STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 04/05/17 an amended Statement of Deficiencies was provided to the facility because the State Agency removed information from tag F-241 that was in the facility's original CMS 2567 report. Event ID# 4RY511.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 157		3/31/17

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

Electronically Signed | 03/31/2017

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F 157	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on family member, staff and physician interviews, and record review, the facility failed to notify the responsible family member of an order for an antipsychotic medication (Abilify) for 1 of 5 sampled residents who received psychoactive medications (Resident #2). The findings included: Resident #2 was admitted to the facility on 02/13/16 with diagnoses which included cerebral vascular accident, anxiety and depression. Review of Resident #2's annual Minimum Data Set (MDS) dated 02/09/17 revealed cognition was not assessed. The MDS indicated Resident #2 demonstrated verbal behaviors directed toward others and received antianxiety and antidepressant medications.	F 157	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 157	Continued From page 2 Review of a telephone physician's order dated 02/22/17 revealed the physician ordered Resident #2 to receive Abilify (an antipsychotic) 2 milligrams by mouth at bedtime. The former Director of Nursing (DON) received the telephone order. Review of Resident #2's Medication Administration Record (MAR) revealed documentation of Abilify administration from 02/22/17 to 02/26/17. Review of a physician's order dated 02/27/17 revealed the Abilify was discontinued due to over-sedation. Telephone interview with Resident #2's family member on 03/08/17 at 10:15 AM revealed she did not receive notification of the new order for Abilify. When Resident #2 appeared sleepy during her daily visits, Resident #2's family member asked Medication Aide (MA) #1 to show her Resident #2's MAR. Resident #2's family member reported she discovered the Abilify order when she looked at the MAR. Resident #2's family member explained she did not want Resident #2 to receive the medication and it was discontinued. Interview with Nurse #1 on 03/09/17 at 10:03 AM revealed the nurse who received and took off the order should notify the responsible person of new orders. Nurse #1 reported she did not know if the former DON notified Resident #2's family member of the Abilify order. Interview with MA #1 on 03/09/17 at 10:17 AM revealed Resident #2's family member requested to see Resident #2's medications and the family	F 157	Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceedings. F157 On 2/27/17, the assigned medication aid notified Resident #2's responsible party (RP) of the Abilify medication order and administration of the medication 2/22/17 through 2/26/17 by showing the RP the medication administration record (MAR). On 2/27/17, the physician gave an order to discontinue the Abilify medication. On 2/27/17, the assigned nurse notified the RP of the new order to discontinue the Abilify medication. On 03/31/2017, the director of nursing (DON), quality improvement (QI) nurse and hall nurse audited the past 30 days of 100% of resident orders and progress notes to ensure resident RPs were notified of all new orders. On the 3/10/17, the DON, QI nurse, and staff facilitator initiated an in-service for 100% of registered nurses (RNs) and licensed practical nurses (LPNs) to notify resident RPs of all new orders, including new medications or medication changes. The in-service will be 100% complete by 3/31/17. After 3/31/17 no RN or LPN will be allowed to work until the in-service is complete. All newly hired RNs and LPNs will complete the in-service during new	

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F 157	Continued From page 3 member did not know Resident #2 began to receive Abilify. Telephone interview with the former DON on 03/09/17 at 2:41 PM revealed she did not recall if she notified Resident #2's family member of the Abilify order. The former DON explained she "possibly forgot" due to the busy pace of the day. Telephone interview with Resident #2's physician on 03/10/17 at 9:38 AM revealed he expected facility staff to notify family members of new medication orders. Interview with the DON on 03/10/17 at 11;10 AM revealed she expected facility staff to notify residents' family members of new medication orders and medication changes.	F 157	employee orientation. On 3/10/17, the DON, QI nurse, staff facilitator, and hall nurse began auditing all new orders and resident progress notes to ensure resident RPs were notified of all new physician orders using the notification of change audit tool. The audit will be completed 5 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. The DON or QI nurse will present the findings of the ADL audits at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF 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 2 of 2 dining observations, a breakfast tray line observation, a resident interview (Resident #105) and staff interviews, the facility failed to serve juice, milk, thickened beverages,	F 241	Ftag 241 On 3/10/17 resident # 105 began being served here beverages to include	3/31/17

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F 241	Continued From page 4 nutritional supplements and dry cereal in non-disposable tableware for a dignified dining experience. The findings included: A dining observation of the lunch meal occurred on 03/07/17 at 12:10 PM for 9 residents who ate in their rooms on the 500 hall. An open cart was delivered to the 500 hall with resident trays for the lunch meal. Disposable containers of nutritional supplements, juices, and thickened beverages were observed on the lunch meal trays with no availability of empty glassware to pour the beverages into. Resident #105 was admitted to the facility on 02/09/17. An admission minimum data set assessment dated 02/16/17 assessed Resident #105 with clear speech, able to be understood, usually understands, moderately impaired cognition, and requiring set-up help, oversight, encouragement or cueing with meals. On 03/08/17 at 12:00 PM, Resident #105 was observed feeding herself a lunch meal in her room. Resident #105 received disposable containers of a nutritional supplement, juice and milk with no availability of empty glassware to pour her beverages into. When asked, Resident #105 stated that she preferred to drink beverages from a glass, but thought that "disposables was what they do here." An observation of the breakfast tray line occurred on 03/09/17 from 7:51 AM - 08:30 AM. The following items were stored in disposable containers on the breakfast tray line, available for the meal service and served to residents:	F 241	nutritional supplement, juice, and milk in glassware rather than disposable containers. On 3/10/17 the facility began serving all residents□ juice, milk, thickened beverages, nutritional supplements, dry cereal and yogurt in non-disposable tableware for a dignified dining experience. On 03/31/2017 an in-service was initiated by CDM (Certified Dietary Manager) for dietary staff and nursing staff related to using non-disposable tableware for juice, milk, thickened beverages, nutritional supplements, dry cereal and yogurt rather than disposable containers to promote a dignified dining experience. The in-service will be 100% complete by 3/31/17. After 3/31/17 no dietary or nursing staff will be allowed to work until in-service is completed. All newly hired staff will receive the in-service during new employee orientation. On 03/31/2017the CDM began auditing 5 resident meal trays a day 5 x week x 4 weeks, then 5 meal trays a week x 4 weeks then 5 meal trays a month x 2 months using the meal tray audit tool. The Executive Quality Improvement Committee will review the results of the audits Monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI	

