STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING ______ B. WING ______	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies cited as a result of the complaint investigation. Event ID# QQE011.	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to repair the torn, ripped, and frayed wheelchair arm rest for 1 of 16 residents observed (Residents #20). The finding included: Resident #20 was admitted to the facility on 04/25/16 and later re-admitted on 10/25/16. Her diagnoses included heart failure, dementia, end stage renal disease, and atrial fibrillation. Resident #20's quarterly Minimum Data Set (MDS) dated 11/17/16 indicated her cognition was intact. The MDS specified Resident #20 as having minimum difficulty in hearing and impaired vision. Resident #20 required extensive staff assistance with most of her activities of daily living. In an observation conducted on 01/30/17 at 4:09 PM, the right arm rest of Resident #20's wheelchair was torn, frayed, and ripped. The area of skin that Resident #20's was in contact with the arm rest was intact without any redness. The arm rest of Resident #20's wheelchair was observed in the same condition again on the following	F 253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F253 How corrective action will be accomplished for each resident found to have been affected by the deficient practice At the time of notification by surveyor of torn frayed arm rest the Maintenance Director replaced the torn armrest or Resident #20s wheelchair on 2/2/2017. How corrective action will be	3/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/27/2017

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

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F 253	Continued From page 1 dates and times: 01/31/17 at 4:16 PM, 02/01/17 at 12:36 PM, 02/01/17 at 3:33 PM, 02/02/17 at 10:37 AM and 02/02/17 at 2:07 PM. During an interview conducted on 01/31/17 at 4:16 PM Resident #20 stated she could not recall how long the right arm rest of her wheelchair had been torn, ripped, and frayed. It bothered her as the ripped arm rest irritated her skin. She would like the facility to fix or replace the right arm rest of her wheelchair as soon as possible. She further stated that the torn right arm rest was visible when the nursing staff transferred her. During an interview with Nurse Aide (NA) #1 on 02/02/17 at 2:01 PM she stated that when she transferred or provided care for the residents, she would take a quick glance at the resident's wheelchair to ensure it was in good repair. NA #1 stated she had not had a lot of interactions with Resident #20 lately. Otherwise, she would have reported the needed repair to the nurse. An interview conducted on 02/02/17 at 2:24 PM Nurse #1 stated that she checked her residents' living environment and their wheelchairs each time she administered medication or provided care. She was not aware of any wheelchair in disrepair and she had not heard of any complaints from Resident #20 or her nursing aides. Otherwise, she would have submitted a work order to the Maintenance department for Resident #20's wheelchair. During an interview conducted with the Unit Manager on 02/02/17 at 2:33 PM she agreed that the torn, ripped, and frayed right arm rest of Resident #20's wheelchair needed to be fixed as soon as possible. Normally the nurse aide would	F 253	accomplished for those residents having the potential to be affected by the same deficient practice A Center inspection of all wheelchairs to observe for any defects that needed to be fixed. Any chair requiring maintenance was completed at the time of the inspection. All wheelchairs labeled with inventory tags and repairs if needed completed on wheelchairs in the building by March 8, 2017. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Administrator ordered inventory tags to attach to the wheel chairs and the maintenance/building work order engine was updated with the new inventory numbers. Wheelchairs scheduled in the system for monthly maintenance checks and repairs. Maintenance Director or designee will print the wheelchair work orders weekly and complete needed repairs. In a one month time frame all wheelchairs will have had a maintenance check completed. The completed work orders, will be given to the Administrator so that the Administrator, DON or designated department head will check the wheelchairs to ensure that no defects were left unaddressed. If areas of needed repairs are found then the wheelchair will be returned to maintenance for immediate repair. This will be noted on the audit tool. Audit will be completed weekly x4, then every 2 weeks x4 for a total of 3 months.	

