STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE GREENSBORO, NC 27455**

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F 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		4/27/17

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

Electronically Signed | 04/21/2017

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

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

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

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

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

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's grievance policy failed to include the residents' rights: the right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including: their name, physical and e-mail business address, and business phone number and the frame of how long a grievance is kept. Findings Included: A review of the facility policy titled "Investigation Grievances and Complaints Grievance Procedure Grievance Policy" dated 7/2016, provided by the Administrator on 3/28/17, revealed "Our facility will investigate all grievances and complaints filed with the facility. The administrator is assigned the responsibility of overseeing investigation of grievances and complaints. Upon receipt of a grievance and complaint Report, the Administrator will assign an investigation into the allegation." A review of the facility policy titled "Section 1557 Grievance Procedure" dated 7/2016, provided by the Administrator on 3/29/17, revealed "1. Grievance must be submitted to the Section 1557 Coordinator within 60 days of the date the person	F 166	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for all our residents. Immediate Action No Residents named were sited to be affected by alleged deficient practice Notification to residents were posted in prominent locations throughout the facility of the right to file grievances orally or in writing along with contact information of the grievance officer by the Administrator on 4/06/2017. A new Policy and procedure with the date of revision march 2017 was initiated on 4/6/2017 and implemented in the facility by the Regional Clinical Consultant #2; this policy and procedures contains the revised regulatory components implemented on phase one as of November 2016.	

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F 166	Continued From page 3 filing the grievance becomes aware of the alleged discriminatory. 2. A complaint must be in writing, containing the name and address off the person filing it. The complaint must state the problem or action alleged discriminatory action. 3. The Section 1557 coordinator or his/her designees shall conduct an investigation of the complaint. This investigation may be informal, but will be thorough, affording all interested persons an opportunity to submit evidence to the complaint etc." An interview with the Administrator on 3/29/17 at 2:45 PM revealed he had given us the wrong Grievance policy on 3/28/2017 and replaced that one with "Section 1557 Grievance Procedure" policy for Grievances. During this interview with the Administrator he also revealed that he was not aware of the new Regulation for the grievance process. He stated that the facility did not have an updated grievance policy with the required components effective November 2016.	F 166	Identification of Others All resident in the facility have the potential to be affected by the alleged deficient practice. Social Worker #1 and Social Worker #2 informed all active residents on the new grievance policy and procedure by 4/27/2017. Systemic Changes Effective 4/27/2017 the new grievance policy and procedure has been added to the admission packet for all new admissions to the facility. New admitted resident(s) and/or responsible party will be informed about their rights to file grievance or concerns orally or in written, as well as steps facility will take to address such grievances. Effective 4/27/2017 the new grievance policy and procedure will be discussed quarterly during resident's council meeting by Activity Coordinator #1 or Activity Coordinator #2 or Administrator. Effective 4/27/2017, Regional nurse consultant will review to ensure the facility receive and implement any updated policies and procedures put forth based on regulatory changes, industry best practices or for any other reasons. This review will take place no later than a week from the date if and when a policy and procedure is put forth.	

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100% of active facility employees will be educated on the new Grievance Policy and Procedure by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all active employees to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually.

Monitoring Process

Effective 4/27/17 weekly audits will be conducted by Social Services #1 or Social Services #2 and or the Administrator to ensure new grievance policy and procedure have been discussed for new admissions during new admission process, and during quarterly resident's council meetings.

Effective 4/27/2017 a weekly audit will be conducted by DON, ADON or Facility payroll and human resources personnel, for all new hires to ensure new Grievance policy and procedure has been discussed during orientation. These audits will be conducted weekly times 4 weeks then monthly times 4 months.

Results of the audits mentioned above will

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F 166	Continued From page 5	F 166	be reported to the facility Quality Assurance, Performance Improvement committee by Social Worker #1 or Social Worker #2, monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility staff interviews, the facility failed to clean and disinfect a resident ' s bathroom floor after an observation was made of red/brown smears and spots on the floor for 1 of 1 resident bathrooms (for Resident #40) observed to have a red/brown substance in the bathroom and facility failed to maintain housekeeping and maintenance services to provide clean resident's rooms and clean toilets in resident's bathroom and proved a maintained, safe and comfortable interior on 4 of 7 residents halls. (Hall 200, Hall 500, Hall 600 and Hall 700) The findings included: 1) An observation made on 3/28/17 at 8:20 AM revealed a towel was lying crumpled on the floor of Resident #40 ' s bathroom between the toilet and the wall. The white towel appeared saturated with many large red spots. Red/brown streak marks were noted on the floor in a curvature	F 253	F253 The white towel that appears to be saturated with red spots removed from resident #40 room by Housekeeping/Laundry supervisor on 3/28/2017 and discarded in biohazard bin. Resident #40s bathroom has been cleaned and disinfected by the House keeping supervisor on 3/28/17, red/brown spots removed from bathroom floor. 200 Hall Room 213 Blinds replaced by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017 500 Hall Room 502 Wall Paper removed by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 503 White patch painted, back of bathroom door repaired and dripping	4/27/17

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F 253	Continued From page 6 pattern (approximately 18" long) starting approximately 12 inches directly in front of the toilet and ending where the towel laid in the corner of the bathroom. In addition, there were several red/brown spots observed on the bathroom floor in the same general area as the streak marks. An interview was conducted on 3/28/17 at 8:25 with NA #1. NA #1 was in Resident #40 ' s room at the time of the observation and had been assisting her roommate with the breakfast meal. Upon inquiry, NA #1 stated Resident #40 had hemorrhoids and the staff was aware she would get blood on the floor at times. When asked what the NA would need to do, the NA stated she would need to bag the towel in a red bag since it had blood on it and would tell the hall nurse so she could alert the housekeeping staff about the blood on the floor. An observation made on 3/28/17 at 9:00 AM revealed the towel was no longer in Resident #40 ' s bathroom. However, the red/brown streaks and drops remained on the floor. An observation made at 9:30 AM revealed the red/brown blood streaks remained on the bathroom floor. An interview was conducted on 3/28/17 at 9:35 AM with Nurse #1. Nurse #1 was the nurse assigned to Resident #40 ' s hall. Upon inquiry, Nurse #1 stated the NA had reported the bloody towel found in Resident #40 ' s bathroom. The nurse stated she would pass this on in report to the next nurse. When asked if she had notified the housekeeping department of the red/brown substance on the bathroom floor, Nurse #1 stated	F 253	faucet repaired by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 504 Wall Paper removed, corner behind bed A painted and door has been cleaned by maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 506 Bathroom and bathroom door frame has been repainted, Drawer under TV has been properly repaired, Wall Paper has been removed and door sanded and re-stained by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017 Room 600 Hall Room 601 Wall Paper removed and floor molding in bathroom repaired by maintenance supervisor and or assistant maintenance supervisor on 04/04/2017 Room 603 Wall by drawers have been painted, door frame near bathroom has been painted and faucet has been repaired (tighten and dripping fixed) by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017 Room 604 Bathroom door frame repainted, Drawer handle under TV repaired and area under dresser and closet cleaned by the maintenance supervisor and or assistant maintenance supervisor on 04/04/2017. Hall 700	

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F 253	Continued From page 7 the NA had already done so. An interview was conducted on 3/28/17 at 9:40 AM with NA #1. During the interview, the NA stated she had told the Housekeeping Supervisor about the blood on Resident #40 ' s bathroom floor. An interview was conducted on 3/28/17 at 9:45 AM with Housekeeper #1. Housekeeper #1 was mopping the floor in the room next to Resident #40 ' s room at the time of the interview. When asked which room she was going to mop next, Housekeeper #1 pointed across the hallway to two other rooms (not Resident #40 ' s). The housekeeper stated when she was finished with those rooms, she would then go the other direction down the hallway. Upon inquiry regarding when she would mop Resident #40 ' s bathroom, the housekeeper stated she usually did that after lunch. Housekeeper #1 stated she knew the bathroom floor got "messy" and she wanted to give the resident a chance to get up and dressed before going there because the floor would get "messed up" again. Upon further inquiry, the housekeeper stated she would mop Resident #40 ' s bathroom floor after lunch so she would not have to go back to do it again. An interview was conducted on 3/28/17 at 9:47 AM with the Housekeeping/Laundry Supervisor. The Supervisor acknowledged NA #1 had told her Resident #40 ' s bathroom floor needed cleaning because there was blood on the floor. The Supervisor reported she had asked Housekeeper #1 to take care of it. When asked how soon she would have expected this to be done, she stated the floor should have been disinfected "Immediately." Accompanied by the	F 253	Room 720 Night stand replaced and 6 holes in bathroom repaired by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017. Room 716 Room wall has been repaired and painted by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017. Room 709 Bathroom floor around toilet cleaned and stains removed by Housekeeping and Laundry supervisor on 04/06/2017. Room 711 Hole in bathroom wall repaired and painted by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017 Room 702 Door sanded and repaired by maintenance supervisor and/or assistant maintenance supervisor on 04/06/2017 Room 708 Residents bathroom walls and floor cleaned by Housekeeping and Laundry supervisor on 04/06/2017 Room 706 Door sanded and repaired by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017 Identification of Others: 100% audit of all resident rooms audited to identify any other room with housekeeping needs to include any blood or body fluids. This audit was completed by housekeeping and laundry supervisor	

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F 253	Continued From page 8 Housekeeping / Laundry Supervisor, an observation was made on 3/28/17 at 9:50 AM of Resident #40 ' s bathroom floor. Upon viewing the floor, the Supervisor stated, "We're going to get this right now." An interview was conducted on 3/30/17 at 10:31 AM with the facility ' s Quality Improvement/Quality Assurance (QI/QA) Nurse and Staff Development Coordinator (SDC). The QI/QA nurse was reported to assume Infection Control responsibilities for the facility; and, the SDC shared some responsibilities (such as staff training) with her. During the interview, the situation encountered in Resident #40 ' s bathroom was discussed from the infection control perspective. The SDC stated, "Going forward, staff will be re-educated." The QI/QA nurse stated, "The blood on the floor should have been cleaned up immediately." An interview was conducted on 3/30/17 at 11:29 AM with the facility ' s Director of Nursing (DON). During the interview, the situation encountered in Resident #40 ' s bathroom was discussed. The DON stated, "My expectation would be for the staff to get the room sanitized as soon as possible." A follow-up interview was conducted on 3/30/17 at 3:11 PM with the Housekeeping/Laundry Supervisor. Upon inquiry, the Supervisor reported Resident #40 ' s bathroom floor was cleaned on 3/28/17 using a disinfectant product. She stated after the floor was cleaned, the water and mop head used were changed out. 2. 200 Hall	F 253	on 3/28/17. No other rooms noted with house keeping needs such as cleaning of blood or body fluids. 100% audits of all resident rooms in the facility conducted by the Maintenance supervisor and/or assistant maintenance supervisor on 4/6/2017, 4/7/2017 and 4/21/2017 to identify any other resident room with the following areas of concerns; 1. Missing or broken blinds; 15 other rooms with blinds not in good repair identified. Maintenance supervisor and/or assistant maintenance supervisor replaced the blinds on the 15 other identified rooms on 4/6/2017, 4/7/2017 and 4/21/2017. 2. Missing Wall paper, torn wall paper, and/or not in a good repair; 58 other rooms identified not to be in a good repair. Maintenance supervisor and/or assistant maintenance supervisor repaired, removed and/or replaced wall papers on all 58 identified rooms started on 4/6/2017 and to be completed by 4/27/2017. Any room not repaired by 4/27/2017 will be removed out of service until repaired. 3. Wall Repair, Door Repair, Floor molding, Door frames painting; 36 other rooms identified to be in need of one or more repair of identified areas mentioned above. Maintenance supervisor and/or assistant maintenance supervisor repaired and/or removed all identified areas in 36 noted rooms started on 4/6/2017 and to be completed by	

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F 253	Continued From page 9 Room 213 was observed on 3/28/2017 at 10:14 AM. The slats in the window blinds are bent at the lower end and one slat was broken and tied to the other slats. 500 Hall Room 502 was observed on 3/28/2917 at 10:04 AM. The room had a missing section of wallpaper border above the doorway in room. Room 503 was observed on 3/28/2017 at 10:15 AM. The wall had white patch on it, the back of the door in the bathroom needs painting. The faucet in the bathroom was dripping. Room 504 was observed on 3/28/2017 at 10:58 AM. The room had missing section of wallpaper above the door. In the corner behind bed A had missing paint. The door in the room appeared to be dirty. Room 506 was observed on 3/28/2017 at 11:28PM. The bathroom walls had gray markings on them. The bathroom door frame needs paint. In the resident's room the bottom drawer under the TV appears to had a wrong-sized face on drawer. The wall paper border above bed A was hanging down, the door on side near hinges appeared banged up and needing staining. Hall 600 Room 601 was observed on 3/28/2017 at 11:23 AM. The wallpaper border was loose above the bed. The bathroom floor molding was warped in 2 places.	F 253	4/27/2017. Any room not repaired by 4/27/2017 will be removed out of service until repaired. 4.Resident□ Bathrooms Repair; to include leaking faucet(s), bathroom floor, walls, and paints.26 other residents'□ bathrooms noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired, all identified areas in 26 noted rooms started on 4/6/2017 and to be completed by 4/27/2017. Any resident bathroom not repaired by 4/27/2017 will be removed out of service until repaired. 5. Condition of residents□' furniture; 9 other furniture noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired all identified furniture in 9 noted rooms on 4/6/2017, 4/7/2017 & 4/8/2017. Systemic Changes: Effective 4/27/2017 House Keeping/Laundry Supervisor re-established a cleaning assignment for housekeeping staff on duty to ensure each resident room is cleaned and sanitized in a daily basis. Effective 4/27/2017, revised deep cleaning schedule put forth by the house keeping/Laundry supervisor for each room to be deep cleaned once monthly, By the Housekeeping staff.	

