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	345128	A. BUILDING _____ B. WING _____	C 03/10/2017

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		4/7/17

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

Electronically Signed | 04/05/2017

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to ensure the grievance investigations and resolutions had follow up and the investigations and resolutions were provided in writing to 3 of 3 sampled residents and/or their responsible parties (Residents #40, #94 and #78). Findings included: 1. Resident #40 was re-admitted to the facility on 08/06/15 with diagnoses of diabetes, heart disease, kidney disease, anemia, dementia and Alzheimer's disease. A review of the most recent Minimum Data Set (MDS) for significant change dated 02/24/17 indicated Resident #40 was severely impaired in cognition for daily decision making and required extensive assistance in activities of daily living. A review of a facility document titled "Concern Form" dated 01/13/17 indicated the heater in Resident #40's room was not working and he had a missing leather coat that was thigh length with a hood that had been bought in the last 2 months. During an interview on 03/10/17 at 3:05 PM with the Social Worker she explained she had only worked in the facility for a couple of months but	F 166	F 166 Criteria #1 On 4/4/17 the Administrator contacted Residents #40, 94 and 78 to review the resolution for most recent concern forms and to offer a written resolution for each concern. Criteria #2 Residents who voice concerns have the potential to be affected by this alleged deficient practice. The Administrator and Social Services Director reviewed the concern log for the past 30 days and contacted current residents to review the resolution of their concerns and to offer a written resolution for each concern. This review will be completed by 4/7/17. Opportunities will be corrected as identified. Criteria #3 The Administrator will re-educate the Department Managers on the facility process for collecting concerns, investigating, developing resolution, and offering a written documentation of the resolution. This Education was provided by the Administrator by 4/7/17. Resident concern forms will be reviewed 4 times	

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F 166	Continued From page 3 had received some grievances. She stated anyone could fill out a grievance and grievance forms were located at the nurse's stations. She explained she attempted to solve the grievance first but if it involved nursing issues she gave the grievance to the Director of Nursing to address. She further explained if it was department specific she gave the grievance to the Department Manager to address it. She stated she had not documented the resolution to a grievance and had never documented the resolution in a letter to a resident or responsible party. During an interview on 03/10/17 at 4:19 PM with the Director of Nursing she explained when there was a concern from a resident or family she had instructed staff to complete the Concern Form and then it should be sent to the appropriate Department Manager. She further explained grievances were usually brought to the morning meetings and were distributed to the appropriate Department Manager and the Department Manager was responsible for investigating and documenting any follow up that was done and then they were sent to the Administrator to log them. She stated once the investigation was completed sometimes a Unit Manager or the Administrator called the resident or responsible party but she had not received any requests for a copy of the resolution of the grievance and she had not given a copy of the resolution to a resident or responsible party. During an interview on 03/10/17 at 4:53 PM with the Administrator she explained if someone had a grievance they or staff filled out a grievance form and the form was brought to morning meeting and was given to the appropriate Department	F 166	per week for 12 weeks by the Administrator or Social Services Director. The resident concern forms will be reviewed to ensure investigations are complete, acceptable resolution developed and communicated with the resident, documented appropriately and a written resolution offered. Opportunities will be corrected as identified. Criteria #4 The Administrator will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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Manager for investigation. She stated the forms were returned to her and she reviewed them and logged them. She confirmed the facility had not provided written follow up to grievances. She stated she was aware of the new regulation to ensure complainants were given the written investigation and resolution of any complaints filed with the facility but had not implemented it in the facility.

2. Resident #94 was admitted to the facility on 12/09/15 with diagnoses of heart disease, high blood pressure, kidney disease, diabetes, dementia, depression and had paralysis of upper and lower extremity on 1 side. A review of the most recent annual Minimum Data Set dated 11/22/16 revealed Resident #94 was cognitively intact for daily decision making and required extensive assistance by staff for hygiene and was totally dependent on staff for bathing.

A review of facility document titled "Concern Form" dated 01/10/17 indicated Resident #94 had no shower on 01/09/17 and would like 1 today.

A review of a facility document titled "Concern Form" dated 03/03/17 indicated Resident #94 complained that he didn't always get his shower. The document revealed according to staff, resident would refuse showers unless a certain Nurse Aide (NA) was working and Resident #94 had made inappropriate comments to that NA. The document further revealed Resident #94 was encouraged to take a shower with other NA assistance.

During an interview on 03/10/17 at 3:05 PM with the Social Worker she explained she had only worked in the facility for a couple of months but

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had received some grievances. She stated anyone could fill out a grievance and grievance forms were located at the nurse's stations. She explained she attempted to solve the grievance first but if it involved nursing issues she gave the grievance to the Director of Nursing to address. She further explained if it was department specific she gave the grievance to the Department Manager to address it. She stated she had not documented the resolution to a grievance and had never documented the resolution in a letter to a resident or responsible party.

During an interview on 03/10/17 at 4:19 PM with the Director of Nursing she explained when there was a concern from a resident or family she had instructed staff to complete the Concern Form and then it should be sent to the appropriate Department Manager. She further explained grievances were usually brought to the morning meetings and were distributed to the appropriate Department Manager and the Department Manager was responsible for investigating and documenting any follow up that was done and then they were sent to the Administrator to log them. She stated once the investigation was completed sometimes a Unit Manager or the Administrator called the resident or responsible party but she had not received any requests for a copy of the resolution of the grievance and she had not given a copy of the resolution to a resident or responsible party.

During an interview on 03/10/17 at 4:53 PM with the Administrator she explained if someone had a grievance they or staff filled out a grievance form and the form was brought to morning meeting and was given to the appropriate Department

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Manager for investigation. She stated the forms were returned to her and she reviewed them and logged them. She confirmed the facility had not provided written follow up to grievances. She stated she was aware of the new regulation to ensure complainants were given the written investigation and resolution of any complaints filed with the facility but had not implemented it in the facility.

3. Resident #78 was admitted to the facility on 11/14/16 with diagnoses of high blood pressure, diabetes, anxiety and depression. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/11/17 revealed Resident #78 was cognitively intact for daily decision making and required limited assistance with hygiene and 1 staff assistance with bathing. The MDS further revealed Resident #78 had range of motion impairment on lower extremity on 1 side.

A review of a facility document titled "Concern Form" dated 01/101/7 indicated Resident #78 had no shower on Wednesday or Saturday.

During an interview on 03/10/17 at 3:05 PM with the Social Worker she explained she had only worked in the facility for a couple of months but had received some grievances. She stated anyone could fill out a grievance and grievance forms were located at the nurse's stations. She explained she attempted to solve the grievance first but if it involved nursing issues she gave the grievance to the Director of Nursing to address. She further explained if it was department specific she gave the grievance to the Department Manager to address it. She stated she had not documented the resolution to a grievance and had never documented the

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F 166	Continued From page 7 resolution in a letter to a resident or responsible party. During an interview on 03/10/17 at 4:19 PM with the Director of Nursing she explained when there was a concern from a resident or family she had instructed staff to complete the Concern Form and then it should be sent to the appropriate Department Manager. She further explained grievances were usually brought to the morning meetings and were distributed to the appropriate Department Manager and the Department Manager was responsible for investigating and documenting any follow up that was done and then they were sent to the Administrator to log them. She stated once the investigation was completed sometimes a Unit Manager or the Administrator called the resident or responsible party but she had not received any requests for a copy of the resolution of the grievance and she had not given a copy of the resolution to a resident or responsible party. During an interview on 03/10/17 at 4:53 PM with the Administrator she explained if someone had a grievance they or staff filled out a grievance form and the form was brought to morning meeting and was given to the appropriate Department Manager for investigation. She stated the forms were returned to her and she reviewed them and logged them. She confirmed the facility had not provided written follow up to grievances. She stated she was aware of the new regulation to ensure complainants were given the written investigation and resolution of any complaints filed with the facility but had not implemented it in the facility.	F 166		
F 241	483.10(a)(1) DIGNITY AND RESPECT OF	F 241		4/7/17

