STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

(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 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		5/25/17

(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) 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

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

Electronically Signed | 05/25/2017

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F 157	Continued From page 1 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 record review and staff, family and Physician interviews, the facility failed to notify the Responsible Party of two newly identified wounds (buttocks and heel) and failed to notify the Physician of one newly identified wound (heel) which resulted in lack of treatment, ongoing assessment, and worsening of a wound for 1 of 3 residents reviewed for notification of condition change (Resident #65). Findings included: Record review revealed Resident #65 was admitted to the facility on 8/22/2012 with diagnoses which included Stage 3 Chronic Kidney Disease, Hypertension and Diabetes. The Care Plan was reviewed and noted as last updated on 12/6/2016. The Care Plan revealed a problem of a risk for Pressure Ulcers related to impaired mobility with the goals listed as no areas of skin breakdown through the next review. Interventions included daily observation of skin with routine care, float heels on pillows at all times and monitor the eschar (a dry dark scab like area) on right heel and notify the doctor if any change noted.	F 157	F-157 Immediate Action: Resident 65 is no longer a resident in the building. He was discharged on 3/27/2017. Identification of others: 100% audit of all active resident□s medical records to include clinical documentation, physician orders and/or resident□s assessments completed, started on 4/28/17 and completed on 5/20/2017, by the Administrator, Director of Nursing and/or Medical Record Clerk to ensure that notification of change was done appropriately for all other residents. Any condition that warranted notification to resident□s responsible party and or the attending physician was corrected upon discovery promptly by the charge nurses or director of nursing. 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing, and charge nurse. This audit focus on identification of any skin alteration and whether or not resident attending physician and responsible party were notified. Any noted alteration of skin	

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F 157	Continued From page 2 The most recent Minimum Data Set (MDS) dated 3/6/2017 indicated Resident #65 was cognitively intact and required the assistance of 1 person for all Activities of Daily Living (ADLs) and was incontinent of bowel and bladder. The MDS indicated Resident #65 was at risk for pressure ulcers and no pressure ulcers were present on assessment. Skin Inspection Report assessments dated 3/8/2017 and 3/15/2017 completed by Unit Manager (UM) #1 indicated Resident #65's skin was intact. A review of the nursing notes revealed a note dated 3/20/2017 at 2:05 AM written by Nurse # 5. The note reported a quarter sized open area was observed on the right buttocks, barrier cream was applied and the area would be reported to the oncoming nurse. Further review of the nursing notes revealed a note dated 3/22/2017 at 1:53 PM written by UM #1. The note reported an open area was observed on Resident #65's right buttocks, barrier cream was applied and the Physician was notified. No new orders were obtained from the Physician. A Physician's Order dated 3/27/2017 was noted on Resident #65's medical record. The order specified Resident #65 be sent to the Emergency Department (ED) to be evaluated for increased temperature and altered mental status. Hospital records were reviewed and revealed Resident #65 was admitted to the hospital with a diagnosis of Sepsis (bacteria in the bloodstream caused by an infection) secondary to a Urinary	F 157	condition was reported to both attending physician and responsible party. Systemic Changes: Effective 5/25/2017, the 24 hour change of condition report sheet will be utilized by licensed nurses on duty to record any alteration in resident□s status during their scheduled shift. Licensed nurses will notify attending physician and responsible party on the following areas; an accident involving the resident, a significant change in resident condition, (such as noted alteration in skin integrity and/or deterioration of existing wound) a need to alter treatment (such as new wound care orders) decision to transfer or discharge a resident from the facility and/or any resident□s room changes. Effective 5/25/2017 the notification of changes tool will be utilized by licensed nurses on duty to record any resident with significant change of condition and ensure that the attending physician and responsible party were notified timely. 100% of licensed nursing staff, were in-serviced on the importance of timely notification of resident□s change of condition to physician and responsible party. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiated on 4/28/17 for all licensed nursing staff to include, full time, part time and as needed employees. This education will be completed by 5/25/17, any licensed nursing staff not educated by 5/25/17 will not be allowed to work until educated.	

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F 157	Continued From page 3 Tract Infection. A Skin Assessment note dated 3/27/2017 at 4:16 PM from the ED revealed Resident #65 had a fluid filled DTI noted on the left heel which measured 4 centimeter in length by 6 centimeter in width and several small areas on the right buttocks which appeared to be from shearing. A telephone interview was conducted with Resident #65's Responsible Party (RP) on 4/26/2017 at 2:12 PM. The RP stated she visited the resident often and visited the resident at the facility on 3/24/2017. The RP stated she was at the Emergency Department (ED) with Resident #65 on 3/27/2017. The RP further stated the resident was observed to have a pressure sore on his buttock and a dark, bloody looking area on his heel. The RP reported she was unaware of these areas until the observation in the ED. An interview was conducted on 4/27/2017 at 10:35 AM with the MDS nurse. The MDS nurse reported she assessed Resident #65 on 3/6/2017 for his quarterly MDS assessment and observed a small purple, bruise-like area on his right heel. The MDS nurse stated she thought she reported the area to the staff nurse but could not remember which nurse or if she reported it. The MDS nurse stated she did not notify the Physician or the RP of the area. A telephone interview was conducted with Nurse #5 on 4/27/2017 at 11:10 AM. Nurse #5 recalled the area on Resident #65's buttock which was discovered on the 11PM to 7AM shift. Nurse #5 stated since the area was small with no drainage she applied barrier cream. Nurse #5 also stated she did not notify families or Physicians during the night shift unless it was a serious situation.	F 157	This education will also be added to new hire process for all new licensed nursing staff effective 5/25/17 and also will be provided annually. Monitoring Process: Effective 5/25/2017 the Director of Nursing, Assistant Director of Nursing and/or Unit manager will review the 24 Hour Change of Condition Report sheet daily during morning clinical meeting (Monday-Friday) to assure that notification of change is conducted appropriately with the corresponding documentation in each resident□s medical records. In addition, this review will be to assure that any changes in condition is communicated to the physician and responsible party as warranted. This monitoring process will be continued by the charge nurses on Saturday and Sunday. This monitoring process will be conducted daily x 4 weeks then weekly x 4 weeks, then monthly thereafter, or until the pattern of compliance is achieved. Effective 5/25/2017 the Director of Nursing, Assistant Director of Nursing and/or Unit Manager will review Notification of Change Log daily during morning clinical meeting (Monday-Friday) to assure that notification of change is conducted appropriately with the corresponding documentation in each resident□s medical records. In addition, this review will be to assure that any changes in condition is communicated to the physician and responsible party as warranted. This monitoring process will be	

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F 157	Continued From page 4 Nurse #5 indicated she would give the information to the oncoming nurse for follow up. Nurse #5 stated she did not recall if she passed the information on to the oncoming nurse regarding the open area on Resident #65's buttock. An interview was conducted with the Physician on 4/27/2017 at 11:30 AM. The Physician stated he recalled Resident #65 and was aware of the open area on the buttock. The Physician reported the wound physician normally assessed the facility residents' wounds and he reviewed the orders and recommendations. The Physician indicated he did not recall notification of any skin issues with Resident #65's heel. An interview was conducted with UM #1 on 4/27/2017 at 1:35 PM. UM #1 indicated she "usually" called the RP after she called the Physician when a change in condition is noted. UM #1 also indicated she would document when the Physician and RP were notified. UM #1 stated she observed a small purple bruise-like area on Resident #65's heel on his weekly skin assessments on 3/8/2017 and 3/15/2017 but did not consider it a wound since it was not open and she did not notify anyone or document the observation. UM #1 further stated she recalled assessing the area on Resident #65's buttock and notifying the Physician but could not remember if the RP was notified. An interview was conducted with UM #2 on 4/27/2017 at 3:00 PM. UM #2 reported she assessed the area on Resident #65's right lower buttock on 3/22/2017 and completed the Skin Inspection Report. UM #2 reported she did not complete a full body assessment at that time and	F 157	continued by the charges nurses on Saturday and Sunday. This monitoring process will be conducted daily x 4 weeks then weekly x 4 weeks , then monthly afterwards, or until the pattern of compliance is achieved. Results of the monitoring process mentioned above will be reported to the facility□s Quality Assurance Performance Improvement Committee by Director of Nursing, Assistant Director of Nursing and/or Unit Manager monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	