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F 253	Continued From page 10 Room 603 was observed on 3/28/2017 at 11:09 AM. The wall by drawers had missing paint. The door frame near bathroom had missing paint. The faucet was dripping and the entire fixture was loosed. Room 604 was observed on 3/28/2017 at 11:15 AM. The door frame going into the bathroom had missing paint. The handle on drawer under the TV was attached on one side and not the other. Black/gray matter was observed under the dresser and closet it appeared to be dirty. Hall 700 Room 720 was observed on 3/27/2017 at 12:08 PM. The resident's night stand was missing wood on the front part and it was rough to touch. In the resident's bathroom had 6(six) holes in wall in need of repairs. Room 716 was observed on 3/27/2017 at 12:53 PM. The resident room wall had multiple areas of painted white patches on the wall which did not match the wall color, this room was missing paint. Room 709 was observed on 3/27/2017 at 2:25 PM. The bathroom's toilet had a ring of red/black substance around the edge and the floor were stained. Room 711 was observed on 3/27/2017 at 2:45 PM. The resident's wall in the bathroom was observed with a large hole in the wall the size of an apple in need of repair. Room 702 was observed on 3/28/2017 at 8:44 AM. The door to the room had jagged edges that were rough to touch.	F 253	Effective 4/27/2017 a maintenance work book will be placed at each nursing station where any maintenance issue(s) can be recorded by any staff member. Maintenance supervisor or assistant maintenance supervisor will check these books daily (Monday to Friday). Any maintenance needs on the week-end that requires immediate attention, a maintenance supervisor or assistant maintenance supervisor will be contacted by staff on duty. 100% of active facility House Keeping and laundry employees received additional training on cleaning and disinfecting of floors and surfaces after blood or body fluid spills and contamination. This education was completed by Housekeeping/Laundry Supervisor and/or Quality assurance nurse. This education was initiated on 4-6-2017 for all active housekeeping and laundry employees, to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any house keeping/Laundry staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new house keeping/laundry employees effective 4/27/17 and also will be provided annually. 100% of active facility employees will be educated on the new maintenance request log and Procedure to request any maintenance needs by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator	

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F 253	Continued From page 11 Room 708 was observed on 3/28/2017 at 10:26 AM. The resident's bathroom wall had brown smeared substance. An observation of bags of dirty laundry on the bathroom floor. Room 706 was observed on 3/28/2017 at 12:23 PM. The door to the room had jagged edges that were rough to touch. During an interview with Housekeeper # 2 on 3/29/2017 at 2:30 PM. She stated that resident's room are clean every day and that rooms are deep clean once a resident were moved to another room and/or discharge out of the facility. She stated we had a special substances that we used in the bathrooms to clean around the toilets to remove the stains. She also stated that rooms are check daily. During an interview with the Maintenance Director (MD) on 3/30/2017 at 4:00 PM. The MD revealed that he had only been at this facility since the first weeks of March 2017. MD revealed that he had a list of room that are in need of repairs from holes in the wall, doors in need of repairs and that the facility had ordered new blinds for some of the rooms and that each resident was going new electric beds. MD stated he still learning the facility. He also indicated housekeeping staff cleans up resident's room daily and if stains remained on resident's floor this needed to be report to maintenance to deep clean the floors. The Maintenance director also indicated that some of the issues in the resident's rooms he was not aware of because he hadn't done a full assessment. He had only been here less than 30 days.	F 253	(SDC). This education was initiated on 4-6-2017 for all active employees to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and will be provided annually. Monitoring Process: Effective 4/27/17 Director of nursing, Assistant Director of Nursing, and/or Maintenance supervisor will review the maintenance request books weekly x 4 weeks, then monthly x 3 months on all halls to assure service requests had been followed up appropriately. Effective 4/27/17 Housekeeping supervisor will complete environmental Infection control audits weekly x 4 weeks, then monthly x 3 months on all halls to assure floors and surfaces are cleaned properly. Results of audits will be reported to Quality assurance performance improvement committee meeting monthly x 4 months by the Housekeeping/laundry supervisor, or until pattern of compliance is achieved. QAPI committee will modify this plan as deemed appropriate to ensure continuous compliance. Maintenance supervisor and/or	

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F 253	Continued From page 12 During an interview with the Administrator on 3/30/2017 at 4:40 PM. The Administrator revealed that Director of Nursing and MD all of us came in this month and are still identifying issues. Administrator indicated expectation would be that resident's rooms and the facility are kept clean and items that need to be repaired be repaired in a timely manner.	F 253	Administrator will review maintenance work books to ensure compliance with work orders. This review will be completed weekly x 4 weeks, then monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		4/27/17

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F 278	Continued From page 13 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the active diagnosis of myoclonic jerk on the Minimum Data Set (MDS) assessment for 1 of 2 residents who received Hospice services within the facility. (Resident #214). The findings included: Resident #214 was admitted to the facility on 2/9/17 with cumulative diagnoses which included chronic systolic heart disease and myoclonic jerk. Review of the physician orders on admission included Depakote for the treatment of myoclonic jerks. Record review of the 14 day MDS dated 2/23/17 revealed myoclonic jerks was not listed in the active diagnoses list for the use of Depakote. Interview on 03/30/2017 at 3:32 PM with MDS coordinator #1 who stated "I must have overlooked coding the diagnoses." Interview on 03/30/2017 at 6:27 PM with the Administrator and Regional Clinical	F 278	F278 Immediate Action Step Minimum data Set (MDS) for resident #214 dated 2/23/17 was modified/corrected by MDS Nurse #1 on 3/30/2017, to include in section I of MDS a diagnosis of a myoclonic jerk diagnosis. Modified assessment was re-transmitted and accepted in CMS data base on 3/30/2017 Identification of Others: 100% audit completed on 4/21/17 and 4/22/2017 of all active residents for the most recent MDS assessment was conducted by Regional MDS consultant #1, Regional MDS consultant #2, MDS Nurse #1, MDS Nurse #2 and/or MDS Nurse #3 to ensure all active diagnoses were coded appropriately in section I of MDS. 19 Other residents noted with inaccurate coding in section I. Modifications/corrections were done to Minimum Data Set as indicated per Resident Assessment Instrument (RAI) guidelines on 4/22/2017 to 4/27/2017 by	

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F 278	Continued From page 14 representative was held. The expectation stated by the administrator was the MDS must be accurate.	F 278	MDS Nurse #1, MDS Nurse #2 and/or MDS Nurse #3. Systemic Changes Effective 4/27/2017, MDS nurse #1, MDS nurse #2 and/or MDS nurse #3 will review each resident's physician-documented diagnosis, completed by Medical Doctor, a nurse practitioner, or physician assistant, in the last 60 days of the assessment reference date (ARD). The source of this review include each resident's physician progress notes, the most recent history and physical, discharge summaries, and or diagnosis listed in each resident's medication and/or treatment signed and with a date falls in the last 60 days of ARD. Once a diagnosis is identified as documented in the last 60 days, MDS Nurse #1, MDS nurse #2 and/or MDS nurse #3 will determine if the diagnosis is active. (Active diagnosis are those that affect the resident's functioning or plan of care during the last 7 days, for all diagnosis except, Item I2300 Urinary Tract Infection (UTI), which has specific coding criteria and does not use the active 7-day look back period). MDS nurse will then code the diagnosis in section I of that resident's MDS assessment when the criterion above are met. UTI will be coded by MDS nurse #1, #2, and/or #3 when determined to be active based on RAI guidelines for UTI assessment and coding. Effective 4/27/17 prior to submission, MDS Nurse #1, #2, and or #3 and/or MDS	

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F 278	Continued From page 15	F 278	Nurse #2 (Whomever is not signing off section I, on the assessment) will review completed MDS assessment to ensure accurate coding of diagnosis in Section I per RAI guidelines. Any assessment noted with inaccurate coding in Section I, Modifications/corrections will be done to Minimum Data Set as indicated per RAI guidelines promptly by MDS Nurse #1, #2, and or #3. MDS nurse #1, MDS 2 and/or MDS #3 re-educated by MDS Consultant #1 on proper ways of coding MDS assessment, specifically section I on 4/6/2017 This education is also added to new hire process for all MDS nurses 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/17/17 MDS Section I reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments weekly x 4 weeks or until compliance is achieved by MDS nurse #1, #2, and or #3. MDS nurse #1, MDS nurse #2, and/or MDS nurse #3 will present the findings of this audit to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		4/27/17

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F 280 SS=D	Continued From page 16 PARTICIPATE PLANNING CARE-REVISE CP	F 280		

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and

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F 280	Continued From page 17	F 280		

cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review

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F 280	Continued From page 18 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to invite the Responsible Party (RP) to participate in Care Plan meetings for 1 of 3 residents (resident #71) reviewed for notification of participation in Care Plan meetings. Findings included: Resident #71 was admitted to the facility on 8/11/2015 and re-admitted again on 3/10/17 with cumulative diagnoses which included Diabetes and Respiratory failure. The Quarterly Minimum Data Set (MDS) dated 1/17/17 indicated that Resident #71 required 1 person for assistance with Activities of Daily Living and was cognitively intact. Medical Records review from August 16, 2016 until March 29, 2017 revealed no documentation of RP being invited to the care plan meeting nor any documentation of RP participating in the meeting. On 3/28/17 at 12:30 PM an interview was attempted with Resident #71 and he would not respond to any questions. A telephone interview was conducted with Resident # 71's Responsible Party on 3/29/2017 at 2PM. The RP stated she never received any notification of Care plan meetings. The RP indicated that she had been actively involved in the care of Resident #71 since his placement, but the staff did not keep her informed of his health condition.	F 280	Immediate Action Resident #71 -care plan meeting letter was sent to family by Social Service #1 but resident was discharged on 4/9/17 from facility prior to an actual care plan meeting. Identification of others 100% audit by Regional nurse Consultant #1 on 4/24/17, 4/25/17, 4/26/17 to validate residents and or responsible party were invited to participate in their care plan meeting. No documented evidence identified that any invitation had been sent/made to either the resident or responsible party, as the proof of such invitation could not be retrieved from the computer that had crush with such proof as reported by Social worker # 1. Social Worker #1 and Social Worker #2 mailed or delivered Care Plan invitations for a Care plan (CP) meeting to Responsible Party or resident for 100% of building on 3/31/2017 Systemic Changes Effective 4/27/2017 a care plan invitation schedule will be adhered to following the Minimum Data Set (MDS) assessment schedule for each resident Omnibus Budget Reconciliation Act (OBRA) assessments. Effective 4/27/2017 Social Worker #1 social worker #2 and or Activity Coordinator #1, and or #2 will document the invitation in the resident's clinical	

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F 280	Continued From page 19 An interview with the MDS Coordinator on 3/29/2017 at 3 PM revealed that she was aware that family members should be invited to care plan meetings. She stated that she had no documentation that Resident #71's family had been invited or had attended any of his care plan meetings since August 2016. She stated that the facility sent out invitation letters to the family members, however the computer that these letters were stored on had crashed. She reported that the facility had no way of knowing if the family members received the invitation because they didn't have any way to track this. The facility was unable to provide any documentation that Resident #71's family had ever been invited to his care plan meeting. An interview with the Administrator on 3/30/2017 at 4 PM revealed that the facility had a letter that went out to each family inviting them to the resident's care plan meeting, but the computer that the letters were stored in had crashed and they were unable to access them. The Administrator stated that his expectation was that the facility would invite family members (RP) and residents to all Care Plan meetings and the notifications would be issued in a timely manner.	F 280	record. Social Worker #1 and or #2 will also document in resident's medical record if the attendance by the resident and or their responsible party is not practical. Social worker #1 and #2, Activity Coordinator #1, and Activity Coordinator #2 were re-educated on 4/18/2017 by Regional Clinical Director #2 on systematic changes pertaining to Interdisciplinary Care Plan invitations process. Monitoring Process: Effective 4/27/17 MDS coordinators #1, #2, and or #3, will audit, that the Care Plan meeting is scheduled and Resident and or Responsible Party have been notified with response charted in medical record by following the MDS schedule of (OBRA) assessments. They will also assure that notification, attendance and or response is documented on each resident clinical record by Social Worker #1, social worker #2 and/or Activity Coordinator #1, and or #2. The audits of Care Plan Invitations will be completed weekly x 4 weeks, then monthly x 3 months by MDS coordinators #1, #2, and or #3. Effective 4/27/2017 MDS coordinators #1, #2, and or #3 will report findings to facility Quality Assurance Performance Improvement Committee, monthly for six months, for any additional monitoring needs or modifications of this requirement.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		4/27/17

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F 282	Continued From page 20 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow care plan interventions for 2 of 31 sampled residents reviewed for care plans. Resident #185's care plan was not followed related to the number of staff needed during a sit to stand lift transfer. Resident #263's care plan was not followed related to implementation of fall interventions. Findings Included: 1. Resident #185 was admitted on 4/4/16 with the diagnoses of muscle weakness, urinary tract infection, and gait abnormality. The Quarterly Minimum Data Set (MDS) dated 3/6/17 revealed the resident was severely cognitively impaired. The resident required extensive assistance with bed mobility, transfers locomotion off the unit, dressing, hygiene, and toilet support. The resident required 2 person assist with toilet use. The resident was always incontinent of bowel and frequently incontinent of urine. The resident had a care plan for falls updated on 3/13/17. Fall Interventions included to use the sit to stand lift for transfers with assistance with 2	F 282	Immediate Action Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator. Resident #263 fall mat was placed beside the bed, a bed and chair alarm was also put in place per resident care plan by the quality assurance nurse on 3/31/2017. Resident's care card was updated to reflect the use of floor mat, bed and chair alarm by the Quality Assurance on 3/31/2017 as well. Identification of Others 32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear. 100% audit of all fall care plans for active residents completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1 to determine if any intervention put in place was implemented and communicated to the nurse aides appropriately. Findings of this audit was	

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F 282	Continued From page 21 people. Nursing Assistant #1 was interviewed on 3/29/17 at 10:11 AM. She stated Resident #185 used the stand-up lift when she changed the resident. She stated she would change the resident in bed or use the lift with assistance from another staff member. Nursing Assistant (NA) #1 was observed taking Resident #185 to the bathroom on 3/29/17 at 11:02 AM. The resident was taken to the bathroom on 600 hall via wheelchair. Nursing Assistant #1 asked Nursing Assistant #2 to come help her with Resident #185 when she was finished with helping another resident. Nursing Assistant #2 never returned to assist NA #1 to care for Resident #185. The sit to stand lift was in the bathroom. NA #1 was observed to place the sit to stand lift pad was placed behind Resident #185 in the wheelchair. The lift was placed in front of the resident and the lift pad went under the resident's arms and was connected via loops to the lift. The waist band that went around the resident's waist was not connected and the waist straps were left dangling beside the resident. The resident was lifted only from under her arms from the sitting position to a standing position with assistance with only 1 staff member (Nursing Assistant #1). Resident's #185 brief was changed and the resident was lowered back to the wheelchair with assistance of only 1 person (Nursing Assistant #1). Nursing Assistant #1 was interviewed on 3/29/17 at 1:55 PM. She stated the resident was not really able to stand or help with the transfer. She stated with the sit to stand lift, she would put the sit to stand lift pad under the resident's her arms and	F 282	documented on “fall intervention audit tool”. No functional documented process of communication identified to be in place for communication to nurse’s aides, thus, 100% of other residents with interventions to be implemented by nurse’s aide had a potential to affect by this alleged noncompliance. Systemic Changes Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident’s individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident’s evaluation by healthcare professional documented on resident plan of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines. Effectively 4/27/2017; Resident’s Care Cards were initiated as a communication tool to alert nurse’s aides of appropriate method to transfer each resident together with minimum number of staff required for the Activity of daily Living (ADL), specifically transfer to take place. Care Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse’s aides. This include but not limited to fall interventions such as bed in low position, fall mat on floor and/or Chair/bed alarm. Three ring binders titled “Care Cards” places at each nurse’s	

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F 282	Continued From page 22 lock the resident's wheelchair then lift the resident up. She stated that technically they used 2 people with the lift but that NA #2 never came back to help her by the time the resident was lifted. NA #1 stated NA #2 must have been busy. She stated the resident was mostly an easy transfer. She stated the waist belt on the lift pad was broken, which was why it was not snapped this morning. She stated the lift pad she used only had 2 plastic prongs on the belt and would slip out. She stated the other sit to stand lift pads were being used. The DON was interviewed on 3/30/17 on 6:07 PM. She stated that she would expect that the resident was care planned for the appropriate lift and that the care plan was followed correctly for each resident requiring assistance with transfers. 2. Resident #263 was admitted to the facility on 3/20/17 and his diagnoses included Alzheimer ' s disease. An admission minimum data set (MDS) had not been completed for Resident #263. An interim care plan dated 3/20/17 for Resident #263 revealed he was at risk for injury from falls related to history of falls and actual fall. Interventions included for staff to frequently check on resident. An update to his care plan was made on 3/23/17 related to a fall and a therapy screen was added as an intervention. An update was made to his care plan on 3/24/17 related to another fall and fall mats, bed alarm, chair alarm and keep bed in lowest position were added as interventions. A review of an incident report for Resident #263 provided by the Director of Nursing (DON)	F 282	station for easy access by the nurse's aides. This process was put in place with the collaboration among the Regional Clinical Consultant #2, Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse, MDS Coordinator #1, MDS Coordinator #2, MDS coordinator #3 and the Staff Development Coordinator 100% active residents in facility were re-assessed for individualized care needs. This re-assessment was completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1, Director of nursing and/or Assistant Director of nursing. Appropriate intervention was put in place and added to each resident's care card. Effective 4/27/2017 Care cards will be initiated on admission by the admitting nurse and updated at least quarterly and with any change in treatment plan, related to resident's direct care and safety, by the hall nurses and/or interdisciplinary care plan team. Interventions to be carried out by nursing aides will be added to be part of each resident care cards. 100% of nursing staff, to include licensed nurses and nurse's aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff	

