DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	**1084 US 64 EAST PLYMOUTH, NC 27962**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiency was cited as a result of the complaint investigation on 3/30/17 Event ID HGTX11	F 000		
F 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on Resident Trust Fund account reviews and staff interviews, the facility failed to forward expired resident funds to the Clerk of Court within 30 days for 4 of 5 resident fund accounts reviewed.(Residnet #130, Resident #40, Resident #95 and Resident #15,) The findings include: 1. Resident #130 expired on 11/23/16. A check for $43.26 was forwarded to the Clerk of Court on 12/27/16. The check was not forwarded o the Clerk of Court within 30 days. During an interview on 03/30/2017 at 8:45 AM, the Corporate Field Accountant for Accounts Receivable revealed she did not know what happened. She stated the previous bookkeeper was in and out in December, 2016 and early	F 160	F 160 As of 3-31-17 all Funds were dispersed by the Facility Business Office Manager to the Estates of Residents who are deceased to include for Residents #130, #40, #95 and #15. All Residents deceased within the past 6 months were reviewed on 3-29-17 by the Business Office Manager and the Corporate Field Accountant to ensure Funds were dispersed as required to the Clerk of Court. Any concerns identified were corrected by 3-31-17 and recorded via the Trust Transaction List. The new Business Office Manager was trained on Policy & Procedures for Personal Fund to include the conveyance of such funds per company policy and State law by Corporate Field Accountant	5/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2017

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

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F 160	Continued From page 1	F 160		

January, 2017 and from that point on the facility did not have a bookkeeper. She revealed they were working on patient funds yesterday and cleaning up all issues.

During an interview on 03/30/2017 at 2:12 PM, the Interim Administrator revealed they just hired a new Business Office Manager and her expectation was to make sure checks are sent within thirty days.

2. Resident #40 expired on 1/1/17. The facility had not mailed a check to the Clerk of Court.

During an inteview on 3/29/17 at 5:20 PM the Corporate Field account for Account Receivables Consultant revealed the expired resident's fund account balance had not been forwarded to the Clerk of Court. She stated the money was still in the resident's account.

During another interview on 3/30/17 the Corporate Field account for Account Receivables Consultant revealed they were aware of the problem and they were tring to get everything caught up.

During an interview on 03/30/2017 at 2:12 PM, the Interim Administrator revealed they just hired a new Business Office Manager and her expectation was to make sure checks are sent within thirty days.

3. Resident #95 expired on 1/24/17. The facility had not mailed a check to the Clerk of Court.

During an inteview on 3/29/17 at 5:20 PM the Corporate Field account for Account Receivables Consultant revealed the expired resident's fund

on 3-30-17 and 4-12-17. This training included the requirement to disperse Resident funds to the Estate of the Resident who is deceased within 30 days. Utilizing a QI Tool the Administrator will review the Resident Trust Fund account with the Business Office Manager on a bi-weekly basis for a minimum of 3 Months to begin on 04/28/17 to ensure the appropriate conveyance of funds to include for deceased Residents. The Corporate Field Accountant will review the results of the audit monthly for a minimum of 3 Months. Any concerns identified will be addressed immediately to include dispersing of funds to the Clerk of Court. The Executive QI committee will meet monthly and review findings of the QI tool for management of trust fund accounts and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3 months.

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F 160	Continued From page 2 account balance had not been forwarded to the Clerk of Court. She stated the money was still in the resident's account. During another interview on 3/30/17 the Corporate Field account for Account Receivables Consultant revealed they were aware of the problem and they were tring to get everything caught up. During an interview on 03/30/2017 at 2:12 PM, the Interim Administrator revealed they just hired a new Business Office Manager and her expectation was to make sure checks are sent within thirty days. 4. Resident #15 expired on 1/27/17. The facility had not mailed a check to the Clerk of Court. During an inteview on 3/29/17 at 5:20 PM the Corporate Field account for Account Receivables Consultant revealed the expired resident's fund account balance had not been forwarded to the Clerk of Court. She stated the money was still in the resident's account. During another interview on 3/30/17 the Corporate Field account for Account Receivables Consultant revealed they were aware of the problem and they were tring to get everything caught up. During an interview on 03/30/2017 at 2:12 PM, the Interim Administrator revealed they just hired a new Business Office Manager and her expectation was to make sure checks are sent within thirty days.	F 160		
F 242	483.10(f)(1)-(3) SELF-DETERMINATION -	F 242		5/10/17