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F 241 SS=D	Continued From page 8 INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to promote the dignity for 1 of 4 sampled residents when 2 staff failed to knock on the door and/or announcing staff presence before entering Resident #13's room. The findings included: Resident #13 was admitted to the facility on 04/2/13. Her diagnoses included osteoarthritis, hypertension, deep vein thrombosis, anxiety and insomnia. The most recent Minimum Data Set, an annual dated 02/27/17, coded her with intact cognition, being nonambulatory, and requiring extensive assistance with most activities of daily living skills. On 03/08/17 at 4:35 PM, Resident #13 and the surveyor were in the resident's room talking. The call light had been on when the surveyor entered with permission. The door to the room was open. On 03/08/17 at 4:38 PM, Nurse Aide (NA) #1 entered Resident #13's room without knocking or announcing her presence. On 03/08/17 at 4:39 PM, NA #2 also entered without knocking or announcing her presence. Resident #13's back was toward the open door and her roommate was	F 241	F 241 Criteria #1 On 3/10/17 NA #1 and NA #2 were immediately re-educated by the Director of Nursing regarding providing care with dignity and respect to include knocking on resident doors and announcing staff presence prior to entering the resident's room. Criteria #2 All residents have the potential to be affected by the alleged deficient practice. Criteria #3 Facility Staff have been re-educated by the Director of Nursing or Nurse Managers on treating residents with dignity and respect, including knocking on resident doors and announcing staff presence prior to entering the resident's room. This education was completed by 4/7/17. The Administrator, Director of Nursing or Nurse Managers will make 5 random observations per week for 12 weeks to validate residents are treated with dignity and respect include knocking on resident doors and announcing staff presence prior to entering the resident's room. Opportunities will be corrected daily as identified.	

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F 241	Continued From page 9 behind the curtain when staff entered. During immediate interview, NA #1 stated she never knocked when entering a room when the door was open but would knock if the door was closed. NA #2 stated she did not knock as she was coming into the room to help NA #1. Resident #13 was interviewed on 03/08/17 at 4:46 PM. Resident #13 stated that it sometimes bothered her that staff did not knock before entering her room and she would prefer staff knocked before entering. During an interview on 03/10/17 at 8:42 AM, Unit Manager #2 stated that she expected staff to knock or to announce their presence each time they enter a resident's room. The Director of Nursing stated on 03/10/17 at 10:08 AM that she expected staff to knock or announce and identify themselves before entering a resident's room.	F 241	Criteria #4 The Administrator will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair a missing call bell cord in 1 of 26 resident bathrooms on the 200 hall (room #232); failed to repair the smoke prevention doors with broken and splintered laminate and wood on the 100 hall, 200 hall and Courtyard Terrace hall; failed to repair the dining room door on the 300 hall with broken and splintered	F 253	F253 Criteria #1 The New Maintenance Director started on April 3, 2017. The following repairs will be completed by the New Maintenance Director and others by 4/07/17 1) 232 bathroom- replaced 03/09/17	4/7/17

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F 253	Continued From page 10 laminate and wood on the lower edges of the door; failed to repair the activity/dining room door on the 400 hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair the activity room door on the main hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair resident room and bathroom doors with broken and splintered laminate and wood in 6 of 23 rooms on the 300 and 400 halls (resident rooms #301, #305, #306, #311, #404 and #405); failed to remove brown stains from sinks drains, overflow drains and faucets in 3 of 13 rooms on the 300 hall (resident bathrooms #301, #305, and #306); failed to repair brown stains around the base of toilets in 2 of 23 rooms on the 300 and 400 hall (resident room #305 and #402); failed to repair wall damage in 6 of 23 rooms on the 300 and 400 halls (resident room #306, #310, #401, #402, #405 and #408) and failed to remove debris inside the grate of a heating and air conditioning unit in the 300 hall dining room. Findings included: 1. Observations on 03/06/17 at 11:37 AM in the bathroom or resident room #232 there was no call bell cord in the bathroom. Observations on 03/08/17 at 9:00 AM in the bathroom or resident room #232 there was no call bell cord in the bathroom. Observations on 03/09/17 at 10:19 AM in the bathroom or resident room #232 there was no call bell cord in the bathroom. 2. a. Observation on 03/06/17 at 11:40 AM of smoke prevention doors on the 100 hall revealed broken and splintered laminate and wood on the lower edges of the door.	F 253	2) Smoke prevention doors on 100 hall broken and splintered laminate and wood on lower edges of the door has been repaired 3) Smoke prevention doors on 200 hall broken and splintered laminate and wood on lower edges of the door has been repaired 4) Smoke prevention doors on courtyard terrace hall broken and splintered laminate and wood on lower edges of the door has been repaired 5) 300 hall dining room broken and splintered laminate and wood on lower edges of the door has been repaired 6) 400 hall activity room door broken and splintered laminate and wood on lower edges of the door has been repaired 7) Main hall activity room broken and splintered laminate and wood on lower edges of the door has been repaired 8) Room 301 broken and splintered laminate and wood on lower edges of the door has been repaired 9) Room 305 broken and splintered laminate and wood on lower edges of the door has been repaired 10) Room 306 broken and splintered laminate and wood on lower edges of the door has been repaired 11) Room 311 broken and splintered laminate and wood on lower edges of the door has been repaired 12) Room 404 broken and splintered laminate and wood on lower edges of the door and bathroom door has been repaired 13) Room 405 2 inch jagged chip in laminate by door handle has been	

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F 253	Continued From page 11 Observation on 03/07/17 at 9:05 AM of smoke prevention doors on the 100 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:35 AM of smoke prevention doors on the 100 hall revealed broken and splintered laminate and wood on the lower edges of the door. b. Observation on 03/06/17 at 11:42 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/07/17 at 9:07 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:36 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door. c. Observation on 03/06/17 at 11:45 AM of smoke prevention doors on the Courtyard Terrace hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/07/17 at 9:09 AM of smoke prevention doors on the Courtyard Terrace hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:38 AM of smoke prevention doors on the Courtyard Terrace hall revealed broken and splintered laminate and wood on the lower edges of the door. 3. Observation on 03/06/17 at 11:45 AM of the dining room doors on the 300 hall revealed broken and splintered laminate and wood on the lower edges of the door.	F 253	repaired 14) Room 301 sink had brown stains around the drain and brown stains extended down the side of the sink from the overflow drain has been removed 15) Room 301 toilet paper holder hanging from wall has been replace 16) Room 305 sink had brown stains around the drain and brown stains extended down the side of the sink from the overflow drain around the base of the toilet has been removed 17) Room 306 baseboard along section of wall in bathroom was detached from the wall and lying on the floor has been replaced and 1 section of the towel bar was missing on the bathroom wall has been replaced 18) Room 310 revealed sheet rock on wall around the air conditioning and heating unit has been repaired and missing towel bar on a wall in the bathroom has been replaced 19) Room 402 wall damage in the bathroom with 8 holes in the wall have been repaired and a rusty seat extender on the bedside commode has been removed and replaced 20) Room 405 towel bar missing from the wall in the bathroom has been replaced 21) Room 408 large area of exposed sheet rock on 1 wall has been repaired 22) Brown stained piece of paper lying on top of metal coil in heating and AC unit has been removed. Criteria #2 All residents have the potential to be	

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F 253	Continued From page 12 Observation on 03/07/17 at 9:09 AM of the dining room doors on the 300 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:38 AM of the dining room doors on the 300 hall revealed broken and splintered laminate and wood on the lower edges of the door. 5. Observation on 03/06/17 at 11:48 AM of the activity room/dining room door on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/07/17 at 9:12 AM of the dining room doors on the activity room/dining room door on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:45 AM of the dining room doors of the activity room/dining room door on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door. 6. Observation on 03/06/17 at 11:50 AM of the activity room door on the main hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/07/17 at 9:15 AM of the activity room door on the main hall revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 03/08/17 at 10:47 AM of the activity room door on the main hall revealed broken and splintered laminate and wood on the lower edges of the door. 7. a. Observations on 03/07/17 at 08:42 AM in resident room #301 revealed the room door and	F 253	affected by this alleged deficient practice. Detailed maintenance rounds have been conducted by the Administrator and the New Maintenance Director and a prioritized list of repairs has been developed for ongoing repairs and maintenance by 4/7/17 Criteria #3 Facility Staff will be re-educated by the Administrator on the process for completion of the Maintenance Request Form for Notification to the Maintenance Department for needed facility repairs. The re-educations will be completed by 4/7/17. The Administrator and the Maintenance Director will conduct facility rounds weekly for 12 weeks to validate completion of needed repairs and maintenance as outlined on the prioritized maintenance list. Criteria #4 The results of these audits and monitoring will be submitted to the QAPI Committee by the Maintenance Director for review by the IDT members each month. The QAPI committee will evaluated the effectiveness and amend as needed. Date of compliance is 4/7/17	