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F 253	Continued From page 2 report to the nurse any required repairs. The nurse would then file a work order for the Maintenance department. Interview with the Maintenance Manager on 02/02/17 at 2:39 PM revealed that he inspected all of the residents' wheelchairs at least once per month. He also utilized the facility's work order system to identify equipment that required repair. Work orders related to residents' safety would be his highest priority. Then he would work on orders related to resident care. Otherwise, it would be on first came first served basis. The Maintenance Manager stated he had not observed any wheelchairs in disrepair when he rounded the facility last month. The Maintenance Manager added that the facility routinely cleaned all of the wheelchairs once a month and the chemical erosion could have led to the torn, ripped, and frayed arm rest. In an interview with the Director of Nursing on 02/02/17 at 3:27 PM she stated she expected all of the nursing staff to check the wheelchairs when they provided care for the residents and report required repairs through the work order system to the Maintenance department. It was her expectation for the Maintenance department to ensure all of the wheelchairs be maintained in good repair at all times.	F 253	Education provided to Housekeeping, Laundry, Nursing, Therapy staff and all department heads by SDC, DON or Administrator on how to put in work orders into the computer system. Education to be completed by 3/8/2017. Anyone not receiving the training will be removed from the schedule until they receive the mandated training. All new employees will be shown and given an instruction sheet with screen shots on how to enter workorders. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The building engines work orders for wheelchair repairs will be reviewed and reported to QA&A Committee by Administrator Quarterly X2 for continued compliance and revisions to the plan if needed.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purpose of this section, a “significant change”	F 274		3/8/17

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F 274	Continued From page 3 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a required significant change Minimum Data Set (MDS) for 1 of 1 resident reviewed for Hospice care (Resident #30). The findings included: Review of the medical record revealed Resident #30 was admitted on 04/15/15 with diagnoses including Alzheimer's disease. Review of Resident #30's physician's orders revealed Hospice services were initiated on 12/07/16. Resident #30's medical record revealed no MDS assessments were completed after 12/07/16 therefore a significant change MDS had not been completed to reflect Resident #30's change in condition. An interview was conducted with the MDS Nurse on 02/02/17 at 11:36 AM in which she stated she failed to complete a significant change MDS assessment on Resident #30 that was required to be completed by the fourteenth day after a resident changed to Hospice care. The MDS Nurse stated her normal routine would be to start	F 274	F274 How the corrective action will be accomplished for the resident(s) affected. The chart reviewed and Care Plan updated and significant change completed on Resident #30. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. All MDS□s audited on Hospice and Palliative patients to ensure that they have been care planned for Hospice or Palliative care and significant change completed. Any patients found to not have, a care plan in place had one put in place and significant change completed during the audit and documented on audit tool. Measures in place to ensure practices will not occur. MDSC Consultant completed education on RAI Manuals scheduling rules for Significant changes completed on 2/6/2017. DON, MDS and Discharge Planning will discuss all Hospice or Palliative Care residents during the morning meeting Monday through Friday for a total period of 3 months ensure that	

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F 274	Continued From page 4 the process of a significant change MDS after she learned about the Hospice order in the morning management meetings. The MDS Nurse further stated that even though she did not complete the significant change assessment on Resident #30 when he became Hospice that she should have caught the mistake when she set up the quarterly MDS assessment that was due to be completed 02/15/17. During an interview with the Administrator on 02/02/17 at 6:51 PM he stated it was his expectation for the MDS Nurse to complete Resident #30's medical information accurately and correctly before it was transmitted.	F 274	there is a care plan in place and completion of significant change submission. How the facility plans to monitor and ensure correction is achieved and sustained. Each patient discussed during the morning meeting that has a referral for Hospice or Palliative Care will have audit tool completed to document review to ensure care plan and significant change has been done. This audit is to be completed daily during morning meetings Monday-Friday for a period of 3 months. The results of the audits will be presented to the next QA&A Committee meeting for continued compliance and revisions to the plan if needed.	
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 observations, record review, and staff interviews the facility failed to implement a care planned intervention for routine dental services for 1 of 2 sampled residents reviewed for dental status and services (Resident #156). The findings included:	F 282	F282 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: On 2/2/17 family contacted by the facility for Resident #156 and asked about having patient sent out to be seen	3/8/17

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F 282

Continued From page 5

Review of the medical record revealed Resident #156 was admitted on 07/01/16 with diagnoses including dementia and dysphagia.

Review of the admission Minimum Data Set (MDS) dated 07/08/16 revealed Resident #156 had severely impaired cognition and received a mechanically altered diet. The admission MDS noted Resident #156 had obvious or likely cavity or broken natural teeth.