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F 241	Continued From page 5 · 55 disposable juice cups · 48 disposable milk cartons · 5 disposable containers of dry cereal · 28 disposable containers of thickened beverages · 21 disposable cartons of nutritional supplements An observation on 03/09/17 at 8:09 AM revealed the following tableware was stored on shelves, clean and available for use for the breakfast tray line: ·105, 9 ounce tea glasses ·79, 6 ounce juice glasses ·52, 9 ounce blue bowls During an interview on 03/09/17 at 9:00 AM with the certified dietary manager (CDM) and the corporate nutrition consultant present, the CDM stated that she expected dietary staff to make empty glassware available for nursing to use for residents who wanted their beverages served from glassware rather than from disposable containers. The CDM further stated "I think we may have gotten away from doing that, I will have to monitor for that again." The CDM stated it was customary for the dietary department to serve beverages, nutritional supplements, thickened beverages and dry cereal in disposable containers from the tray line to reduce the time it took to wash dishes, but that sufficient supply of non-disposable tableware was available for use and she would consult with the nursing department regarding transferring items served in disposable containers to non-disposable tableware based on resident preference. The CDM stated that she had not interviewed residents to determine their preference for the use of non-disposable tableware, but that she would do so.	F 241	monitoring	

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F 241	Continued From page 6 A follow-up interview with the CDM occurred on 03/09/17 at 12:23 PM and revealed that the dietary department had in current rotation or in storage the following non-disposable tableware available for use: ·440, 9 ounce tea glasses ·360, 6 ounce juice glasses ·115, 9 ounce blue bowls An interview with the administrator occurred on 03/10/17 at 5:00 PM and revealed that she expected residents to have glassware available for use per their preference during dining.	F 241		
F 242 SS=E	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews the facility failed to provide showers according to the preference of the resident for 1 of 3 sampled residents who	F 242	F tag 242 On 03/10/2017, Resident #57 was interviewed by the social worker (SW)	3/31/17

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F 242	Continued From page 7 were reviewed for choices (Resident #57). The findings included: A record review revealed that the resident had been admitted to the facility 1/28/17 with diagnosis that included: Spinal Stenosis, Osteoarthritis, Diabetes, Hypertension, previous Myocardial Infarct, and history of respiratory diseases. The Minimum Data Set (MDS) admission assessment indicated that the resident was cognitively intact. The MDS assessment also listed the preferences for Resident # 57. The preferences stated that it was very important for resident #57 to pick which clothes to wear and what kind of bath to have. The resident was assessed to require limited assistance for personal grooming and toileting, eating, and mobility. Resident #57 required assistance for transfers and was dependent for bathing activity. On 3/9/17 a copy of the form entitled "Lake Park Nursing and Rehabilitation Center Medical Unit Shower Schedule" indicated that Resident #57 was scheduled for a shower on Wednesday and Friday on the 7-3 shift. On 3/8/17 at 9:00 a.m. Resident # 57 was observed sitting up in wheelchair dressed in print knit shirt, dark knit trousers, hose and shoes. The resident's hair was neatly combed. An interview was conducted with the resident on 3/9/17 at 9:00 a.m. Resident #57 stated that during the admission process she had been given the choice of having a shower or bed bath. A shower had been chosen by the resident. It was also stated by the resident that a choice had not be given as to the number of showers per week.	F 242	related to shower preferences including how many showers per week the resident prefers. On 03/10/2017, Resident # 57'□s shower schedule was updated by the social worker to accommodate resident preferences. On 03/30/2017, 100% of alert and oriented residents were interviewed by the social worker related to shower preferences to include how many showers per week they preferred and during what shift they were preferred. On 03/30/2017, 100% of all non-alert and oriented resident□s' responsible parties (RPs) were contacted by the SW related to resident shower preferences. All shower schedules were updated by the SW to accommodate resident preferences. On 03/31/2017, the director of nursing (DON) initiated an in-service with admissions, social work, and the nursing department related to Resident Rights- the resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident to include resident shower preferences. The in-service will be 100% complete by 3/31/17. After 3/31/17, no admissions, social work, or nursing staff will be allowed to work until the in-service is completed. All newly hired staff will receive the in-service during new employee orientation. On 03/31/2017, the DON, ADON, staff facilitator, treatment nurse, and/or staff nurse began auditing to ensure residents	