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F 282	Continued From page 23 revealed he had a fall on 3/20/17 at 8:02 pm. He was attempting to sit in a chair and fell. He had no injuries and actions to be taken included his bed was to be in low position. A review of an incident report for Resident #263 provided by the DON revealed on 3/23/17 at 5:45 am Resident #263 was found on the floor in front of his dresser. Resident stated he hit his right arm and a very light greenish area was noted to his right upper arm and a skin tear was noted to his right lateral hand. Actions taken included active range of motion to upper and lower extremities, skin assessment, vital signs and that his bed was to be in a low position. A review of an incident report for Resident #263 provided by the DON revealed on 3/24/17 at 5:30 am Resident #263 was found lying on the floor in his room on his right side. He had some redness to the right side of his head. Actions taken included neurological checks, ice applied to the right side of his head, observations and bed in low position. An observation on 3/27/17 at 2:21 pm of Resident #263 revealed he was sitting in a chair in his room. His bed was not in a low position. There were no fall mats, chair alarm or bed alarm in place. A nursing note dated 3/28/17 for Resident #263 revealed that he had an order on 3/24/17 for his bed to be in low position, fall mat beside bed, bed alarm and chair alarm. An observation on 3/28/17 at 10:29 am of Resident #263 revealed he was sitting in a chair in his room. His bed was not in a low position.	F 282	development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information from such. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017, resident care cards will be reviewed by the clinical interdisciplinary team daily (Monday thru Friday), and by the week-end supervisor or nurse in-charge on (Saturday & Sundays), to ensure its presence and accuracy as appropriate. This team will consist of but not limited to the DON, ADON, QA Nurse, SDC, MDS#1, MDS#2, and/or MDS#3. , this review will take place daily (Monday thru Friday) for 4 weeks	

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F 282	Continued From page 24 There were no fall mats, chair alarm or bed alarm in place. An observation on 3/30/17 at 1:45 pm of Resident #263 revealed he was standing up and starting to exit his room. He sat down in his chair when this surveyor entered his room. His bed was observed to be in a low position. There were no fall mats, chair alarm or bed alarm in place. An interview on 3/30/17 at 1:53 pm with Nursing Assistant (NA) #2 revealed that she was the NA for Resident #263. She stated that he should not walk on his own because he was not that stable and needed to use a walker. She stated that he was confused. She stated he had a bed and chair alarm because he was at risk for falls. She checked his room and confirmed that there were no bed or chair alarms in place. She stated that they should have been there. She stated she was not aware that he was supposed to have fall mats. An interview on 3/30/17 at 2:02 pm with Nurse #4 revealed that Resident #263 was supposed to have a bed and chair alarm. She reviewed the March 2017 medication administration record (MAR) for Resident #263 and the bed and chair alarms had been signed off as being present. She stated that she was not aware that he was supposed to have fall mats and they were not listed on his MAR. An interview on 3/30/17 at 1:36 pm with the Director of Nursing (DON) revealed it was her expectation that fall interventions were in place per the resident ' s plan of care.	F 282	then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed by the member of the interdisciplinary team promptly. Quality Assurance nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all new admission for previous day, daily (Monday thru Friday) and the week-end supervisor or nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly QAPI nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effective 4/27/2017, central supplies clerk or Quality Assurance nurse will inspect the condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.	

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F 314 SS=D	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 from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interviews the facility failed to provide wound care as ordered by the physician for 1 of 2 residents reviewed for pressure ulcers (Resident #22). Findings Included: Resident #22 was admitted to the facility on 10/20/15 and his diagnosis included venous stasis insufficiency, protein calorie malnutrition and coronary artery disease. A quarterly minimum data set (MDS) dated 3/14/17 for Resident #22 revealed a stage 2 pressure ulcer with onset date of 3/14/17 that had worsened since the last assessment. It also identified that Resident #22 was cognitively intact.	F 314	Immediate Action Resident #22: Treatment rendered per physician order by a treatment nurse on 3/29/2017. Wound was assessed by the Regional Nurse Consultant #2 and treatment nurse on 3/30/2017. No deterioration in the wound was noted from treatment nurse assessment on 3/27/2017. Treatment was deemed appropriate for wounds and wounds showed improvement from prior assessments. Performance improvement action were implemented for weekend licensed nurse who was responsible for resident care and treatment on 3/25/2017 & 3/26/2017 during day shift (7AM-7PM). This action	4/27/17

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F 314	Continued From page 26 A care plan dated 3/23/17 for Resident #22 identified that he had pressure ulcers to his right and left heels. Interventions included treatment as ordered to the left and right heels and nutritional supplements to promote wound healing. A review of the physician ' s orders for Resident #22 revealed an order on 3/23/17 to cleanse the right heel with normal saline, apply santyl, cover with a 4x4 gauze and wrap with kerlix daily. An order was written on 3/23/17 to cleanse the left heel with normal saline, apply medihoney, cover with a 4x4 gauze and wrap with kerlix daily. A wound assessment dated 3/27/17 for Resident #22 revealed he had a stage 3 pressure ulcer on his left heel that had been identified on 3/23/17. Measurements for this ulcer were documented as 0.5 centimeters (cm) length by 0.40cm width by 0.10cm depth. Foot care assessment indicated dorsal and pedal pulses non-palpable, peripheral vascular disease (PVD) present and no signs or symptoms of infection. A wound assessment dated 3/27/17 for Resident #22 revealed he had an unstageable pressure ulcer to his right heel that had been identified on 3/23/17. Measurements for this ulcer were documented as 0.80cm length by 0.70cm width. Foot care assessment indicated the pressure ulcer was unstageable due to slough at the wound bed, there were no signs or symptoms of infection, no dorsal or pedal pulses present and PVD present. An observation on 3/27/17 at 12:00 pm revealed Resident #22 was sitting up in his wheelchair. Both of his heels had dressings on them that were dated 3/24/17. Resident #22 stated the	F 314	was put forth by the Director of Nursing on 4/6/2017. Identification of Others 100% audit of all active resident's with wound care orders completed by the Regional nurse Consultant #2, and the treatment nurse to ensure that Physicians orders matched the treatment administration records record on 4/12/17, as well as the documentation for completion of such orders are noted in resident's record per order and to include Saturdays and Sundays 100% of all active residents with pressure ulcers were assessed by Treatment nurse and by Certified wound nurse from sister facility on 4/27/2017. No pressure ulcers were noted to have deteriorated from their previous documented assessment. Systemic Changes: Effective 4/27/2017, each resident treatment is rendered per physician order. On- coming nurse will check treatment records for omissions prior to accepting cart form previous shift nurse. On- coming Nurse will not accept cart until treatments are completed or reconciled. 100% of licensed nurses employed by the facility ware re-educated on ensuring treatment orders are rendered per physician order, completed on the frequency ordered and documented on	

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F 314	Continued From page 27 dressings on his feet had been done on Friday (3/24/17), but had not been changed over the weekend. An observation on 3/27/17 at 4:30 pm revealed Resident #22 was sitting up in his wheelchair and he had socks on both of his feet. Resident #22 stated that the dressings on his feet were changed today and should be changed again tomorrow, "but you never know for sure until they are actually changed." An observation of wound care for Resident #22 was conducted on 3/29/17 at 10:00 am with the wound nurse. Resident #22 was lying in bed with dressings on both of his feet that were dated 3/28/17. The wound nurse reviewed the treatment orders for both of his heels and showed this surveyor the wound supplies she would be using. She removed the dressing from his right foot and observed a very small amount of light yellow drainage on the dressing. The area on his right heel appeared smaller than the size of a dime, circular in shape with a small red center. She cleaned the wound with normal saline, applied the santyl, 4x4 gauze, a foam heel cushion and wrapped it in gauze. She dated the gauze 3/29/17. She removed the dressing from his left heel and observed a small amount of light yellow drainage on the dressing. The area on his left heel appeared smaller than the size of a dime, circular in shape with white edges. She cleaned his left heel with normal saline, applied the medihoney, 4x4 gauze, a foam heel cushion and wrapped it in gauze. She dated the gauze 3/29/17. She was observed to wash her hands and change her gloves in between the old and new dressing changes.	F 314	each resident treatment administration record. This education also covered on what to do when a pressure ulcer is identified and documentation for residents who refuse their wound care treatment to be done. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all licensed nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nursing staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new licensed nurses effective 4/27/17 and also will be provided annually. Monitoring Process: Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all treatments records daily (Monday Friday) and the week-end supervisor or nurse in-charge will audit treatment records on (Saturday & Sundays), to ensure they have been completed and signed for as ordered by physician. This review will take place daily for 2	

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F 314	Continued From page 28 An interview with the wound nurse on 3/29/17 at 10:00 am revealed she provided the wound care for Resident #22 Monday through Friday. She stated that the resident ' s assigned nurse was responsible for completing his wound care on the weekends. She confirmed that his wound care was to be completed every day. She stated that Resident #22 ' s wound was classified as a pressure ulcer because he had complained of pain when his heels were resting on a surface. An interview on 3/29/17 at 4:18pm with Nurse #6 revealed she had been the nurse for Resident #22 on 3/25/16 and 3/26/16 from 7:00 pm to 7:00 am. She stated that she did not do any wound treatments for Resident #22. She stated that she wasn ' t aware that he any actual breakdown on his heels and she thought he just received skin prep to the areas. She stated that on the weekends the day shift nurse was responsible for wound treatments for residents in the "A" beds and the evening shift nurse was responsible for wound treatments for residents in the "B" beds. Resident #22 resided in a "A" bed. An interview on 3/30/17 at 12:18pm with Nurse #7 revealed she had been the nurse for Resident #22 on 3/25/16 and 3/26/17 from 7:00 am to 7:00 pm. She stated that the treatment for Resident #22 ' s heels was to apply skin prep and that there were no dressings required to be placed on his heels. She stated that the area on his left heel was approximately the size of a half dollar and the area on his right heel was approximately the size of a quarter. She did not confirm that she had completed any treatment to his heels on 3/25/16 or 3/26/17. An interview on 3/30/17 at 12:52pm with the	F 314	weeks, weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Quality assurance nurse will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this plan.	

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F 314	Continued From page 29 physician for Resident #22 revealed that he was familiar with the wounds to his heels. He stated he believed the areas were a combination of pressure from his heels resting on his wheelchair pedals and his compromised circulatory system. He stated that it was his expectation that Resident #22 ' s dressings were changed daily as per his order. An interview on 3/30/17 at 1:36pm with the Director of Nursing (DON) revealed that it was her expectation that residents with wounds would receive wound care in accordance with the physician ' s orders.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		4/27/17

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F 323	Continued From page 30 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to use a lift pad that was in good repair to transfer a resident using the sit to stand lift for 1 of 5 residents which resulted in a potential for an accident (Resident # 185). The facility additionally failed to implement the use of planned interventions for a resident who had fallen resulting in injury for 1 of 5 residents which resulted in the risk for additional falls (Resident #263). Findings Included: The operator's manual dated 2013 for the sit to stand lift stated that "the use of the patient lift by one assistant should be based on the evaluation of the healthcare professional for each individual case." The manual also stated that the "belt must be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, causing possible injury." 1. Resident #185 was admitted on 4/4/16 with the diagnoses of muscle weakness, urinary tract infection, and gait abnormality. The Quarterly Minimum Data Set (MDS) dated 3/6/17 revealed the resident was severely cognitively impaired. The resident required extensive assistance with bed mobility, transfers locomotion off the unit, dressing, eating, hygiene, and toilet support. The resident required 2 person assist with toilet use. The resident was always	F 323	Immediate Action Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator. Resident #263 fall mat was placed beside the bed, a bed and chair alarm was also put in place per resident care plan by the quality assurance nurse on 3/31/2017. Resident's care card was updated to reflect the use of floor mat, bed and chair alarm by the Quality Assurance on 3/31/2017 as well. Identification of Others 32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear. 100% audit of all fall care plans for active residents completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1 to determine if any intervention put in place was implemented and communicated to the nurse aides appropriately.	

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BLUMENTHAL NURSING & REHABILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 323	Continued From page 31 incontinent of bowel and frequently incontinent of urine. The resident had a care plan for falls updated on 3/13/17. Fall Interventions included to use the sit to stand lift for transfers with assistance with 2 people. Nursing Assistant #1 was interviewed on 3/29/17 at 10:11 AM. She stated the resident used the sit to stand lift when she changed the resident. She stated she would change the resident in bed or use the lift with assistance from 2 people. Nursing Assistant (NA) #1 was observed taking the resident to the bathroom on 600 hall via wheelchair on 3/29/17 at 11:02 AM. Nursing Assistant #1 asked Nursing Assistant #2 to come help her with resident #185 when she was finished with helping another resident. Nursing Assistant #2 never returned. NA #1 began to transfer the resident without assistance. NA #1 placed the sit to stand lift pad behind resident #185's lower back in the wheelchair. The lift was placed in front of the resident and the lift pad went under the resident's arms and was connected via circular loops to the lift. The waist band that went around the resident's waist was not connected and the waist straps were left dangling beside the resident. The resident was lifted only with pad support under her arms from the sitting position to a standing position with assistance with 1 staff member (Nursing Assistant #1). Resident #185's brief was changed while the resident was in the standing position and the resident was lowered back to the wheelchair with assistance of 1 person (Nursing Assistant #1).	F 323	Findings of this audit was documented on “fall intervention audit tool”. No functional documented process of communication identified to be in place for communication to nurse’s aides, thus, 100% of other residents with interventions to be implemented by nurse’s aide had a potential to affect by this alleged noncompliance. Systemic Changes Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident’s individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident’s evaluation by healthcare professional documented on resident plan of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines. Effectively 4/27/2017; Resident’s Care Cards were initiated as a communication tool to alert nurse’s aides of appropriate method to transfer each resident together with minimum number of staff required for the Activity of daily Living (ADL), specifically transfer to take place. Care Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse’s aides. This include but not limited to fall interventions such as	

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F 323	Continued From page 32 Nursing Assistant #1 was interviewed on 3/29/17 at 1:55 PM. She stated the resident was not really able to stand or help with the transfer. She stated with the sit to stand lift, she would put the lift pad under the resident's her arms and locked the resident's wheelchair then lift the resident up. She stated that technically they used 2 people with the lift but that NA #2 never came back to help her by the time the resident was lifted up. NA #2 must have been busy. She stated the resident was mostly an easy transfer. She stated that the waist belt on the lift pad was broken which was why it was not snapped during the observed transfer. She stated the lift pad she used only had 2 plastic prongs on the belt that would not stay fastened. She stated the other sit to stand lift pads were being used when she used the sit to stand lift for Resident # 185. On 3/29/17 at 2:01 PM, The sling was observed. The sling's waist belt was supposed to clasp via three plastic prongs on one end and a socket for insertion of the plastic prongs on the other end. However, the observed lift pad only had 2 plastic prongs on the waist belt. The 3rd plastic prong was broken off of the waist belt that was supposed to wrap around the resident's waist. The receiving end of the lift's pad waist band would not fit properly in the insertion end with the broken prong. The Director of Nursing (DON) was interviewed on 3/29/17 at 2:40 PM. She stated she had not known of any problems with the lift pads. She stated she would expect that if a lift pad was broken that it was not used on a resident and was to be reported. She was shown the broken lift pad in the bathroom and the lift pad was taken out of the bathroom by the DON on 3/29/17 at 2:41 PM.	F 323	bed in low position, fall mat on floor and/or Chair/bed alarm. Three ring binders titled “Care Cards” places at each nurse’s station for easy access by the nurse’s aides. This process was put in place with the collaboration among the Regional Clinical Consultant #2, Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse, MDS Coordinator #1, MDS Coordinator #2, MDS coordinator #3 and the Staff Development Coordinator 100% active residents in facility were re-assessed for individualized care needs. This re-assessment was completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1, Director of nursing and/or Assistant Director of nursing. Appropriate intervention was put in place and added to each resident’s care card. Effective 4/27/2017 Care cards will be initiated on admission by the admitting nurse and updated at least quarterly and with any change in treatment plan, related to resident’s direct care and safety, by the hall nurses and/or interdisciplinary care plan team. Interventions to be carried out by nursing aides will be added to be part of each resident care cards. 100% of nursing staff, to include licensed nurses and nurse’s aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical	