Review of the Care Area Assessment (CAA) Summary for Dental Care dated 07/14/16 revealed Resident #156 needed a dental consult when the family let the facility know which dentist they wanted him referred to. The CAA Summary noted upper dentures were present and his lower teeth had decay. Resident #156 denied problems chewing and his oral mucosa was moist and intact.

Review of a care plan dated 07/22/16 revealed Resident #156 had dental problems due to poor oral hygiene. Interventions included to coordinate arrangements for dental care and transportation as needed/as ordered. The care plan was updated on 08/17/16 and noted his family wanted him added to the facility dental consult list (which was scheduled for November of 2016) for a loose upper plate.

Review of a progress note dated 08/18/16 revealed Resident #156 was seen by the Nurse Practitioner (NP) who noted his family had requested a dental consult for loose fitting dentures. The plan was to request a dental consult per the family's request.

F 282

by a dentist, at which time the family requested the patient be seen by the dentist at the next facility visit.

How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Discharge Planner/MDS audited all patient charts for consults to ensure consult had been completed as recommended. The consult audit identifying patients requiring consults was completed by March 8, 2017.

Measures to be put in place or systemic changes made to ensure practice will not Re-occur DON, Unit Manager, Unit Coordinator and Unit Secretary and Staff Nurses educated on the consult process from the time of receipt to the completion of scheduling by the Unit Secretary. Monday through Friday a Daily Order Summary report will be run by the DON or designated staff member daily, to see if any consults were ordered. Consults will be given to the Unit Secretary for scheduling and transportation arrangements. Unit Manager or Unit Coordinator will monitor and ensure that consults are scheduled by the Unit Secretary and transportation arranged. Unit Secretary will give a list of the scheduled consults to the DON so that it can be compared to the order summary to ensure all consults that were received were scheduled. Education on this process was provided by the DON. Audit to be completed Daily x 4 weeks then

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F 282	Continued From page 6 Observations of Resident #156 revealed the following: - On 01/30/17 at 2:58 PM Resident #156 was awake in bed. He was not wearing his upper denture plate and his lower teeth were worn down and decayed. - On 02/01/17 at 12:58 PM a nurse was observed providing oral care using a swab. Resident #156 was not wearing his upper denture plate and his lower teeth were worn down and decayed. An interview was conducted with the Resident Assessment Coordinator (RAC) on 02/02/17 at 5:25 PM. The RAC stated a care plan meeting was conducted on 08/17/16 and Resident #156's family member requested for him to be seen by the dentist at the facility instead of being sent out. The RAC indicated she filled out a communication form and placed it in the notebook used to communicate with the Physician and NP. The RAC stated the dentist came to the facility quarterly and had actually come in December of 2016 instead of November 2016. The RAC confirmed Resident #156 had not been seen by the dentist in December 2016 and could not explain why he did not get on the list to be seen. The interview further revealed the unit manager who would have been responsible for communicating the request for the dental consult no longer worked for the facility. The RAC further stated she was certain the NP had received her communication regarding the dental consult for Resident #156 because the NP acknowledged it in the progress note dated 08/18/16. During an interview the Director of Nursing stated she would have expected Resident #156 to be seen by the dentist in December of 2016 per his	F 282	Daily every two weeks x 3 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - The results of these audits will be reviewed during the Monthly QA&A Committee meeting for a period of 2 quarters for review for compliance and revision as needed.	

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F 282	Continued From page 7 plan of care.	F 282		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide a dietary supplement for weight loss for 1 of 4 residents reviewed for nutrition (Resident #164). The findings included: Review of the medical record revealed Resident #164 was admitted on 10/11/16 with diagnoses including dementia and dysphagia. Review of the admission Minimum Data Set (MDS) dated 10/18/16 revealed Resident #164 had severely impaired cognition and required set	F 325	F325 How corrective action will be accomplished for each resident found to have been affected by the deficient practice. A special request for a frozen nutritional supplement BID at lunch/dinner was placed into Meal Tracker for resident #164 on 2/2/17. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.	3/8/17