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bathroom door had broken and splintered laminate and wood on the lower edges of the doors and laminate on the doors were blistered.
Observations on 03/08/17 at 10:49 AM in resident room #301 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors and laminate on the doors were blistered.
Observations on 03/09/17 at 10:50 AM in resident room #301 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors and laminate on the doors were blistered.

b. Observations on 03/07/17 at 08:50 AM in resident room #305 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors.
Observations on 03/08/17 at 10:50 AM in resident room #305 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors.
Observations on 03/09/17 at 10:52 AM in resident room #305 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors.

c. Observations on 03/07/17 at 9:01 AM in resident room #306 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors.
Observations on 03/08/17 at 10:51 AM in resident room #306 revealed the room door and bathroom door had broken and splintered laminate and wood on the lower edges of the doors.
Observations on 03/09/17 at 10:54 AM in resident room #306 revealed the room door and bathroom

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door had broken and splintered laminate and wood on the lower edges of the doors.

d. Observations on 03/06/17 at 10:07 AM in resident room #311 revealed the door of the resident's room had broken and splintered laminate and wood on the lower edges of the doors.
Observations on 03/07/17 at 10:07 AM in resident room #311 revealed the door of the resident's room had broken and splintered laminate and wood on the lower edges of the doors.
Observation on 03/09/2017 10:55 AM in resident room #311 revealed the door of the resident's room had broken and splintered laminate and wood on the lower edges of the doors.

e. Observations on 03/06/17 at 11:53 AM in resident room #404 revealed the door of the room and bathroom door had broken and splintered laminate and wood on the lower edges of the doors and a long black mark was present on the floor from the door of the room past the first bed.
Observation on 03/07/17 at 09:25 AM in resident room #404 revealed the door of the room and bathroom door had broken and splintered laminate and wood on the lower edges of the doors and a long black mark was present on the floor from the door of the room past the first bed.
Observations on 03/08/17 at 9:16 AM in resident room #404 revealed the door of the room and bathroom door had broken and splintered laminate and wood on the lower edges of the doors and a long black mark was present on the floor from the door of the room past the first bed.

f. Observations on 03/06/2017 11:49:20 AM in resident room #405 revealed the door of the room had a 2 inch jagged chip in the laminate by the

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door handle.
Observations on 03/07/17 at 9:12 AM in resident room #405 revealed the door of the room had a 2 inch jagged chip in the laminate by the door handle.
Observations on 03/08/17 at 9:18 AM in resident room #405 revealed the door of the room had a 2 inch jagged chip in the laminate by the door handle.

8. a. Observations on 03/07/17 at 08:42 AM in the bathroom of resident room #301 revealed the sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain. Further observations revealed a toilet paper holder hanging from the wall from 1 screw and 1 side of the holder was hanging down.
Observations on 03/08/17 at 10:49 AM in the bathroom of resident room #301 revealed the sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain. Further observations on 03/07/17 at 08:42 AM in resident room #301 revealed a toilet paper holder hanging from the wall from 1 screw and 1 side of the holder was hanging down.
Observations on 03/09/17 at 10:50 AM in the bathroom of resident room #301 revealed the sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain. Further observations on 03/07/17 at 08:42 AM in resident room #301 revealed a toilet paper holder hanging from the wall from 1 screw and 1 side of the holder was hanging down.

b. Observations on 03/07/17 at 08:50 AM in the bathroom of resident room #305 revealed the

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sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain and brown stains around the base of the toilet.
Observations on 03/08/17 at 10:50 AM in the bathroom of resident room #305 revealed the sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain and brown stains around the base of the toilet.
Observations on 03/09/17 at 10:52 AM in the bathroom of resident room #305 revealed the sink had dark brown stains around the drain and brown stains extended down the side of the sink from the overflow drain and brown stains around the base of the toilet.

c. Observations on 03/07/17 at 9:01 AM in the bathroom of resident room #306 revealed the sink in the bathroom had brown stains around the sink and faucet.
Observations on 03/08/17 at 10:51 AM in the bathroom of resident room #306 revealed the sink in the bathroom had brown stains around the sink and faucet.
Observations on 03/09/17 at 10:54 AM in the bathroom of resident room #306 revealed the sink in the bathroom had brown stains around the sink and faucet.

d. Observations on 03/06/17 at 11:53 AM in the bathroom of resident room #402 revealed brown stains around the base of the toilet.
Observation on 03/07/17 at 09:25 AM in the bathroom of resident room #402 revealed brown stains around the base of the toilet.
Observations on 03/08/17 at 9:16 AM in the bathroom in resident room #402 revealed brown stains around the base of the toilet.

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9. a. Observations on 03/07/17 at 9:01 AM in resident room #306 revealed the baseboard along a long section of wall in the bathroom was detached from the wall and was lying on the floor and 1 section of a towel bar was missing on a bathroom wall.
Observations on 03/08/17 at 10:51 AM in resident room #306 revealed the baseboard along a long section of wall in the bathroom was detached from the wall and was lying on the floor and 1 section of a towel bar was missing on a bathroom wall.
Observations on 03/09/17 at 10:54 AM in resident room #306 revealed the baseboard along a long section of wall in the bathroom was detached from the wall and was lying on the floor and 1 section of a towel bar was missing on a bathroom wall.

b.. Observation on 03/07/17 at 08:57 AM in resident room #310 revealed the sheet rock on the wall around the air conditioning and heating unit was broken and unpainted.
Observation on 03/0817 at 08:57 AM in resident room #310 revealed the sheet rock on the wall around the air conditioning and heating unit was broken and unpainted.
Observation on 03/09/17 at 10:55 AM in resident room #310 revealed the sheet rock on the wall around the air conditioning and heating unit was broken and unpainted. .

c. Observations on 03/06/17 at 11:38 AM in resident room #401 revealed the sheet rock was unpainted around the air conditioning and heating unit and a missing towel bar on a wall in the bathroom.
Observations on 03/07/17 at 11:13 AM in resident

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room #401 revealed the sheet rock was unpainted around the air conditioning and heating unit and a missing towel bar on a wall in the bathroom.
Observations on 03/08/17 at 10:58 AM in resident room #401 revealed the sheet rock was unpainted around the air conditioning and heating unit and a missing towel bar on a wall in the bathroom.

d. Observations on 03/06/17 at 11:53 AM in resident room #402 revealed wall damage in the bathroom with 8 holes in the wall and a rusty seat extender on the bedside commode.
Observation on 03/07/17 at 09:25 AM in resident room #402 revealed wall damage in the bathroom with 8 holes in the wall and a rusty seat extender on the bedside commode
Observations on 03/08/17 at 9:16 AM in resident room #402 revealed wall damage in the bathroom with 8 holes in the wall and a rusty seat extender on the bedside commode.

e. Observations on 03/06/17 at 11:49 AM in resident room #405 revealed a towel bar was missing on a wall in the bathroom with 1 bracket still attached to the wall.
Observations on 03/07/17 at 9:07 AM in resident room #405 revealed a towel bar was missing on a wall in the bathroom with 1 bracket still attached to the wall.
Observations on 03/08/17 at 9:17 AM in resident room #405 revealed a towel bar was missing on a wall in the bathroom with 1 bracket still attached to the wall.

f. Observations on 03/06/17 at 12:36 PM in the bathroom of resident room #408 revealed a large area of exposed sheet rock on 1 wall.

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Observations on 03/07/17 at 10:25 AM in the bathroom of resident room #408 revealed a large area of exposed sheet rock on 1 wall.
Observations on 03/08/17 at 9:25 AM in the bathroom of resident room #408 revealed a large area of exposed sheet rock on 1 wall.

10. Observation on 03/06/17 at 11:45 AM revealed a heating and air conditioning unit mounted on the wall and inside the top grate was a brown stained piece of paper lying on top of metal coils and warm air was coming from the unit.
Observation on 03/07/17 at 9:09 AM revealed a heating and air conditioning unit mounted on the wall and inside the top grate was a brown stained piece of paper lying on top of metal coils and warm air was coming from the unit.
Observation on 03/08/17 at 10:38 AM revealed a heating and air conditioning unit mounted on the wall and inside the top grate was a brown stained piece of paper lying on top of metal coils and warm air was coming from the unit.