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F 323	Continued From page 33 Nursing Assistant #3 was interviewed on 3/30/17 at 9:48 AM. She stated that if she saw a pad that was broken she would not use it and report it. She stated about one month ago, there was a lift pad that had a tear in one of the loops and it was taken to the laundry. She stated that about the same time, a month ago, she did hear that a sit to stand pad had a plastic prong that was broken where it snapped around the waist, but she never used that pad and said that there were several other pads to use. Nurse #1 was interviewed on 3/30/17 at 10:30 AM. She stated she was not made aware of any problems with the lift pads or lifts and if there was an issue staff would usually go get another one. She stated if she was made aware of a problem with the lift pad or lift, and stated she would tell maintenance about it and that it would not be used for residents. The DON was interviewed on 3/30/17 on 6:07 PM. She stated she would expect that the nursing staff would check and use safe equipment for each resident. 2. Resident #263 was admitted to the facility on 3/20/17 and his diagnoses included Alzheimer ' s disease. An admission minimum data set (MDS) had not been completed for Resident #263. An interim care plan dated 3/20/17 for Resident #263 revealed he was at risk for injury from falls related to history of falls and actual fall. Interventions included for staff to frequently check on resident. An update to his care plan was made	F 323	lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information from such. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017, resident care cards	

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F 323	Continued From page 34 on 3/23/17 related to a fall and a therapy screen was added as an intervention. An update was made to his care plan on 3/24/17 related to another fall and fall mats, bed alarm, chair alarm and keep bed in lowest position were added as interventions. A review of an incident report for Resident #263 provided by the Director of Nursing (DON) revealed he had a fall on 3/20/17 at 8:02 pm. He was attempting to sit in a chair and fell. He had no injuries and actions to be taken included his bed was to be in low position. A review of an incident report for Resident #263 provided by the DON revealed on 3/23/17 at 5:45 am Resident #263 was found on the floor in front of his dresser. Resident stated he hit his right arm and a very light greenish area was noted to his right upper arm and a skin tear was noted to his right lateral hand. Actions taken included active range of motion to upper and lower extremities, skin assessment, vital signs and that his bed was to be in a low position. A review of an incident report for Resident #263 provided by the DON revealed on 3/24/17 at 5:30 am Resident #263 was found lying on the floor in his room on his right side. He had some redness to the right side of his head. Actions taken included neurological checks, ice applied to the right side of his head, observations and bed in low position. An observation on 3/27/17 at 2:21 pm of Resident #263 revealed he was sitting in a chair in his room. His bed was not in a low position. There were no fall mats, chair alarm or bed alarm in place.	F 323	will be reviewed by the clinical interdisciplinary team daily (Monday thru Friday), and by the week-end supervisor or nurse in-charge on (Saturday & Sundays), to ensure its presence and accuracy as appropriate. This team will consist of but not limited to the DON, ADON, QA Nurse, SDC, MDS#1, MDS#2, and/or MDS#3. , this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed by the member of the interdisciplinary team promptly. Quality Assurance nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all new admission for previous day, daily (Monday thru Friday) and the week-end supervisor or nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly QAPI nurse will report findings to facility Quality Assurance	

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F 323	Continued From page 35 A nursing note dated 3/28/17 for Resident #263 revealed that he had an order on 3/24/17 for his bed to be in low position, fall mat beside bed, bed alarm and chair alarm. An observation on 3/28/17 at 10:29 am of Resident #263 revealed he was sitting in a chair in his room. His bed was not in a low position. There were no fall mats, chair alarm or bed alarm in place. An observation on 3/30/17 at 1:45 pm of Resident #263 revealed he was standing up and starting to exit his room. He sat down in his chair when this surveyor entered his room. His bed was observed to be in a low position. There were no fall mats, chair alarm or bed alarm in place. An interview on 3/30/17 at 1:53 pm with Nursing Assistant (NA) #2 revealed that she was the NA for Resident #263. She stated that he should not walk on his own because he was not that stable and needed to use a walker. She stated that he was confused. She stated he had a bed and chair alarm because he was at risk for falls. She checked his room and confirmed that there were no bed or chair alarms in place. She stated that they should have been there. She stated she was not aware that he was supposed to have fall mats. An interview on 3/30/17 at 2:02 pm with Nurse #4 revealed that Resident #263 was supposed to have a bed and chair alarm. She reviewed the March 2017 medication administration record (MAR) for Resident #263 and the bed and chair alarms had been signed off as being present. She stated that she was not aware that he was	F 323	Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effective 4/27/2017, central supplies clerk or Quality Assurance nurse will inspect the condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.	

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F 323	Continued From page 36 supposed to have fall mats and they were not listed on his MAR. An interview on 3/30/17 at 1:36 pm with the Director of Nursing (DON) revealed it was her expectation that fall interventions were in place to ensure the safety of the resident.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		4/27/17

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F 329	Continued From page 37 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews, the facility failed to obtain a laboratory test as ordered by the physician to monitor the effects of a medication dosage change for 1 of 5 sampled residents (Resident #2) reviewed for unnecessary medications. The findings included: Resident #2 was admitted to the facility on 9/3/12 from the hospital. Her cumulative diagnoses included hypothyroidism (an underactive thyroid gland). A review of the resident ' s medical record revealed her medications included 112 micrograms (mcg) of levothyroxine (a thyroid hormone medication used to treat	F 329	Resident #2 TSH level was drawn and medication adjusted and lab redrawn on 4/5/2017. Level was high. Medication was adjusted and TSH will be re-drawn again in 6 weeks. All residents on medications requiring therapeutic monitoring of labs have the potential to be affected. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: A medication review and lab audit was completed of all Residents charts on 4/24/17 by the contracted pharmacist. a second 100% audit was completed of all	

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F 329	Continued From page 38 hypothyroidism) given as one tablet by mouth once daily (ordered on 5/1/15). On 9/8/16, a Thyroid Stimulating Hormone (TSH) laboratory test was drawn to help monitor the thyroid replacement therapy she was receiving. The TSH level was reported as 0.07 (normal range 0.27 - 4.20). (A low TSH level may reflect excessive amounts of thyroid hormone medication in those who are being treated for an underactive thyroid gland.) The medical record revealed no change in the levothyroxine dosage was made at that time. On 12/9/16, a physician ' s order was received to decrease Resident #2 ' s levothyroxine from 112 mcg to 88 mcg to be given as one tablet by mouth once daily. The order also indicated the TSH level should be rechecked in 6 weeks (1/20/17). A review of Resident #2 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 1/6/17 revealed the resident had severely impaired cognitive skills for daily decision making. She required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for locomotion. A review of the resident ' s care plans included an area of focus for hypothyroidism and the potential for hypothyroid crisis related to a diagnosis of hypothyroidism and the need for medication management. The goal was initiated on 1/30/15; and, it was last revised on 1/13/17 with a handwritten notation to continue with the current goal and interventions. The interventions included, in part: "Labs as ordered."	F 329	lab orders to include meds requiring monitoring on 4/25/17 by administrative nursing staff. A lab tickler file and calendar was also initiated to assure labs are drawn timely. All nurses and unit secretaries were in-serviced on the new system on 4/19/17 by the DON. Monitoring Process: All charts will be audited monthly by Pharmacist for all lab orders. A second audit of all due and new labs ordered will be reviewed for by DON,ADON and QAPI nurse weekly for compliance with this requirement to assure labs were drawn timely as ordered. Labs will be audited weekly by DON,ADON and QAPI nurse as stated above x 4 week,Then monthly x4 months Pharmacist will audit all labs monthly for meds requiring monitoring, as well as other therapeutic lab levels as well as auditing that labs were drawn timely. audits will be completed monthly x 4 months or until 100% compliance is achieved. DON will report findings from nursing audits and pharmacist audit to the facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this requirement.	

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F 329	Continued From page 39	F 329		

An interview was conducted on 3/29/17 at 10:40 AM with the Unit Secretary assigned to work on the hall where Resident #2 resided. Upon review of the laboratory reports available via the facility ' s electronic system, the Unit Secretary reported the September 2016 TSH level was the last TSH level drawn for Resident #2.

An interview was conducted on 3/30/17 at 11:15 AM with the facility ' s Director of Nursing (DON) upon her request. The DON reported that a record review was done for Resident #2 and it confirmed the last TSH lab was drawn on 9/8/16 with a result of 0.07. The DON reported she would expect labs to be drawn as ordered by the physician or NP.

A telephone interview was conducted on 3/30/17 at 12:40 PM with the resident ' s Medical Doctor (MD). When asked if he would be concerned about the 3 month lapse between obtaining a TSH level of 0.07 and changing a resident ' s dose of levothyroxine, the MD stated it all depended on the clinical situation. If the resident did not have any clinical signs or symptoms, the MD reported he may not change the dose right away. The MD was then asked when he would recommend a TSH level be rechecked if a resident ' s levothyroxine dose was changed. The MD reported it was typical to do a TSH recheck in 6 weeks - 8 weeks after a dose change. Resident #2 ' s history was reviewed and it was noted a TSH recheck was ordered to be done 6 weeks after her levothyroxine dose was changed on 12/9/16. Upon inquiry as to what his thoughts were about the TSH recheck not having been done to date (3 and ½ months after the levothyroxine dose change), the MD stated, "That should not have happened. They

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F 329	Continued From page 40 need to have a follow-up system in place to get the labs done."	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6%, for 1 of 6 residents (Resident #174) observed during medication pass. The findings included: 1) A review of the facility ' s policy, "Specific Medication Administration Procedures; #13. Enteral Tube Medication Administration" (Revised 11/1/11) included the following procedural step: "6) Administer each medication separately, flushing tube with water after each dose." On 3/29/17 at 9:58 AM, Nurse #2 was observed as she pulled medications from the medication cart for administration to Resident #174 via a percutaneous endoscopic gastrostomy (or PEG, which is a feeding tube put directly into the stomach). The medications pulled for administration included the following: one - 100 milligram (mg) allopurinol tablet (an antigout agent); one - 10 mg amlodipine tablet (an	F 332	Patient #174 medical assessment was found to be within the patients baseline without acute changes. Nurse #2 was in-serviced on Medication administration by mouth and via PEG tube on 4/6/17. She was given a post test and competency med pass review by Regional nurse and by pharmacist. Nurse #2 was able to pass post- test and competency med pass observations following education and training. All nurses employed and potentially given medications to this resident also received the same training and competency evaluations. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All facility residents have potential to be affected. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur:	4/27/17

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F 332	Continued From page 41 antihypertensive medication); one - 81 mg chewable aspirin tablet; one - 80 mg atorvastatin tablet (a medication used to treat high blood cholesterol); one - 0.6 mg colchicine tablet (an antigout agent); one - 1 mg folic acid tablet (a vitamin supplement); one - 100 mg hydralazine tablet (an antihypertensive medication); one - 325 mg iron sulfate tablet (a mineral supplement); one - 20 mg isosorbide dinitrate tablet (a medication used to prevent angina or chest pain); one - 100 mg Vitamin B1 tablet; one - 1000 microgram (mcg) Vitamin B12 tablet; one - 1000 unit Vitamin D3 tablet; one - 25 mg carvedilol tablet (an antihypertensive medication); 5 milliliters (ml) of 100 mg/ml levetiracetam (an anticonvulsant medication); and, 1 - 250/50 mcg Advair Diskus inhaler (an inhaled medication used to manage chronic obstructive pulmonary disease or asthma). On 3/29/17 at 10:07 AM, Nurse #2 was observed as she placed two tablets into a plastic sleeve, crushed them together, and poured the powder into a medication cup. She then placed five tablets into a plastic sleeve, crushed them together, and poured this powder into a second medication cup. The nurse repeated this process with the remaining five tablets and poured the powder from these tablets into a third medication cup. Nurse #2 reported the resident had an order to give the iron sulfate tablet orally mixed with applesauce, so she placed the iron tablet into a separate medication cup. She then poured the levetiracetam liquid into another medication cup. The nurse was observed as she went to Resident #174 ' s room, re-positioned the resident, raised the head of his bed, and checked for residual / placement of the tube. At 10:15 AM, the nurse tipped over one of the medication cups containing	F 332	All Nurses and med aids were educated on Medication Administration Procedures for oral, PEG tube, eye drops, inhalers, ear drops, IM injections, subcutaneous injections and IV infusions between 4/6/17 and 4/23/17 by Regional clinical consultant and regional QAPI nurse . All Nurses were given a post test for PEG tube drug administration by 4/24/27. 100% of all Nurses and Med aids had competency med- pass observations completed that required a 0% error rate to continue passing meds to facility Residents. Competency evaluations were completed by DON, Regional Nurse Consultant, Pharmacist and ADON. Competency check off were initiated on 4/6/17 and were completed with observation of med-pass of all nurses and all shifts to include weekends on 4/24/17. All Nurses and med- aid new hires will be required to pass a competency medication pass observation during their orientation on the floor with their mentor prior to completing orientation. They will also have medication administration policies reviewed in orientation. Monitoring Process: Medication administration reviews will be completed with 20% of Nurses and med-aids on all shifts weekly to include weekends by DON, ADON and Pharmacist x 4 weeks then monthly x 3	

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F 332	Continued From page 42 crushed medications. Nurse #2 stated she did not know which medications had been tipped over so she would need to start again. On 3/29/17 at 10:19 AM, Nurse #2 was observed as she pulled the same medications previously observed from the med cart for administration to Resident #174. The medications were crushed together using the same procedure as previously observed. However during this observation, the medications were divided into two groups of six tablets each and crushed together, leaving the iron tablet uncrushed and the levetiracetam liquid in a separate cup. At 10:23 AM, the nurse re-entered Resident #174 ' s room. She added 10 ml of water to each of the medication cups, flushed the tube with water, then administered the contents of each medication cup via the tube, flushing the tube with 20 ml of water in between. She flushed the tube with 15 ml of water after the medications were administered. The iron tablet was mixed with applesauce and administered to the resident without difficulty; and, then assisted the resident to use the Advair Diskus inhaler. An interview was conducted on 3/29/17 at 10:42 AM with Nurse #2. Upon inquiry as to what the facility ' s policy was in regards to crushing the medications together for administration via tube, the nurse reported she was not sure. Nurse #2 stated, "(The) last place I went we were told we could crush 5 meds together, but no more than 5." An interview was conducted on 3/30/17 at 9:04 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated her expectation was that the nurses would separate medications and administer them individually via	F 332	months. Nurses with more than 5% medication errors will not be allowed to continue passing medications until they receive further education and achieve substantial compliance error rate below 5%. DON will present the findings of Medication Administration reviews to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 4 months or until pattern of compliance is achieved. QAPI will be modified according to outcomes as needed and determined by QAPI committee.	

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a gastrostomy tube, with the correct amount of water used to flush the tube in between each medication administered.

2) On 3/29/17 at 9:58 AM, Nurse #2 was observed as she pulled medications from the medication cart for administration to Resident #174. The medications pulled for administration included one - 20 mg isosorbide dinitrate tablet (a medication used to prevent angina or chest pain). Nurse #2 was observed as she crushed the isosorbide dinitrate tablet with four other tablets in preparation for administration to Resident #174. A continuous observation was made as the nurse went to Resident #174 ' s room, re-positioned the resident, raised the head of his bed, and checked for residual / placement of the tube. At 10:15 AM, the nurse tipped over one of the medication cups containing crushed medications. Nurse #2 stated she did not know which medications had been tipped over so she would need to start again.

On 3/29/17 at 10:19 AM, Nurse #2 was observed as she pulled the same medications previously observed from the med cart for administration to Resident #174, which included one - 20 mg isosorbide dinitrate tablet. The isosorbide dinitrate tablet was again crushed together with other medications. At 10:23 AM, Nurse #2 re-entered Resident #174 ' s room and was observed as she administered the medication to the resident.