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F 242	Continued From page 8 On 3/9/17 at 3:20 p.m. an interview was conducted with NA #1. During the interview it was stated that Resident #57 liked to take showers, did not refuse care, and was scheduled for showers twice per week. An interview was conducted with Nurse #1 on 3/9/17 at 11:41 a.m. It was stated during the interview that the nurses told the residents that showers would be given twice in a week. It was also stated that the resident was not asked about their preference for frequency of showers. An interview was conducted at 4:20 p.m. on 3/9/17 with SW#2. It was stated during that interview that a form to list the preferences of the resident in regards to bathing was not completed by SW personnel. On 3/9/17 at 3 p.m. an interview was conducted with Director of Admissions who stated that a meeting was held with the resident and/or the responsible person at the time of admission to the facility. It was stated during the interview that listing of resident's preferences was not filled out by the Admission personnel.	F 242	are receiving showers/bath according to their preference. The "Shower/CHOICES/ADLs" audit tool will be completed for 5 residents daily 5 x per week x 4 weeks, then 5 residents weekly x 4 weeks, then 5 residents monthly x 2 months. As of 3/31/2017, the admissions coordinator and/or social worker are including in the admissions packet a bathing preferences form. The admissions coordinator and/or social worker will complete the bathing preferences form upon admission to ensure residents are given the opportunity to choose bathing preferences. The social worker shall maintain the completed bathing preferences forms in the social worker office. The social worker will also enter the information from the bathing preferences form into the resident's electronic health record for reference by nursing. The Executive Quality Improvement Committee will review the results of the audits monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F 253		3/31/17

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F 253	Continued From page 9 comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label denture cups and brush for 2 of 10 sampled residents (Resident #74 and #102). The findings included: On 3/8/17 at 10:00 a.m. and observation was made of the room for Resident #74 and Resident #102. On the counter area at the sink there were two hair brushes with grey hair embedded in the bristles and without the name of a resident. There were three denture cups, two had no name on them, and one had first name only. On 3/10/17 at 9:02 a.m. dentures observed stored in denture cups without any names on them. The denture cup with first name of resident had no dentures. Resident #74 had no dentures in his mouth. Resident #74 and Resident #102 could not be interviewed due to their dementia. On 3/10/17 NA #6 and SW assistant were in the room dressing Resident #74. An interview was conducted with NA #6 and SW assistant stated that they could not tell whose dentures were in the unlabeled denture cups. NA #6 stated that the personal care items should have been labeled with the resident's names. On 3/10/17 at 10:42 a.m. an interview was conducted with Nurse #1 who stated that it is the expectation that personal care items be labeled with resident names.	F 253	F 253 On 3/10/17 the SW discarded two hair brushes and three denture cups in the bathroom of residents #72 and #102. On 3/10/17 the SW gave resident # 72 a hair brush with resident name and denture cup with resident name on cup and lid, and resident # 102 a hair brush with resident name and denture cup with resident name on cup and lid. On 03/31/2017 the Activities Director and designees completed a 100% audit of all resident rooms, and bathrooms to ensure all resident care items were labeled with resident name to ensure Housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior. All unlabeled items were discarded and replaced immediately by Activities Director and designee during the audit. All staff were in-serviced by the DON and ADON on 03/31/2017 on ensuring all personal items for each resident are labeled with resident name and stored appropriately to ensure Housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior. This in-service will be completed by 3/31/17. No staff will be allowed to work after 3/31/17 until in-service is completed. This in-service will be added to the orientation of all new	

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F 253	Continued From page 10 An interview was conducted with DON on 3/10/17 at 10:52 a.m. who stated it is the expectation that personal care items be labeled with resident names.	F 253	staff. The DON, ADON and Designees will audit 50% of resident rooms and resident bathrooms, to ensure personal items are labeled appropriately, weekly x 6 weeks then 25% of resident rooms and resident bathrooms weekly x 6 weeks using the Personal Item Labeling Audit Tool. The results of the audits will be presented by the DON at the monthly QI meeting months for further review and recommendations. The Executive Quality Improvement Committee will review the results of the audits monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 272		3/31/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 11 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to cognition, falls and	F 272	F272 The Care Area Assessments for the last comprehensive MDS assessment including the triggered areas of cognition,	

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	345502	A. BUILDING _____ B. WING _____	C 03/10/2017

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F 272	Continued From page 12 psychotropic medications for 1 of 5 sampled residents (Resident #2). The findings included: Resident #2 was admitted to the facility on 02/13/16 with diagnoses which included cerebral vascular accident, anxiety and depression. Review of Resident #2's annual Minimum Data Set (MDS) dated 02/09/17 revealed cognition was not assessed. The MDS indicated Resident #2 demonstrated verbal behaviors directed toward others, received antianxiety and antidepressant medications, and had one fall with injury since the last assessment. The MDS indicated Cognitive Loss, Falls and Psychotropic Drugs were among the areas that triggered for further analysis. Review of Resident #2's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/22/17 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to cognitive loss. The CAA indicated a BIMS score without a number and the annual MDS did not contain a Brief Interview for Mental Status (BIMS) score, description of care rejection or staff assessment of Resident #2's cognition. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Review of Resident #2's Falls CAA dated 02/22/17 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to falls. The CAA did not describe or analyze Resident #2's fall of 02/07/17. There was no documentation of an	F 272	falls, and psychotropic medications completed for resident #2 were reviewed and a progress note was entered into the clinical record by DON and designees on 03/31/2017. The progress notes includes a description of the problem, contributing factors, risk factors, and an analysis of the findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary including the triggered areas of cognition, falls, and psychotropic medications . A 100% audit of all the residents with comprehensive MDS assessments in the past 30 days was completed by DON and/ or designee on 3/31/2017 to ensure all Care Area Assessments (CAAs) contain the a description of the problem, contributing factors, risk factors, and an analysis of the findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary including the areas of cognition, falls, and psychotropic medications. A progress note was entered into the clinical record by the MDS Nurse, Dietary Manager, Social Worker, and/or Activities Director for any identified areas of concern that includes a description of the problem, contributing factors, risk factors, and an analysis of the findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary. All care plan team members SW, CDM, AD to include RN #1(MDS Coordinator) were re-educated on the requirement to describe the resident's clinical status	