An environmental tour and interview was conducted on 03/09/17 at 9:35 AM with a Maintenance Assistant and the Administrator. The Administrator explained they did not currently have a Maintenance Director but had just hired someone. She further explained the Maintenance Assistant had been in the building since January and had been working on painting and making repairs from items on a priority list. The Maintenance Assistant verified they used a work order system and had a notebook at the nurse's stations for staff to write down any repairs that were needed. He further stated he tried to check the work orders every day and he documented in the notebook when he had

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F 253	Continued From page 20 completed the repairs. He explained new employees were told about the work order system and staff came to him every day to tell him when things needed to be fixed. He stated he was caught up on maintenance requests and worked Monday through Friday and was on call on Saturday and Sunday. He further stated if he needed help he called a Maintenance Director to come in from another facility within their corporation. During the tour the Maintenance Assistant and Administrator verified damage to doors and stated they needed to be repaired. The Administrator stated she expected for the wall damage and missing towel bars and toilet paper hangers to be repaired and grout around toilets to be repaired. On 03/09/17 at 9:53 AM the Housekeeping Director joined the tour and explained the black mark on the floor in resident room #404 needed to be removed with a floor buffer and it had not been reported to him. He confirmed the dark brown stains in sinks and around faucets and stated they had not been reported to him. During a follow up interview with the Administrator on 03/09/17 at 10:32 AM she stated it was her expectation for staff to report anything that was unsafe for a resident immediately to the Maintenance Staff and she expected Maintenance staff to repair anything unsafe in the facility immediately. She further stated she expected for Maintenance staff to prioritize the list of maintenance issues and repair them.	F 253		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		4/7/17

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F 281	Continued From page 21 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to implement a physician's order for medication administration for 1 of 6 sampled residents (Resident #12) reviewed for unnecessary medication. Findings included: The most recent quarterly Minimum Data Set (MDS) dated 01/16/17 indicated Resident #12 was cognitively intact and required limited assistance with bed mobility and transfers and required extensive assistance with dressing, toileting and personal hygiene. Resident #12 was readmitted to the facility on 03/01/17 and diagnoses included osteoarthritis with degenerative features. A review of the physician's admission orders dated 03/01/17 indicated Resident #12 was to receive calcium-vitamin D 600-400 milligram (mg) 1 tablet by mouth two times a day. A review of the Medication Administration Record (MAR) revealed per staff documentation on the MAR that Resident #12 received 1 dose of calcium-vitamin D at 9:00 AM on 03/01/17 and did not receive calcium-vitamin D on 03/01/17 at 9:00 PM and did not receive the medication at 9:00 AM and 9:00 PM on 03/02, 04, 05, 06, 07,	F 281	F 281 Criteria #1 On 3/10/17 Unit Manager #1 completed a Medication Variance Form regarding the administration of Calcium-Vitamin D for resident # 12. The Physician was notified immediately and new orders were received by Unit Manager #1 on 3/10/17. Criteria #2 All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing or Nurse Managers will complete an audit of Medication Administration Records for current residents to verify accurate transcription of Physician's orders by 4/7/17. Medication Variance forms will be completed as required and opportunities corrected as identified. Criteria #3 The Director of Nursing or Nurse Managers will re-educate all Licensed Nurses on the accurate transcription of Physician's orders including the process for Month End verification of accurate transcription of Physician's Orders by 4/7/17. The Director of Nursing or Nurse Managers will review the Order Listing report via Point Click Care 4 times per week for 12 weeks to verify accurate	

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F 281	Continued From page 22 and did not receive the 9:00 AM dose on 03/08/17 and had not received a total of 14 doses of calcium-vitamin D for a supplement. On 03/08/2017 at 12:28 PM an interview was conducted with Unit Manager #1 who verified the physician's admission order for calcium-vitamin D tablet 600-400 mg was received on 03/01/17 and indicated Resident #12 was to have one tablet by mouth two times a day. Unit Manager #1 stated she transcribed Resident #12's admission orders and missed transcribing the order for calcium-vitamin D and verified that Resident #12 had not received 14 doses of calcium-vitamin D as ordered by the physician. On 03/08/2017 at 12:57 PM a telephone interview was conducted with the physician who stated she had ordered calcium-vitamin D for Resident #12 and expected that the order would have been implemented by the staff. The physician stated her expectation was that the staff would have administered the medication to Resident #12 as ordered. On 03/08/2017 at 2:55 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that calcium-vitamin D would have been administered to Resident #12 as ordered by the physician. The DON stated her expectation was that Unit Manager #1 would have accurately transcribed the calcium-vitamin D onto Resident #12's MAR so that the staff would have known to administer the medication to Resident #12. On 03/08/2017 at 3:26 PM an interview was conducted with the Administrator who stated her expectation was that Resident #12 would have	F 281	transcription to the Medication Administration Record. Opportunities will be corrected daily as identified. Criteria #4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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F 281	Continued From page 23 received calcium-vitamin D as ordered by the physician and the resident would not have missed 14 doses of the medication. The administrator stated her expectation was that the medication should have been transcribed onto the MAR accurately so that Resident #12 would have received the calcium-vitamin D.	F 281		
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 faclity failed to follow the care plan for 2 of 4 residents sampled for falls. Resident #50's wheelchair was not placed out of his sight while he was in bed per care plan. Resident #29's bed alarm was not turned on while she was in bed per care plan. The findings included: 1. Resident #50 was admitted to the facility on 04/04/16. His diagnoses included vascular dementia with behavioral disturbances, hemiplegia and hemiparesis, cerebral infarction, abnormal posture, restlessness and agitation, tremor, other seizures, anxiety disorder, and major depressive disorder.	F 282	F 282 Criteria #1 On 3/10/17 the Unit Manager validated placement and function of bed and chair alarms and wheelchair for Resident #50 and placement and function of bed alarm for Resident #29. Criteria #2 Residents with care planned interventions to reduce risk of falls are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of residents with care planned interventions to validate placement and function. This audit was completed by 4/7/17. Opportunities were corrected as identified. Criteria #3	4/7/17

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F 282	Continued From page 24 The admission Minimum Data Set (MDS) dated 04/13/16 coded Resident #50 with intact cognition, having no moods or behaviors, requiring extensive assistance with all activities of daily living skills (ADLs) except for eating, and being nonambulatory. He had upper and lower impairment of range of motion on one side, needed assistance to balance during surface to surface transitions, and had a fall one month prior to admission, 2-6 months prior to admission and 2 or more falls since admission with no injury. The Fall Care Area Assessment (CAA) dated 04/14/16 stated he had a cerebral vascular accident resulting in left sided hemiplegia. He was admitted for therapy due to a history of falls from the wheelchair. The CAA also stated he has had a decline in strength, postural alignment, functional mobility and balance. The quarterly MDS dated 07/14/16 noted he had 2 or more falls since the last assessment with one involving a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance. The quarterly MDS dated 10/07/16 also noted Resident #50 had 2 or more falls since the last assessment one with a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance. Review of recent Incident Reports and Investigations revealed: *On 12/12/16 at 9:45 AM a nurse aide reported	F 282	The Director of Nursing or Nurse Managers will re-educate all Nursing staff on implementation of fall interventions as care planned to include the placement of alarms, function of alarms. This education was completed on 4/7/17. The Director of Nursing or Nurse Managers will randomly observe 10 residents weekly for 12 weeks to verify care planned interventions are in place. Opportunities will be corrected as identified as a result of these audits Criteria #4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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the resident was found on his abdomen on the floor at foot of his bed with a reddened temple area. The investigation noted he was trying to get from his bed to his wheelchair. The alarm was sounding. The recommendation added to the care plan on 12/12/16 was to re-educate staff to keep wheelchair out of sight when resident was in bed.

The most recent quarterly MDS dated 01/03/17 noted he had one fall since the last assessment with a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance.

Further incidents and investigations included:
*On 02/06/17 at 3:05 PM resident attempted to transfer from bed to wheelchair and found on floor on back with scratch to right side of nose. He stated he hit his face on the foot pedal. Intervention to remind staff to keep wheelchair out of sight when resident is in bed. The recommendation added to the care plan on 02/06/17 was to re-educate staff to keep resident wheelchair out of sight while in bed.