A review of Resident #174 ' s physician medication orders revealed there was a current order for isosorbide dinitrate to be given as two - 20 mg tablets via tube once daily (for a total dose of 40 mg).

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F 332	Continued From page 44 An interview was conducted on 3/29/17 at 10:42 AM with Nurse #2. During the interview, the nurse confirmed only one tablet of 20 mg isosorbide dinitrate was administered to Resident #174 during the medication administration observation. Upon review of the resident's MAR, the nurse stated she did not realize the resident was supposed to receive 2 tablets (20 mg each) of isosorbide dinitrate for a total dose of 40 mg. The nurse stated she would need to go back and give the resident another 20-mg tablet of isosorbide dinitrate. An interview was conducted on 3/30/17 at 9:04 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated, "I expect the nurse to give the medications according to the physician's order."	F 332		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]	F 353		4/27/17

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F 353	Continued From page 45 (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews with resident, staff and family members , the facility failed to provide staffing of sufficient quantity and quality to provide pressure sore care and to prevent accident for residents who required assistance. This affected 3 out of 40 residents (Resident #22, Resident #185 and Resident # 263).	F 353	Immediate Action Resident #22, resident #185, and resident #263 care and services explained below rendered on stated dates here under by the nursing staff with appropriate competencies and skill set to provide those nursing and related services to assure resident safety. Such care was	

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F 353	Continued From page 46 Finding included: This tag is cross referenced to F 314 Based on observations, record review, resident interviews and staff interviews the facility failed to provide wound care as ordered by the physician for 1 of 2 residents reviewed for pressure ulcers (Resident #22). F 323 Based on record review, observations and interviews the facility failed to use a lift pad that was in good repair to transfer a resident using the sit to stand lift for 1 of 6 residents which resulted in a potential for an accident (Resident # 185). The facility additionally failed to implement the use of planned interventions for a resident who had fallen resulting in injury for 1 of 6 residents which resulted in the risk for additional falls (Resident #263). During an interview with Nurse # 26 on March 26, 2017 at 9 PM. Nurse #26 revealed that she works from 7 PM until 7 AM. Nurse #26 stated that we had 4 call in and no staff to replace them. Nurse # 26 indicated that this was a problem. Nurse #26 was unsure of the census because March 26, 2017 was not posted only March 24, 2017 this was Friday census of 124. During an interview with the Nursing Assistant #2 on March 28, 2017 at 2:10 PM. NA #2 stated that for residents who required the assistance of two (2) NA's, resident that we use lifts on required two NA's. NA indicated that these residents would have to wait longer to get help because the facility need more staff to meet the needs of the residents.	F 353	provided based on resident assessments and individual plans of care. Resident #22: Treatment rendered per physician order by a treatment nurse on 3/29/2017. Wound was assessed by the Regional Nurse Consultant #2 and treatment nurse on 3/30/2017. No deterioration in the wound was noted from treatment nurse assessment on 3/27/2017. Treatment was deemed appropriate for wounds and wounds showed improvement from prior assessments. Performance improvement action were implemented for weekend licensed nurse who was responsible for resident care and treatment on 3/25/2017 & 3/26/2017 during day shift (7AM-7PM). This action was put forth by the Director of Nursing on 4/6/2017. Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator. Resident #263 fall mat was placed beside the bed, a bed and chair alarm was also put in place per resident care plan by the quality assurance nurse on 3/31/2017. Resident's care card was updated to reflect the use of floor mat, bed and chair alarm by the Quality Assurance on 3/31/2017 as well. Identification of Others Facility staffing pattern re-assessed by the Regional nurse consultant #2, and the Assistant Administrator on 4/12/2017, to	

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F 353	Continued From page 47 During an interview with the Director of Nursing (DON) on March 29, 2017 at 2:30 PM. DON stated that she had only been here since March 13, 2017. She indicated that she had been informed of the staffing concerns and call out during the week and weekend. DON also indicated that her expectation would be that the facility have sufficient staff to meet the resident's needs During an interview with the Administrator on March 29, 2017 at 2:30 PM at 2:30 PM. Administrator stated he had only been here since March 19, 2017. He indicated that staffing had been identified as an issue here in the facility. However his expectation was that the facility have enough staff to meet all the resident's needs. During an interview with Quality Assessment and Assurance (QAA) Nurse on March 30, 2017 at 5:50 PM. She stated she had only been here since January, 2017. She stated they have done multiple in-services on hand washing lately on hand washing and blood spills. Staffing is discussed every morning during the morning meeting. She would expect that if there are QA issues that they would be fixed.	F 353	determine opportunities to maximize direct care nursing hours, to meet resident's individual needs. This audit identified opportunities for improvement, including lack of enforcement on attendance policy, employee call out protocol as well as lack on on-call schedule to cover when another nursing employee is unable to report to work, to ensure continuous quality of care with sufficient nursing staff. 100% audit of all active resident's with wound care orders completed by the Regional nurse Consultant #2, and the treatment nurse to ensure that Physicians orders matched the treatment administration records record on 4/12/17, as well as the documentation for completion of such orders are noted in resident's record per order and to include Saturdays and Sundays 100% of all active residents with pressure ulcers were assessed by Treatment nurse and by Certified wound nurse from sister facility on 4/27/2017. No pressure ulcers were noted to have deteriorated from their previous documented assessment. 32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear.	

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F 353	Continued From page 48	F 353	100% audit of all fall care plans for active residents completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1 to determine if any intervention put in place was implemented and communicated to the nurse aides appropriately. Findings of this audit was documented on “fall intervention audit tool”. No functional documented process of communication identified to be in place for communication to nurse’s aides, thus, 100% of other residents with interventions to be implemented by nurse’s aide had a potential to affected by this alleged non compliance Systemic Changes: Effective 4/27/2017, open position for all classification of nursing staff, Registered nurses, Licensed Practical Nurses and/or nursing aides will be posted on a worldwide staffing advertisement websites for easier attraction of new hires. When such needs arise, the Human Resources will coordinate the posting of such positions. Effective 4/27/2017 Human resource department will conduct job fail at least once quarterly for recruiting staff. New incentive program that aide of staff recruitments put in place effective 4/27/2017. Facility will utilize agency staff as the last resort to ensure sufficient number is staff is maintained effective	

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F 353	Continued From page 49	F 353	4/27/2017 Effective 4/27/2017, any call-in, (nursing employee unable to report to work), for any nursing staff will be reported to the Director of nursing and to the staffing coordinator so replacement can be made for call ins to assure adequate staffing is maintained to meet the need of each resident. Each employee is expected to contact the facility at the minimum of two hours before the beginning of their shift if will be unable to come to work. Director of Nursing will oversee the assurance of sufficient staff in the facility. Effective 4/27/2017, staff development coordinator will ensure that each nursing staff has appropriate competencies and skill set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Effective 4/27/2017, each resident treatment is rendered per physician order. On- coming nurse will check treatment records for omissions prior to accepting cart form previous shift nurse. On- coming Nurse will not accept cart until treatments are completed or reconciled. 100% of licensed nurses employed by the facility ware re-educated on ensuring treatment orders are rendered per physician order, completed on the	

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F 353	Continued From page 50	F 353	frequency ordered and documented on each resident treatment administration record. This education also covered on what to do when a pressure ulcer is identified and documentation for residents who refuse their wound care treatment to be done. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all licensed nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nursing staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new licensed nurses effective 4/27/17 and also will be provided annually. Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident's individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident's evaluation by healthcare professional documented on resident plan of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines.	

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F 353	Continued From page 51	F 353	Effectively 4/27/2017; Resident's Care Cards were initiated as a communication tool to alert nurse's aides of appropriate method to transfer each resident together with minimum number of staff required for the Activity of daily Living (ADL), specifically transfer to take place. Care Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse's aides. This include but not limited to fall interventions such as bed in low position, fall mat on floor and/or Chair/bed alarm. Three ring binders titled "Care Cards" places at each nurse's station for easy access by the nurse's aides. This process was put in place with the collaboration among the Regional Clinical Consultant #2, Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse, MDS Coordinator #1, MDS Coordinator #2, MDS coordinator #3 and the Staff Development Coordinator 100% active residents in facility were re-assessed for individualized care needs. This re-assessment was completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1, Director of nursing and/or Assistant Director of nursing. Appropriate intervention was put in place and added to each resident's care card. Effective 4/27/2017 Care cards will be initiated on admission by the admitting nurse and updated at least quarterly and with any change in treatment plan, related	

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to resident's direct care and safety, by the hall nurses and/or interdisciplinary care plan team. Interventions to be carried out by nursing aides will be added to be part of each resident care cards.

100% of nursing staff, to include licensed nurses and nurse's aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information from such.

This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not

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F 353	Continued From page 53	F 353	educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017, sufficient nursing staffing for past 24 hours and upcoming 24 hours will be discussed in a daily morning meeting (Monday thru Friday), and the week-end supervisor or nurse in-charge will audit staffing pattern on (Saturday & Sundays), to ensure the facility has sufficient number of staff to meet resident need. Any identified problem during this monitoring process will be addressed promptly to unsure resident care and services is not affected. This review will take place daily for 2 weeks, weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Staffing coordinator, Director of Nursing and/or the assistant administrator will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this plan. Effective 4/27/2017, Assistant administrator will review staffing sheets for the week to ensure facility had sufficient nursing staffing to meet the need of resident based on determined	

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F 353	Continued From page 54	F 353	minimum hours per patient day (PPD) requirements. This review will take place weekly x 12 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Staffing coordinator, Director of Nursing and/or the assistant administrator will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 6 months for any additional monitoring needs or modifications of this plan. Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all treatments records daily (Monday Friday) and the week-end supervisor or nurse in-charge will audit treatment records on (Saturday & Sundays), to ensure they have been completed and signed for as ordered by physician. This review will take place daily for 2 weeks, weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Quality assurance nurse will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this plan. Effective 4/27/2017, resident care cards will be reviewed by the clinical interdisciplinary team daily (Monday thru Friday), and by the week-end supervisor or nurse in-charge on (Saturday & Sundays), to ensure its presence and	

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F 353	Continued From page 55	F 353	accuracy as appropriate. This team will consist of but not limited to the DON, ADON, QA Nurse, SDC, MDS#1, MDS#2, and/or MDS#3. , this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed by the member of the interdisciplinary team promptly. Quality Assurance nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all new admission for previous day, daily (Monday thru Friday) and the week-end supervisor or nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly QAPI nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effective 4/27/2017, central supplies clerk or Quality Assurance nurse will inspect the condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed	

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F 353	Continued From page 56	F 353	from circulation promptly and new sling will be ordered. Quality Assurance or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.	
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 356		4/24/17

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F 356	Continued From page 57 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post daily nurse staffing information during one (1) of four (4) days; and the facility failed to post the correct resident census on the daily nurse staffing information for three (3) of four (4) days during the recertification survey. Finding included; An observation on 3/26/2017 at 8:30 PM revealed the daily nurse staffing information for 3/24/2017 was posted in a plastic see-through cover on a stand on top of a desk in the facility's front lobby. The staffing information was not posted for 3/26/2017. An observation on 3/27/2017 at 10 AM revealed daily nurse staffing information was posted in a	F 356	No residents were affected by this alleged deficient practice Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Staffing Coordinator, Receptionist and all nurses were educated on the correct way to complete and post the Nurse Staffing Information. Staffing Coordinator will complete posting sheets for the week. Nurse managers and or hall nurses will modify posting as needed for any staffing changes. Receptionist will check to assure that the posted nurse staffing information is	

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F 356	Continued From page 58 plastic see-through cover on a stand on top of a desk in the facility's front lobby and was dated 3/27/2017. The facility's resident census sheet revealed there were 121 residents on 3/27/2017. The nursing staff posted included all residents in the facility, including the assisted living residents. An observation on 3/28/2017 at 11 AM revealed the daily nurse staffing information was posted in a plastic see-through cover on a stand on top of a desk in the facility's front lobby and was dated 3/28/2017. The facility's resident census sheet revealed there were 124 residents. The census number on the posting continued to combine assisted living residents with the skilled nursing residents. An observation on 3/29/2017 at 10:30 AM revealed the daily nurse staffing information was posted in a plastic see-through cover on a stand on top of a desk in the facility's front lobby and was dated 3/29/2017. The resident census number on the posting continued to combine assisted living residents with the skilled nursing residents. An interview with the Director of Nursing on 3/29/2017 at 4:10 PM revealed that the census was 124 on 3/29/2017. She stated that she was not aware the posting included assisted living Residents. An interview with the Administrator on 3/29/2017 at 4:20 PM revealed that the census for skilled nursing was 115 on 3/29/2017 and that the census posted should not include the Assisted Living residents. He stated that it was his expectation that the posted nurse staffing be correct and not combine the nursing home and	F 356	correct and has the correct date posted on a daily basis. Assistant Administrator will review staffing sheets once a week x 4 weeks then monthly x 3 months to assure Nurse staffing information was posted correctly. Monitoring Process: Staffing reviews will be completed on a weekly basis x 4 weeks then monthly x 3 months. Results of reviews will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee by the Assistant Administrator monthly for 4 months or until pattern of compliance is achieved. QAPI will be modified according to outcomes as needed and determined by QAPI committee.	

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F 356	Continued From page 59 assisted living residents.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure opened food products were stored in sealed containers, dishware were clean, in good repair and allowed to air dry, equipment and ceiling vents were clean and male employee ' s with facial hair wore beard guards while working in the kitchen. This had the potential to impact the 112 residents who resided	F 371	Immediate Action The open and unsealed case of Okra, fish fillets and sausage in the walk-in freezer, and unsealed box of rice in the dry storage room ware discarded by the Dietary Manager on 3/27/2017. A male employee with facial hair who was	4/27/17

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F 371	Continued From page 60 in the facility. Findings Included: 1. An observation of the kitchen on 3/27/17 at 9:15 am with the Dietary Manager revealed the following: a. In the kitchen ' s walk-in freezer an open, unsealed case of okra; an open, unsealed case of fish fillets and an open, unsealed case of sausage patties were stored exposed to the air. b. In the kitchen ' s dry storage room an open, unsealed box of rice was stored exposed to the air. c. A male employee with facial hair did not have a beard guard on while he was preparing dessert for the lunch meal. d. A ceiling vent located in the beverage preparation area of the kitchen had a thick layer of dust on the grates. e. A storage cart that contained clean meal trays had dried food spills and food particles on it. An interview with the Dietary Manager on 3/27/17 at 9:40 am revealed that all opened food items should be re-sealed or placed in sealed plastic bags to prevent exposure to the air. She stated that the male employee should have had a beard guard on while working in the kitchen; especially if he was working on food preparation. She stated that the ceiling vent did need to be cleaned and that the storage cart for the meal trays should be cleaned before storing clean trays on it.	F 371	noted with no beard guard on while he was preparing desert for the lunch meal re-educated on 3/27/2017 by Dietary manager and worm a beard guard rite away. The ceiling vent in the beverage preparation area was cleaned and is free of dust on 3/27/2017 by Dietary Manager. The storage cart that contained clean meal trays observed on 3/27/2017 was cleaned by Dietary Manager on 3/27/2017. 15 meal trays that had dark staining, cracks and exposed metal edges ware discarded on 3/29/2017 by Dietary manager and The Registered Dietician. Four divided plates noted with dried food particles ware cleaned, sanitized, dried and stored properly on 3/29/2017 by Dietary aide #1 12- 8 ounce clear glasses were cleaned, re-sanitized, air dried on 3/29/2017 and stored appropriately, by Dietary aide #1, Solid tray that prevented those glasses from air drying on 3/29/2017 removed from being a surface used to air dry dishes in the facility by Dietary Manager on 3/29/2017. Identification of others: 100% audit of all food storage areas inspected by dietary Manager and/or	