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F 325	Continued From page 8 up help only with eating. The admission MDS further revealed Resident #164 received a mechanically altered diet and was 70 inches tall and weighed 141 pounds. In addition, the admission MDS noted Resident #164 exhibited physical behavioral symptoms towards others, verbal behavioral symptoms towards others, and other behavioral symptoms not directed toward others 1 to 3 days during the 7 day assessment period. Review of a care plan dated 10/18/16 revealed Resident #164's nutrition was at risk related to a recent hospitalization, poor intake, and a pressure sore. The care plan noted he was underweight and had refused to be weighed since October 2016. It was noted he became agitated and combative when they asked him to be weighed. The goals included to provide and serve supplements as ordered. Continued review of the medical record revealed Resident #164 weighed 135 pounds on 10/19/16. Review of a dietary note dated 11/29/16 revealed the Registered Dietician (RD) assessed Resident #164 and noted his family member reported a 40 pound weight loss over the last year. Review of the medical record revealed a physician's order dated 11/29/16 for 240 ml (milliliters) of a high calorie, high protein supplement drink twice a day. Review of the quarterly Minimum Data Set (MDS) dated 12/14/16 revealed Resident #164 had severely impaired cognition and required supervision with eating. The quarterly MDS further revealed Resident #164 experienced	F 325	All nutritional supplement orders were reviewed and crosschecked with dining services manager□s recommendations and entered into Meal Tracker on 2/2/17. Dining services manager and dining staff were in-serviced on the proper procedures for entering nutritional snack recommendations into Meal Tracker on 2/2/17. Measures to be put in place or systemic changes made to ensure practice will not re-occur. Nutritional supplement accuracy audits will be completed weekly x 4 weeks and at least monthly thereafter by corporate dietitian to ensure all supplements are being administered. All significant weight changes to be discussed in weekly risk meetings for possible interventions and further required monitoring where a member of dining services and nursing will be present. Any deficient practice identified through the supplement audits will result in reeducation or disciplinary action as indicated. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. Results of audits will be presented to Quarterly Quality Assurance meeting for further problem resolution if needed.	

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F 325	Continued From page 9	F 325		

coughing or choking during meals or when swallowing medications and received a mechanically altered diet. In addition, the quarterly MDS noted Resident #164 was 70 inches tall and weighed 135 pounds.

Further review of the medical record revealed a weight of 118.9 pounds on 01/05/17.

Review of risk meeting documentation for the week ending on 01/06/17 revealed the interdisciplinary team noted Resident #164 had a weight loss of 16.1 pounds since admission and needed him to be weighed again but he had refused. It was noted he received a liquid protein supplement and high calorie, high protein supplement drink. Review of the risk meeting notes for the week ending on 01/13/17 revealed Resident #164 refused to be weighed. The notes for the risk meeting for the week ending 01/27/17 noted Resident #164 refused to be weighed when he was readmitted to the facility on 01/19/17.

Review of a dietary note dated 01/23/17 revealed the Dietary Manager (DM) documented Resident #164's intake was 50% of most meals. The DM noted he was already ordered a liquid protein supplement and a high calorie, high protein supplement drink which was administered by the nurse during medication pass. The DM recommended a frozen nutritional supplement with lunch to help add extra calories and protein.

Observations of meals revealed the following:
- On 01/30/17 at 1:25 PM Resident #164 was observed feeding himself lunch without difficulty. There was no frozen nutritional supplement on his tray and it was not listed on his tray card.
- On 02/01/17 at 8:35 AM Resident #164 was

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F 325	Continued From page 10 observed eating breakfast in his room. He had no difficulty feeding himself and consumed 50 to 75% of his meal. He told the staff he was finished eating when they came to get the tray. - On 02/01/17 at 1:21 PM Resident #164 was observed eating lunch in his room. He had already consumed an entire bowl of pudding and was starting on the food on his plate. There was no frozen nutritional supplement on his tray and it was not listed on his tray card. The nurse checked on him at 1:31 PM and he allowed her to feed him one bite of mashed potatoes and told her he did not want anything else to eat. She asked if he wanted something else to eat and tried to feed him again but he refused. - On 02/02/17 at 8:45 AM Resident #164 was observed eating breakfast in his room. He had already consumed 1/2 of his scrambled eggs and 2 of the 3 cups of fluids provided. An interview with the DM on 02/02/17 at 9:49 AM revealed she did not need a physician's order for a resident to receive a frozen nutritional supplement with meals. The DM explained she entered the frozen nutritional supplement into the dietary computer system for the resident so it would print out on the tray card and be sent out on the specified meal tray(s). The DM reviewed Resident #164's tray card during the interview and confirmed she had not entered the frozen nutritional supplement at lunch and was not sure how she had missed putting the recommendation in the dietary computer system after she assessed him on 01/23/17. The DM stated she had observed Resident eating on 01/23/17 and 01/26/17 and he had no difficulty feeding himself. The DM recalled she also asked him if he would let them weigh him on 01/23/17 and 01/26/17 and he refused both times.	F 325		