The current care plan initially developed on 04/14/16 to address his history of falls and most recently reviewed and updated on 02/10/17 had the ongoing goal for Resident #50 to resume his usual activities without further incident and not obtain any injury through next review. The care plan was updated following his repeated falls. Interventions and implementation dates included:
*On 04/20/16 bed pad alarm and check placement and function every shift;
*On 06/09/16 keep wheelchair out of sight when in bed;

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*On 07/16/16 staff education to keep wheelchair out of sight when in bed;
*On 12/12/16 re-educate staff to keep wheelchair out of sight while in bed; and
*On 02/06/17 re-educate staff to keep resident's wheelchair out of sight while in bed.

Review of the undated nurse aide assignment sheet revealed instructions for Resident #50 included bed, chair tab alarms. This form did not address where the wheelchair should be kept when he was in bed.

On 03/07/17 at 9:42 AM, Resident #50 was observed in bed. The pressure alarm was not blinking indicating it was not turned on. At 10:54 AM, Resident #50 was attempting to sit up in his bed. Nurse Aides (NA) #3 and #4 passing the door entered to assist. Both staff were needed to assist Resident #50 to a standing position. Once upright they pivoted him to the high back wheelchair which was in his room at the foot of his bed. The bed alarm did not sound. At this time staff were asked about the alarm not sounding. NA #3 pushed on it several times until it sounded and determined it had a very delayed response. NA #4 stated she would replace it.

On 03/08/17 at 10:05 AM, the facility driver and Medication aide #1 assisted Resident #50 to bed. The alarm did not sound when he sat on the bed. Once in bed, staff left the room at 10:12 AM without checking the alarm in bed and left the wheelchair at the end of his bed. The alarm was turned off per observation of switch and no light blinking at 10:17 AM and again at 11:07 AM. At 11:38 AM the maintenance assistant was in the room fixing the side of his w/c and then he left the wheelchair in the room. On 03/08/17 at 11:54

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AM, Resident #50 was attempting to sit up on the side of his bed with his feet off the side of the bed. At 11:42 AM NA #4 and medication aide #1 entered the room. With extensive assistance of both staff, Resident #50 was transferred to the wheelchair which was in his room at the end of his bed. No bed alarm sounded. Interview with staff at this time confirmed the alarm was not turned on. Medication aide #1 stated she should have checked the alarm when she assisted him to bed earlier in the morning. NA #4 stated she replaced the alarm with a new one yesterday.

Additional observations of Resident #50 in bed with his wheelchair positioned in his room at the foot of his bed occurred on 03/08/17 at 6:46 PM, on 03/08/17 at 7:34 PM, and on 03/09/17 at 10:28 AM.

On 03/09/17 at 10:30 AM NA #3 was interviewed relating to the fall interventions. NA 3 stated that alarms were to be used in bed and in the wheelchair. She further stated that staff kept the wheelchair in the room but tried to keep it on the other side of the room so it was not next to the bed.

NA #5 stated during interview on 03/09/17 at 10:39 AM that she tried to keep the wheelchair far enough away from him but still in his room so that he would not attempt to get into it. She further stated that if you removed the wheelchair from the room he became irate.

During an interview on 03/10/17 at 10:15 AM, the Director of Nursing stated that Resident #50's wheelchair was to be kept in the bathroom or out of his room so that it was out of his sight due to repeated attempts to transfer himself from bed to

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chair. She also stated it was her expectation to make sure the alarms were on and functioning in bed and in the wheelchair. Unit Manager #2 was present at this time and stated that she tried to make rounds every morning to ensure fall interventions were in place but that Resident #50 was often already out of bed in his wheelchair when she made these rounds.

2. Resident #29 was admitted to the facility on 06/15/16. Her diagnoses included cerebral vascular accident, Alzheimer's disease, contractures, and muscle weakness.

The admission Minimum Data Set dated 06/23/16 coded her with having severely impaired cognition, and requiring extensive assistance with bed mobility, total assistance with transfers and being nonambulatory.

The Fall Care Area Assessment dated 06/24/16 stated she required extensive assistance with bed mobility and was totally dependent on two staff with transfers and other activities of daily living skills. She was at risk for falls due to incontinence, psychotropic medication use and her cognition and needed a mechanical lift to transfer from bed to chair.

The care plan for falls was established on 06/24/16 due to her being high risk for falls and having a decline in condition was anticipated. Initial interventions included to anticipate resident needs, and keep call light in reach and provide prompt response. On 08/15/16 the intervention of a low bed with fall mats was implemented.

Review of the incident reports revealed Resident #29 fell on 11/19/16 at 2:42 AM when she was

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found lying on the floor mat from bed. She sustained no injuries and it was noted the bed alarm was sounding. No changes were noted to the care plan and the care plan did not include the use of a bed alarm.

Another incident report dated 01/30/17 at 9:00 PM revealed Resident #29 was placed in bed via hoyer lift and resident fell off the bed onto the floor. Review of the investigation revealed the bed alarm was not on, the bed was not in the lowest position and staff left the room. She was subsequently sent to the emergency room due to neck and shoulder pain and diagnoses with cervical and lumbar spine sprains. Staff were reminded to complete task when putting residents to bed before moving on to another resident and keeping bed in lowest position.

Review of the undated nurse aide assignment sheet revealed Resident #29 was to have a bed alarm in place.

On 03/08/17 at 9:03 AM, Resident #29 was observed in bed with the head of the bed up approximately 80 degrees. She had a drink on the overbed table and was asleep. The bed was in the low position and there were mats on each side of the bed but the pressure bed alarm was turned off. The alarm was observed in the off position when checked again on 03/08/17 at 9:57 AM. On 03/08/17 at 10:19 AM the hospice aide was in to provide a bath to Resident #29. After Hospice staff left, Resident #29 was observed in bed asleep on 03/08/17 at 11:07 AM and 11:39 AM.

On 03/08/17 at 11:50 AM, Nurse Aide (NA) #4 and the surveyor checked to find the bed alarm

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F 282	Continued From page 30 turned off. NA #4 stated that when she served Resident #29 her breakfast this morning, the alarm sounded as she repositioned the resident. NA #4 stated she reset the alarm and was unsure how is was not on and functioning. Interview with Unit Manager #1 on 03/10/17 at 9:40 AM revealed that Resident #29 should have a low bed, mats on the floor and a bed alarm in place. She could not say why the bed alarm was not on the care plan but stated it was on the nurse aide assignment sheet indicating it was an intervention to be used. Unit Manger #1 further stated that on her master list of devices, Resident #29 was to have a bed alarm in place as an intervention to alert staff to the resident moving in bed.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309		4/7/17

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F 309	Continued From page 31 care plan, and the residents' choices, including but not limited to the following: (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, resident and dialysis staff interviews, and record review the facility failed to provide communication regarding resident's condition prior to receiving hemodialysis services for 1 of 1 sampled resident (Resident #17). The findings included: Resident #17 was admitted to the facility on 01/14/17 with diagnoses that included end stage renal disease, type 2 diabetes, bilateral above the knee amputations, congestive heart failure, debility and others. The most recent Minimum Data Set (MDS) dated 01/21/17 specified the resident's cognition was intact and she received dialysis. The Care Area Assessment (CAA) dated 01/23/17 for nutrition specified Resident #17 was at risk for fluid fluctuations from end stage renal	F 309	F 309 Criteria #1 On 3/10/17 the Unit Manager contacted the Dialysis Center to provide a verbal update on the current condition of Resident #17 and to explain to the Dialysis Center that a written communication form would be transported with Resident #17 going forward. Criteria #2 Residents receiving Dialysis treatments are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of Residents receiving Dialysis and provided the Dialysis Center with an update of each residents current condition and explained that a written communication form would be transported with each resident going forward. This audit was completed by 4/7/17.	