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F 242 SS=D	Continued From page 3 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 record review, staff, family and resident interviews and observation, the facility failed to honor food dislikes documented on tray slips for 1 of 3 sampled residents (Resident #109) who were reviewed for dining experience and meal intake. Findings included: Resident #109 was admitted to the facility 8/31/16. A review of the most recent quarterly Minimum Data Set (MDS) revealed Resident #109 was cognitively intact and required extensive assistance for most activities of daily living except, locomotion on and off the unit and eating. Locomotion and eating required supervision only. Active diagnoses included multi-system degeneration of the autonomic nervous system, gastro-esophageal reflux (GERD), muscle weakness, dysphagia and speech disturbance.	F 242	F 242 Resident #109 did not eat from the original meal tray and was offered an alternative meal by the dietary manager on 3-27-17. 100% of meal trays for supper were audited to include Resident #109 by the dietary manager and dietary consultant in the kitchen to ensure no dislikes had been placed on any resident□s trays, completed 3-27-17. 100% of supper trays audited by the dietary manager prior to setting up trays to ensure no dislikes had been placed on any of the residents trays, completed 3-27-17. Any issues identified with trays were addressed immediately by the dietary manager and trays were returned	

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F 242	Continued From page 4 A quarterly dietary supplemental assessment dated 3/17/17 revealed Resident #109 ate 76-100% (percent) of breakfast, 51-75% of lunch, and 76-100% of dinner. The assessment also read, in part, "Will honor preferences as made known and monitor." A lunch meal observation was made on 3/27/17 at 12:05 PM of Resident #109. A nursing assistant (NA #1) brought the meal tray in, placed it on the table, removed the cover and stated, "Oh. They gave you lasagna and you don't like lasagna. I'll get you a peanut butter and jelly sandwich." A review of the lunch tray slip for Resident #109 revealed lasagna listed as a dislike. An interview was conducted on 3/27/17 at 12:10 PM with NA #1. She stated, "I know (Resident #109) doesn't like lasagna. I don't know why they send it to him. I usually get him a sandwich, or they just put a sandwich on his tray." An interview was conducted on 3/27/17 at 12:45 PM with the Dietary Manager. She stated she asked residents when they were first admitted for a list of likes and dislikes. She returns to the resident after they had been in the facility for "a while" and asked them again. She also stated, "If I know a resident dislikes a meal choice, like lasagna, I or the facility staff tell the resident the meal today is something you dislike. What would you like instead?" An interview was conducted on 3/28/17 at 12:30 PM with a family member (FM) of Resident #109. She stated, "There's a sheet outside the dining room with alternatives if the residents don't like something. The things listed aren't always	F 242	to the kitchen and a new one was provided. 100% of dietary staff in-serviced by dietary consultant and dietary manager on checking trays prior to being sent out of the kitchen to ensure residents do not receive dislikes on trays. The in-service was initiated on 3-27-17 and completed on 3-29-17. 100% of all nursing staff in-serviced beginning on 3-29-17 by the Director of Nursing and the Staff Facilitator on checking tray cards to include no dislikes are served on the residents trays prior to setting up, passing, or feeding the residents, and any trays that are not correct will be returned to the kitchen and a new tray provided to the resident, completed on 04-20-17. 100% of all staff will be in-serviced by the ombudsman program on residents rights to make choices to be completed by 05-01-17. All newly hired licensed nurses and nursing assistants will be in-serviced by the Staff Facilitator on orientation on checking tray cards to include Resident #109 to ensure no dislikes are served on the residents trays prior to setting up, passing, or feeding the residents, and any trays that are not correct will be returned to the kitchen and a new tray provided to the resident. The Dietary Manager will audit all trays for 3 Meals per week to include the tray for Resident #109 weekly x 8 weeks, monthly x 1 month utilizing the QI tool for Meal	