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F 157	Continued From page 5 only looked at the area on the buttock. UM #2 stated she did not notify the Physician or the RP. An interview was conducted with the facility Administrator on 4/27/2017 at 4:15 PM. The Administrator stated the facility expectation was for any resident change of condition to be thoroughly assessed. The Administrator further stated the expectation included the condition change assessment be reported to the Physician and the RP with documentation to include the condition change, any new orders or treatments and notification.	F 157		
F 241 SS=D	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 observations, record review, and resident and staff interviews, the facility failed to treat residents in a dignified manner by failing to knock on door or ask permission to enter 1 of 1 resident room which resulted in feelings of embarrassment and disrespect. (Resident #84) Findings included: 1. Record review revealed Resident #84 was admitted to the facility on 11/20/2014 with diagnoses which included Hypertension, Osteoarthritis and Chronic Kidney Disease.	F 241	F241 Immediate Action: On 4/27/2017 an in-service was conducted by the Assistant Director of Nursing (ADON) to address how imperative it is for employees to knock and announce themselves before entering a resident□s room. On 05/5/2017, Resident #84 attended resident council meeting and stated she did not have any further issues. Identification of Others: The Social Worker conducted interviews with 100% of active resident residing in	5/25/17

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F 241	Continued From page 6 The most recent comprehensive Minimum Data Set (MDS) dated 3/6/2017 indicated Resident #84 was moderately cognitively impaired, able to make herself understood and understood others with clear comprehension. The MDS indicated Resident #84 required the assistance of one person for all Activities of Daily Living. On 4/27/2017 at 9:01 AM, Resident #84 was observed in her room, seated in a wheelchair beside the bed with the bedside table positioned in front of the wheelchair. At 9:03 AM, Nursing Assistant (NA) #6 entered resident #84's room, placed a breakfast tray on the bedside table, removed the lid from the tray, asked the resident if she needed anything and exited the room. Resident #84 told NA #6 she did not need anything and began eating. A continues observation of Resident #84's hall was conducted on 4/27/2017 from 9:06 AM to 9:22 AM. During the observation NA #6 was observed entering 5 rooms which had residents present without knocking or revealing her name, title or purpose for entrance. An interview was conducted with Resident #84 on 4/27/2017 at 11:30 AM. Resident #84 stated the staff were in and out of her room all day. Resident #84 stated it was not unusual for the facility staff to enter the room without knocking. The resident explained it embarrassed her when they come in without knocking, especially if she was bathing or getting dressed. Resident #84 added the facility was her home and felt it was disrespectful for the facility staff to walk in without knocking.	F 241	the facility on 5/17/17 and 5/18/17 to determine any issues with staff members knocking and announcing themselves. There were no identified issues. Systemic Changes: Effective 5/25/2017 active facility employees will knock and announce themselves before entering resident□s room. 100% of all active facility staff, were in-serviced on the resident□s dignity specifically knocking and announcing themselves. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiated on 4/28/17 for all active facility staff to include, full time, part time and as needed employees. This education will be completed by 5/25/17, any active facility staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hire process for all new employees effective 5/25/17 and also will be provided annually. Monitoring Process: Effective 5/25/17, the Social Worker, Activities Director, and Medical Records Clerk will conduct 10 random audits, daily, of staff members entering the resident□s room to determine compliance with knocking and announcing themselves. The weekend manager on duty will conduct 10 random audits of staff members entering resident□s room to determine compliance with knocking and announcing themselves. The result, of this random audits, will be logged using and	

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F 241	Continued From page 7 An interview was conducted with NA #6 on 4/27/2017 at 10:13 AM. NA #6 reported awareness of the need to knock and announce prior to entering residents' rooms. NA #6 stated she remembered to knock sometimes but not all the time. NA #6 reported the only reason for not knocking was just forgetfulness when she was busy. NA #6 stated when resident's room doors were opened the residents would see her coming in the room, so she didn't see a reason to knock. An interview was conducted with the Administrator and Cooperate representative on 4/27/2017 at 4:15 PM. The Administrator stated the expectation was for every facility employee to knock and announce themselves when entering resident's rooms.	F 241	the Knocking & Announce Audit tool. These audits will continue daily for 4 weeks, weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. Effective 5/25/2017, Social Worker and/or Activity Director will monitor compliance by discussing, knocking and announcing requirement monthly during resident council meeting. Concerns related to knocking and announcing during resident council meetings will be documented in resident council minutes. Results of these audits mentioned above will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee by Activity Director and/or Director of Social Services monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	
F 242 SS=D	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	F 242		5/25/17

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F 242	Continued From page 8 community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, the facility failed to honor a resident's choice of changing the placement of the bed in the room (Resident #61) for one of three residents reviewed for choices. Findings included: A review of the medical record revealed Resident #61 was admitted 2/21/2011 and readmitted 11/17/2016 with diagnoses of stroke with right side paralysis, anxiety, contracture of the right hand and vascular dementia. The 14 day Minimum Data Set (MDS) dated 12/1/2016 noted Resident #61 was moderately impaired for cognition and had no rejection of care or behaviors. The MDS indicated Resident #61 needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person. In an interview on 4/25/2017 at 4:00 PM, Resident #61 stated he would like his bed parallel to the other bed in the room, and the bed had been that way before, but the Administrator told him the bed had to be pointed toward the window because a roommate would not have room to get by the bed in a wheel chair or specialty chair. Resident #61 indicated he was disappointed because that was how he really wanted his bed to be. On 4/27/2017 at 3:18 PM, in an interview, the Administrator stated the facility had tried to accommodate him several times. The	F 242	F242 Self Determination Immediate Action: Resident #61 bed was repositioned in the way he requested on 4/28/2017 at 6:30 PM. Identification of Others: 100% interviews of all active residents residing in the facility conducted on 5/17/17, 5/18/17 and 5/19/17 by the Social Worker to determine each resident□s satisfaction and preferences of their furniture placement in their rooms. No other residents concerns related to accommodation of needs, specifically furniture placement were voiced. Systemic Changes: Effective 5/25/2017, resident□s choices about aspects of his or her life in the facility that are significant to the resident, like furniture location in resident room, will be discussed during admission process by the admission Director and/or Social services director. This discussion will focus on accommodation of resident□s choices while ensuring safety for all residents, (i.e. ensuring that preferred location do not block the means of ingress/egress). Effective 5/25/17, residents and/or responsible party will be advised on the process to follow if they prefer to change the furniture placement in their room through communicating such preferences when they arise to the Director of Social	

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F 242	Continued From page 9 Administrator indicated if Resident #61's bed were moved parallel to the other bed in the room, there would not be enough room for a roommate to get by the end of the bed in a specialty chair or motorized wheel chair. The Administrator noted Resident #61 did not have a roommate The Administrator stated there were very few residents in the facility that were bedbound or ambulatory, and previous roommates had issues sharing a room with Resident #61. The Administrator stated the facility would try to keep working with Resident #61. On 4/28/2017 at 3:00 PM, in an interview, the former roommate of Resident #61 was interviewed, and stated he never had any problems with Resident #61 and they had gotten along just fine. On 4/28/2017 at 6:30 PM, the bed in Resident #61's room had been repositioned in the way the Resident had requested.	F 242	Services and/or Administrator. This communication to resident and/or responsible party will take place during the admission process. Effective 5/25/2017, the Social Services Director and/or Activity Director will interview each resident and/or responsible party quarterly during the care plan process to ensure that resident choices and preferences of furniture placement and/or room arrangement are accommodated without compromising any safety needs of all residents. Any identified problems with furniture placement will be addressed by the director of social Services and/or Activity director promptly. Administrator conducted an education with the Admission Director, Director of Social services and the Activity director on 5/22/2017 on the new process of determining resident□s choices and preferences. This was to ensure that while resident□s choices related to furniture placement is accommodated, resident safety would not be compromised. Monitoring Process: Effective 5/25/17, the Director of Social Services, and/or Activity Director will monitor and interview newly admitted residents from previous business day (Monday-Friday) to ensure choices about aspects of resident□s life in the facility that are significant to the resident, like furniture placement in residents' room, are discussed during admission process. Any identified issues will be addressed promptly by the Activity Director and/or	