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F 309	Continued From page 32 disease (ESRD) and was on hemodialysis. A care plan developed on 01/23/17 for hemodialysis related to renal failure identified a "dialysis communication record" was sent to the dialysis center with each appointment, and return of form is ensured after appointment is completed. A document titled "Dialysis Communication Record" was reviewed. The document included specific pre-dialysis information to be completed by the skilled nursing facility related to the resident. The requested information included: - Vital signs - Medications administered - Medications sent with the resident - Meal provision - Condition alert On 03/09/17 at 9:10 AM Resident #17 was interviewed and reported she had been at dialysis the previous day. Resident #17 reported that she did not know how the dialysis center communicated with the skilled nursing facility and the resident did not take a "communication record" with her. On 03/09/17 at 9:26 AM Nurse #5 assigned to Resident #17 was interviewed and reported that she was unaware of communications sheets used for dialysis residents. Nurse #5 added that if dialysis had concerns regarding resident condition/status they called the skilled nursing facility. On 03/09/17 at 10:00 AM Unit Manager #3 was interviewed and explained all dialysis residents	F 309	Opportunities were corrected as identified. Criteria #3 The Director of Nursing or Nurse Managers will re-educate Licensed Nurses on the completion of the facility's policy regarding management of Dialysis Residents to include the completion of a dialysis communication form to be transported with the resident prior to going to the dialysis center and reviewed of same communication when returned from the Dialysis Center. This education was completed on 4/7/17. The Director of Nursing or Nurse Managers will randomly review 5 residents weekly for 12 weeks to verify Dialysis communication was completed as required. Opportunities will be corrected as identified as a result of these audits Criteria #4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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F 309	Continued From page 33 had communication sheets sent with them each dialysis session to alert dialysis of the resident's condition prior to starting hemodialysis. The Unit Manager added that the sheet was faxed back to the skilled nursing facility and filed in the medical record. On 03/09/17 at 3:21 PM the Dialysis Center Charge Nurse was interviewed on the telephone and explained the dialysis center relied on the communication sheets to alert the center of the resident's condition prior to starting dialysis. The Charge nurse reviewed the forms on file for Resident #17 and reported she had not received a communication sheet from the skilled nursing facility as long as the resident had been in the facility. The Charge Nurse stated that the form was necessary because it gave a summary of the resident's condition before starting hemodialysis. The Charge Nurse provided an example such as if a resident presented with a lower than usual blood pressure as result of receiving as needed pain medication, that information was important for nursing staff to know to monitor the resident while receiving dialysis. The Charge nurse added that often Resident #17's dialysis treatment had been delayed because the dialysis nurse had to call the skilled nursing facility to inquire about the resident's condition before starting the dialysis. On 03/09/17 at 4:00 PM the Director of Nursing (DON) was interviewed and stated she expected nursing staff to utilize the Dialysis Communication Record forms.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents.	F 323		4/7/17

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F 323	Continued From page 34 The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the faclity failed to implement planned interventions of bed alarms and positioning a wheelchair out of sight in order to prevent falls for 2 of 4 residents reviewed for falls (Resident #50 and #29). The findings included: 1. Resident #50 was admitted to the facility on 04/04/16. His diagnoses included vascular dementia with behavioral disturbances, hemiplegia and hemiparesis, cerebral infarction,	F 323	F 323 Criteria #1 On 3/10/17 the Unit Manager validated placement and function of bed and chair alarms and wheelchair for Resident #50 and placement and function of bed alarm for Resident #29. Criteria #2 Residents with interventions to reduce risk of falls are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of residents with interventions to	

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F 323	Continued From page 35 abnormal posture, restlessness and agitation, tremor, other seizures, anxiety disorder, and major depressive disorder. The admission Minimum Data Set (MDS) dated 04/13/16 coded Resident #50 with intact cognition, having no moods or behaviors, requiring extensive assistance with all activities of daily living skills (ADLs) except for eating, and being nonambulatory. He had upper and lower impairment of range of motion on one side, needed assistance to balance during surface to surface transitions, and had a fall one month prior to admission, 2-6 months prior to admission and 2 or more falls since admission with no injury. The Fall Care Area Assessment (CAA) dated 04/14/16 stated he had a cerebral vascular accident resulting in left sided hemiplegia. He was admitted for therapy due to a history of falls from the wheelchair. The CAA also stated he has had a decline in strength, postural alignment, functional mobility and balance. The quarterly MDS dated 07/14/16 noted he had 2 or more falls since the last assessment with one involving a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance. The quarterly MDS dated 10/07/16 also noted Resident #50 had 2 or more falls since the last assessment one with a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance.	F 323	validate placement and function. This audit was completed by 4/7/17. Opportunities were corrected as identified. Criteria #3 The Director of Nursing or Nurse Managers will re-educate all Nursing staff on implementation of fall interventions to include the placement of alarms, function of alarms. This education was completed on 4/7/17. The Director of Nursing or Nurse Managers will randomly observe 10 residents weekly for 12 weeks to verify interventions to reduce risk of falls are in place. Opportunities will be corrected as identified as a result of these audits Criteria #4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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Review of recent Incident Reports and Investigations revealed:
*On 12/12/16 at 9:45 AM a nurse aide reported the resident was found on his abdomen on the floor at foot of his bed with a reddened temple area. The investigation noted he was trying to get from his bed to his wheelchair. The alarm was sounding. The recommendation added to the care plan on 12/12/16 was to re-educate staff to keep wheelchair out of sight when resident was in bed.

The most recent quarterly MDS dated 01/03/17 noted he had one fall since the last assessment with a non-major injury. He continued to be nonambulatory and required extensive assistance for transfers and needing staff assistance with surface to surface transfers due to poor balance.

Further incidents and investigations included:
*On 02/06/17 at 3:05 PM resident attempted to transfer from bed to wheelchair and found on floor on back with scratch to right side of nose. He stated he hit his face on the foot pedal. Intervention to remind staff to keep wheelchair out of sight when resident is in bed. The recommendation added to the care plan on 02/06/17 was to re-educate staff to keep resident wheelchair out of sight while in bed.

The current care plan initially developed on 04/14/16 to address his history of falls and most recently reviewed and updated on 02/10/17 had the ongoing goal for Resident #50 to resume his usual activities without further incident and not obtain any injury through next review. The care plan was updated following his repeated falls. Interventions and implementation dates included:

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*On 04/15/16 reeducate resident to ask for assistance when toileting and transferring from wheelchair to bed.
*On 04/20/16 bed pad alarm and check placement and function every shift;
*On 06/07/16 low bed with mat on floor;
*On 06/09/16 keep wheelchair out of sight when in bed;
*On 07/05/16 concave mattress;
*On 07/16/16 staff education to keep wheelchair out of sight when in bed;
*On 12/12/16 re-educate staff to keep wheelchair out of sight while in bed; and
*On 02/06/17 re-educate staff to keep resident's wheelchair out of sight while in bed.

On 03/07/17 at 9:42 AM, Resident #50 was observed in bed. The pressure alarm was not blinking indicating it was not turned on. At 10:54 AM, Resident #50 was attempting to sit up in his bed. Nurse Aides (NA) #3 and #4 passing the door entered to assist. Both staff were needed to assist Resident #50 to a standing position. Once upright they pivoted him to the high back wheelchair which was in his room at the foot of his bed. The bed alarm did not sound. At this time staff were asked about the alarm not sounding. NA #3 pushed on it several times until it sounded and determined it had a very delayed response. NA #4 stated she would replace it.

On 03/08/17 at 10:05 AM, the facility driver and Medication aide #1 assisted Resident #50 to bed. The alarm did not sound when he sat on the bed. Once in bed, staff left the room at 10:12 AM without checking the alarm in bed and left the wheelchair at the end of his bed. The alarm was turned off per observation of switch and no light blinking at 10:17 AM and again at 11:07 AM. At

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11:38 AM the maintenance assistant was in the room fixing the side of his w/c and then he left the wheelchair in the room. On 03/08/17 at 11:54 AM, Resident #50 was attempting to sit up on the side of his bed with his feet off the side of the bed. At 11:42 AM NA #4 and medication aide #1 entered the room. With extensive assistance of both staff, Resident #50 was transferred to the wheelchair which was in his room at the end of his bed. No bed alarm sounded. Interview with staff at this time confirmed the alarm was not turned on. Medication aide #1 stated she should have checked the alarm when she assisted him to bed earlier in the morning. NA #4 stated she replaced the alarm with a new one yesterday.

Additional observations of Resident #50 in bed with his wheelchair positioned in his room at the foot of his bed occurred on 03/08/17 at 6:46 PM, on 03/08/17 at 7:34 PM, and on 03/09/17 at 10:28 AM.

On 03/09/17 at 10:30 AM NA #3 was interviewed relating to the fall interventions. NA 3 stated that alarms were to be used in bed and in the wheelchair. She further stated that staff kept the wheelchair in the room but tried to keep it on the other side of the room so it was not next to the bed.