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F 242	Continued From page 5 available though. (Resident #109) has asked for chicken sandwiches because he loves their chicken sandwiches and was told they don't have them. Then they just bring him peanut butter and jelly. Sometimes they bring him peanut butter and jelly without even asking what he wants. He loves chicken any which way. He likes peanut butter and jelly but doesn't want it all the time. He loves hot dogs too. He doesn't like fresh tomatoes but they sometimes come on his burger or salad. We just take it off. The dietary manager came to talk to us when he first came in, and when the new one was hired recently she spoke with (Resident #109) too." An interview was conducted with NA #2 on 3/28/17 at 2:15 PM. She stated, "I've worked the hall (Resident #109) lives on for 5-6 years. (Resident #109) doesn't like lasagna. He (Resident #109) loves chicken. He can make his needs known and if lasagna is being served he shouldn't get it. He doesn't like lasagna at all. If lasagna is on the menu I'll just automatically bring him something else. A lot of times the kitchen will just send him a substitute without asking. When he gets burgers and salads there are fresh tomatoes on them, but I've never seen him eat one. Their meal tickets list likes/dislikes." An additional interview was conducted on 3/28/17 at 3:40 PM with the Dietary Manager. She stated, "When I started here I went by the meal tickets for preferences. Then I interviewed the residents and updated the tickets as needed. I spoke to each resident or their family. Chicken nuggets, hot dogs, soup, sandwiches of various kinds and cheese omelets available as an alternate lunch every day. I don't always have chicken patties on hand to make chicken sandwiches, but I always	F 242	Tray Audit to ensure no residents receive dislike foods on meal tray prior to the tray leaving the kitchen. Any issues noted with the meal trays will be addressed immediately and dietary staff retrained as applicable by the Dietary Manager. The Administrator will review and initial the QI tool for Meal Tray Audit to ensure completion weekly x 8 weeks, monthly x 1 month. Any issues identified with the Audit will be addressed immediately by the Administrator. The QI nurse will present the findings of the Meal tray Audit to The Executive QI committee monthly and review findings of the Meal tray Audit and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3 months.	

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F 242	Continued From page 6 have the other things. My dietary aides look at the tickets, which list likes, dislikes, adaptive equipment, allergies, and texture. The aides tell the cook or the line person so the tray goes out correctly. Our menu rotates every 4 weeks, so we know 4 weeks in advance that lasagna will be served. The staff should be asking the residents what they want as an alternative and not just sending them whatever they feel like. They should ask the residents what they want."	F 242		
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, staff and resident interviews, and record reviews the facility failed to repair the ceiling for 2 of 4 halls, the ceiling at the nursing station and the ceiling in 4 of 21 rooms (rooms 420, 422, 505, and 507), failed to repair a splintered corner of a closet for 1 of 21 rooms (room 401), failed to repair the laminate on 1 of 21 sink counters (room 401), and failed to repair the over-bed table for 1 of 21 rooms (room 511). Findings Included: A. During observations on 3/27/17 at 10:35 AM, 3/28/17 at 11:23 AM, and 3/29/17 at 9:16 AM, room 420 was observed to have a textured ceiling with paint peeling away from ceiling above the resident's bed. There was a brown stain around the edges where the paint had peeled away. During an interview on 3/29/17 at 10:02 AM Resident #6's family member in 420 stated that	F 253	F 253 The ceiling for 2 of the 4 Halls, the ceiling at the Nursing Station and the ceilings in Rooms #420, #422, #505 and #507 will be repaired by 5-10-17 by Corporate Support Services. The splintered corner of the closet for Room #401 was repaired on 3-30-17 by the Maintenance Supervisor. The laminate on the sink counter for Room #401 was repaired on 3-30-17 by the Maintenance Supervisor. The over-bed-table from room #511 was removed, discarded and replaced on 3-30-17 by the Maintenance Supervisor. 100% observation of the facility and all resident□s rooms to include rooms #420, #422, #505, #507, #401 and #511 was completed on 4-15-17 by the Activity Assistant to ensure all areas and rooms	5/10/17

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the ceiling was peeling and cracked ever since her sister had moved in to the room about two weeks ago. She stated it was difficult not to notice it so she remembered it had been there the entire time.

B. During observations on 3/27/17 at 10:30 AM, 3/28/17 at 11:20 AM, and 3/29/17 at 9:11 AM, room 422 was observed to have a textured ceiling with paint peeling away from ceiling above the door. A quarter sized hole was observed in the ceiling where the paint was peeling away. The paint was also observed peeling away from the ceiling over the empty A bed. During an interview on 3/29/17 at 9:32 AM Resident #75, assessed as cognitively intact, stated that he had been in Room 422 for over 2 years and that the small hole in the ceiling above the door and the ceiling above the left side of the room had always been peeling and in disrepair.

C. During observations on 3/27/17 at 10:38 AM, 3/28/17 at 11:29 AM, and 3/29/17 at 9:19 AM, room 505 was observed to have two brown stains, approximately 6 inches in diameter, on the ceiling over the door.

D. During observations on 3/27/17 at 10:41 AM, 3/28/17 at 11:32 AM, and 3/29/17 at 9:22 AM, room 507 was observed to have a bean shaped patch, approximately 9 inches long and 5 inches wide, of a textured ceiling paint missing from the ceiling above the window. The edges of the patch were observed to be peeling away from the ceiling.