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F 242	Continued From page 10	F 242	Social Services Director. This monitoring process will take place daily (Monday thru Friday) for 4 weeks, weeks for 4 more weeks then monthly for three months or until the pattern of compliance is achieved. Effective 5/25/17, the Director of Social Services, and/or Activity Director will interview all active residents in the facility to determine satisfaction of furniture placement in their rooms. Findings of this monitoring process will be documented on Furniture Placement Tool. This monitoring process will take place for 100% of active residents for 1 month, 50% of active resident for another one month, and then 25% of active residents for another month or until a pattern of compliance is achieved. Results of the monitoring process mentioned above will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee by the Social Services Director monthly for 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	
F 272 SS=G	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	F 272		5/25/17

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 272	Continued From page 11 assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.	F 272		

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F 272	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to accurately assess a resident's skin status for 1 of 3 residents reviewed for Pressure Ulcers (Resident #65). Findings included: Record review revealed Resident #65 was admitted to the facility on 8/22/2012 with diagnoses which included Stage 3 Chronic Kidney Disease, Hypertension and Diabetes. The Care Plan was reviewed and noted as last updated on 12/6/2016. The Care Plan revealed a problem of a risk for Pressure Ulcers related to impaired mobility with a goal of no new areas of skin breakdown through the next review. Interventions included daily observation of skin with routine care, float heels on pillows at all times and monitor the eschar (a dry dark scab like area) on right heel and notify the doctor if any change noted. The Skin Inspection Report Assessments dated 2/22/2017 and 3/1/2017 completed by Unit Manager (UM) #1 indicated Resident #65's skin was intact. The Quarterly Minimum Data Set (MDS) dated 3/6/2017 indicated Resident #65 was cognitively intact and required the assistance of 1 person for all Activities of Daily Living (ADLs) and was incontinent of bowel and bladder. The MDS indicated Resident #65 was at risk for pressure ulcers and no pressure ulcers were present on assessment.	F 272	F272 Immediate Action Resident 65 is no longer a resident in the building. He was discharged on 3/27/2017. On 4/28/2017, the MDS nurse and Unit Manger #1 were in-serviced on the importance of documenting accurate findings related to alteration in skin integrity. UM #1 was also in-serviced related to recognition of deep tissue injury as a pressure ulcer by the Administrator. Identification of Others: 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing and unit manager. This audit focused on identification of alteration in skin integrity. Any changes in the overall skin condition of a resident was assessed thoroughly, reported to the physician and treatment orders received. The responsible parties were also notified of any alteration in skin integrity. 100% wound assessment were initiated on 5/15/2017 and completed on 5/20/2017, of all active residents that currently reside in the facility by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager. These assessments focused on identification of wound types, measurement and whether or not wounds were coded appropriately in section M of MDS assessment per RAI guidelines. Any negative finding of this audit was addressed appropriately by the	

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F 272	Continued From page 13 Review of the clinical record further revealed Resident #65 was admitted to the hospital on 3/27/2017 with a diagnosis of Sepsis (bacteria in the blood caused by an infection) secondary to Urinary Tract infection. Hospital records were reviewed and revealed Resident #65 was admitted to the hospital on 3/27/2017 with a diagnosis of Sepsis (bacteria in the bloodstream caused by an infection) secondary to a Urinary Tract Infection. A Skin Assessment note dated 3/27/2017 at 4:16 PM from the Emergency Department revealed Resident #65 had a fluid filled Deep Tissue Injury noted on the left heel which measured 4 centimeter in length by 6 centimeter in width. An interview was conducted on 4/27/2017 at 10:35 AM with the MDS nurse. The MDS nurse reported she assessed Resident #65 for his quarterly MDS assessment and observed a small purple, bruise-like area on his right heel. The MDS nurse stated the documentation in the Quarterly MDS dated 3/6/2017 was an "error oversight" and the heel area was not eschar as documented on the Care Plan. The MDS nurse reported the 3/6/2017 skin assessment was incorrect. An interview was conducted with UM #1 on 4/27/2017 at 2:30 PM. UM #1 stated she completed a full body assessment on Resident #65 for the Skin Inspection Report on 3/8/2017 and 3/15/2017 and documented the skin was intact. UM #1 stated she saw a small dark purple area on Resident's #65's heel on both dates but did not recall which heel. UM #1 further stated since the area was not open she did not consider	F 272	MDS nurse. 100% audit of all active residents most recent minimum data set (MDS) assessments were conducted by the facility□s MDS coordinator and MDS consultant, on 5/17/2017, 5/18/2017, 5/19/2017 and 5/20/2017, to ensure accurate coding of section M, per Resident Assessment Instrument (RAI) guidelines. Any identified issues were addressed at time of discovery. Systemic Changes: Effective 5/25/2017, the Director of Nursing revised the skin assessment schedule utilized in the facility. The resident□s' weekly skin assessments schedule will show residents□ assessments due between the days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration Monday-Friday. Any identified skin integrity issues (pressure ulcers including deep tissue injuries {DTI}) discovered during skin assessments will be reported daily Monday-Friday in the morning clinical meeting. The MDS nurse will attend the daily morning meeting and ensure accurate coding of MDS per RAI guidelines of any reported skin integrity issues. Effective 5/25/17, the MDS nurse will enter documentation related to the pressure area including DTI based on observation and communication with other licensed and non-licensed staff members. The MDS nurse will update the resident□s' care plan related to skin	

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F 272	Continued From page 14 it a problem and did not document it or report the area. UM #1 could not recall if Resident #65's heels were floated or if he wore a heel protector to the right foot. On 4/27/2017 at 4:15 PM an interview was conducted with the Administrator. The Administrator stated the facility expectation was the MDS assessments to be completed thoroughly and all of the MDS information to be accurate.	F 272	alterations and any preventive measures or assistance devices, such as heel protectors, skin barrier cream, low air loss mattress or other positioning devices. Effective 5/25/2017, the Certified Nursing Assistants (CNA) will be responsible for inspection and documentation of any identified skin issues on shower/bath sheets, report findings to the charge nurse and document such findings on the shower/bath sheet. Monitoring Effective 5/25/2017 the DON will monitor the daily shower/bath sheets and report any pressure area including DTI to the MDS nurse and/or wound nurse during daily clinical meeting. The charge nurse of each unit will monitor shower/bath sheets on Saturday and Sunday and report any alteration of skin integrity to the DON. The DON will assure that the weekend charge nurses obtains an appropriate order and the care plan is updated by the charge nurse on each unit to accurately reflect the identified skin integrity alteration. This monitoring process will take place daily x 2 weeks, then weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained The DON will compile data obtained from the daily shower/bath sheets and reconcile her findings with the care plan, daily (Monday-Friday) during the morning meeting. The DON, wound nurse, and/or Assistant Director of Nursing will audit the MDS weekly to assure that residents with identified alteration in skin integrity (pressure ulcers, DTI) are accurately	

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F 272	Continued From page 15	F 272	coded in the MDS system. This monitoring process will take place daily x 2 weeks, then weekly x 4 weeks then monthly x 3 months or until a pattern of compliance is achieved. Effective 5/25/2107, this practice will occur daily for 4 weeks, weekly for 4 weeks and monthly for 3 months. The DON, ADON and/or charge nurse will report findings from shower/bath sheets, care plans and MDS monthly during the Quality Assurance Performance Improvement Committee for additional monitoring needs or modifications of this requirement. Any negative finding will be addressed promptly.	
F 278 SS=G	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	F 278		5/25/17

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F 278	Continued From page 16 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 staff interviews and record review, the facility failed to accurately code section M (skin conditions) of the Minimum Data Set (MDS) assessment to reflect a deep tissue injury (DTI) on the resident's heel which resulted in lack of treatment and progression in the size of the wound for 1 of 3 residents reviewed for Pressure Ulcers (Resident #65). Findings included: Record review revealed Resident #65 was admitted to the facility on 8/22/2012 with diagnoses which included Stage 3 Chronic Kidney Disease, Hypertension and Diabetes. The Care Plan last updated on 12/6/2016 was reviewed. The Care Plan revealed a problem of a risk for Pressure Ulcers related to impaired mobility with a goal of no new areas of skin breakdown through the next review. The Quarterly Minimum Data Set (MDS) dated	F 278	F278 Immediate Action Resident 65 is no longer a resident in the building. He was discharged on 3/27/2017. On 4/28/2017, the MDS nurse and Unit Manger #1 were in-serviced on the importance of documenting accurate findings related to alteration in skin integrity. UM #1 was also in-serviced related to recognition of deep tissue injury as a pressure ulcer by the Administrator. Identification of Others: 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing and unit manager. This audit focused on identification of alteration in skin integrity. Any changes in the overall skin condition of a resident was assessed thoroughly, reported to the physician and treatment orders received. The	