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F 325	Continued From page 11 A telephone interview was conducted with the facility's Corporate Registered Dietitian (RD) on 02/02/2017 4:01 PM. The Corporate RD stated she had been coming to the facility 1 to 2 times a week since the end of December 2016 when the previous RD left. The Corporate RD recalled discussing Resident #164 with the DM on 01/08/17 or 01/09/17 and was aware of the weight recorded on 01/05/17 and also that he had refused to be weighed since then. The Corporate RD stated she would have reviewed the risk meeting notes and the DM's notes but did not need to see him since he was already on a liquid protein supplement and a high calorie, high protein supplement drink. The Corporate RD explained she had better compliance with dietary supplements given by the nurses when they were passing medications and did not frequently order supplements that came out on the meal tray. During an interview on 02/02/17 at 6:35 PM the Director of Nursing (DON) stated she recalled discussing Resident #164's weight loss during the weekly risk meeting the first week of January 2017 as well as weekly thereafter. She recalled the team questioned the accuracy of the weight on 01/05/17 but Resident #164 had refused to be weighed since then. The interview further revealed she expected him to receive the dietary supplement recommended by the DM on his meal tray.	F 325		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility-	F 411		3/8/17

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F 411	Continued From page 12 (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide routine dental services for 1 of 2 sampled residents reviewed for dental status and services (Resident #156). The findings included: Review of the medical record revealed Resident #156 was admitted on 07/01/16 with diagnoses including dementia and dysphagia. Review of the admission Minimum Data Set (MDS) dated 07/08/16 revealed Resident #156 had severely impaired cognition and received a mechanically altered diet. The admission MDS noted Resident #156 had obvious or likely cavity or broken natural teeth. Review of the Care Area Assessment (CAA)	F 411	F411 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: On 2/2/17 family contacted by the facility for Resident #156 and asked about having patient sent out to be seen by a dentist, at which time the family requested the patient be seen by the dentist at the next facility visit. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Discharge Planner/MDS audited all patient charts for consults to ensure consult had been completed as recommended. The consult audit identifying patients requiring consults was completed by March 8,	

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Summary for Dental Care dated 07/14/16 revealed Resident #156 needed a dental consult when the family let the facility know which dentist they wanted him referred to. The CAA Summary noted upper dentures were present and his lower teeth had decay. Resident #156 denied problems chewing and his oral mucosa was moist and intact.

Review of a care plan dated 07/22/16 revealed Resident #156 had dental problems due to poor oral hygiene. Interventions included to coordinate arrangements for dental care and transportation as needed/as ordered. The care plan was updated on 08/17/16 and noted his family wanted him added to the facility dental consult list (which was scheduled for November of 2016) for a loose upper plate.

Review of a progress note dated 08/18/16 revealed Resident #156 was seen by the Nurse Practitioner (NP) who noted his family had requested a dental consult for loose fitting dentures. The plan was to request a dental consult per the family's request.

Observations of Resident #156 revealed the following:
- On 01/30/17 at 2:58 PM Resident #156 was awake in bed. He was not wearing his upper denture plate and his lower teeth were worn down and decayed.
- On 02/01/17 at 12:58 PM a nurse was observed providing oral care using a swab. Resident #156 was not wearing his upper denture plate and his lower teeth were worn down and decayed.

An interview was conducted with the Resident Assessment Coordinator (RAC) on 02/02/17 at

F 411

2017.

Measures to be put in place or systemic changes made to ensure practice will not Re-occur DON, Unit Manager, Unit Coordinator and Unit Secretary and Staff Nurses educated on the consult process from the time of receipt to the completion of scheduling by the Unit Secretary. Monday through Friday a Daily Order Summary report will be run by the DON or designated staff member daily, to see if any consults were ordered. Consults will be given to the Unit Secretary for scheduling and transportation arrangements. Unit Manager or Unit Coordinator will monitor and ensure that consults are scheduled by the Unit Secretary and transportation arranged. Unit Secretary will give a list of the scheduled consults to the DON so that it can be compared to the order summary to ensure all consults that were received were scheduled. Education on this process was provided by the DON. Audit to be completed Daily x 4 weeks then Daily every two weeks x 3 months.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - The results of these audits will be reviewed during the Monthly QA&A Committee meeting for a period of 2 quarters for review for compliance and revision as needed.