E. During observations on 3/27/17 at 10:42 AM, 3/28/17 at 11:33 AM, and 3/29/17 at 9:23 AM, on the 500 hall outside of room 521, paint was

are in good repair. Work orders were completed on 4-15-17 by Activity Assistant for notification to Maintenance Director for any identified areas of concern. All identified areas of concerns from the audit will be corrected under the direction of the Maintenance Director.
The Maintenance Director was in-serviced by the Administrator on 4-13-17 regarding ensuring rooms are in good repair. All license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers were in-service by SDC by 4-20-17 to notify Maintenance of any areas in the facility in need of repair or painting to include resident rooms by completing a work order slip. All newly hired License Nurses, Nursing Assistants, Dietary staff, Housekeeping staff, Therapy staff and Department Managers will be in-serviced by the Staff Facilitator regarding notification of Maintenance for any areas in the facility in need of repair or painting to include resident□s rooms by completing a work order slip during orientation.
The Activity Director Assistant was trained on 4-13-17 by the Administrator regarding facility inspection for needed repairs. The Activity Assistant will monitor all areas of the facility to include Rooms #420, #422, #505, #507, #401 and #511 to ensure rooms are in good repair weekly x 8 weeks then monthly x 1 utilizing a Facility Map QI Audit tool and complete a work order slip for all identified areas of concerns. The Maintenance Director will address any identified areas of concern found during the audit. The Administrator

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F 253	Continued From page 8 observed to have peeled and cracked away from the ceiling leaving a patch approximately 10 inches in diameter. The paint around the edges of patch were peeling away from the ceiling. F. During observations on 3/27/17 at 10:44 AM, 3/28/17 at 11:36 AM, and 3/29/17 at 9:27 AM, the paint above and to the right of the entrance to the conference room was cracked and had a brown stain approximately 6 inches long and four inches wide. G. During observations on 3/27/17 at 10:45 AM, 3/28/17 at 11:37 AM, and 3/29/17 at 9:28 AM, the ceiling at the nurses' station, above the entrance to the 300 hall, had two spots where white putty had been used on the ceiling. The putty was approximately 6 inches by 16 inches for the spot closest to the nurses' station and approximately softball sized for the spot next to the light fixture. The putty was cracked from the ceiling. The two spots of white putty had brown stains around the areas where the putty was cracking. The ceiling above the 400 hall entrance at the nurses' station was observed to have a large area where white putty had been used on the ceiling. The putty was cracking and had a large tan stain on and around the area. H. During observations on 3/27/17 at 10:30 AM, 3/28/17 at 11:20 AM, and 3/29/17 at 9:11 AM, room 401 was observed to have splintered wood to the lower right corner of the closet. Room 401 was also observed to have laminate finish peeling and missing from the front left corner of the counter around the sink. During an interview on 3/29/17 at 9:40 AM Resident #100 in Room 401, assessed as cognitively intact, stated that the corner of his sink had been in disrepair a long	F 253	will review the Home like Environment QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Homelike Environment QI Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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time. He stated he had been there for over a year. He stated if he could fix it himself he would and he would not have a sink with a corner like that in his own home. He further stated he would not have a closet with splintered wood in his home.

I. During observations on 3/27/17 at 10:45 AM, 3/28/17 at 11:39 AM, and 3/29/17 at 9:30 AM, room 511 was observed to have an over-bed table in use for the A bed that had veneer peeling away from the edges of the top of the table.

Review of the general facility daily check list dated 3/24/17 revealed the Maintenance Assistant performed the inspection of resident rooms and the building interior. No rooms were identified as having any maintenance issues.

Review of the general facility daily check list dated 3/29/17 revealed the Maintenance Director performed the inspection of resident rooms and the building interior. Room 509 and 401 were noted to need repair on the wall behind the bed. No other rooms were mentioned as needing repair.

During an interview on 3/29/17 at 10:17 AM Nurse Aide #2, who was assigned the 500 hall, stated that when Nurse Aides noticed any issues in resident rooms or on the hall that required maintenance such as disrepair or leaking or general environmental issues, the Nurse Aides filled out a maintenance slip at the nurses' station. The maintenance director then checked the repair slips and fixed the issues.