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F 278	Continued From page 17 3/6/2017 indicated Resident #65 was cognitively intact and required the assistance of 1 person for all Activities of Daily Living (ADLs) and was incontinent of bowel and bladder. The MDS indicated Resident #65 was at risk for pressure ulcers and no pressure ulcers were present on assessment. The Skin Inspection Report Assessments dated 3/8/2017 and 3/15/2017 completed by Unit Manager (UM) #1 indicated Resident #65's skin was intact. Review of the clinical record further revealed Resident #65 was admitted to the hospital on 3/27/2017 with a diagnosis of Sepsis (bacteria in the blood caused by an infection) secondary to Urinary Tract infection. Hospital Emergency Department records were reviewed and revealed Resident #65 was admitted to the hospital on 3/27/2017 with a diagnosis of Sepsis (bacteria in the bloodstream caused by an infection) secondary to a Urinary Tract Infection. A Skin Assessment note dated 3/27/2017 at 4:16 PM from the Emergency Department revealed Resident #65 had a fluid filled Deep Tissue Injury (DTI) noted on the left heel which measured 4 centimeters in length by 6 centimeters in width. An interview was conducted on 4/27/2017 at 10:35 AM with the MDS nurse. The MDS nurse reported she assessed Resident #65 on 3/6/2017 for the quarterly MDS assessment. The MDS nurse stated she completed a skin assessment on Resident #65 on 3/6/2017 and observed a small purple, bruise-like area on his heel. The MDS nurse stated the documentation of the skin assessment she entered in the Quarterly MDS	F 278	responsible parties were also notified of any alteration in skin integrity. 100% wound assessment were initiated on 5/15/2017 and completed on 5/20/2017, of all active residents that currently reside in the facility by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager. These assessments focused on identification of wound types, measurement and whether or not wounds were coded appropriately in section M of MDS assessment per RAI guidelines. Any negative finding of this audit was addressed appropriately by the MDS nurse. 100% audit of all active residents most recent minimum data set (MDS) assessments were conducted by the facility□s MDS coordinator and MDS consultant, on 5/17/2017, 5/18/2017, 5/19/2017 and 5/20/2017, to ensure accurate coding of section M, per Resident Assessment Instrument (RAI) guidelines. Any identified issues were addressed at time of discovery. Systemic Changes: Effective 5/25/2017, the Director of Nursing revised the skin assessment schedule utilized in the facility. The resident□s weekly skin assessments schedule will show residents□ assessments due between the days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration Monday-Friday. Any identified skin integrity issues (pressure ulcers including deep tissue injuries {DTI}) discovered during skin	

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F 278	Continued From page 18 dated 3/6/2017 was not accurate. The MDS Nurse further reported Resident #65 had an identified suspected DTI on the heel during the 3/6/2017 physical assessment for the Quarterly MDS assessment which she failed to document. The MDS nurse reported the 3/6/2017 skin assessment information was inaccurate as she did not indicate Resident #65 was observed to have a suspected DTI on 3/6/2017. The MDS nurse did not give an explanation for the inaccuracy. An interview was conducted with UM #1 on 4/27/2017 at 2:30 PM. UM #1 stated she completed a full body assessment on Resident #65 for the Skin Inspection Report on 3/8/2017 and 3/15/2017 and documented the skin was intact. UM #1 stated she saw a small dark purple area on Resident's #65's heel on both dates but did not recall which heel. UM #1 further stated since the area was not open she did not consider it a problem and did not document it or report the area. On 4/27/2017 at 4:15 PM an interview was conducted with the Administrator. The Administrator stated the facility expectation was the MDS assessments to be completed thoroughly and all of the MDS information to be accurate.	F 278	assessments will be reported daily Monday-Friday in the morning clinical meeting. The MDS nurse will attend the daily morning meeting and ensure accurate coding of MDS per RAI guidelines of any reported skin integrity issues. Effective 5/25/17, the MDS nurse will enter documentation related to the pressure area including DTI based on observation and communication with other licensed and non-licensed staff members. The MDS nurse will update the resident□s care plan related to skin alterations and any preventive measures or assistance devices, such as heel protectors, skin barrier cream, low air loss mattress or other positioning devices. Effective 5/25/2017, the Certified Nursing Assistants (CNA) will be responsible for inspection and documentation of any identified skin issues on shower/bath sheets, report findings to the charge nurse and document such findings on the shower/bath sheet. Monitoring Effective 5/25/2017 the DON will monitor the daily shower/bath sheets and report any pressure area including DTI to the MDS nurse and/or wound nurse during daily clinical meeting. The charge nurse of each unit will monitor shower/bath sheets on Saturday and Sunday and report any alteration of skin integrity to the DON. The DON will assure that the weekend charge nurse obtains an appropriate order and the care plan is updated by the charge nurse on each unit to accurately reflect	

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F 278	Continued From page 19	F 278	the identified skin integrity alteration. This monitoring process will take place daily x 2 weeks, then weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained The DON will compile data obtained from the daily shower/bath sheets and reconcile her findings with the care plan, daily (Monday-Friday) during the morning meeting. The DON, wound nurse, and/or Assistant Director of Nursing will audit the MDS weekly to assure that residents with identified alteration in skin integrity (pressure ulcers, DTI) are accurately coded in the MDS system. This monitoring process will take place daily x 2 weeks, then weekly x 4 weeks then monthly x 3 months or until a pattern of compliance is achieved. Effective 5/25/2107, this practice will occur daily for 4 weeks, weekly for 4 weeks and monthly for 3 months. The DON, ADON and/or charge nurse will report findings from shower/bath sheets, care plans and MDS monthly during the Quality Assurance Performance Improvement Committee for additional monitoring needs or modifications of this requirement. Any negative finding will be addressed promptly.	
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	F 312		5/25/17

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F 312	Continued From page 20 by: Based on observation, staff interviews and record review, the facility failed to provide oral care for a resident unable to do oral care for themselves (Resident #46) out of 35 residents reviewed for oral status. Findings included: A review of the medical record revealed Resident #46 was admitted 12/30/2016 with diagnoses of wound infection, brain injury and hemiplegia (paralysis on one side of the body). The care plan, dated 1/16/2017, noted a focus of Resident #46 required assistance for all Activities of Daily Living (ADLs), and a goal of increased independence would be achieved. Interventions included: Occupational Therapy will work with the resident on ADL re-training. Give resident verbal cues to help prompt resident. Break tasks into smaller steps. Allow rest breaks between tasks. One person to assist resident with bathing. The Quarterly Minimum Data Set (MDS) dated 3/27/2017 noted Resident #46 was severely impaired for cognition and needed extensive to total assistance for all ADLs with the physical assistance of one to two persons. The range of motion in the MDS indicated Resident #46 as having impairment on both sides of the upper and lower extremities. Resident #46 was observed on 4/25/2017 at 11:30 AM, with a white slimy appearing substance on her teeth. Resident #46 did not respond when asked if staff cleaned her teeth. An observation was made on 4/27/2017 at 10:30 AM of Resident #46 having a light colored, slimy	F 312	F312 Immediate Action: Resident #46 was provided with oral care on 4/28/2017, oral care supplies were placed at the bedside. Identification of Others: 100% audit of all active residents in the facility completed by the Director of nursing, Assistant Director of nursing and/or unit manager on 5/1/2017 to determine if any other resident who is unable to carry out activities of daily living receives the necessary services to maintain good oral care is identified as affected by this alleged noncompliance. No other resident identified as being affected. On 5/1/2017, 100% of residents who were unable to do their own oral care, mouth care was completed by certified nursing aides. Systemic Changes: Effective 5/25/2017, certified nursing aide will complete oral care for all assigned residents unable to carry out activities of daily living, daily during morning care. Any refusal of oral care will be reported to the nurse in charge timely. Effective 5/25/17 certified nursing assistants will document completion of oral care in resident□s clinical records as rendered routinely. 100% of nursing staff, to include licensed nurses and certified nursing assistants were in-serviced on the importance of completing oral care on daily basis for resident who are unable to do it on their own. This education also emphasized the	