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F 272	Continued From page 13 analysis of findings supporting the decision to proceed or not to proceed to the care plan. Review of Resident #2's Psychotropic Drug Use CAA dated 02/23/17 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to psychotropic drug use. The CAA did not contain the medication name, dose, frequency and need for medication. The CAA did not describe or analyze the physician's order for an increase in the dose of Ativan. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Observation on 03/09/17 at 9:47 AM revealed Resident #2 self-propelled in a wheelchair and shouted to staff. Restorative Aide #1 spoke softly to Resident #2 and Resident #2 smiled and stopped shouting. Observation on 03/09/17 at 9:54 AM revealed Resident #2 rejected care from Nurse Aide (NA) #2. Observation on 03/09/17 at 11:27 AM revealed Resident #2 seated in a wheelchair listening to music in the main dining room. Interview with the MDS Coordinator on 03/10/17 at 10:41 AM revealed she did not realize documented descriptions, contributing factors, risk factors and analysis of findings were required on the CAAs. The MDS Coordinator explained she used a BIMS score from Resident #2's prior quarterly assessment since Resident #2's cognition was not assessed prior to the required submission date of the MDS.	F 272	including description of the problem, contributing factors, risk factors, and an analysis of findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary by the DON on 03/31/2017. The MDS Coordinator, Social Worker, Dietary Manager, and Activity Director will address the information describing the resident's clinical status including a description of the problem, contributing factors, risk factors, and an analysis of the findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary, directly within the CAA. The DON or designee will audit 10% all comprehensive assessments completed during the previous week to include any assessments for resident #2 weekly x 4 weeks, then 10% comprehensive assessments monthly x 3 months to ensure documentation includes a description of the problem, contributing factors, risk factors, and an analysis of the findings impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary, directly within the CAA utilizing the MDS Audit Tool. The results of the MDS Audit Tools will be compiled by the administrator and/ or director of nursing and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 272	Continued From page 14 Interview with the Administrator on 03/10/17 at 11:16 AM revealed she expected the MDS Coordinator to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		3/31/17

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F 278	Continued From page 15 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interviews with a resident and staff and review of the medical record, the facility failed to document the current weight on an admission Minimum Data Set (MDS) assessment for 1 of 23 sampled residents reviewed for MDS assessment accuracy (Resident #103). The findings included: Resident #103 was re-admitted to the facility on 02/17/17. Diagnoses included congestive heart failure (CHF), chronic atrial fibrillation (A fib), and bilateral lower extremity (BLE) edema. A dietary assessment dated 02/23/17 recorded Resident #103's current weight as 110 pounds (lb). An admission MDS assessment dated 02/24/17 assessed Resident #103 with clear speech, able to be understood and to understand, with intact cognition, and a weight in the last 30 days of 117 lb. Further review of the computerized clinical record (progress notes and vital signs) revealed no further documentation of weight data for Resident #103 since re-admission. An interview with Resident #103 occurred on 03/08/17 at 12:07 PM. During the interview Resident #103 stated that her weight had only	F 278	F tag 278 Resident #103 was discharged from facility on 3/15/17. On 03/31/2017 100% audit of resident's last Minimum Data Set (MDS) assessment was completed by CDM to ensure that each resident's weight was accurately coded. A progress note was entered into the resident's clinical record addressing any identified areas of concern Completed on 03/31/2017 the dietary manager, MDS nurse, and MDS coordinator were in-serviced by DON related to accurately coding the MDS assessment including the coding of weights. On 03/31/2017, the DON and/ or designee will begin auditing MDS assessments for accurate coding of weights using the MDS Audit Tool. 10% of completed assessments will be audited weekly x 4 weeks, then 10% of completed assessments monthly x 3months. The monthly QI committee will review the results of the MDS Audit Tool monthly for 4 months for identification of trends,	

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F 278	Continued From page 16 been checked once since re-admission, but that she did not recall the results of the weight monitoring. An interview and review of the medical record for Resident #103 with the Director of Nursing (DON) on 3/10/17 at 1:00 PM revealed the DON was unable to locate weight data since re-admission for Resident #103. The DON provided a weight of 117 lb. dated 02/20/15 for Resident #103, but with further review stated "that's from 2015, so we don't have a current weight for her." The DON stated she was unable to locate the weight report that had been given to the previous DON by RA #1. An interview with the Administrator occurred on 03/10/17 at 2:15 PM and a follow-up interview on 03/10/17 at 5:30 PM. The interviews revealed she was continuing to research the lack of weight data for Resident #103, but could not locate any current weights for the Resident. The Administrator further stated that the weight of 110 lb. which was recorded on the Dietary Assessment of 02/23/17 was a weight documented on the Resident's FL2 which was obtained before admission to the facility and could not be verified as an accurate current weight. The Administrator further stated that the weight of 117 lb. documented on the admission MDS dated 02/24/17 was a weight in the Resident's medical record from February 2015 and was recorded on the MDS in error. The Administrator then stated that the facility could not locate any current weight data for Resident #103.	F 278	actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		3/31/17

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F 309	Continued From page 17 483.24 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 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, interviews with a resident, nurse practitioner and staff and review	F 309	F309	