During an interview on 3/29/17 at 10:34 AM, Nurse Aide #1, who was assigned the 400 hall,

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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 253	Continued From page 10 stated that she reported maintenance issues to the maintenance director. She stated she completed a maintenance slip at the nurses' station. She further stated she would report issues like peeling laminate from the resident sinks, general environment issues, bedside tables in disrepair and anything else in the room or on the hall that was in disrepair including walls and ceilings. During an interview on 3/29/17 at 10:41 AM, Nurse #1, assigned to the 400 hall, stated that if she noticed any maintenance issues such as beds not functioning correctly, side rails that did not fit or were broken, or if the ceiling was in disrepair she filled out a maintenance slip and the maintenance director checked the box that the slips go to each morning. She further stated that she reported any issues in rooms that are in disrepair if it was walls, ceilings, sinks, or bedside tables. During an interview on 3/29/17 at 10:48 AM, the Maintenance Assistant stated that each morning when he comes in he checks water temperatures, call bells, beds and plumbing on specific halls through the week. He further stated that for small maintenance issues he was the one who generally did the maintenance and for larger issues like a bed motor failing his boss takes care of the issue. He further stated that the Nurse Aides were usually the individuals who notify him and the Maintenance Director of issues in rooms and on the halls. He further stated that the staff writes the concern on a maintenance slip at the nurses' station and he or the Maintenance Director checked these slips each morning and worked on the issues.	F 253		

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F 253	Continued From page 11 During an interview on 3/29/17 at 11:04 AM, the Maintenance Director, stated he began working in the facility in October 2016. He stated that there are a lot of things that need to be done in the facility but he only had a part time maintenance assistant on Monday, Wednesday, and Fridays and sometimes they pulled his maintenance assistant away from him even on those days. He further stated that because of this, his work has backed up and he has not been able to get to everything that has been reported to him and he has had to prioritize what work he had done on the facility. He further stated that he is alerted to the work that needs to be done in the facility usually by nurses and nurse aides and he also performs rounds on the facility himself and completes work orders for himself as needed. During an interview on 3/29/17 at 11:58 AM, the Maintenance Director, stated that when a general facility daily check list was completed, it is completed for the whole facility. He further stated that when the forms were stapled together, the name and date on the first sheet of the general facility daily check list was the date that all of the inspections stapled to that first sheet were performed. He stated he used this check list to find maintenance issues and keep track of them. He stated that peeling ceilings, splintered closets, bedside tables and sinks in disrepair are reported to him. He stated that on the report dated 3/29/17 performed by him was for the entire building and that the only rooms observed for issues with building interior and resident rooms were room 509, and room 401. He stated for room 401 he noted that he needed to repair the wall behind the bed and there were no other maintenance issues in that room.	F 253		

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F 253	Continued From page 12 During an interview on tour on 3/29/17 at 12:12 the Maintenance Director stated that no one alerted him to the issues in the resident rooms. He further stated that, during his general facility tours, he and the Maintenance Assistant had not noticed the issues on the 500 hall, at the nurses' station, in rooms 401, 420, 422, 505, 507, and 511 and there were no work requests or plans to correct these issues. He further stated that these maintenance issues should have been noticed and corrected. During an interview on tour on 3/29/17 at 12:25 PM, the Administrator stated she agreed the ceiling in the hallway next to the conference room, the ceiling around the nurses' station, rooms 401, 420, 422, 505, 507, 521, and 511 were in disrepair. She further stated that she expected the Maintenance Director to identify maintenance concerns during his tours of the facility and also that staff would bring issues observed during their shift to the Maintenance Director's attention.	F 253		
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.	F 278		5/10/17

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F 278	Continued From page 13 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to correctly code the most recent quarterly Minimum Data Set (MDS) for the presence of hallucinations for one of eighteen residents (Resident #77). Findings included: Resident #77 was admitted to the facility on 3/31/15 with diagnoses which included dementia. A review of the quarterly MDS dated 1/3/17 revealed Resident #77 was mildly cognitively impaired and had no hallucinations. Active diagnoses included Alzheimer's disease, and dementia.	F 278	F 278 Resident #77 most recent MDS assessment modified on 04-14-17 by the MDS Nurse to reflect behaviors to include hallucinations. 100% audit of all residents most recent MDS assessments in facility to include resident # 77 to ensure all behaviors including hallucinations are accurately coded on the most recent MDS assessment by DON\QI nurse, to be completed by 04-28-17 Any issues noted during the audit will be immediately addressed by the DON.	

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Continued From page 14

A review of the behavior flowsheet for Resident #77 dated 12/28/16 through 1/3/17 revealed Resident #77 experienced hallucinations on 12/28/16.