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F 312	Continued From page 21 appearing substance on her teeth. Resident #46 appeared to be clean and neatly dressed and her hair was combed and neat. On 4/28/2017 at 10:00 AM, an observation was made of ADL care for Resident #46. The Nursing Assistant (NA) #1, gave Resident #46 a bed bath and completed catheter care. NA #1 finished this care and stated she was finished. When asked about oral care, NA #1 stated "I didn't know you wanted to see everything." NA #1 went to Resident #46's bedside table, opened the drawer and there was no toothbrush, toothpaste or oral swabs sometimes used for oral care. An interview, on 4/28/2017 at 11:20 AM, with NA #3 who also worked on Resident #46's hall, stated ADL care consisted of a bath, hair and oral care and nail care. On 4/28/2017 at 11:25 AM, the Director of Nursing (DON) was interviewed and stated her expectation for ADL care was a complete bath and oral care and anything else the resident desired, such as being shaved.	F 312	importance of communicating with the charge nurses if a resident refuse oral care. The education was provided by the, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator. The education was initiated on 4/28/17 for all nursing staff to include, full time, part time and as needed employees. This education will be completed by 5/25/17, any nursing staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing staff effective 5/25/17 and also will be provided annually. Monitoring Process: Effective 5/25/2017, the charge nurses will monitor compliance to assure the assistance for the activity of daily living is being provided to each resident as needed. The charge nurse will sign off, daily, on the assignment sheet when mouth care is completed. Any identified issues related to oral care will be corrected promptly. This monitoring process will take place daily for 4 weeks, weekly for 4 more weeks, then monthly for 3 months, or until the pattern of compliance is maintained. Effective 5/25/2017, the Director of Nursing, Assistant Director of Nursing and/or unit managers will monitor oral care supplies at the resident□s bedside daily for 2 weeks, weekly for 4 weeks, then monthly for three months or until a pattern of compliance is achieved. Effective 5/25/2017, the Director of	

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F 312	Continued From page 22	F 312	Nursing, Assistant Director of Nursing and/or unit managers will monitor 5 randomly selected residents from different assignments to assure oral care is being provided. This monitoring process will take place daily for 4 weeks, then weekly for 4 weeks, then monthly for 3 months or until the pattern of compliance is maintained. Results of the monitoring process mentioned above will be reported to the facility Quality Assurance Performance Improvement Committee by the Director of Nursing and/or Assistant Director of Nursing monthly x 6 months. The QAPI Committee will recommend any additional monitoring needed or modification of these plans as the committee deems appropriate.	
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314		5/25/17

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F 314	Continued From page 23 from developing. This REQUIREMENT is not met as evidenced by: Based on record review and responsible party and staff interviews, the facility failed to provide a comprehensive wound assessment, initiate treatment and monitor a newly identified Suspected Deep Tissue Injury (DTI) to the left heel resulting in worsening of the DTI. The facility also failed to assess a wound caused by shearing and delayed treatment for 2 days after the wound was discovered and failed to thoroughly complete a skin assessment for 1 of 3 residents reviewed for pressure ulcers (Resident #65). Findings included: Record review revealed Resident #65 was admitted to the facility on 8/22/2012 with diagnoses which included Stage 3 Chronic Kidney Disease, Hypertension and Diabetes. A review of the Care Area Assessment (CAA) for Pressure Ulcer dated 6/10/2016 noted Resident #65 required extensive assistance for bed mobility and spent time up in his wheelchair almost daily which put Resident #65 at an increased risk for Pressure Ulcers. The Care Plan was reviewed and noted as last updated on 12/6/2016. The Care Plan revealed a problem of a risk for Pressure Ulcers related to impaired mobility with the goals listed as no areas of skin breakdown through the next review. Interventions included daily observation of skin with routine care, float heels on pillows at all times and monitor the eschar (a dry dark scab like area) on right heel and notify the doctor if any change noted. The most recent Minimum Data Set (MDS) dated 3/6/2017 indicated Resident #65 was cognitively	F 314	F314: Immediate Action: Resident 65 is no longer a resident in the building. He was discharged on 3/27/2017. Identification of others: 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing and unit manager. This audit focused on identification of alteration in skin integrity. Any changes in the overall skin condition of a resident was assessed thoroughly, reported to the physician and treatment orders received. The responsible parties were also notified of any noted alteration in skin integrity. 100% wound assessment was initiated on, 5/15/2017 and completed on 5/20/2017, for all residents with wounds who reside in the facility by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager. These assessments focused on identification of wound types, measurement and whether or not wound treatment were initiated within 24 hours of wound discovery. Any negative finding of this audit was addressed appropriately by the nursing management team. 100% audit of all active resident□s treatment administration records (TAR), and medication administration records (MAR) was completed by Medical Records Clerk on 5/17/17, 5/18/17 and 5/19/17 to identify any other resident that	

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intact and required the assistance of 1 person for all Activities of Daily Living (ADLs) and was incontinent of bowel and bladder. The MDS indicated Resident #65 was at risk for pressure ulcers and no pressure ulcers were present on assessment.

a) Nursing notes were reviewed from 1/1/2017 through 3/27/2017 with no entries which reported skin issues with Resident #65's heels.
The Physician Orders for March 2017 were reviewed and revealed an order to float heels on pillows at all times and to wear pressure relieving heel protector on right foot at all times. The Medication Administration Record (MAR) for March 2017 included entries for Resident #65 to wear pressure relieving heel protector to right heel at all times with blocks for the 7 AM-3 PM, 3 PM-11 PM and 11 PM-7 AM nurse to initial. There were 10 shifts from 3/1/2017 to 3/26/2017 without initials. The MAR also revealed Resident #65 was to float heels on pillows at all times with blocks for the nurse on each shift to initial. Five of those shifts were without initials from 3/1/2017 to 3/26/2017.

The Skin Inspection Report Assessments dated 3/8/2017 and 3/15/2017 completed by Unit Manager (UM) #1 indicated Resident #65's skin was intact.
A Physician's Order dated 3/27/2017 to send Resident #65 to the Emergency Department (ED) to be evaluated for increased temperature and altered mental status was noted in the medical record.
Hospital records were reviewed and revealed Resident #65 was admitted to the hospital with a diagnosis of Sepsis (bacteria in the bloodstream caused by an infection). A Skin Assessment note

may have been effected by this alleged deficient practice. Any negative finding of this audit was addressed appropriately by the nursing management team.
Systemic Changes:
The facility will institute the following measures to ensure that this alleged deficient practice will not recur;
Effective 5/25/2017, the Director of Nursing will revised the skin assessment schedule utilized in facility. Resident□s weekly skin assessments schedule will show resident assessments due between the days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration Monday-Friday. Any identified skin integrity issues (pressure ulcers, deep tissue injuries {DTI}) discovered during skin assessments will be reported daily Monday thru Friday in the morning clinical meeting. The MDS nurse will attend the daily morning meeting and ensure accurate coding of MDS per RAI guidelines of any reported skin integrity issues.
Effective 5/25/2017, a designated licensed wound nurse will oversee the wound program in the facility. The wound nurse will be responsible for identification and staging of wounds and ensure that appropriate treatments are initiated per physician□s orders. The licensed wound nurse will also ensure that each resident attending Physician and responsible party is made aware of resident□s wounds.
Effective 5/25/2017, Certified Nursing Assistants will be responsible for

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F 314	Continued From page 25 dated 3/27/2017 at 4:16 PM from the ED revealed Resident #65 had a fluid filled DTI noted on the left heel which measured 4 centimeter in length by 6 centimeter in width. A telephone interview was conducted with the Responsible Party (RP) of Resident #65 on 4/26/2017 at 2:12 PM. The RP was present during the resident's ED visit on 3/27/2017. The RP reported Resident #65's heel had a dark purple bloody looking area and there was an area on his sacrum that was open. The RP reported she visited Resident #65 often and did not recall his heels being floated and did not recall the resident had heel protectors. An interview was conducted on 4/27/2017 at 9:25 AM with Nursing Assistant (NA) #2. NA #2 reported Resident #65 was on the assignment she worked daily. NA #2 stated she was unaware of any skin problems on Resident #65's heels. NA #2 stated she applied socks to Resident #65's feet daily after a bath. NA #2 reported the resident's heels were floated sometimes and did not recall if a heel protector was applied to the right foot daily. NA #2 also reported she worked with Resident #65 on 3/26/17 and did not recall any issues with his heels when he was bathed. NA #2 indicated Resident #65 was discharged to the hospital prior to her day shift on 3/27/2017. The NA on duty for the night shift when Resident #65 was transported to the hospital no longer worked at the facility and was unavailable for interview. An interview was conducted with the MDS nurse on 4/27/2017 at 10:35 AM. The MDS nurse reported she completed an assessment on Resident #65 on 3/6/2017 for the quarterly review	F 314	inspection and documentation of any identified skin issues on the shower/bath sheets, report findings to the charge nurse and document such findings on the shower sheet. Effective 5/25/2017, during shift change incoming and off going nurses will review treatment administration records (TAR) in electronic health records by checking my unsigned records tab. This tab will list all residents with treatment orders noted as not signed off as rendered. The incoming nurse will not accept responsibility for resident care until those records are rectified and treatment rendered per orders. Effective 5/25/2017, the Director of Nursing implemented Resident Care Cards as a communication tool to alert nurse□s aides of any skin protectant intervention for residents with pressure ulcers or with risk for developing pressure ulcers. 100% of nursing staff, to include licensed nurses and certified nursing assistants were in-serviced on the importance of completing weekly skin assessments per schedule, to ensure that alteration of skin integrity is documented, communicated to the physician and responsible party and that appropriate orders are received and rendered. The training also included the use of care cards as a communication tool. The licensed nurses were in-serviced on the use of the Care Cards and initiation of cards with new admissions and revision with treatment changes. The certified nursing assistants were informed on where the cards are located and how to	