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F 371	Continued From page 61 An interview on 3/30/17 at 6:11 pm with the Administrator revealed it was his expectation that opened food products were fully sealed and not exposed to the air. He stated that he expected male employees with facial hair would have beard guards on while working in the kitchen. He additionally stated that he expected vents to be clean and on the cleaning schedule. 2. An observation of the kitchen on 3/29/17 at 11:45 am with the Registered Dietitian revealed the following: a. 15 meal tray that had dark staining, cracks and exposed metal edges were stored in a storage cart ready to be used for lunch meal service. b. 4 of 6 divided plastic plates had dried food particles on them and were stored on a shelf ready to be used for lunch meal services. c. 12 - 8 ounce clear glasses were wet and stored on a solid tray that prevented them from air drying. An interview on 3/30/17 at 3:43 pm with the Dietary Manager revealed that the damaged meal trays should have been removed from service and discarded. She stated that she expected all dishware to be clean and left in the drying racks to air dry before they were stored. She additionally stated that the ceiling vents and the tray storage rack should be added to the cleaning schedule. An interview on 3/30/17 at 6:11 pm with the Administrator revealed it was his expectation that dishware was clean, air dried and in good condition.	F 371	Registered Dietician 3/27/2017 to identify any other open item that is unsealed and/or not sored appropriately. No other items identified as being inappropriately stored. 100% of dietary staff working on duty on 3/27/2017, re-educated by the Dietary manager on the importance of wearing hair cover and/or beard guard while preparing resident's meals. All other employees noted to have hair cover and/or beard guard while preparing residents' meal on 3/27/2017 100% inspection of all ceiling vents in the kitchen audited by Dietary Manager and/or Registered Dietician on 3/27/2017to identify its cleanliness. No other ceiling vent in the Kitchen noted to be unclean or with dust. 100% inspection of all storage carts completed on 3/27/2017 by the Dietary Manager and/or Registered Dietician to identify any other cart that needs to be cleaned and sanitized. No other dietary storage cart noted to be unclean 100% inspection of all meal trays completed by the dietary Manager and/or Registered Dietician on 3/29/2017, 7 other meal trays noted with cracks and/or exposed metal edges. Those seven trays ware discarded immediately by the Dietary Manager and/or Registered Dietician. 100% of all resident meal wares including plates, cups, glasses, spoon and forks	

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F 371	Continued From page 62	F 371	rewashed on 3/29/2017 by Dietary aides to ensure cleanliness and sanitation. After being, dish wares allowed to air dry, no other dishware noted to be unclean. 100% inspection of all surfaces used for dish ware air drying process inspected by Dietary Manager and the Registered Dietician on 3/29/2017 to ensure no other surface can potentially obstruct air drying process. All other storage surfaces identifies as being capable of allowing dishes to air dry with no obstruction. Systemic Changes: Effective 4/27/2017 A new Dietary Manager was hired and trained and will oversee dietary services, sanitation, food storage and employee practices to ensure compliance. Root cause of such alleged compliances concluded to be staff training and managerial supervision. Effective 4/27/2017, A cook on duty is designated to work as a Kitchen supervisor on duty. On the absence of the dietary manager, the cook on duty will oversee kitchen sanitation, proper storage of foods, ensuring dish wares are allowed to air dry, cleanness of dishware before use, employee compliance with wearing beard guard and hair cover while preparing resident food as well as ensuring any dish wares not in good repair are removed out of circulation immediately. 100% of dietary employees, to include	

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F 371	Continued From page 63	F 371	cooks and dietary aides ware re-educated on proper storage of food in all food storing location to include but not limited to freezer, Walk-in refrigerator, reach in refrigerator and dry storage food, proper use of beard guards & hair cover while preparing residents' food, proper cleaning of the ceiling vents and the proper way to clean storage carts for meal trays. This re-education also covered and emphasized on proper technique to clean and store plates and glasses to allow air drying as well as how to identify damaged trays for disposal, and notifying Dietary Manager so that replacements could be ordered. This education provided by Dietary Manager and/or Registered Dietician. This educated was initiated on 3/27/2017 for all dietary staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any dietary staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017 The Registered Dietician, Dietary Manager, designated cook, and or designated dietary aide will monitor compliance with proper food storage all food storing locations, to include but not limited to freezer, Walk-in refrigerator, reach in refrigerator and dry	

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F 371	Continued From page 64	F 371	storage food, proper use of beard guards & hair cover while preparing residents' food, proper cleaning of the ceiling vents and the proper way to clean storage carts for meal trays. This monitoring will also assure proper technique to clean and store plates & glasses to allow air drying as well as monitoring any damaged trays for disposal. Effective 4/27/2017, This monitoring process will be accomplished, and findings will be documented in a daily Daily Kitchen Rounds Audit Tool and a Sanitation Checklist daily for 2 weeks, then 3 times a week for 2 weeks then weekly times 12 week, then monthly x 6 months afterwards, or until the pattern of compliance is maintained. Effective 4/27/2017 the Dietary Manager or Registered Dietician will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement monthly x 6 months,	
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes	F 428		4/27/17

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

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

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

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

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

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

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

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F 428	Continued From page 66 identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and pharmacy and facility staff interviews, the facility failed to maintain documentation of the pharmacist's monthly Medication Regimen Review (MRR) within the facility and readily available for 4 of 5 sampled residents (Resident #2, #49, #61, and #70) reviewed for unnecessary medications. The findings included: 1) Resident #2 was admitted to the facility on 9/3/12 from the hospital. Her cumulative diagnoses included dementia, hypothyroidism, depression, anxiety and psychotic disorder. A review of Resident #2 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 1/6/17 revealed the resident received an antipsychotic, antianxiety, and antidepressant on each of the 7 days during the look back period. A review of Resident #2 ' s paper and electronic medical records revealed the consultant pharmacist conducted a Medication Regimen Review (MRR) on 6/30/16. However, MRRs were not available for the months of July 2016, August 2016, or September 2016. A consultant pharmacist MRR was next completed and documented in the medical record on 10/28/16; and, once each month thereafter up through the most recent pharmacist review dated 3/27/17. An interview was conducted on 3/29/17 at 5:20 PM with the facility ' s Director of Nursing (DON). During the interview, an inquiry was made as to	F 428	A Complete Pharmacy Review was conducted for Resident # 2, Resident # 49, Resident # 61 and Resident # 70 on 3/27/17 by the Contracted Pharmacist. All recommendations for Nursing and Physicians received appropriate follow up and reconciliation. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All facility residents have potential to be affected and will receive monthly Pharmacy reviews with timely interventions . Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: DON and unit managers were trained by Regional Nurse Consultant on proper Processing of Resident Pharmacy reviews on 4/21/17. Medical Records was in-serviced on timely filing of pharmacy Reviews on Residents charts by the Regional Nurse Consultant on 4/21/17. All Pharmacy Reviews will be discussed on exit, rather than simply emailed by the Contracted pharmacist with either the ED, and or DON, and or Regional Nurse Consultant. DON will receive a hard copy of Pharmacy recommendations in addition to emailed copy. Any critical areas	

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F 428	Continued From page 67 where the consultant pharmacist ' s Medication Regimen Reviews (MRRs) for the months of July 2016, August 2016, and September 2016 were located. A review of Resident #2 ' s paper and electronic medical records revealed the monthly MRRs for these three consecutive months were missing. A follow-up interview was conducted on 3/30/17 at 9:04 AM with the DON. During the interview, the DON reported she and her team tried to find the missing MRRs, but were not yet able to locate these records. The DON stated she had placed a call to the consultant pharmacist to further check on the missing MRRs. An interview was conducted with the DON on 3/30/17 at 9:56 AM. Upon inquiry, the DON stated she would expect medication regimen reviews to be, "done and addressed on each (resident ' s) chart monthly." An interview was conducted on 3/30/17 at 10:07 AM with the facility ' s Nurse Consultant. During the interview, the Nurse Consultant reported the facility was not sure where the communication breakdown was during the 3 months of missing MRRs. However, she added, "We will fix it going forward." A telephone interview was conducted on 3/30/17 at 11:50 AM with the facility ' s consultant pharmacist. The consultant pharmacist reported she was the current consultant pharmacist for the facility. However, the pharmacist stated she was on leave from May 2016 until December of 2016. She was unable to provide insight as to how the consultant pharmacist coverage was provided to the facility during the months she was on leave.	F 428	requiring immediate attention will be called to the attention of the DON and or ED immediately in addition to inclusion in formal report. The DON or ADON will disseminate the orders to the appropriate provider. Physician recommendations will be placed in a folder in physician□s box to be completed on next physician visit. Physicians were made aware of the expectation for all recommendations to be addressed promptly within 5 business days by the ED on 4/25/17. Upon completion of Pharmacy recommendations, Physician, will give the competed folder to the DON for processing. DON will then assure that orders are written and processed according to doctors□ orders. Nursing recommendations will be given to unit managers for completion and will be returned to the DON and signed as completed by unit managers DON will check to make sure she has received all recommendations back from physicians and unit managers by comparing them to her original email to assure all recommendations are accounted for and completed timely within 5 business days. Once Physician recommendations are completed they will be placed on the resident□s charts under pharmacy tab by medical records. All Pharmacy	

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F 428	Continued From page 68 A telephone interview was conducted on 3/30/17 at 1:36 PM with the Clinical Director of the pharmacy contracted to provide consultant pharmacist services to the facility. During the interview, the Clinical Director reported she had hired a new consultant pharmacist to cover the facility for the months of July, August, and September of 2016. She recalled the new pharmacist's computer could not replicate her consultation report in the facility ' s electronic medical record. Therefore, the residents ' MRRs were electronically sent to the DON (who was no longer working at the facility) for July, August, and September 2016. When asked, the Clinical Director indicated she typically would have expected a copy of these notes to have been put on the residents ' charts. The Clinical Director reported the missing MRRs would be in the pharmacy ' s computer system. The Clinical Director also stated she could email the MRRs to the facility so they would be available for review. On 3/30/17 at 2:51 PM, an interview was conducted with the DON. During the interview, inquiry was made as to whether the facility had received the missing MRRs via an electronic communication from the pharmacy ' s Clinical Director. The DON indicated she would follow-up on this. On 3/30/17 at 4:06 PM, the facility provided a copy of Resident #2 ' s consultant pharmacist ' s MRR from July 2016 and August 2016 for review. During an interview conducted at that time, the Nurse Consultant indicated she was not able to pull up the September 2016 MRR for this resident. Upon review of the resident ' s medical record, the Nurse Consultant confirmed the	F 428	recommendations are to be addressed within 5 business days. Pharmacy will audit 100% of resident charts and review their previous recommendations when they do the next month□s pharmacy reviews. Any reviews or recommendations found without appropriate follow up will be dictated on the following months pharmacy reviews and sent to DON, Administrator and Regional Clinical Director for prompt intervention and modification as needed to systems implemented. Monitoring Process: Contacted Pharmacist will audit compliance with previous months□ reviews on a monthly basis x 6 months. Results of audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee by the Contracted Pharmacist monthly for 6 months or until pattern of compliance is achieved. QAPI will be modified according to outcomes as needed and determined by QAPI committee.	

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resident was in the facility during the month of September 2016.

On 3/30/17 at 6:00 PM, the facility provided a copy of Resident #2 ' s September 2016 MRR for review.

2) Resident #49 was admitted to the facility on 7/29/09, with reentry from the hospital on 12/6/09. Her cumulative diagnoses included diabetes, hypothyroidism, edema (fluid retention), atrial fibrillation (irregular heart beat), anxiety disorder, and depression.

A review of Resident #49 ' s annual Minimum Data Set (MDS) assessment dated 1/10/17 revealed the resident had intact cognitive skills for daily decision making. She required limited assistance for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance from staff for bed mobility, supervision for eating, and was independent for locomotion on the unit. Section N of the MDS indicated the resident received insulin, an anticoagulant, antidepressant, and diuretic medication on each of the 7 days during the look back period. She received an antianxiety medication on 1 of the 7 days during the look back period.

A review of Resident #49 ' s paper and electronic medical records revealed the consultant pharmacist conducted a Medication Regimen Review (MRR) on 6/30/16. MRRs were not available for the months of July 2016, August 2016, or September 2016. A consultant pharmacist MRR was completed and documented in the medical record on 10/31/16; and, once each month thereafter up through the most recent pharmacist review dated 3/27/17.

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An interview was conducted on 3/29/17 at 5:20 PM with the facility ' s Director of Nursing (DON). During the interview, an inquiry was made as to where the consultant pharmacist ' s Medication Regimen Reviews (MRRs) for the months of July 2016, August 2016, and September 2016 were located. A review of Resident #49 ' s paper and electronic medical records revealed the monthly MRRs for these three consecutive months were missing.

A follow-up interview was conducted on 3/30/17 at 9:04 AM with the DON. During the interview, the DON reported she and her team tried to find the missing MRRs, but were not yet able to locate these records. The DON stated she had placed a call to the consultant pharmacist to further check on the missing MRRs.

An interview was conducted with the DON on 3/30/17 at 9:56 AM. Upon inquiry, the DON stated she would expect medication regimen reviews to be, "done and addressed on each chart monthly."

An interview was conducted on 3/30/17 at 10:07 AM with the facility ' s Nurse Consultant. During the interview, the Nurse Consultant reported the facility was not sure where the communication breakdown was during the 3 months of missing MRRs. However, she added, "We will fix it going forward."

A telephone interview was conducted on 3/30/17 at 11:50 AM with the facility ' s consultant pharmacist. The consultant pharmacist reported she was the current consultant pharmacist for the facility. However, the pharmacist stated she was

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on leave from May 2016 until December of 2016. She was unable to provide insight as to how the consultant pharmacist coverage was provided to the facility during the months she was on leave.

A telephone interview was conducted on 3/30/17 at 1:36 PM with the Clinical Director of the pharmacy contracted to provide consultant pharmacist services to the facility. During the interview, the Clinical Director reported she had hired a new consultant pharmacist to cover the facility for the months of July, August, and September of 2016. She recalled the new pharmacist's computer could not replicate her consultation report in the facility ' s electronic medical record. Therefore, the residents ' MRRs were electronically sent to the DON (who was no longer working at the facility) for July, August, and September 2016. When asked, the Clinical Director indicated she typically would have expected a copy of these notes to have been put on the residents ' charts. The Clinical Director reported the missing MRRs would be in the pharmacy ' s computer system. The Clinical Director also stated she could email the MRRs to the facility so they would be available for review.

On 3/30/17 at 2:51 PM, an interview was conducted with the DON. During the interview, inquiry was made as to whether the facility had received the missing MRRs via an electronic communication from the pharmacy ' s Clinical Director. The DON indicated she would follow-up on this.

On 3/30/17 at 4:06 PM, the facility provided a copy of the missing MRRs from July, August, and September 2016 for Resident #49.

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3. Resident #61 was admitted on 1/22/15 with the current diagnosis of dementia, anxiety and depression.

Resident #61 Minimum Data Set (MDS) dated 1/23/17 revealed the resident was severely cognitively impaired. The resident had no moods or behaviors. The resident had an active diagnoses of anxiety, depression and a psychotic disorder. The resident was on an Antipsychotic medication for 7 days and antidepressant medication for 7 days.

The resident had a care plan dated 6/16/16 for risk of side effects from psychotropic medication use. An intervention included pharmacy consultant reviewed medications monthly.

An interview was conducted on 3/29/17 at 5:20 PM with the facility's Director of Nursing (DON). During the interview, an inquiry was made as to where the consultant pharmacist's Medication Regimen Reviews (MRRs) for the months of July 2016, August 2016, and September 2016 were located

The morning of 3/30/17, monthly pharmacy reviewed were reviewed from 6/2016 through 3/2016. Monthly Pharmacy reviews were not available at the facility and were missing in the resident's medical record for the months of July, 2016, August, 2016 and September, 2016.