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F 411	Continued From page 14 5:25 PM. The RAC stated a care plan meeting was conducted on 08/17/16 and Resident #156's family member requested for him to be seen by the dentist at the facility instead of being sent out. The RAC indicated she filled out a communication form and placed it in the notebook used to communicate with the Physician and NP. The RAC stated the dentist came to the facility quarterly and had actually come in December of 2016 instead of November 2016. The RAC confirmed Resident #156 had not been seen by the dentist in December 2016 and could not explain why he did not get on the list to be seen. The interview further revealed the unit manager who would have been responsible for communicating the request for the dental consult no longer worked for the facility. The RAC further stated she was certain the NP had received her communication regarding the dental consult for Resident #156 because the NP acknowledged it in the progress note dated 08/18/16. During an interview the Director of Nursing stated she would have expected Resident #156 to be seen by the dentist in December of 2016 per the family member's request and his plan of care.	F 411		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes	F 428		3/8/17

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and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she

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Continued From page 16

identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, facility staff and consultant pharmacist interviews the facility failed to ensure monthly reviews were conducted for each resident for 2 of 5 residents (Resident #62 and Resident #65) reviewed for unnecessary medications.

The finding included:

1. Resident #62 was admitted to the facility on 12/21/16. Her diagnosis included diabetes mellitus, depression, hypertension, respiratory failure, and insomnia. Resident #62's electronic Medication Administration Records (eMAR) indicated that the resident was receiving medications for the listed diagnosis. The Minimum Data Set (MDS) dated 01/04/17 revealed Resident #62 was being treated with insulin, diuretic, and antidepressant.

A review of the consultant pharmacist's monthly Medication Regimen Reviews (MRR) indicated the consultant pharmacist had not conducted any MRRs for Resident #62 since her admission to the facility on 12/21/16.

On 02/01/17 at 3:16 PM, an interview was conducted with the facility's Director of Nursing (DON) concerning the missing January 2017 MRR for Resident #62. The DON reviewed the electronic charts and found that there were no MRR entries documented by the facility's consultant pharmacist for the mentioned month. The DON stated she would contact the facility's consultant pharmacist for the missing monthly

F 428

F428
How the corrective action will be accomplished for the resident(s) affected. Medication chart review were reviewed by the pharmacist for Resident #62 and #65. Reviews were completed 2/1 for both residents when the missed patients were identified.

How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Pharmacy consultant completed chart reviews for patients found to have been missed during the January review and the review completed on those patients 2/2/17.

Measures in place to ensure practices will not re-occur. Pharmacy consultant will obtain a current census from the Administrator or Director of Nursing upon entering the facility and check off the patient they have reviewed and sign the completed checklist. Any patients not checked, will be presented to the consultant prior to exiting to be reviewed. The Director of Nursing will compare the census to the pharmacy consultant report to ensure that all patients were reviewed during the pharmacy consultant visit, the review will be placed on the Midnight Census Report for the last date of the consultant review. This audit will be completed monthly for a period of 4

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F 428	Continued From page 17 MRRs of January 2017. The DON added whenever the consultant pharmacist came to the facility to do monthly MRR, the facility would provide her a list of new admissions to ensure each resident's MRR would be reviewed. On 02/02/17 at 8:27 AM, a subsequent interview with the DON revealed that the consultant pharmacist had forgotten to conduct the January 2017 MRR for Resident #62. According to the DON, it was her expectation that the drug regimen of each resident to be reviewed at least once a month by the facility's licensed pharmacist and the pharmacist must report any irregularities to the attending physician and the DON. On 02/02/17 at 9:30 AM, a phone interview was conducted with the facility's consultant pharmacist. The pharmacist acknowledged that she was expected to conduct the monthly MRR for all the residents in the facility. To ensure all resident's MRR would be reviewed, she had utilized facility census to identify existing and newly admitted residents. The pharmacist's priority was to review residents who were about to discharge from the facility or residents who had urgent needs for medication review. Otherwise, she would go by the sequence that she had from the previous month. The pharmacist could not explain how or why she had missed the monthly MRR for Resident #62 in January 2017. 2. Resident #65 was admitted to the facility on 12/23/16. Her diagnosis included diabetes mellitus, psychotic, anxiety, asthma, and Arnold-Chari syndrome. Resident #65's eMAR indicated that the resident was receiving medications for the listed diagnosis. The MDS dated 12/30/16 revealed Resident #65 was being	F 428	months. How the facility plans to monitor and ensure correction is achieved and sustained. - DON educated on the process of obtaining Census checklist by Corporate Nurse Consultant. The checklist will be reviewed during the Monthly QA&A Committee meeting for a period of 4 months for review for compliance and revision as needed.	