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F 309	Continued From page 18 of the medical record, the facility failed to monitor 1 of 2 sampled residents with congestive heart failure/edema for daily changes in their weight per physician's order (Resident #103). The findings included: Resident #103 was admitted to the facility on 02/17/17. Diagnoses included congestive heart failure (CHF), chronic atrial fibrillation (A fib), bilateral lower extremity (BLE) edema, and bladder cancer. Review of the medical record for Resident #103, revealed the following physician (MD) orders: ·MD order dated 02/17/17, Administer Lasix (diuretic) 40 milligrams (mg) daily. ·MD order dated 02/22/17, Administer Lasix 60 mg daily for 3 days, then discontinue and start Lasix 40 mg daily. ·MD order dated 02/22/17, Obtain daily weights and notify the MD of weight gain greater than 3 pounds (lb). ·MD order dated 02/22/17, Apply compression hose to bilateral lower extremities. ·MD order dated 03/02/17, Administer Lasix 60 mg in the morning for CHF. A dietary assessment dated 02/23/17 recorded Resident #103's current weight as 110 lb. An admission Minimum Data Set (MDS) assessment and Care Area Assessment dated 02/24/17 assessed Resident #103 with clear speech, able to be understood and to understand, with intact cognition, required monitoring of vital signs (to include weights) regarding ineffective breathing patterns related to CHF/A fib and a weight in the last 30 days of 117 lb.	F 309	On 03/15/2017, Resident #103 was discharged. On 03/31/2017, the director of nursing (DON), assistant director of nursing (ADON), and/or treatment nurse audited 100% of resident□s' charts to ensure weights are being obtained as directed by the physician. All negative findings were corrected by the DON, ADON and/or treatment nurse immediately when noted. On 03/31/2017, the DON began in-servicing all nurses on: 1.following physician orders including weights. 2. 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. 3. 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 care plan, and the residents' choices, including but not limited to the following: The facility must ensure that pain management is provided to residents who require such services,	

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F 309	Continued From page 19 Review of the Care Plan and Resident Care Guide, created 02/27/17, revealed instructions to monitor vital signs, obtain daily weights and to notify the MD of weight gain greater than 3 lb. as ordered due to ineffective breathing patterns regarding CHF/A fib. Review of the February 2017 and March 2017 medication administration records (MAR) revealed nurses recorded their initials daily for the MD order to obtain daily weights, but weight results were not documented on the MAR or in the medical record. Further review of the medical record (progress notes and vital signs) revealed no further documentation of weight data for Resident #103 since re-admission. An interview with Resident #103 occurred on 03/08/17 at 12:07 PM. During the interview Resident #103 was observed wearing compression hose to her bilateral lower extremities which were edematous. Resident #103 stated that her weight had only been checked once since re-admission, and had not been checked daily. She did not recall the results of the weight monitoring. An interview with restorative aide (RA) #1 occurred on 03/10/17 at 11:30 AM. During the interview RA #1 stated that she worked at the facility for the past year and it was her practice to receive a list of residents to weigh weekly/monthly from the Director of Nursing (DON). RA #1 further stated that she had not yet received a resident list for March 2017 from the current DON who had just started employment. RA #1 stated newly	F 309	consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 in-service will be completed by 3/31/17. No nurse will be allowed to work after 3/31/17 until in-service is complete. This in-service will be added to the orientation for all new nurses. Beginning 03/31/2017, the facility will have a weekly weight meeting. Attendees will include the dietary manager/assistant dietary manager, the DON/ADON, the treatment nurse/restorative, MDS nurse. The weekly weight meeting will include reviewing daily and weekly weights. Once monthly, the weight meeting will review monthly weights. The DON and/ or designee will audit 10% of charts weekly x 4 weeks then 10% of charts monthly x 3 months to ensure weights are being obtained per physician order using the chart audit tool. The DON will present the findings to the QI improvement committee monthly for review for 3 months. The Executive Quality Improvement Committee will review the results of the audits monthly x 4 months with	

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F 309	Continued From page 20 admitted residents were weighed on admission, then weekly for the first 4 weeks and then monthly thereafter unless the MD wrote an order to obtain weights more frequently. RA #1 stated she was currently in the process of obtaining weekly/monthly weights for all residents for March 2017 using a list of residents she received from the previous DON. RA #1 also stated that she was not currently aware of any residents who required daily weights and so she was not weighing anyone daily. RA #1 stated that she did recall obtaining a weight on admission for Resident #103, but she wrote the weight down and gave the report to the previous DON, but she did not remember the results. RA #1 also stated that she had not obtained weekly weights for Resident #103 since admission, but that she was in the process of obtaining monthly weights for all residents. Resident #103 was observed weighed on 03/10/17 at 11:45 AM per surveyor request. Her weight was 119 lb. An interview with nurse #1 who cared for Resident #103 on the 7AM - 7PM shift occurred on 03/10/17 at 11:46 AM and revealed that residents with a MD order for daily weights could have their weights checked at any time, but it was typically checked on the 7PM - 7AM shift by the nurse and documented on the MAR. Review of the February 2017 and March 2017 MAR for Resident #103 with nurse #1 revealed nurse initials, but no weight data. Nurse #1 then stated regarding Resident #103, "I am not sure where the weights are documented, but I have not checked her weights or assessed her for weight gain."	F 309	recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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The nurse practitioner (NP) stated in interview on 03/10/17 at 11:47 AM and a follow-up interview on 03/10/17 at 12:30 PM that due to Resident #103's medical history, she routinely monitored Resident #103's clinical progress each time she rounded (Monday, Wednesday and Friday). The NP stated she ordered/reviewed labs for Resident #103 and adjusted the diuretic due to BLE edema, but that she wanted to carefully consider whether or not to further increase the diuretic due to complications that could result from the bladder cancer. The NP stated that she did not know if Resident #103 had gained weight; weight gain had not been reported by nursing to her and she could not access weight data in the Resident's computerized clinical record since several of the facility's computers had not been working. The NP further stated that Resident #103 complained of voiding, but not feeling as if she had completely emptied her bladder. As a result the NP stated that she felt Resident #103's "kidneys may not be functioning well due to the cancer" so she planned to insert a Foley catheter and try administering Lasix intramuscularly. The NP further stated that she expected nursing to obtain/monitor her weights as ordered, document the weights in the computerized clinical record and to notify the NP/MD of weight gain greater than 3 lb.