A follow-up interview was conducted on 3/30/17 at 9:04 AM with the DON. During the interview, the DON reported she and her team went back to try and find the missing MRRs but were not yet able to locate these records. The DON stated

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she had placed a call to the consultant pharmacist to further check on the missing MRRs.

An interview was conducted with the DON on 3/30/17 at 9:56 AM. Upon inquiry, the DON stated she would expect medication regimen reviews to be, "done and addressed on each chart monthly."

An interview was conducted on 3/30/17 at 10:07 AM with the facility's Nurse Consultant. During the interview, the Nurse Consultant reported the facility was not sure where the communication breakdown was during the 3 months of missing MRRs. However, she added, "We will fix it going forward."

A telephone interview was conducted on 3/30/17 at 11:50 AM with the facility's consultant pharmacist. The consultant pharmacist reported she was the current consultant pharmacist for the facility. However, the pharmacist stated she was on leave from May 2016 until December of 2016. She was unable to provide insight as to how the consultant pharmacist coverage was provided to the facility during the months she was on leave.

A telephone interview was conducted on 3/30/17 at 1:36 PM with the Clinical Director of the pharmacy contracted to provide consultant pharmacy services to the facility. During the interview, the Clinical Director reported she had hired a new consultant pharmacist to cover the facility for the months of July, August, and September of 2016. She recalled the pharmacist's computer could not replicate her consultation report in the facility's electronic medical record. Therefore, electronic chart notes

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with the MRR information were emailed to the DON (who was no longer working at the facility). When asked, the Clinical Director indicated she typically would have expected these notes to have been put on the residents' charts. The Clinical Director reported the missing MRRs were in the pharmacy's computer system and she could email these to the facility so they would be available for review.

On 3/30/17 at 2:51 PM, an interview was conducted with the DON. During the interview, inquiry was made as to whether the facility had received the missing MRRs via an electronic communication from the pharmacy's Clinical Director.

On 3/30/17 at 4:07 PM, The Director of Nursing provided a copy of the monthly Pharmacy reviews which were emailed to her for the months of July, 2016, August, 2016 and September, 2016.

The DON was interviewed on 3/30/17 on 6:07 PM. She stated that she would expect for pharmacy to conduct drug regiment reviews as required.

4. Resident #70 was admitted on 7/18/11 with Parkinson's disease, diabetes, depression and anxiety.

Resident #70 Minimum Data Set (MDS) dated 1/17/17 revealed the resident was cognitively intact. The resident was receiving an injection for 7 days, insulin for 7 days, an antipsychotic medication for 7 days, an antianxiety medication for 6 days, an antidepressant medication for 6 days and a diuretic medication for 7 days. The resident had the current active diagnoses of

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Diabetes, depression, anxiety and psychotic disorder.

An interview was conducted on 3/29/17 at 5:20 PM with the facility's Director of Nursing (DON). During the interview, an inquiry was made as to where the consultant pharmacist's Medication Regimen Reviews (MRRs) for the months of July 2016, August 2016, and September 2016 were located.

The morning of 3/30/17, monthly pharmacy reviewed were reviewed from 6/2016 through 3/2016. Monthly Pharmacy reviews were not available at the facility and were missing in the resident's medical record for the months of July, 2016, August, 2016 and September, 2016.

A follow-up interview was conducted on 3/30/17 at 9:04 AM with the DON. During the interview, the DON reported she and her team went back to try and find the missing MRRs but were not yet able to locate these records. The DON stated she had placed a call to the consultant pharmacist to further check on the missing MRRs.

An interview was conducted with the DON on 3/30/17 at 9:56 AM. Upon inquiry, the DON stated she would expect medication regimen reviews to be, "done and addressed on each chart monthly."

An interview was conducted on 3/30/17 at 10:07 AM with the facility's Nurse Consultant. During the interview, the Nurse Consultant reported the facility was not sure where the communication breakdown was during the 3 months of missing MRRs. However, she added, "We will fix it going

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forward."

A telephone interview was conducted on 3/30/17 at 11:50 AM with the facility's consultant pharmacist. The consultant pharmacist reported she was the current consultant pharmacist for the facility. However, the pharmacist stated she was on leave from May 2016 until December of 2016. She was unable to provide insight as to how the consultant pharmacist coverage was provided to the facility during the months she was on leave.

A telephone interview was conducted on 3/30/17 at 1:36 PM with the Clinical Director of the pharmacy contracted to provide consultant pharmacy services to the facility. During the interview, the Clinical Director reported she had hired a new consultant pharmacist to cover the facility for the months of July, August, and September of 2016. She recalled the pharmacist's computer could not replicate her consultation report in the facility's electronic medical record. Therefore, electronic chart notes with the MRR information were emailed to the DON (who was no longer working at the facility). When asked, the Clinical Director indicated she typically would have expected these notes to have been put on the residents' charts. The Clinical Director reported the missing MRRs were in the pharmacy's computer system and she could email these to the facility so they would be available for review.

On 3/30/17 at 2:51 PM, an interview was conducted with the DON. During the interview, inquiry was made as to whether the facility had received the missing MRRs via an electronic communication from the pharmacy's Clinical Director.

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F 428	Continued From page 77 On 3/30/17 at 4:07 PM, The Director of Nursing provided a copy of the monthly Pharmacy reviews which were emailed to her for the months of July, 2016, and September, 2016. Upon exit of the facility on 3/30/17, the facility was unable to provide a copy for the pharmacy's monthly review for August, 2016. The DON was interviewed on 3/30/17 on 6:07 PM. She stated that she would expect for pharmacy to conduct drug regiment reviews as required.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		4/27/17

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F 431	Continued From page 78 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility: 1) Failed to securely lock 1 of 6 medication carts (700 hall med cart) during a medication pass while the cart was not under the direct observation of the nurse administering the medications; 2) Failed to store a medication inside of 1 of 6 medication carts (700 hall med cart) during a medication pass while the cart was not under the direct observation of the nurse	F 431	Immediate Action Nurse #3 was re-educated by Regional Nurse Consultants #2 and Staff Development Coordinator (SDC). On 4/6/2017, on the proper way to lock the med-cart and were reminded that it is unacceptable to wait for the med-cart to lock itself after 2 minute time out.	

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F 431	Continued From page 79	F 431		

administering the medications; and, 3) Failed to store a medication in accordance with the manufacturer's recommendations on 1 of 6 medication carts (500 hall med cart).

The findings included:

1) A review of the facility ' s policy, "Specific Medication Administration Procedures; #1. General Procedures to Follow for All Medications" (Revised 11/1/11) included the following procedural step:
"f. Medication cart is to be kept locked at all times when nurse is away from the cart, unless in use."

On 3/28/17 at 4:47 PM, Nurse #3 was observed as she left the 700 Hall medication cart to administer medications to a resident without locking the cart. The 700 Hall medication (med) cart was placed along the wall of the hallway between two rooms. It was not within view of Nurse #3 when she went into the resident ' s room. A continuous observation of the med cart was made during the nurse ' s absence. Resident #61 was observed to self-propel himself in a wheelchair down the hallway and was two doors down from where the med cart was positioned. At 4:49 PM, the med cart lock mechanism was heard as it automatically engaged the lock on the cart.

On 3/28/17 at 4:51, Nurse #3 was observed as she left the 700 Hall medication cart unlocked to administer medications to Resident #39. The med cart was not within view of Nurse #3 when she went into the resident ' s room. When the nurse exited the resident ' s room at 4:58 PM, Resident #68 was observed to be sitting in his

Nurse #2 was re-educated on policy for storage of drugs and biologicals. This re-education was conducted on 4/6/17 by Regional

Nurse Consultants #2 and Staff Development Coordinator (SDC). Emphasis was placed on not leaving medications on top of cart unattended.

One opened bottle of prednisone acetate 1% ophthalmic suspension noted lying down in its side in the 500 hall medication cart on 3/30/2017, discarded by the Regional Nurse Consultant on 3/30/2017 and new bottle for resident #70 re-ordered.

Identification of Others:

100% walk though of the facility conducted by Regional nurse consultant #1 to identify if any other medication cart noted to be unlocked while the cart is not under the direct observation of the administering nursing staff (Licensed nurses or Medication Aides) on 3/28/2017. No any other medication cart noted to be unlocked without a direct observation of the medication/treatment administering nursing staff.

100% walk though of the facility conducted by Regional nurse consultant #1 to identify if any medication is noted to be stored on top of medication cart, without a direct observation of the administering nursing staff (Licensed

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F 431	Continued From page 80 wheelchair next to the medication cart waiting for the nurse. The med cart had automatically engaged the lock on the cart during her absence and was locked upon her return. On 3/28/17 at 5:05 PM, Nurse #3 was observed as she left the 700 Hall medication cart unlocked to do a blood glucose (sugar) check and to administer insulin for Resident #1. The med cart was not within view of Nurse #3 when she went into the resident ' s room. While in the room, the nurse realized she had forgotten to bring a lancet along for the blood glucose check so returned to the med cart to retrieve one. After the blood glucose check was completed and the insulin administered to the resident in her room, Nurse #3 returned to the medication cart at 5:09 PM. Upon the nurse ' s return to the med cart, the green light in the front right corner of the cart was blinking, indicating the cart was unlocked. At that time, the top drawer of the medication cart was pulled open to confirm the medication cart was unlocked. An interview was conducted on 3/28/17 at 5:10 PM with Nurse #3. Upon inquiry as to why the medication cart was left unlocked multiple times during her medication pass, the nurse stated she could not lock the cart when she left it because she, "did not have a key to unlock it." The nurse reported the med cart would lock automatically "after a while." Nurse #3 stated after the med cart automatically locked itself, she could input her numerical code to electronically unlock the cart. On 3/29/17 at 10:10 AM, Nurse #2 was observed to electronically lock the 700 Hall medication cart as she left the med cart to administer medications	F 431	nurses or Medication Aides) on 3/28/2017. No any other medication noted to be stored on top of the cart without a direct observation of the medication/treatment administering nursing staff. 100% audits of all medication carts in the facility completed by the Regional Nurse consultant #1 on 3/31/2017 to identify if any other medication noted to be stored against manufacturer's recommendation. No other medication identified as stored against manufacturer recommendation. Systemic Changes: Effective 4/27/2017 all active licensed nurse and active medication aides locks the medication carts when they walk away from the cart is not in their direct observation while on duty. Effective 4/27/2017 all active licensed nurses and active medication aides are not allowed to leave any medication on top of their cart while the cart is not in their direct observation while on duty. Effective 4/27/2017, a "storage guidelines guide" per manufacturer recommendation for most commonly used drugs are kept available for nurses to review as the second source of information in addition to medication label. These guides will be available on each medication cart and medication rooms for easy accessibility by licensed nurses. 100% of nursing staff who allowed to pass	

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F 431	Continued From page 81 to a resident during a medication pass. A key was not used to lock the med cart. This was the same medication cart observed to be in use by Nurse #3 the afternoon of 3/28/17. An interview was conducted on 3/30/17 at 9:04 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the medication cart to be locked when the nurse was not within view of the cart. 2) On 3/29/17 at 9:58 AM, Nurse #2 was observed as she pulled medications from the medication cart for administration to Resident #174. The medications pulled for administration included one - 325 mg iron sulfate tablet (a mineral supplement), which was placed in a medication cup and set on top of the 700 Hall med cart. On 3/29/17 at 10:10 AM, Nurse #2 was observed as she went to Resident #174 ' s room to administer his medications. The iron sulfate tablet was left in the medication cup on top of the 700 Hall med cart. The med cart was not within view of Nurse #2 when she went into the resident ' s room. When Nurse #2 returned to the medication cart at 10:17 AM, the iron sulfate tablet left on top of the 700 Hall med cart was gone. An interview was conducted on 3/29/17 at 10:42 AM with Nurse #2. When asked about the iron sulfate tablet left on top of the medication cart during the med pass administration, Nurse #2 stated she was told this tablet was noticed by another staff member. She reported the tablet had been discarded.	F 431	medication and have access to drugs and Biologicals in accordance with North Carolina State and Federal laws to include Licensed Nurses & Medication aides, ware re-educated on the policy & procedures for storage drugs and biologicals, with the emphasis on locking of medication cart while the cart is not on direct observation of the medication administering nursing staff, proper storage of medications (not to be left on top of cart),and storage of medications to be stored upright per manufacturer recommendation. This education provided by Regional nurse consultant #2, Director of Nursing (DON), Assistant Director (ADON) of Nursing and/or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all licensed nurses and Medication aides, to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nurse or medication aide not educated by 4/27/2017 will not be allowed to administer medication or have access to any drugs and biologicals until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017 Medication administration reviews will be completed	

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F 431	Continued From page 82 An interview was conducted on 3/30/17 at 9:04 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated her expectation was that medications would not be stored on top of the med cart without supervision. 3) An observation of the 500 Hall medication cart on 3/30/17 at 3:36 PM revealed an opened bottle of prednisolone acetate 1% ophthalmic suspension eye drops (a steroid medication) was stored lying down on its side in a drawer of the medication cart. The eye drops were dispensed from the pharmacy on 12/16/16 and labeled for use by Resident #70. The manufacturer ' s storage instructions printed on the eye drop bottle read, in part, "Store in upright position." An interview was conducted on 3/30/17 at 3:38 PM with Nurse #5. Nurse #5 was assigned to the 500 Hall medication cart. Upon inquiry, Nurse #5 confirmed the manufacturer ' s labeling on the prednisolone acetate eye drops indicated the medication needed to be stored upright, and the eye drop bottle had been stored lying down on its side in the drawer of the med cart. The nurse indicated she would share this information with the facility ' s Director of Nursing (DON). A review of Resident #70 ' s March 2017 physician orders revealed the resident had a current medication order for prednisolone acetate 1% ophthalmic suspension eye drops to be given as one drop instilled into the right eye twice daily. An interview was conducted on 3/30/17 at 4:50 PM with the DON. During the interview, the DON reported she was told of the prednisolone acetate eye drop bottle being stored on its side in the	F 431	with 20% of Nurses and med-aids on all shifts to include weekends, weekly by DON, ADON, SDC, QA Nurse and/or Licensed Pharmacist x 4 weeks then monthly x 3 months. The emphasis during observation will be to determine whether each nurse or medication aide store medication appropriately per manufacturer recommendation, lock the medication cart when the medication cart is not on direct observation the observed staff and no medication is left on top of medication cart. Findings of this monitoring process will be documented on medication pass observation sheet. Medication carts and medication storage areas will be audited by DON, ADON, SDC, QA Nurse and/or Pharmacist during medication pass competencies weekly x 4 weeks and monthly x 3 months for proper storage of medications. Negative findings will be reported on med-pass observation sheet. Pharmacy nurse will also audit all carts and med rooms for proper storage of medications per manufacturer’s recommendations monthly. DON and/or ADON will present the findings of Medication Administration reviews to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 4 months or until pattern of compliance is achieved. QAPI committee will modify this monitoring process as deemed appropriate to assure continue compliance.	

