pm, observation of the	F 431	F431 Undated Multi-dose vials were discarded 2/8/17. An audit was conducted by the Administrative Nurses, on 2/8/17, of medication carts, medication rooms and medication refrigerators, and treatment carts to identify any multi-dose vials undated. There were no other opened, undated vials identified. Staff Development Director will provide re-education, on 3/9/17, related to labeling and dating any opened multi-dose vials, to licensed nurses, including PRN, weekend, and agency nurses. Director of Nursing and/or Administrative Nurses will audit medication rooms, carts, refrigerators and treatment carts to	

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F 431	Continued From page 89 medication storage refrigerator at nurse ' s station #3 and interview with Nurse #3 were conducted. A multi-dose vial of injectable Turberculin Purified Protein Derivative, Diluted Aplisol 5 TU/0.1 ml was observed to be opened, half empty, and not dated. Nurse #3 stated all opened multi-dose medication vials were required to be dated. Nurse #3 could not state when this vial was opened or would expire. On 1/8/17 at 12:22 pm observation of the medication storage refrigerator at nurse ' s station #2 and interview with Nurse #4 were conducted. A multi-dose vial of injectable Pneumococcal Vaccine Poly Valent Pneumovax and a multi-dose vial of Tuberculin were observed to be opened, not full, and not dated. Nurse #4 stated that opened multi-dose medication vials were required to be dated on a yellow label. Nurse #4 also stated that he was not sure who checked for expired medication. Nurse #4 stated he checked for an expiration date when he used the medication. Nurse #4 could not state when the vials were opened or expired. On 1/9/17 at 10:08 am, an interview was conducted with the Director of Nursing (DON). The DON stated that her expectation that staff would date a multi-dose medication vial when they open it. The DON further stated that all stored medications were to be checked weekly for expiration date by the unit ' s nurse manager and discarded as appropriate.	F 431	ensure all muti-does vials are labeled and dated, daily for 2 weeks, weekly for 4 weeks, and then monthly for 3 months, to ensure sufficient nursing staff are available Director of Nursing will complete a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement committee monthly for 6 months or until a trend of compliance is evident.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		3/9/17

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F 520	Continued From page 90 (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 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:	F 520		

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F 520	Continued From page 91 Based on observation, record review and staff interview, the facility ' s Quality Assessment and Assurance committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 2/9/17 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies for assessment accuracy (F278) on the recertification survey 2/9/17 and the complaint investigations conducted on 8/25/16 and 10/20/16. The findings included: The tag is cross referenced to F278. Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Preadmission Screening and Resident Review (PASRR) level II (Residents #27, #73, #115, and #215), behaviors (Resident #151), and discharge status (Resident #147) for 6 of 35 residents reviewed. On 2/9/17 at 5:32PM, an interview was conducted with the Administrator and the Director of Nursing. The Administrator stated the facility had been working on assessment accuracy. There had been changes in MDS staffing. They had hired a new Social worker who would begin working next week. She said they had also hired another MDS Coordinator in January 2017.	F 520	F520 The referenced MDS of residents #27, #73, #115, #215, #151 and #147 was reviewed by the District Director of Care Management, on 2/22/17, related to PASARR, behaviors, and discharge status. Modifications to the references MDS assessments will be completed on or by 3/9/17 to accurately reflect the residents' PASARR status, behaviors, and discharge status. Administrator competed a re-education with facility QAPI Committee on 3/7/17, related to the facility process and intent of the Quality Assurance Performance Improvement (QAPI), which included the responsibilities of the QAPI Committee to ensue sustainability with identified areas of opportunity, with members of the QAPI committee, which included, MDS Nurses, Director of Nursing, ADON, Administrative Nurses, Social Services and Activities. Facility Administrator, Director of Nursing and ADON, met with the facility Medical Director, on 2/23/17, to review the current survey outcome and reviewed preliminary plan of correction for this survey. The District Case Mix Specialist will audit all comprehensive MDS completed weekly x 4 weeks to ensure that PASRR status is accurately reflected in Section A of the MDS. After 4 weeks, the ADON and/or District Case Mix Specialist will audit a minimum of 10 comprehensive MDS monthly x 3 months to ensure PASRR status is accurately reflected in	

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F 520	Continued From page 92	F 520	Section A of the MDS. The ADON will report the results of all monitoring efforts and present findings at the monthly QAPI meeting for 3 months than quarterly thereafter. The Quality Assurance Performance Improvement committee will review monitoring outcomes and make recommendations to ensure continued compliance is sustained and determine the need if any changes are necessary to ensure continued compliance.	