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F 314	Continued From page 26 and discovered a small dark purple area to his heel. The MDS nurse stated she thought it was the right heel but was unable to recall. The MDS nurse stated it was not eschar as indicated on the Care Plan and the information she added to the Care Plan was an "error oversight". The MDS nurse said she informed the nurse on duty during day shift on 3/6/2017 of the area observed on Resident #65's heel but could not recall the nurse. The MDS nurse further stated the resident was in a wheelchair almost daily and recalled times the resident's heels were not floated and the heel protector not applied. An interview was conducted with Nurse #4 on 4/27/2017 at 11:45 AM. Nurse #4 stated she was the nurse on duty on the day shift on 3/6/2017. Nurse #4 stated no recollection no recollection of any skin issues reported by the MDS nurse. Nurse #4 reported being unaware of any issues with pressure areas on Resident #65's heels. Nurse #4 reported she thought the resident's heels were floated and recalled the resident wearing heel protectors at times. An interview was conducted with Unit Manager (UM) #1 on 4/27/2017 at 2:30 PM. UM #1 stated she completed a full body assessment on Resident #65 for the Skin Inspection Report on 3/8/2017 and 3/15/2017 and documented the skin was intact. UM #1 stated she saw a small dark purple area on Resident's #65's heel on both dates but did not recall which heel. UM #1 further stated since the area was not open she did not consider it a problem and did not document it or report the area. UM #1 could not recall if Resident #65's heels were floated or if he wore a heel protector to the right foot.	F 314	use the cards. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiated on 4/28/17 for all nursing staff to include, full time, part time and as needed employees. This education will be completed by 5/25/17, any nursing staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing staff effective 5/25/17 and also will be provided annually. Monitoring Process: Effective 5/25/17, DON, ADON and/or Unit Manager will review the completion of the prior day weekly skin assessment on daily clinical meeting (M-F) for the next 30 days then weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented to the Quality Assurance and Performance Improvement committee monthly x 3 months for any additional monitoring needs or modification of this plan by the DON. Any negative findings noted will be addressed promptly. Effective 5/25/2017, the resident Care Cards will be reviewed by the DON, ADON or MDS nurse daily (Monday-Friday), and by the charge nurse (Saturday and Sunday), to assure that it is available and accurate. This review will take place daily (Monday-Friday) for 4 weeks then weekly for 4 weeks, then monthly for 3 months. Any negative findings noted will be addressed by the DON, ADON and/or MDS nurse. Results	

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F 314	Continued From page 27 An interview was conducted with the facility Administrator (Adm) on 4/27/2017 at 4:15 PM. The Adm stated the facility followed the Pressure Ulcer Prediction, Prevention and Treatment Pathway provided by a healthcare consulting firm. A copy was reviewed and indicated a head to toe skin assessment was to be conducted weekly and any changes in the overall skin condition of a resident was to be assessed thoroughly, reported to the Physician, treatment obtained and family notified. The Adm also provided documentation of Common Wound Treatment Modalities and stated the facility followed the Treatment Modalities for wounds. The Modalities contained descriptions of wounds, treatments and frequency of treatments. The Modalities included a Suspected Deep Tissue Injury and listed the description as a purple or maroon localized area of discolored intact or blood filled blister. The recommended treatment was listed as pressure relief or hydrocolloid dressing (a non-breathable transparent wound dressing). The treatment also included to monitor the area daily for worsening condition or drainage. The Adm stated the facility expectation was the pathway would be followed as well as the treatment modalities. The Adm indicated the treatment modality for a Suspected Deep Tissue Injury specified the area should be monitored daily for changes. The Adm further stated the expectation was for all skin issues to be identified on the weekly body assessments and to be classified accurately and reported to the Physician immediately for treatment orders. b) Review of the nursing notes revealed a note dated 3/20/2017 at 2:05 AM written by Nurse #5 which indicated a quarter sized open area was noted on the right buttock of Resident #65. The note reported barrier cream was applied and the	F 314	of these audits will be presented to the Quality Assurance and Performance Improvement committee monthly x 3 months for any additional monitoring needs or modification of this plan by the DON. Effective 5/25/2107, the DON, ADON, Medical Records Clerk and/or MDS nurse will audit all new admissions Care Cards from the previous day (Monday-Friday). The weekend charge nurses will audit new admits on Saturday and Sunday. This audit will be completed daily for 4 weeks, weekly for 4 weeks, then monthly for 3 months, or until a pattern of compliance is maintained. DON will report findings to facility QAPI Committee for additional monitoring needs or modifications of this requirement.	

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area would be reported to the oncoming nurse.
Further review revealed a nursing note dated 3/22/2017 at 1:53 PM signed by Unit Manager (UM) #1 revealed UM #1 was notified of an open area to Resident #65's right buttock by Nursing Assistant (NA) #2. The note indicated barrier cream was applied, the Physician was notified and no new orders were given.
A review of the Treatment Administration Record for March 2017 revealed an order for Barrier cream to be applied to buttocks every shift by Nursing Assistant. The order was documented on 3/22/2017.
A review of the Skin Inspection Report for 3/22/2017 revealed the skin status of Resident #65 was not intact. The information was entered by UM #2.

A Physician's Order dated 3/27/2017 to send Resident #65 to the Emergency Department (ED) to be evaluated for increased temperature and altered mental status was noted in the medical record.
A Skin Assessment note dated 3/27/2017 at 4:16 PM from the Emergency Department revealed Resident #65 had a Stage 3 pressure ulcer on the sacrum which measured 1 centimeter in length by 1 centimeter in width and several small areas on the right buttocks which appeared to be from shearing.

An interview was conducted on 4/27/2017 at 9:25 AM with NA #2. NA #2 reported Resident #65 was on the assignment she worked daily. NA #2 stated she discovered the open area to Resident #65's lower right buttock during bathing on the morning of 3/22/2107. NA #2 reported it was quarter sized and looked like the skin was just scraped off a little. NA #2 stated she covered the

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resident and immediately reported to the Nurse #4 who was the hall nurse on that day. NA #2 said she was instructed to cover the area with barrier cream. NA #2 stated she covered the area with barrier cream every day after that until the resident went to the hospital. NA #2 also stated she worked with Resident #65 the day before he was admitted to the hospital and recalled the area was still there and looked the same.

A telephone interview was conducted with Nurse #5 on 4/27/2016 at 11:10 AM. Nurse #5 indicated she recalled the NA reporting Resident #65 had an area on the lower right buttock and also recalled assessing the area. Nurse #5 stated the area was small and open and looked like it was just the top layer of skin so she applied barrier cream. Nurse #5 stated if a small skin area is noted during the night shift, she will report it to the oncoming nurse to follow up with the Physician and the family. Nurse #5 could not recall if she included the skin area in report with the oncoming nurse and stated sometimes if it was a really busy night she may have forgotten if she did not write it down.

An interview was conducted with Nurse #4 on 4/27/2017 at 11:45 AM. Nurse #4 stated she was the nurse for the day shift on 3/20/2017 for Resident #65. Nurse #4 reported there was no mention of any skin issues for Resident #65 from the night nurse. Nurse #4 stated she was made aware of an area to Resident #65's buttocks on the morning of 3/22/2017 and reported it to UM #1 as soon as it was reported. Nurse #4 stated UM #1 assessed the wound and wrote the order to apply barrier cream every shift.