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treated with insulin, antipsychotic, anticoagulant, and antianxiety.

A review of the consultant pharmacist's monthly MRR indicated the consultant pharmacist had not conducted any MRRs for Resident #65 since her admission to the facility on 12/23/16.

On 02/01/17 at 3:16 PM, an interview was conducted with the facility's DON concerning the missing January 2017 MRR for Resident #65. The DON reviewed the electronic charts and found that there were no MRR entries documented by the facility's consultant pharmacist for the mentioned month. The DON stated she would contact the facility's consultant pharmacist for the missing monthly MRRs of January 2017. The DON added whenever the consultant pharmacist came to the facility to do monthly MRR, the facility would provide her a list of new admission to ensure each resident's MRR would be reviewed.

On 02/02/17 at 8:27 AM, a subsequent interview with the DON revealed that the consultant pharmacist had forgotten to conduct the January 2017 MRR for Resident #65. According to the DON, it was her expectation that the drug regimen of all resident to be reviewed at least once a month by the facility's licensed pharmacist and the pharmacist must report any irregularities to the attending physician and the DON.

On 02/02/17 at 9:30 AM, a phone interview was conducted with the facility's consultant pharmacist. The pharmacist acknowledged that she was expected to conduct the monthly MRR for all the residents in the facility. To ensure each resident's MRR would be reviewed, she had

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F 428	Continued From page 19 utilized facility census to identify existing and newly admitted residents. The pharmacist's priority was to review residents who were about to discharge from the facility or residents who had urgent needs for medication review. Otherwise, she would go by the sequence that she had from the previous month. The pharmacist could not explain how or why she had missed the monthly MRR for Resident #65 in January 2017.	F 428		
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. (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	F 520		3/8/17

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F 520	Continued From page 20 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: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in February of 2016. This was for one recited deficiency that was originally cited in January of 2016 subsequently cited in February of 2017 on the current recertification survey. The repeated deficiency was in the area of dental services. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag was cross referred to: F 411: Dental Services. Based on observations, record review, and staff interviews the facility failed to provide routine dental services for 1 of 2 sampled residents reviewed for dental status and services (Resident #156).	F 520	F520 How the corrective action will be accomplished for the resident(s) affected. F411 - On 2/2/17 family contacted by the facility, for Resident #156 and asked about having patient sent out to be seen by a dentist, at which time the family requested the patient be seen by the dentist at the next facility visit. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Individual actions denoted on said area for citation F411. Measures in place to ensure practices will not re-occur. Individual actions denoted on said area for citation F411. Administrator and DON educated on the audit required for F411 and educated on the necessity to review audits monthly and ensure compliance.	

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F 520	Continued From page 21 The facility was recited for F 411 on the current recertification survey for failing to provide routine dental services for a loose upper denture as requested by the family member during a care plan meeting. F 411 was originally cited during the January of 2016 recertification survey for failing to provide an extraction recommended as a result of a comprehensive dental exam for 1 of 2 sampled resident reviewed for dental status and services. Interview with the Administrator on 02/02/17 6:51 PM revealed that Dental Services was no longer reviewed in the facility's Quality Assurance Program but that he would personally monitor the Quality Assurance Program closer to ensure compliance.	F 520	How the facility plans to monitor and ensure correction is achieved and sustained. The Results of audit will be reported during monthly QA specifically to discuss F411 and first meeting will be the March meeting to discuss compliance with POC and for further analysis and revision if needed for a period of 12 months.	