An interview with MDS Nurse #1 was conducted on 3/30/17 at 10:15 AM. She stated MDS assessments are limited to a 7 day look back period and the quarterly MDS assessment dated 1/3/17 for Resident #77 included 12/28/16. She also stated the quarterly MDS dated 1/3/17 for Resident #77 was not accurate and hallucinations should have been checked.

An interview was conducted on 3/30/17 at 11:15 AM with Nurse #2. She stated, "She (Resident #77) sometimes has hallucinations, especially in the morning."

An interview was conducted on 3/30/17 at 11:35 AM with the Director of Nursing. She stated her expectation was for the MDS to be completed accurately.

F 278

MDS Nurse#1 and MDS nurse #2 in-serviced on ensuring all behaviors to include hallucinations are accurately coded on the MDS assessment by the MDS Consultant on 04-20-17 DON and QI nurse in-serviced on ensuring all MDS assessments reviewed were accurately coded with behaviors to include hallucinations prior to signing on 04-20-17 by MDS Consultant. All newly hired MDS nurses will be in-serviced on ensuring all behaviors to include hallucinations are accurately coded on the MDS assessment on orientation by the MDS Consultant.

10% of resident MDS assessments will be audited to include resident # 77 to ensure all behaviors including hallucinations are accurately coded on the most recent MDS assessment by QI nurse weekly x 8 weeks and monthly x 1 month utilizing the MDS Coding Accuracy Audit Tool. Any areas of concern will be addressed immediately to include providing additional training by the QI nurse to ensure resident MDS assessments are accurately coded for behaviors to include hallucinations. The Director of Nursing will review and initial the audits for completion and address any areas of concern weekly x 8 weeks and monthly x 1 month.

The Executive QI committee will meet monthly and review audits of the MDS Coding Accuracy Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring

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F 278	Continued From page 15	F 278	monthly x 3 months.	
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: (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:	F 441		5/10/17

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F 441	Continued From page 16 (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 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 observations, interviews and record review the facility failed to wear personal protective equipment (PPE) while preforming exercises with 1 (Resident #129) of 1 resident on contact precautions. The findings included: A review of the 9/2014 facility policy titled Methicillin-Resistant Staphylococcus Aureus (MRSA) on page VII-3 revealed the policy of the	F 441	Resident #129 no longer requires Contact Isolation as of 3-30-17. PTA #1 in-serviced immediately upon notification regarding not wearing a gown in Resident #129 room requiring isolation precautions on 3-29-17 by SDC. 100% of staff will be audited to include PTA #1 with return demonstration of proper donning and doffing of personal	

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F 441	Continued From page 17 facility that transmission-based precautions will be discontinued when: 1. Resident is no longer displaying signs and symptoms of active infection, or 2. Attending physician determines the resident is no longer actively infected 3. Seventy-two (72) hours after resident completes antibiotic. 4. If ordered, re-culture is negative for MRSA. Resident #129 was admitted to the facility on 3/23/17 with diagnoses which included surgery for a hip fracture and MRSA (an infection caused by a type of bacteria that has become resistant to many of the antibiotics used to treat the infection) of the nares. A review of the discharge summary from the hospital revealed the medication "Mupirocin 2% ointment 1 application topical twice a day" which was last provided on 3/23/17 at 4:31 PM. Hand written beside this was "X (times) 7 doses." A review of the facility's physician orders for resident #129 revealed an order of "Mupirocin 2% ointment apply to nares BID X 7 doses for a diagnosis of MRSA in nares". There was also an order which stated "Contact isolation due to MRSA (nares)." The Medication Administration Record (MAR) for Resident #129 revealed she received Mupirocin 2% ointment from 3/23/17 until 3/26/17. The MAR indicated 7 doses had been administered. An observation of the resident's room on 3/28/17 at 1:45PM revealed a "Contact Isolation" sign posted on the door which listed the precautions that a mask, gown and gloves were required. A PPE rack was located on the door containing gloves and masks. There were no isolation	F 441	protective equipment including a gown prior to entering a residents room requiring isolation precautions to include contact precautions to ensure correct isolation precautions are followed by SDC\DON on 3-28-17, and will be completed on 5-5-17 Any identified areas of concern will be immediately addressed by the SDC\DON during the audit. 100% of staff to include PTA #1 was in-serviced on following isolation precautions to include contact precautions posted on residents door including wearing appropriate personal protective equipment to include a gown as applicable when entering residents room by the Staff Facilitator on 3-28-17, and completed on 4-20-17. All newly hired staff to include all therapy staff will be in-serviced on following isolation precautions to include contact precautions posted on residents door including wearing appropriate personal protective equipment to include a gown as applicable when entering residents room on orientation by the Staff Facilitator. 10% of all staff to include therapy department will be observed entering residents rooms on isolation precautions to ensure isolation precautions are followed to include contact precautions by QI nurse weekly x 8 weeks, monthly x 1 month utilizing the QI audit tool for Isolation Precautions to ensure isolation precautions to include contact precautions are followed including wearing a gown when entering residents rooms as applicable. Any issues identified during the observation will be addressed	