An interview was conducted with UM #1 on

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4/27/2017 at 2:30 PM. UM #1 stated she recalled being informed of the wound on Resident #65's buttocks. UM #1 further stated the wound was assessed and was a small open area which was superficial with no depth and was pink. UM #1 also stated the wound was not measured but it was about quarter sized. UM #1 recalled the Physician was notified and agreed with the barrier cream for treatment. UM #1 indicated all new wounds were assessed by the Wound Physician every Tuesday and Resident #65 was on the list for the Wound Physician on 3/28/2017 but Resident #65 was admitted to the hospital on 3/27/2017.

An interview was conducted with UM #2 on 4/27/2017 at 3:00 PM. UM #2 stated she assessed the wound on 3/22/2017 and it was a quarter sized open area to the right buttocks with no drainage and appeared pinkish red with no drainage. UM #2 further stated she only assessed the lower right buttocks of Resident #65. UM #2 said she completed the documentation in the Skin Inspection Report but did not measure the wound. UM #2 also stated Resident #65 was on the Wound Physician list for 3/28/2017 but discharged to the hospital on 3/27/2017.

An interview was conducted with the facility Administrator (Adm) on 4/27/2017 at 4:15 PM. The Adm stated the facility followed the Pressure Ulcer Prediction, Prevention and Treatment Pathway provided by a healthcare consulting firm. A copy was reviewed and indicated a head to toe skin assessment was to be conducted weekly and any changes in the overall skin condition of a resident was to be assessed thoroughly, reported to the Physician, treatment obtained and family notified. The Adm also provided documentation

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F 314	Continued From page 31 of Common Wound Treatment Modalities and stated the facility followed the Treatment Modalities for wounds. The Modalities contained descriptions of wounds, treatments and frequency of treatments. The Modalities included description of a Stage 2 wound as a partial thickness loss of dermis (second layer of skin) with a red, pink wound bed with the treatment listed as polyurethane film dressing to be changed every 3-7 days and as needed. The Adm stated the facility expectation was the pathway would be followed as well as the treatment modalities. The Adm further stated the expectation was for all skin issues to be identified on the weekly body assessments and to be classified accurately and reported to the Physician immediately for treatment orders.	F 314		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F 371		5/25/17

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F 371	Continued From page 32 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 observation and staff interview the facility failed to remove 7 cans of expired supplements from 1 of 3 of medication rooms (500 Hall medication room). Findings included: On 4/28/207 at 12:24 PM an observation was made of the 500 hall medication room located behind the 500 hall nurses station. Nurse #8 was present during the observation. Seven cans of nutritional supplement were observed on a table beside the refrigerator. Each can held 237 milliliters of liquid supplement. There were 2 cans of chocolate supplement with the expiration date of 1/17/2017 and 5 cans of vanilla supplement with the expiration date of 2/2/2017. An interview was conducted with Nurse #8 during the Medication room observation. Nurse #8 reported the cans of supplement were used for the residents on the hall and were kept in the med room for staff convenience. Nurse #8 stated she was unaware the supplements were expired. Nurse #8 also stated she was unsure who was responsible for checking the supplements for expiration dates. An interview was conducted with the Administrator on 3/28/2017 at 2:30 PM. The Administrator stated the facility expectation was	F 371	F371 Immediate Action: On 4/28/2017, 5 cans of vanilla supplement dated 2/2/2017 and 2 cans of chocolate supplement dated 1/17/2017 were discarded by the licensed nurse #8. Identification of Others: 100% audit of completed by the Central Supply Clerk to identify any other expired item. No other expired supplements were identified. 100% audit of all food storage areas inspected by dietary Manager and/or Central Supply Clerk on 5/5/2017 to identify any other open item that is noted to be expired. This audit covered all supplements located in the medication rooms, storage rooms, and food pantries (100/200 Halls; 300/400 Halls and 500 Hall). No other expired items identified. Systemic Changes Effective 5/25/2017, Central supplies clerk will ensure all supplement placed in circulation, in the medication rooms, storage rooms and/or pantries are not expired. Central supply Clerk will verify expiration dates upon receipt of the supplies, and before placing supplements in circulation. Effective 5/25/2017, Central supplies will	

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F 371	Continued From page 33 for all expired supplements to be discarded prior to expiration dates to prohibit resident consumption.	F 371	rotate all supplements places on the medication rooms, storage rooms and/or Pantries. This will ensure the oldest supplies will be used first. Effective 5/25/2017, a tickler system will be used to identify supplements nearing its expiration date. Red will designate expiration within the next 2 weeks, yellow will designate expiration within the next month and green will designate expiration in the coming year. Monitoring Process Effective 5/25/2017, the Central Supply Clerk, Dietary Manager, and/or designated licensed nurse, will monitor compliance with proper food storage in all food storage locations, to include but not limited to location of resident supplements such as medication rooms, resident pantries and/or storage rooms. This monitoring process will assure no expired item is noted in the storage areas. The monitoring process will be conducted daily for 2 weeks, then weekly for 4 weeks then monthly for 3 months or until the pattern of compliance id achieved. Effective 5/25/2017, the Dietary Manager and/or Central Supplies Clerk will report findings of this monitoring process to the facility□s Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement monthly x 6 months, Effective 5/25/2017, the central supply clerk will conduct weekly audits of the supplements in the medications rooms,	

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F 371	Continued From page 34	F 371	storage rooms and pantries to ensure supplements are rotated and no expired supplement is noted. This monitoring system will also ensure a tickler system is used appropriately to identify supplements nearing its expiration date. Any negative finding will be addressed promptly. This monitoring process will be completed daily for 2 weeks, weekly for 4 weeks and then monthly for 3 months or until the pattern of compliance is maintained. Effective 5/25/17, results of the monitoring process mentioned above will be reported to the facility Quality Assurance Performance Improvement Committee by Dietary Manager and/or Central Supplies Clerk monthly for 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		5/25/17

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F 520	Continued From page 35 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 staff and family interviews and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place for pressure sores (tag F314) following the annual recertification survey of 08/13/2015, the complaint investigation of 04/15/2016, the annual recertification survey of 06/09/2016 and the current recertification survey of 04/24/2017. Also the facility failed to maintain implemented procedures and monitor the interventions put into	F 520	F520 Immediate Action: Resident 65 is no longer a resident in the building. He was discharged on 3/27/2017 Identification of Others: All residents that resides at the facility has a potential to be affected by this alleged deficient practice. On 4/28/2017, the MDS nurse and Unit Manger #1 were in-serviced on the importance of documenting accurate findings related to alteration in skin	

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F 520	Continued From page 36 place for notification of the responsible party and physician (tag 157) during the annual recertification survey of 06/09/2016 and the current recertification survey of 04/24/2017. The re-citation of F314 and F157 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross-referenced to: 1. F314 Pressure Ulcers: Based on record review and staff interviews, the facility failed to provide a comprehensive wound assessment, initiate treatment and monitor a newly identified Suspected Deep Tissue Injury (DTI) to the left heel resulting in worsening of the DTI. The facility also failed to assess a wound caused by shearing and delayed treatment for 2 days after the wound was discovered and failed to thoroughly complete a skin assessment for 1 or 3 residents reviewed for pressure ulcers (Resident #65). Review of the facility's survey history revealed F314 was cited during the facility's 08/13/2015 annual recertification survey, during a 04/15/2016 complaint investigation, during the 06/09/2016 annual recertification survey and was re-cited during the current 04/24/2017 annual recertification/ complaint survey. 2. F157 Notify of Changes: Based on record review and staff and family interviews, the facility failed to notify the Responsible Party of two newly identified wounds and failed to notify the Physician of one newly identified wound for 1 of 3 residents reviewed for notification of condition	F 520	integrity. UM #1 was also in-serviced related to recognition of deep tissue injury as a pressure ulcer by the Administrator. 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing and unit manager. This audit focused on identification of alteration in skin integrity. Any changes in the overall skin condition of a resident was assessed thoroughly, reported to the physician and treatment orders received. The responsible parties were also notified of any noted alteration in skin integrity. 100% wound assessment was initiated on, 5/15/2017 and completed on 5/20/2017 of all active residents with wounds that currently reside in the facility by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager. These assessments focused on identification of wound types, measurement and whether or not wound treatment were initiated within 24 hours of wound discovery. Any negative finding of this audit was addressed appropriately by the nursing management team. 100% audit of all active resident□s treatment administration records (TAR), and medication administration records (MAR) was completed by Medical Records Clerk on 5/17/17, 5/18/17 and 5/19/17 to identify any other resident that may have been effected by this alleged deficient practice. Any negative finding of this audit was addressed appropriately by the nursing management team. 100% audit of all active resident□s medical records to include clinical	