NA #5 stated during interview on 03/09/17 at 10:39 AM that she tried to keep the wheelchair far enough away from him but still in his room so that he would not attempt to get into it. She further stated that if you removed the wheelchair from the room he became irate.

During an interview on 03/10/17 at 10:15 AM, the Director of Nursing stated that Resident #50's

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wheelchair was to be kept in the bathroom or out of his room so that it was out of his sight due to repeated attempts to transfer himself from bed to chair. She also stated it was her expectation to make sure the alarms were on and functioning in bed and in the wheelchair. Unit Manager #2 was present at this time and stated that she tried to make rounds every morning to ensure fall interventions were in place but that Resident #50 was often already out of bed in his wheelchair when she made these rounds.

2. Resident #29 was admitted to the facility on 06/15/16. Her diagnoses included cerebral vascular accident, Alzheimer's disease, contractures, and muscle weakness.

The admission Minimum Data Set dated 06/23/16 coded her with having severely impaired cognition, and requiring extensive assistance with bed mobility, total assistance with transfers and being nonambulatory.

The Fall Care Area Assessment dated 06/24/16 stated she required extensive assistance with bed mobility and was totally dependent on two staff with transfers and other activities of daily living skills. She was at risk for falls due to incontinence, psychotropic medication use and her cognition and needed a mechanical lift to transfer from bed to chair.

The care plan for falls was established on 06/24/16 due to her being high risk for falls and having a decline in condition was anticipated. Initial interventions included to anticipate resident needs, and keep call light in reach and provide prompt response. On 08/15/16 the intervention of a low bed with fall mats was implemented.

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Review of the incident reports revealed Resident #29 fell on 11/19/16 at 2:42 AM when she was found lying on the floor mat from bed. She sustained no injuries and it was noted the bed alarm was sounding. No changes were noted to the care plan and the care plan did not include the use of a bed alarm.

Another incident report dated 01/30/17 at 9:00 PM revealed Resident #29 was placed in bed via hoyer lift and resident fell off the bed onto the floor. Review of the investigation revealed the bed alarm was not on, the bed was not in the lowest position and staff left the room. She was subsequently sent to the emergency room due to neck and shoulder pain and diagnoses with cervical and lumbar spine sprains. Staff were reminded to complete task when putting residents to bed before moving on to another resident and keeping bed in lowest position.

On 03/08/17 at 9:03 AM, Resident #29 was observed in bed with the head of the bed up approximately 80 degrees. She had a drink on the overbed table and was asleep. The bed was in the low position and there were mats on each side of the bed but the pressure bed alarm was turned off. The alarm was observed in the off position when checked again on 03/08/17 at 9:57 AM. On 03/08/17 at 10:19 AM the hospice aide was in to provide a bath to Resident #29. After Hospice staff left, Resident #29 was observed in bed asleep on 03/08/17 at 11:07 AM and 11:39 AM.

On 03/08/17 at 11:50 AM, Nurse Aide (NA) #4 and the surveyor checked to find the bed alarm turned off. NA #4 stated that when she served

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F 323	Continued From page 41 Resident #29 her breakfast this morning, the alarm sounded as she repositioned the resident. NA #4 stated she reset the alarm and was unsure how is was not on and functioning. Interview with Unit Manager #1 on 03/10/17 at 9:40 AM revealed that Resident #29 should have a low bed, mats on the floor and a bed alarm in place. She could not say why the bed alarm was not on the care plan but stated it was on the nurse aide assignment sheet indicating it was an intervention to be used. Unit Manger #1 further stated that on her master list of devices, Resident #29 was to have a bed alarm in place as an intervention to alert staff to the resident moving in bed.	F 323		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		4/7/17

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F 371	Continued From page 42 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to have adequate chemical solution in a 3 compartment sink for sanitizing pots and pans for 1 of 1 three compartment sink; failed to keep a microwave clean and failed to label and date personal items for 3 of 3 nourishment rooms. The findings included: 1. On 03/08/17 at 11:20 AM observations were made of the facility's kitchen with the Dietary Manager (DM). During the observations, the 3 compartment sink was in use. On 03/08/17 at 11:32 AM the Dietary Manager (DM) was asked to test the chemical solution. The test strip used to measure the amount of chemical concentration in the sink indicated 100ppm (parts per million). The DM was interviewed and reported that the proper amount of chemical solution was 200ppm to sanitize dishware. The DM reported that he was not aware of problems with the chemical solution and/ or mixing valve. On 03/08/17 at 11:35 AM the dietary aide using the 3 compartment sink was interviewed and stated she set the sink up but had not checked the chemical concentration prior to using the sink. The dietary aide verified she had washed pots and pans from the breakfast meals service.	F 371	F 371 Criteria #1 The 3 compartment sink chemical solution was corrected during the survey and all the dishes were rewashed. The microwave on the 100 hall nourishment room was immediately cleaned The ice cream in the 300 hall nourishment room was immediately thrown away The fast food in the 200 hall nourishment room was immediately thrown away. Criteria #2 All residents have the potential to be affected by this alleged deficient practice. The Dietary Manager and the Administrator made detailed nourishment room rounds to ensure there was no further debris in the microwaves nor unlabeled or undated food in the nourishment room refrigerators or freezers and that the Sanitizer was reading the proper PPM. Criteria #3 Facility Staff will be re-educated by the Administrator and the Dietary Manager about food debris in the microwave and labeling and dating food prior to placing it in the nourishment room refrigerator.. The re-educations will be completed by 4/7/17.	

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F 371	Continued From page 43 2. On 03/06/17 at 9:44 AM observations were of station 1's nourishment room with the Dietary Manager (DM). Inside the nourishment room was a microwave oven for resident use. Observations inside the microwave revealed splattered food debris on the walls and ceiling inside the microwave. The DM reported that housekeeping was responsible for cleaning the microwave. 3. On 03/06/17 at 9:47 AM observations were made of station 3's nourishment room with the DM. Inside the freezer contained a gallon of partially consumed ice cream. The ice cream was not labeled or dated and observations of the ice cream revealed ice crystals indicating freezer burn and evidence of re-freezing. The DM removed the gallon of ice cream and reported the facility had a two-check system. He explained dietary staff were supposed to check refrigerators and freezers for outdated items and nursing was to check as well. 4. On 03/06/17 at 9:50 AM observations of station 2's nourishment room were made with the DM. Inside the refrigerator were two bags of fast food not labeled or dated. The DM removed the bags of food and explained items should be labeled and dated before storing the in the refrigerator.	F 371	The Administrator and/or the Dietary Manager will conduct facility rounds weekly for 12 weeks to validate that Microwaves are free of food debris and that food is labeled and dated in the nourishment room refrigerators and review the logs weekly for the proper PPM in the sanitizer. Criteria #4 The results of these audits and monitoring will be submitted to the QAPI Committee by the Dietary Manager for review by the IDT members each month. The QAPI committee will evaluated the effectiveness and amend as needed. Date of compliance is 4/7/17	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		4/7/17

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(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable

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F 441	Continued From page 45 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to properly dispose of a used insulin syringe with an uncapped exposed contaminated needle on 1 of 5 medication carts. Findings included: A record review of the facility document revised on 09/15 entitled Regulated Medical Waste Management indicated sharps would be placed directly into an impervious, ridged, leak-proof, and puncture resistant container to eliminate the hazard of physical injury. Used needles would not be recapped, purposefully bent or broken by hand, removed from disposable syringes or otherwise manipulated by hand. On 03/09/2017 at 10:38 AM an observation of the 200 front hall medication cart was conducted with	F 441	F 441 Criteria #1 The Charge Nurse removed the contaminated syringe from the medication cart and discarded into the sharps container on 3/9/17. Criteria #2 All staff working from medication carts have the potential to be affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of all medication carts to validated there were no other instances of improper disposal of used sharps. This was completed on 3/10/17. Criteria #3 The Director of Nursing or Nurse Managers will re-educate all Licensed Nurses on Infection Prevention	