An interview and review of the computerized clinical record for Resident #103 with the DON on 3/10/17 at 1:00 PM revealed the DON was unable to locate weight data since admission for Resident #103. The DON provided a weight of 117 lb. dated 02/20/15 for Resident #103, but with further review stated "that's from 2015, so we don't have a current weight for her." The DON stated that she expected the restorative aide or

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F 309	Continued From page 22	F 309		

the nurse on the 7PM - 7AM shift to obtain daily weights, monitor for/notify the MD/NP of weight gain of greater than 3 lb. and to record the weight results in the resident's computerized clinical record. The DON also stated she began employment at the facility on 03/06/17 and had not yet had a chance to provide RA #1 with a list of residents to weigh or follow-up with her regarding daily/weekly/monthly weights. The DON stated she was unable to locate the weight report that had been given to the previous DON by RA #1.

An interview with the administrator occurred on 03/10/17 at 2:15 PM and a follow-up interview on 03/10/17 at 5:30 PM. The interviews revealed she was continuing to research the lack of weight data for Resident #103, but could not locate any current weights for the Resident. The administrator further stated that the weight of 110 lb. which was recorded on the Dietary Assessment of 02/23/17 was a weight documented on the Resident's FL2 which was obtained before admission to the facility and could not be verified as an accurate current weight. The Administrator further stated that the weight of 117 lb. documented on the admission MDS dated 02/24/17 was a weight in the Resident's medical record from February 2015 and was recorded on the MDS in error. The administrator then stated that the facility could not locate any weight data for Resident #103 except the weight obtained that day (03/10/17), after inquiries were made.

A telephone interview on 03/10/17 at 3:56 PM with nurse #2 who worked with Resident #103 on the 7PM - 7AM shift after re-admission, revealed she could not recall whether or not she obtained

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F 309	Continued From page 23 daily weights for Resident #103, but stated that if she did, the weights would be recorded in the Resident's computerized clinical record. Nurse #2 further stated that she did not recall monitoring Resident #103 for weight gain.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to provide 1 of 10 residents (Resident # 74) assistance for shaving, nail care, and dressing. The findings included: Resident #74 was admitted to the facility on 10/18/16 and had re-admission on 1/18/17 following a hospital discharge. The resident had diagnosis which included: Dementia, compression fracture of lumbar vertebra, Hypertension, Diabetes, and difficulty walking. The Minimum Data Set assessment dated 2/15/17 indicated that the resident was severely cognitively impaired. The resident required extensive assistance for bed mobility, transfers, and dressing. The resident was dependent for toileting and personal hygiene. Resident #74 was assessed to always be incontinent of bowel and bladder functions. A record review revealed a care plan dated 10/30/16 had interventions for Resident #74 for	F 312	F tag 312 On 3/10/17, the certified nursing assistant (CNA) assisted Resident # 74 with personal care and grooming as allowed by Resident # 74. On 03/31/2017, the director of nursing (DON), ADON/ quality improvement (QI) nurse and hall nurse audited 100% of residents to ensure residents had received assistance with, shaving, nail care, and being appropriately dressed. Any areas of concern were immediately addressed by the auditors. On 03/31/2017, the DON and ADON/ QI nurse initiated an in-service for 100% of registered nurses (RNs), licensed practical nurses (LPNs), and CNAs. The in-service instructed staff to provide to a resident who is unable to carry out activities of daily living the necessary services to maintain good nutrition,	3/31/17

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F 312	Continued From page 24 bathing. The care plan stated that the resident did refuse showers and a full bed bath was to be provided when shower refused. The care plan also stated the resident required assistance for personal hygiene. The intervention of total care to comb hair, shave, wash and dry face and hands and provide incontinence care was included on the care plan for Resident #74. A review of the form entitled Lake Park Nursing and Rehabilitation Center Shower Schedule indicated Resident #74 scheduled for shower in evening shift on Wednesday and Friday. A record review revealed a care plan dated 10/30/16 had interventions for Resident #74 for bathing. The care plan stated that if the resident refused showers that a full bed bath was to be provided. The care plan also stated the Resident required assistance for personal hygiene. The interventions listed included to comb hair, shave, wash and dry face and hands and provide incontinence care. Resident # 74 observed on 3/8/17 at 9:53 a.m. lying in bed and had facial hair 1/8th to 1/4th inch in length, fingernails approximately 1/8th inches over length of fingers and with light brown debris under nails. The Resident had light yellow drainage and dried matter in eyes. The resident was wearing a long sleeved knit shirt and had legs covered with a blanket. The Resident was edentulous. On 3/09/17 at 8:25 a.m. and 10: 18 a.m. Resident #74 was lying in bed and continued to have facial hair and long fingernails with light brown debris under nails. Resident wore light tan knit shirt.	F 312	grooming, and personal and oral hygiene to include nail care, dressing, and shaving. The in-service will be 100% complete by 3/31/17. No RN, LPN, or CNA will be allowed to work after 3/31/17 until in-service is completed. All newly RNs, LPNs, and CNAs will receive the in-service during new employee orientation. On 03/31/2017 the DON, ADON/ QI nurse and hall nurse began auditing resident nail care, shaving, and dressing to ensure residents are receiving assistance with nail care, shaving, and dressing. The audits are documented on the ADL Audit tool. The ADL audit tool will be completed for 5 residents daily 5 x per week x 4 weeks, then 5 residents weekly x 4 weeks , then 5 residents monthly x 2 months. The DON or ADON/ QI nurse will present the findings of the ADL audits at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	