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F 441	Continued From page 18	F 441		

gowns in the rack. The Director of Nursing (DON) was informed the isolation gowns were not present in the PPE rack.

On 3/28/17 at 1:55 PM Physical Therapist (PT) #1 was observed inside the resident's room. She was wearing gloves and a mask. She was not wearing an isolation gown. She was observed in a squatted position in front of Resident #129 who was seated in a wheelchair.

On 3/28/17 at 1:57PM the DON had obtained a package of isolation gowns and returned to the resident's room with the gowns.

On 3/28/17 at 2:01 PM PT #1 exited the room and was interviewed. She stated she had started physical therapy exercises with the resident before lunch and she wore a gown. PT #1 stated she left while the resident ate lunch then returned to continue exercises with Resident #129. PT #1 reported she did not wear a gown because she was only going to touch the resident ' s legs with her gloved hands. She stated the resident was able to perform the leg exercises with only assistance with removing her legs from the leg rest.

On 3/28/17 at 2:10 PM the DON stated she expected the staff to wear PPE including an isolation gown when a resident was on contact precautions.

On 3/30/17 the Infection Control nurse stated there was not an actual doctor's order for contact isolation precautions but the facility initiated the contact precautions to error on the side of caution. She stated if the resident was not symptomatic then there were no concerns for

immediately by providing additional training by the SDC to ensure compliance. The Director of Nursing will review and initial the audit tool weekly to ensure completion and address any issues identified weekly x8 weeks and monthly x 1 month.
The QI nurse will present the findings of the audit to The Executive QI committee monthly and review audits of the QI audit tool for Isolation Precautions and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3 months.

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F 441	Continued From page 19 spread of the organism. She stated Resident #129 had 7 more doses of antibiotic so the facility chose to put the resident on contact precautions and to remove the precautions they had to follow the policy so the resident would remain on contact precautions until 72 hours after she finished the antibiotic which would be 8:00pm on 3/29/17 so she was removed from contact precautions on the morning of 3/30/17.	F 441		
F 460 SS=D	483.90(e)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY (e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; (e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to ensure a resident's room was equipped to ensure full privacy for 1 of 21 rooms observed (room 412). Findings Included: During observation on 3/27/17 at 3:25 PM, room 412 was observed to have privacy curtains that were unable to provide full privacy to the residents. The curtain runners on the ceiling ran from the head of the beds halfway down the side of the beds where a light fixture about a foot wide broke the runner into two separate sections. The second section continued along the ceiling from the other side of the light fixture, around the foot	F 460	F 460 The privacy curtain for Room #412 was altered on 3-30-17. 100% observation of all Resident Room privacy curtains were completed on 3-30-17 by the Maintenance Supervisor to ensure privacy curtains provided full privacy. No other concerns were identified. Shower Room privacy curtains were inspected by the Maintenance Supervisor and work orders completed as a result of the inspection were addressed on 4-13-17. The Maintenance Supervisor and the	5/10/17