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F 441	Continued From page 46 Nurse #1 present and revealed an unwrapped disposable insulin syringe with an uncapped exposed needle in the top right hand drawer of the medication cart. Nurse #1 stated he had used the insulin syringe to administer insulin to a resident and placed the used insulin syringe with the uncapped exposed contaminated needle in the top drawer of the medication cart rather than disposing of the used syringe and contaminated needle in the sharps box located on the side of the medication cart. Nurse #1 stated he got called away to assist the medication aide and placed the used insulin syringe with the uncapped exposed contaminated needle in the top drawer of the medication cart. Nurse #1 stated he did not have time to appropriately dispose of the used insulin syringe and contaminated needle in the sharps container located on the medication cart prior to assisting the medication aide. Nurse #1 stated he should have properly disposed of the used insulin syringe with contaminated needle in the sharps container on the medication cart as per facility policy prior to assisting the medication aide. Nurse #1 immediately picked up the syringe with the exposed contaminated needle from the top right hand corner of the medication cart and disposed into the sharps container that was attached to the right hand side of the medication cart. Nurse #1 stated the facility policy was that after a syringe and needle were used to administer an injection than the syringe with the contaminated needle was to be disposed of in the sharps container located on the medication cart. Nurse #1 stated he had not followed facility policy for properly disposing of the used syringe and contaminated needle. Nurse #1 verified that the needle on the insulin syringe had been used on a resident and was exposed and uncapped and was a safety risk.	F 441	techniques to include the immediate disposal of sharps into the sharps container following usage. The Director of Nursing or Nurse Managers will complete random observations of 10 Licensed Nurses weekly on varying shifts, while providing injections to verify acceptable infection prevention techniques including sharps disposal are being utilized. Opportunities identified as a result of these audits will be corrected by the Director of Nursing or designee. Criteria #4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required.	

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	345128	A. BUILDING _____ B. WING _____	C 03/10/2017

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F 441	Continued From page 47	F 441		

On 03/09/2017 at 11:14 AM an interview was conducted with Unit Manager #1 who stated if an insulin syringe was used to administer insulin to a resident than after the injection was completed the nurse was to properly dispose of the used syringe and contaminated needle in the sharps box located on the medication cart per facility policy. Unit Manager #1 stated the resident ' s room was not equipped with a biohazardous sharps container. Unit Manager #1 stated it was her expectation that Nurse #1 would have properly disposed of the insulin syringe with exposed contaminated needle in the sharps container on the medication cart prior to assisting the medication aide. Unit Manager #1 stated her expectation was that Nurse #1 should not have placed a used insulin syringe with an exposed contaminated needle back into the drawer of the medication cart due to safety reasons and infection control concerns.

On 03/09/2017 at 11:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Nurse #1 would have disposed of the used insulin syringe with an uncapped exposed contaminated needle into the sharps container on the medication cart as per facility policy. The DON stated her expectation was that Nurse #1 should not have placed a used insulin syringe with a contaminated exposed needle into the drawer of the medication cart. The DON stated it was her expectation that Nurse #1 would have properly disposed of the used syringe with contaminated needle into the sharps container prior to assisting the medication aide. The DON stated a used syringe with an uncapped exposed contaminated needle should not be placed in the drawer of the medication

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F 441	Continued From page 48 cart due to safety because the exposed needle could cause a needle puncture wound to another person, cause potential harm form blood borne pathogens, and cause contamination of the medication cart. The DON stated the medication cart top drawer would be immediately cleansed with the proper disinfectant and Nurse #1 would be investigated and disciplined accordingly. On 03/09/2017 at 11:52 AM an interview was conducted with the Administrator who stated her expectation was that the used insulin syringe with an exposed contaminated needle would not have been placed in the top drawer of the medication cart after use and should have been disposed of in the sharps container on the medication cart. The Administrator stated she was not a nurse but an exposed used syringe and needle could cause a safety risk for staff members using the medication cart and could expose the medication cart to blood borne pathogens.	F 441		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		4/7/17

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F 520	Continued From page 49 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: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in April 2016, May 2016 and September 2016. This was for 1 recited deficiency originally cited in April 2016 on an annual recertification survey; 1 recited deficiency originally cited in May 2016 on a follow-up and complaint survey; and for 1 deficiency originally cited in September 2016 on a complaint survey. The 3 deficiencies were recited on the current recertification survey. The deficiencies were in	F 520	F 520 Criteria #1 Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting by 4/4/17 to discuss the outcomes of the annual survey and repeat citations of FF253 Housekeeping and Maintenance, F309 Maintain Well Being, and F323 Providing Supervision to prevent Accideents. QAPI education was provided for the	

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F 520	Continued From page 50 the areas of maintenance and housekeeping services, supervision to prevent accidents and care and services to maintain wellbeing. 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 Assessment and Assurance Committee. The findings included: This tag is cross referred to: F 253: Based on observations and staff interviews the facility failed to repair a missing call bell cord in 1 of 26 resident bathrooms on the 200 hall (room #232); failed to repair the smoke prevention doors with broken and splintered laminate and wood on the 100 hall, 200 hall and Courtyard Terrace hall; failed to repair the dining room door on the 300 hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair the activity/dining room door on the 400 hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair the activity room door on the main hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair resident room and bathroom doors with broken and splintered laminate and wood in 6 of 23 rooms on the 300 and 400 halls (resident rooms #301, #305, #306, #311, #404 and #405); failed to remove brown stains from sinks drains, overflow drains and faucets in 3 of 13 rooms on the 300 hall (resident bathrooms #301, #305, and #306); failed to repair brown stains around the base of toilets in 2 of 23 rooms on the 300 and 400 hall (resident room #305 and #402); failed to repair wall damage in 6 of 23 rooms on the 300 and 400 halls (resident room	F 520	Administrator and Interdisciplinary Team by the Divisional Director of Clinical Services on 4/4/17. The education included the Sava QAPI program and the expectations associated with the program. The program enables the identification of opportunities for improvement, prioritization of those opportunities, root cause analysis, performance improvement plans and routine evaluation of the plan, do, study, act philosophy to ensure sustainability. Criteria #2 F253 -All residents have the potential to be affected by this alleged deficient practice. Detailed maintenance rounds have been conducted by the Administrator and the New Maintenance Director and a prioritized list of repairs has been developed for ongoing repairs and maintenance by 4/7/17 F309 - Residents receiving Dialysis treatments are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of Residents receiving Dialysis and provided the Dialysis Center with an update of each residents current condition and explained that a written communication form would be transported with each resident going forward. This audit was completed by 4/7/17. Opportunities were corrected as identified. F323 - Residents with interventions to reduce risk of falls are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of residents with interventions to validate placement	

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F 520	Continued From page 51 #306, #310, #401, #402, #405 and #408) and failed to remove debris inside the grate of a heating and air conditioning unit in the 300 hall dining room. The facility was cited for F 253 in April 2016 for failure to repair resident doors with splintered wood, failed to repair smoke barrier doors with splintered wood, paint the door of a nourishment room and failed to clean an arm trough on a resident's wheelchair and failed to cover a plunger in a shared bathroom. F 323: Based on observations, record review and staff interviews, the facility failed to implement planned interventions of bed alarms and positioning a wheelchair out of sight in order to prevent falls for 2 of 4 residents reviewed for falls (Resident #50 and #29). The facility was cited for F 323 in May 2016 for failure to monitor a resident at risk for falls and the resident sustained a fractured wrist after a fall from her bed. F 309: Based on observations, staff, resident and dialysis staff interviews, and record review the facility failed to provide communication regarding resident's condition prior to receiving hemodialysis services for 1 of 1 sampled resident (Resident #17). The facility was cited for F 309 in September 2016 when the facility failed to assess a resident for constipation when the resident when 6 days with no bowel movement. On 03/10/17 at 4:10 PM the Administrator was interviewed and explained that she was new	F 520	and function. This audit was completed by 4/7/17. Opportunities were corrected as identified. Criteria #3 The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirements for F253 Housekeeping and Maintenance, F309 Maintain Well Being, and F323 Providing Supervision to prevent Accidents. This education was completed by 4/7/17. The Administrator will hold a weekly Ad Hoc QAPI committee meeting to review F253 Housekeeping and Maintenance, F309 Maintain Well Being, and F323 Providing Supervision to prevent Accidents, to ensure all regulatory aspects are addressed and in compliance. Opportunities will be corrected as identified. Criteria #4 The Administrator and Director of Nursing will analyze the data obtained and report any patterns and/or trends to the QAPI Committee monthly for 12 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance.	

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F 520	Continued From page 52 since the 04/01/16 survey but had worked to implement corrective actions for the areas cited on the annual recertification. She stated that facility was working very hard to correct areas identified due to the extent of some concerns and staffing challenges, the facility still had work to do.	F 520		