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F 312	Continued From page 25 On 3/10/17 at 10:27 a.m. Resident #74 observed in bed with unshaven facial hair and had untrimmed nails with light brown debris under nails. The Resident wore light tan knit shirt. Nurse Aide (NA) #6 was assisting Resident to put on a pair of jeans and preparing to get Resident #74 up into chair. Resident #74 was unable to be interviewed due to severe dementia and inability to participate in conversation. On 3/10/17 at 9:29 a.m. an interview was conducted with NA #6. It was stated during the interview that Resident #74 had not been shaved or had nails cleaned. At 10:42 a.m. on 3/10/17 an interview was conducted with Nurse #1. It was verified during the interview that the resident had not been shaved or had nails cleaned. Nurse #1 stated it is the expectation that the resident receive personal care. An interview was conducted with Director of Nursing and Administrator on 3/10/17 at 10:52 a.m. and it was stated that it was the expectation that residents be assisted with personal care and grooming.	F 312		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 371		3/31/17

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F 371	Continued From page 26 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of 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 2 of 2 observations, staff interviews and review of facility records, the facility failed to provide staff with hand washing facilities equipped with water at the proper temperatures of 100 - 108 degrees Fahrenheit. As a result two dietary staff failed to complete proper hand hygiene at 2 of 3 hand sinks in the kitchen. The findings included: Review of section 5-202.12 Handwashing Facility, Installation, of the 2013 Food and Drug Administration Food Code, revealed the following: "An inadequate flow or temperature of water may lead to poor handwashing practices by food employees. Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil	F 371	F371 On 3/6/2017 the Maintenance Supervisor immediately adjusted water temperature to ensure that it meets the proper temperature of 100-108 degrees Farenheit. All dietary staff on the schedule on 3/6/2017 were educated by CDM on proper hand washing using appropriate temperature of warm water and to report immediately to CDM if water temperature is not meeting recommended temperature. To be completed by 3/31/2017, the CDM re-educated all dietary staff with proper hand washing policy with the recommended water temperature and to report any discrepancies immediately.	

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F 371	Continued From page 27 quickly from the hands. Standards for testing the efficacy of handwashing formulations specify a water temperature of 40°C ± 2°C (100 to 108ºF)." Review of the facility's policy "Dietary, Personal Hygiene", revised August 2013, revealed in part, "Employees will wash their hands before beginning work, after visiting toileting facilities, after handling their hair, face, or other body parts, and throughout their shift." An observation occurred on 03/06/17 at 10:55 AM of dietary staff #1 (head cook) conducting hand hygiene at a hand sink next to the walk-in cooler. Immediately after this observation, the surveyor completed hand hygiene at the same sink. The water was cold to touch. Temperature monitoring from 10:55 AM - 10:59 AM of the water from this hand sink, using the facility's calibrated thermometer, resulted in a constant temperature of 45 degrees (º) Fahrenheit (F). Dietary staff #1 stated during the observation that "the water at that sink eventually gets warm, not hot when I wash my hands." Dietary staff #1 further stated that "it (water) does take a while to get hot" and that she was not aware of any problems with the hot water to that hand sink. There was no signage next to this hand sink to indicate that hot water was not available. An observation occurred on 03/06/17 at 11:06 AM of dietary staff #2 conducting hand hygiene at a hand sink next to the dish machine. Immediately after this observation, the surveyor completed hand hygiene at the same sink. The water was slightly warm to touch. Temperature monitoring of the water from this hand sink, using the facility's calibrated thermometer, resulted in a constant temperature of 89.8º F. Dietary staff #2 stated	F 371	The staff are made aware to run the water until the recommended water temperature is attained to complete hand washing procedure. Completed on 3/31/2017, all dietary staff have been educated that when the water temperature does not meet the recommended temperature, the staff have been in-serviced by the CDM to immediately report it to the CDM, Maintenance or Administrator so the issue can be immediately resolved. As of 3/31/2017, daily water temperature check will be completed by the CDM, cook or designated dietary staff and will be recorded. Maintenance completed an audit on 3/31/2017 of temperature log for the hand sinks in the kitchen. This will be completed daily and logged. As of 3/31/2017, the scheduled opening hours dietary employee or designee will record hand sink temperature 3x/day x 2 weeks. Then hand sink water temperature will be checked and recorded every morning by the scheduled opening hours employee or designee. Temperature log results and hand washing compliance will be reported to the QA committee by CDM during QAPI meeting at least monthly x3 months then at least quarterly x 3 months.	

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F 371	Continued From page 28	F 371		

during the observation that "it (water) was warm, but not hot." Dietary staff #2 further stated that he routinely used the hand sink near the dish machine to wash his hands and that the temperature of the water that day (03/06/17) was about the usual temperature of the water when he washed his hands at that sink. He stated that he was not aware of any problems with the hot water.