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F 460	Continued From page 20 of the A bed to the door. There were curtains hanging from both sections that could be pulled to meet at the light fixture, leaving a foot wide gap in the privacy curtains that could not be closed. During observation on 3/28/17 at 11:55 AM, the curtains were observed to be in the same condition. During an interview on 3/28/17 at 11:57 AM, Resident #35, the resident in room 412's B bed, assessed as cognitively intact, stated that she did not care about the gap in the curtains. She further stated when care is provided to her or the resident in the A bed, the curtains are pulled to the light fixture and the gap is left open. She stated that the resident in the A bed has never complained about the gap as well. During an interview on 3/29/17 at 3:40 PM, Resident #83, the resident in room 412's A bed, assessed as severely cognitively impaired, stated that the gap in the curtain has been there a long time. She stated she did not care that there was a gap during her ADL care because her roommate "is a girl too." During an interview on 3/30/17 at 10:10 AM, Nurse Aide #3 demonstrated how she closed the curtains for resident care in room 412. She stated that when providing care to the resident she pulls the curtains closed as much as possible but, because of the light fixture, the curtains leave a foot gap which could not be closed. During an interview on 3/30/17 at 10:13 AM, Nurse #2 stated that she does not usually provide care for the resident but if she needed to pull the curtains closed, she would pull the curtains to the	F 460	Maintenance Assistant were in-serviced by the Administrator on 4-13-17 regarding their responsibility to monitor and ensure rooms were equipped with privacy curtains that were installed in a manner that allows and provides full visual privacy during facility rounds. All license nurses and nursing assistants were in-service by the Staff Facilitator starting on 3-29-17 and completed on 4-20-17 to notify Maintenance services of any concern related to privacy curtains not providing full privacy by completing a work order slip. All newly hired license nurses and nursing assistants will be in-serviced by the Staff Facilitator regarding to notify Maintenance services of any concern related to privacy curtains not providing full privacy by completing a work order slip. The Maintenance Supervisor will monitor 100% of all Privacy Curtains to ensure they are installed in a manner that allows and provides full visual privacy during routine facility rounds to include Room #412 and will document monitoring weekly on a QI tool weekly x 8 weeks and monthly x 1 month. Concerns observed will be addressed immediately under the direction of the Maintenance Supervisor. The Administrator will review and initial the audit tool weekly to ensure completion and address any issues identified weekly x 8 weeks and monthly x 1 month.	

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F 460	Continued From page 21 light fixture. She stated because of the light fixture she was unable to fully close the curtains when she provided care. During an interview on 3/30/17 at 10:17 AM the Maintenance Director stated the room had been that way since he began work in October. He stated there was no way to provide full privacy with the curtain in that state. During an interview on 3/30/17 at 10:19 AM the Director of Nursing, after observing room 412 stated that there was no way to provide full privacy to the residents because the runners for the curtain were stopped by the light fixture. She stated that the room had been that way since she had been working at the facility for the last five years. She stated that it was expectation that privacy curtains for residents be capable of providing full privacy for the residents. During an interview on 3/30/17 at 10:20 AM the Administrator, after observing room 412, stated the curtains did not provide full privacy to the residents of 412 because the light fixture created a gap in the privacy curtains. She stated it was her expectation that the residents would be provided full privacy for care.	F 460	The Administrator will review the findings of the Housekeeping Privacy curtain QI tool Audit with The Executive QI committee monthly and address any issues, concerns and\or trends and make changes as needed, to include continued frequency of monitoring x 3 months.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 520		5/10/17

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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 520	Continued From page 22 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures, monitor interventions and revise the action plan developed to correct	F 520	F520 The Administrator, DON and QI Nurse were educated by the Corporate consultant on the QI process, to include implementation of Action Plans,	

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F 520	Continued From page 23 the deficiency in the areas of resident ' s choices (F242). The facility had a pattern of a recited deficiencies which were originally cited in June 2015 on a recertification survey and recited on the 3/31/16 recertification survey and the current survey. The continued failure of the facility during three federal surveys of record demonstrate a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F242: Based on record review, staff, family and resident interviews and observations the facility failed to honor food dislikes documented on the tray slip for 1 of 3 sampled residents (Resident #109) who were reviewed for dining experience and meal intake. Resident choices (F242) was originally cited during the June 2015 recertification survey for not allowing a resident to choose to take her medication at a later time. During the recertification survey of 3/31/16 the facility was cited for failing to honor a resident's choice of time to get out of bed preventing her from attending an activity. During an interview with the QAA nurse on 3/31/17 at 11:30 AM she stated the QA committee met monthly and as needed. She added the QAA committee consisted of the required staff plus additional staff members. An interview was conducted with the interim Administrator and the Director of Nursing (DON) on 3/30/17 at 4:20 PM. The DON stated the residents have the right to make choices and she expected the choices to be honored. The DON	F 520	Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include residents right to make choices on 4-20-17. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 4-20-17. The QI nurse completed 100% audit of previous citations and action plans within the past year to include resident□s right to make choices to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by QI nurse on 4-19-17 for any concerns identified. All data collected for identified areas of concerns to include urinary incontinence will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by QI nurse. The Corporate Consultant will ensure the facility is maintaining an effect QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	03/30/2017

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F 520	Continued From page 24 stated the expectation was that the QA Committee identified problems and the nursing home corrected them to prevent repeat deficiencies.	F 520	program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include residents right to make choices and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	