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F 520	Continued From page 37 change (Resident #65). Review of the facility's survey history revealed F157 was cited during the facility's 06/09/2016 annual recertification survey and re-cited during the current 04/24/2017 annual recertification/complaint survey. In an interview on 04/28/2017 at 05:13 pm, the Administrator acknowledged understanding of the reciting of F314 and F157 during the recertification/complaint survey of 04/24/2017.	F 520	documentation, physician orders and/or resident□s assessments completed, started on 4/28/17 and completed on 5/20/2017 by the Administrator, Director of Nursing and/or Medical Record Clerk ensure that notification of change was done appropriately for all other residents. Any condition that warranted notification to resident□s responsible party and or the attending physician was corrected upon discovery promptly by the charge nurses or director of nursing. 100% skin audit was initiated on 5/15/2017 and completed on 5/20/2017, by Director of Nursing, Assistant Director of Nursing, and charge nurse. This audit focus on identification of any skin alteration and whether or not resident attending physician and responsible party were notified. Any noted alteration of skin condition was reported to both attending physician and responsible party. Systemic Changes: The facility will institute the following measures to ensure that alleged deficient practice will not recur; The facility will diligently follow the policies and procedures of the quality assurance process to prevent a deficiency from recurring. On 5/19/2017, the Clinical Regional Consultant will conduct in-service training with the Administrator and Director of Nursing regarding the QAPI process. The education will include how to identify quality deficiencies specifically skin care management program and notification of	

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F 520	Continued From page 38	F 520	change of physician and responsible parties. Effective 5/25/2017, the 24 hour change of condition report sheet will be utilized by licensed nurses on duty to record any alteration in resident□s status during their scheduled shift. Licensed nurses will notify attending physician and responsible party on the following areas; an accident involving the resident, a significant change in resident condition, (such as noted alteration in skin integrity and/or deterioration of existing wound) a need to alter treatment (such as new wound care orders) decision to transfer or discharge a resident from the facility and/or any resident□s room changes. Effective 5/25/2017, the notification of changes tool will be utilized by licensed nurses on duty to record any resident with significant change of condition and ensure that the attending physician and responsible party were notified timely. 100% of licensed nursing staff were in-serviced on the importance of timely notification of resident□s change of condition to physician and responsible party. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiated on 4/28/17 for all licensed nursing staff to include, full time, part time and as needed employees. This education will be completed by 5/25/17, any licensed nursing staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hire process for all new licensed nursing	

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F 520	Continued From page 39	F 520	staff effective 5/25/17 and also will be provided annually. Effective 5/25/2017, the Director of Nursing will revised the skin assessment schedule utilized in facility. Resident□s weekly skin assessments schedule will show resident assessments due between the days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration Monday-Friday. Any identified skin integrity issues (pressure ulcers, deep tissue injuries {DTI}) discovered during skin assessments will be reported daily Monday thru Friday in the morning clinical meeting. The MDS nurse will attend the daily morning meeting and ensure accurate coding of MDS per RAI guidelines of any reported skin integrity issues. Effective 5/25/2017, a designated licensed wound nurse will oversee the wound program in the facility. The wound nurse will be responsible for identification and staging of wounds and ensure that appropriate treatments are initiated per physician□s orders. The licensed wound nurse will also ensure that each resident attending Physician and responsible party is made aware of resident□s wounds. Effective 5/25/2017, Certified Nursing Assistants will be responsible for inspection and documentation of any identified skin issues on the shower/bath sheets, report findings to the charge nurse and document such findings on the shower sheet. Effective 5/25/2017, during shift change	

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F 520	Continued From page 40	F 520	incoming and off going nurses will review treatment administration records (TAR) in electronic health records by checking my unsigned records tab. This tab will list all residents with treatment orders noted as not signed off as rendered. The incoming nurse will not accept responsibility for resident care until those records are rectified and treatment rendered per orders. Effective 5/25/2017, the Director of Nursing implemented Resident Care Cards as a communication tool to alert nurse□s aides of any skin protectant intervention for residents with pressure ulcers or with risk for developing pressure ulcers. 100% of nursing staff, to include licensed nurses and certified nursing assistants were in-serviced on the importance of completing weekly skin assessments per schedule, to ensure that alteration of skin integrity is documented, communicated to the physician and responsible party and that appropriate orders are received and rendered. The training also included the use of care cards as a communication tool. The licensed nurses were in-serviced on the use of the Care Cards and initiation of cards with new admissions and revision with treatment changes. The certified nursing assistants were informed on where the cards are located and how to use the cards. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiated on 4/28/17 for all nursing staff to include, full time, part time	

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F 520	Continued From page 41	F 520	and as needed employees. This education will be completed by 5/25/17, any nursing staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing staff effective 5/25/17 and also will be provided annually. Monitoring Process: The Administrator and Director of Nursing will meet weekly to review daily audits related to notification of change and wound management program. The Administrator and Director of Nursing will compile finding of daily and weekly audits, □notification of change audit tool, bath/shower sheet, and 24 hour change of condition sheet reports, care plan audits and MDS accuracy audits. The findings will be reviewed for modification. The weekly audits will be reported during the monthly Quality Assurance Performance Improvement Committee meetings. This process will continue weekly for 4 weeks, monthly for 4 months. Effective 5/25/17, DON, ADON and/or Unit Manager will review the completion of the prior day□s weekly skin assessment during daily clinical meetings (M-F) for the next 30 days then weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented to the Quality Assurance Performance Improvement Committee monthly x 3 months for any additional monitoring needs or modification of this plan by the DON. Any negative findings noted will be addressed promptly.	

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F 520	Continued From page 42	F 520	Effective 5/25/2017, the resident Care Cards will be reviewed by the DON, ADON or MDS nurse daily (Monday-Friday), and by the week-end manager on duty or on call nurse (Saturday and Sunday), to assure that it is available and accurate. This review will take place daily (Monday-Friday) for 4 weeks then weekly for 4 weeks, then monthly for 3 months. Any negative findings noted will be addressed by the DON, ADON and/or MDS nurse. Results of these audits will be presented to the Quality Assurance and Performance Improvement committee monthly x 3 months for any additional monitoring needs or modification of this plan by the DON. Effective 5/25/2107, the DON, ADON, Medical Records Clerk and/or MDS nurse will audit all new admissions Care Cards from the previous day (Monday-Friday). The weekend manager on duty or charge nurses will audit new admits on Saturday and Sunday. This audit will be completed daily for 4 weeks, weekly for 4 weeks, then monthly for 3 months, or until the pattern of compliance is maintained. DON will report findings to facility QAPI for additional monitoring needs or modifications of this requirement. Effective 5/25/2017 the Director of Nursing, Assistant Director of Nursing and/or Unit manager will review the 24 hour change of condition report sheet daily during morning clinical meeting (Monday-Friday) to assure that notification of change is conducted appropriately with the corresponding documentation in each	

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F 520	Continued From page 43	F 520	resident□s medical records. In addition this review will to assure that any changes in condition is communicated to the physician and responsible party as warranted. This monitoring process will be continued by the charges nurses on Saturday and Sunday. This monitoring process will be conducted daily x 4 weeks then weekly x 4 weeks , then monthly afterwards, or until the pattern of compliance is achieved. Effective 5/25/2017 the Director of Nursing, Assistant Director of Nursing and/or Unit manager will review notification of changes log daily during morning clinical meeting (Monday-Friday) to assure that notification of change is conducted appropriately with the corresponding documentation in each resident□s medical records. In addition this review will to assure that any changes in condition is communicated to the physician and responsible party as warranted. This monitoring process will be continued by the charges nurses on Saturday and Sunday. This monitoring process will be conducted daily x 4 weeks then weekly x 4 weeks , then monthly afterwards, or until the pattern of compliance is achieved. Results of the monitoring process mentioned above will be reported to the facility Quality Assurance, Performance Improvement committee by Director of Nursing, Assistant Director of Nursing and/or Unit manager monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the	

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F 520	Continued From page 44	F 520	committee deems appropriate.	