The maintenance director entered the kitchen on 03/06/17 at 11:07 AM and stated that due to facility renovations near the dietary department, the construction crew asked him to turn off the hot water to the hand sink next to the walk-in cooler on Monday afternoon, 03/05/17, and so he did. He stated he advised the dietary staff who was working at the time, but that he did not post any signage to alert oncoming staff. The maintenance director stated that the hot water to the hand sink next to the walk-in cooler remained off until just now. He further stated that he had just turned the hot water on when he received a call moments before advising him that the survey team was in the kitchen and there was no hot water to one of the hand sinks. He stated that he monitored the hot water in the dietary department once weekly and monitored the hand sinks for a temperature range of 92 - 115º F. Review of documentation of temperature monitoring conducted by the maintenance director December 2016 - March 2017 revealed a temperature range of 110 - 115º F. The maintenance director left the kitchen and returned at 11:08 AM with a digital thermometer. The maintenance director conducted temperature monitoring of each hand sink and obtained the following temperatures:

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F 371	Continued From page 29 " 11:08 AM, hand sink at walk-in cooler, 110 - 111º F " 11:09 AM, hand sink at dry storage, 113 - 113.3º F " 11:10 AM, hand sink at dish machine, 113 - 113.5º F An interview on 03/06/17 at 11:11 AM with dietary staff #3 revealed that she used all 3 hand sinks to wash her hands, but that the water at the hand sink next to the walk-in cooler "did not get that hot, you have to let it run awhile". She further stated that the water at each of the hands sinks that day had been warm, not real hot, and that she was not aware that the hot water to the hand sink next to the walk-in cooler was off. An interview with dietary staff #4 (cook) occurred on 03/06/17 at 11:12 AM and revealed that she was not aware that the hot water to the hand sink at the walk-in cooler was off. An interview with the certified dietary manager (CDM) occurred on 03/09/17 at 8:30 AM and revealed she was not aware that the maintenance director had turned off the hot water to the hand sink next to the walk-in cooler and therefore she had not instructed dietary staff not to use that hand sink. The CDM stated that she would have expected the maintenance director to put up signage to alert staff that the hot water had been turned off so that staff would be aware. The CDM stated "As the supervisor I should have been advised to that I could ensure all staff in the department was aware."	F 371		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		3/31/17

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F 520	Continued From page 30 (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of 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	F 520		

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F 520	Continued From page 31 sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2016 following a recertification and complaint survey in that month and on the current survey. The deficiencies of the November 2016 recertification and complaint survey were in the areas of notification of the responsible party (F157) and resident well-being (F309). These deficiencies were recited during the facility's current survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a) F157: Notify Physician/Responsible Party of Change: Based on family member, staff and physician interviews, and record review, the facility failed to notify the responsible family member of an order for an antipsychotic medication (Abilify) for 1 of 5 sampled residents who received psychoactive medications (Resident #2). During the recertification and complaint survey of 11/02/16, this regulation was cited as a result of the facility's failure to notify the resident's responsible party (RP), the physician and the physician assistant of a resident's fall in the	F 520	F 520 QAA Committee On April 2017 the facility Executive QI Committee will hold a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 3/27/17 the corporate facility consultant in-serviced the facility administrator, director of nursing, admissions, activities director, maintenance director, dietary manager, therapy director, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 157 notification of responsible party and F 309 resident well-being. As of 3/27/17, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident	

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F 520	Continued From page 32 transportation van which resulted in a head laceration for a sampled resident. This regulation was cited at an immediate jeopardy level. During the current recertification and complaint survey of 03/10/17, this regulation was cited as a result of the facility's failure to notify a resident's RP of a physician's order to administer an antipsychotic medication. 1b) F309: Maintain Well-Being: Based on observations, interviews with a resident, nurse practitioner and staff and review of the medical record, the facility failed to monitor 1 of 2 sampled residents with congestive heart failure/edema for daily changes in their weight per physician's order (Resident #103). During the recertification and complaint survey of 11/02/16, this regulation was cited as a result of the facility's failure to get professional staff to assess a resident for possible injury after a fall in the transportation van which resulted in a head laceration and before moving and driving the resident to the facility and to complete neuro checks for a resident who sustained a head injury from a fall. This regulation was cited at an immediate jeopardy level. During the current recertification and complaint survey of 03/10/17, this regulation was cited as a result of the facility's failure to monitor weights daily for a sampled resident with congestive heart failure/edema and a physician's order to obtain daily weights. Interview with the Administrator on 03/10/17 at 5:12 PM revealed that all department managers, corporate consultants, the pharmacy consultant	F 520	council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F 157 notification of responsible party and F 309 resident well-being. The Committee will continue to meet at a minimum of Quarterly with oversight by a corporate staff member. The QI Committee meeting agenda and minutes with resulting plans of corrections and audit results will be reviewed as a component of this oversight after each QI Committee meeting. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or	

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F 520	Continued From page 33 and the medical director attended quarterly QAPI meetings to discuss unfavorable trends, previously cited federal deficiencies, significant changes identified with department rounds, operational concerns and monitoring. The Administrator stated that the agenda items were discussed and reviewed for modifications which resulted in subcommittees that further reviewed and tracked the daily/weekly progress of the modifications for further discussion in the monthly/quarterly QAPI meetings. The Administrator further stated that she attributed a repeat deficiency regarding notifying the RP of a new medication (F157) to QAPI's failure to use an applicable audit tool, a lack of monitoring and the need for more frequent follow up with the director of nursing. She stated that she attributed a repeat deficiency regarding maintaining well-being (F309) to QAPI's failure to educate new staff, having an effective system for monitoring weight data for residents who required daily weights and monitoring the system for data entry in the computerized medical record regarding daily weights.	F 520	his designee will report back to the Executive QI Committee at the next scheduled meeting.	