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F 431	Continued From page 83 medication cart. The DON stated she was aware these eye drops needed to be stored upright and had instructed the nurse to discard them. She reported a replacement bottle of the eye drops had been ordered from the pharmacy.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		4/27/17

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F 441	Continued From page 84 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility staff interviews, the facility failed to complete surveillance on one of one resident (Resident #2) identified with scabies for the tracking and trending of infections.	F 441	Resident #1 was effectively treated for sarcoptes scabiei var hominis on 12/15/16 and was placed on Contact isolation from 12/15/16-1/4/17. Resident's #1 roommate nor other facility residents were noted to	

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F 441	Continued From page 85 The findings included: Resident #2 was admitted to the facility on 9/3/12 from the hospital. Her cumulative diagnoses included dementia. A review of Resident #2 ' s medical record included a Nurse Practitioner (NP) note dated 12/13/16. The note indicated Resident #2 was seen for an itchy rash to chest, shoulders, and arms. The NP indicated a referral would be made to a dermatologist for this persistent rash. Further review of Resident #2 ' s included documentation of the dermatology consultation visit on 12/14/16. The "Report of Consultation" from the dermatologist (dated 12/14/16) indicated there was no need to do a skin scraping to determine scabies. The dermatologist noted the resident ' s clinical presentation was "more than adequate to make this diagnosis." Two medications were initiated and included: 5% permethrin cream (a topical medication used to treat parasites and scabies) with instructions to apply the topical cream at bedtime from the jawline down on days 1, 2, and 7 and to wash upon awakening; and, 0.1% triamcinolone acetonide cream (a topical steroidal cream) with instructions to apply the cream topically twice daily to the affected areas as needed for itching. A review of the resident ' s Nursing Notes revealed Resident #2 was placed on Contact Precautions 12/15/16. Contact Precautions were discontinued on 1/4/17 by the resident ' s Medical Doctor (MD). An interview was conducted on 3/30/17 at 10:31 AM with the facility ' s Quality	F 441	have rashes or symptoms of sarcoptes scabiei var hominis as a result of cross contamination during this time period. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All facility residents have potential to be affected. all residents have the potential for facility acquired contagious disease and infectious outbreaks and require infection control surveilance. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: All Employees were in-serviced on facility policy for treating scabies and preventing scabies outbreak on 4/6/17 by the Regional nurse Consultant. Housekeeping staff were In-serviced on 4/19/17 and 4/20/17 for deep cleaning of Residents room and belongings to prevent out- break per facility policy by the House-keeping/Laundry Supervisor . QAPI nurse, DON and SDC were trained on proper way to conduct surveillance, infection control, Ad hoc meeting and monitoring with any contagious outbreak by the Regional Nurse Consultant on 4/22/17. QAPI nurse and DON will complete all infection control reports, surveillance trending and monitoring of infections.	

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F 441	Continued From page 86 Improvement/Quality Assurance (QI/QA) Nurse and Staff Development Coordinator (SDC). The QI/QA nurse was reported to assume Infection Control responsibilities for the facility; and, the SDC shared some responsibilities (such as staff training) with her. Both nurses reported they were new to the facility as of January 2017. The QI/QA nurse reported she had access to the Quality Assessment and Assurance (QAA) reports from December 2016 regarding surveillance of infections. However, she reported there were no notes of scabies on this report for any residents (including Resident #2) in the facility. Upon further inquiry, the QI/QA nurse stated there was no additional information available to indicate if any other residents in the facility were diagnosed with scabies. An interview was conducted on 3/30/17 with the facility ' s Director of Nursing (DON). Upon inquiry, the DON stated her expectation would be for contagious diseases (such as scabies) to be reported and followed for infection control purposes.	F 441	Monitoring Process: DON and QAPI nurse will audit Infection control schematics reports weekly x 4weeks then monthly x 3 months to assure that any trends or infectious process have been identified and appropriate interventions and surveillance was initiated. Audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 4 months by the QAPI nurse or until pattern of compliance is achieved. QAPI will be modified according to outcomes as needed and determined by QAPI committee.	
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and	F 456	Immediate Action	4/27/17

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F 456	Continued From page 87 interviews, the facility failed to maintain one of four lift slings used for the sit to stand lift in safe working condition. Findings Included: The operator's manual dated 2013 for the sit to stand lift stated that "bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately. Be sure to check the sling's attachments each time the sling is removed and replaced, to ensure that it is properly attached before the patient is removed from the stationary object." Nursing Assistant (NA) #1 was observed taking the resident to the bathroom on 600 hall via wheelchair on 3/29/17 at 11:02 AM. NA #1 placed the sit to stand lift sling behind resident #185's lower back in the wheelchair. The lift was placed in front of the resident and the lift sling was placed under the resident's arms and was connected via circular loops to the lift. The waist band that went around the resident's waist was not connected and the waist straps were left dangling beside the resident. The resident was lifted only with sling support under her arms from the sitting position to a standing position with assistance with 1 staff member (Nursing Assistant #1). Resident #185's brief was changed while the resident was in the standing position and the resident was lowered back to the wheelchair with assistance of 1 person (Nursing Assistant #1). Nursing Assistant #1 was interviewed on 3/29/17 at 1:55 PM. She stated that the waist belt on the lift sling was broken, which was why it was not attached during an observed transfer. She stated	F 456	Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator. Identification of Others 32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear. Systemic Changes Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident's individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident's evaluation by healthcare professional documented on resident plan of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines. 100% of nursing staff, to include licensed nurses and nurse's aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical	

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F 456	Continued From page 88 the lift sling she used only had 2 plastic prongs to secure the belt to the lift and the resident would slip out of the sling. She stated the other sit to stand lift slings were being used. On 3/29/17 at 2:01 PM, the sling was observed on the 700 hall. The sling's waist belt was designed to clasp via three plastic prongs on one end of the sling and three sockets for insertion of the plastic prongs on the other end. However, the observed lift sling only had 2 plastic prongs on the waist belt. The 3rd plastic prong was broken off of the waist belt. The receiving end of the lift's sling waist band would not fit properly in the insertion end with the broken prong. NA #2 was interviewed on 3/29/17 at 2:36 PM. She stated that she obtained the residents' weights in the facility. She stated there were 4 to 5 slings for the sit to stand lift and had not known of any problems with the lift slings. If a sling was broken, staff would report it, put it away and would not use it if broken. The Director of Nursing (DON) was interviewed on 3/29/17 at 2:40 PM. She stated she had not known of any problems with the lift slings. She stated she would expect that if a lift sling was broken that it was not used on a resident and was to be reported. She was shown the broken lift sling in the bathroom on 700 hall and the lift sling was taken out of the bathroom by the DON on 3/29/17 at 2:41 PM. Nursing Assistant #3 was interviewed on 3/30/17 at 9:48 AM. She stated that if she saw a sling that was broken she would not use it and report it. She stated that about a month ago, she did hear that a sit to stand lift sling had a plastic prong that	F 456	lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information from such. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/27/2017, central supplies clerk	

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F 456	Continued From page 89 was broken, where it snapped around the waist, but she never used that sling and said that there were several other slings to use. The DON was interviewed on 3/30/17 on 6:07 PM. She stated she would expect that the nursing staff would check and use safe equipment for each resident.	F 456	or Quality Assurance nurse will inspect the condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance nurse or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.	
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality	F 520		4/27/17

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F 520	Continued From page 90 assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on May 2016. This was for five (5) recited deficiency, which was originally cited in May 26, 2016 during a recertification survey and on the current recertification and complaint survey. The deficiency was in the area of housekeeping and maintenance, Minimum Data Set accuracy, sufficient staffing, and dietary Services. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to	F 520	F520 The quality assurance and performance improvement committee approved the following plan to resolve alleged non compliance for identified residents immediately. The white towel that appears to be saturated with red spots removed from resident #40 room by Housekeeping/Laundry supervisor on 3/28/2017 and discarded in biohazard bin. Resident #40s bathroom has been cleaned and disinfected by the House keeping supervisor on 3/28/17, red/brown spots removed from bathroom floor. 200 Hall Room 213 Blinds replaced by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017	

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F 520	Continued From page 91 F 253 Based on observations, record review, and facility staff interviews, the facility failed to clean and disinfect a resident ' s bathroom floor after an observation was made of red/brown smears and spots on the floor for 1 of 1 resident bathrooms (for Resident #40) observed to have a red/brown substance in the bathroom and facility failed to maintain housekeeping and maintenance services provide clean resident's rooms and clean toilets in resident's bathroom and proved a maintained, safe and comfortable interior on 4 of 7 residents halls. (Hall 200, Hall 500, Hall 600 and Hall 700) F 278 Based on record review and staff interview the facility failed to accurately code the active diagnosis of myoclonic jerk on the Minimum Data Set (MDS) assessment for 1 of 2 residents who received Hospice services within the facility. (Resident #214). F 353 Based on record review, interviews with resident, staff and families and observation the facility failed to provide staffing of sufficient quantity and quality to provide pressure sore and accident for resident who required assistance. This affected (2) out of 40 residents (Resident # 22 and Resident # 185) F 371 Based on observations and staff interviews the facility failed to ensure opened food products were stored in sealed containers, dishware were clean, in good repair and allowed to air dry, equipment and ceiling vents were clean and male employee ' s with facial hair wore beard guards while working in the kitchen. This had the potential to impact the 112 residents who resided in the facility.	F 520	500 Hall Room 502 Wall Paper removed by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 503 White patch painted, back of bathroom door repaired and dripping faucet repaired by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 504 Wall Paper removed, corner behind bed A painted and door has been cleaned by maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 506 Bathroom and bathroom door frame has been repainted, Drawer under TV has been properly repaired, Wall Paper has been removed and door sanded and re-stained by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017 Room 600 Hall Room 601 Wall Paper removed and floor molding in bathroom repaired by maintenance supervisor and or assistant maintenance supervisor on 04/04/2017 Room 603 Wall by drawers have been painted, door frame near bathroom has been painted and faucet has been repaired (tighten and dripping fixed) by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017	

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F 520	Continued From page 92 F 456 Based on record review, observations, and interviews, the facility failed to maintain one of four lift slings used for the sit to stand lift in safe working condition. This was originally cites in May 2016 during the recertification survey when the facility failed to maintain housekeeping and maintenance services to clean resident's room and bathroom. The facility failed to code the Minimum Data Set for assessment to reflect a resident unnecessary drug. The facility failed to provide staffing of sufficient quantity and quality to provide incontinence care, toileting, nail care, and snack for resident who required assist with Activities of daily living (ADL's). The facility failed to remove expired foods and maintain a clean kitchen. The facility failed to maintain floor, baseboards and a sink in clean, working condition in the kitchen. The Quality Assessment Assurance Nurse was interview on March 30/ 2017 at 5:50 PM. She stated she had only been here since January, 2017. She stated they have done multiple in-services on hand washing lately on hand washing and blood spills. Staffing is discussed every morning during the morning meeting. She stated they did have some equipment that was not working and in the last 2 months it had been talked about getting them fixed (stove, ice makers, air conditioning units.) She would expect that if there are QA issues that they would be fixed. The Director of Nursing was interviewed on March 30, 2017 on 6:07 PM. She would expect that nursing staff would check and only use safe equipment for each resident. She stated that she would expect for QA to identify areas of concern	F 520	Room 604 Bathroom door frame repainted, Drawer handle under TV repaired and area under dresser and closet cleaned by the maintenance supervisor and or assistant maintenance supervisor on 04/04/2017. Hall 700 Room 720 Night stand replaced and 6 holes in bathroom repaired by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017. Room 716 Room wall has been repaired and painted by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017. Room 709 Bathroom floor around toilet cleaned and stains removed by Housekeeping and Laundry supervisor on 04/06/2017. Room 711 Hole in bathroom wall repaired and painted by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017 Room 702 Door sanded and repaired by maintenance supervisor and/or assistant maintenance supervisor on 04/06/2017 Room 708 Residents bathroom walls and floor cleaned by Housekeeping and Laundry supervisor on 04/06/2017 Room 706 Door sanded and repaired by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017	

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F 520	Continued From page 93 and follow up with a plan of correction.	F 520	F 278 Step Minimum data Set (MDS) for resident #214 dated 2/23/17 was modified/corrected by MDS Nurse #1 on 3/30/2017, to include in section I of MDS a diagnosis of a myoclonic jerk diagnosis. Modified assessment was re-transmitted and accepted in CMS data base on 3/30/2017 F353: Resident #22, resident #185, and resident #263 care and services explained below rendered on stated dates here under by the nursing staff with appropriate competencies and skill set to provide those nursing and related services to assure resident safety. Such care was provided based on resident assessments and individual plans of care. Resident #22: Treatment rendered per physician order by a treatment nurse on 3/29/2017. Wound was assessed by the Regional Nurse Consultant #2 and treatment nurse on 3/30/2017. No deterioration in the wound was noted from treatment nurse assessment on 3/27/2017. Treatment was deemed appropriate for wounds and wounds showed improvement from prior assessments. Performance improvement action were implemented for weekend licensed nurse who was responsible for resident care and treatment on 3/25/2017 & 3/26/2017 during day shift (7AM-7PM). This action was put forth by the Director of Nursing on 4/6/2017. Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator.	

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F 520	Continued From page 94	F 520	Resident #263 fall mat was placed beside the bed, a bed and chair alarm was also put in place per resident care plan by the quality assurance nurse on 3/31/2017. Resident□s care card was updated to reflect the use of floor mat, bed and chair alarm by the Quality Assurance on 3/31/2017 as well. F371: The open and unsealed case of Okra, fish fillets and sausage in the walk-in freezer, and unsealed box of rice in the dry storage room ware discarded by the Dietary Manager on 3/27/2017. A male employee with facial hair who was noted with no beard guard on while he was preparing desert for the lunch meal re-educated on 3/27/2017 by Dietary manager and worm a beard guard rite away. The ceiling vent in the beverage preparation area was cleaned and is free of dust on 3/27/2017 by Dietary Manager. The storage cart that contained clean meal trays observed on 3/27/2017 was cleaned by Dietary Manager on 3/27/2017. 15 meal trays that had dark staining, cracks and exposed metal edges ware discarded on 3/29/2017 by Dietary manager and The Registered Dietician. Four divided plates noted with dried food particles ware cleaned, sanitized, dried and stored properly on 3/29/2017 by Dietary aide #1 12- 8 ounce clear glasses were cleaned, re-sanitized, air dried on 3/29/2017 and stored appropriately, by Dietary aide #1, Solid tray that prevented those glasses	

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from air drying on 3/29/2017 removed from being a surface used to air dry dishes in the facility by Dietary Manager on 3/29/2017.
Resident #185 -Lift pad used on resident during survey was discarded on 3/29/17 by the Assistant Administrator.

Identification of Others:

100% audit of all cited deficiencies for the last 2 years, 2016 and 2017 completed by the Regional Clinical Consultant #2 on 4/25/2017 to identify if any other repeated citation is noted, other than the identified citation during this survey. No other cited deficiencies noted as a repeated non compliance.

100% audit of all resident rooms audited to identify any other room with housekeeping needs to include any blood or body fluids. This audit was completed by housekeeping and laundry supervisor on 3/28/17. No other rooms noted with house keeping needs such as cleaning of blood or body fluids.

100% audits of all resident rooms in the facility conducted by the Maintenance supervisor and/or assistant maintenance supervisor on 4/6/2017, 4/7/2017 and 4/21/2017 to identify any other resident room with the following areas of concerns;

1. Missing or broken blinds; 15 other rooms with blinds not in good repair identified. Maintenance supervisor and/or assistant maintenance supervisor

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F 520	Continued From page 96	F 520	replaced the blinds on the 15 other identified rooms on 4/6/2017, 4/7/2017 and 4/21/2017. 2. Missing Wall paper, torn wall paper, and/or not in a good repair; 58 other rooms identified not to be in a good repair. Maintenance supervisor and/or assistant maintenance supervisor repaired, removed and/or replaced wall papers on all 58 identified rooms started on 4/6/2017 and to be completed by 4/27/2017. Any room not repaired by 4/27/2017 will be removed out of service until repaired. 3. Wall Repair, Door Repair, Floor molding, Door frames painting; 36 other rooms identified to be in need of one or more repair of identified areas mentioned above. Maintenance supervisor and/or assistant maintenance supervisor repaired and/or removed all identified areas in 36 noted rooms started on 4/6/2017 and to be completed by 4/27/2017. Any room not repaired by 4/27/2017 will be removed out of service until repaired. 4.Resident□ Bathrooms Repair; to include leaking faucet(s), bathroom floor, walls, and paints.26 other residents'□ bathrooms noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired, all identified areas in 26 noted rooms started on 4/6/2017 and to be completed by 4/27/2017. Any resident bathroom not repaired by 4/27/2017 will be removed out of service until repaired.	

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5. Condition of residents□' furniture; 9 other furniture noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired all identified furniture in 9 noted rooms on 4/6/2017, 4/7/2017 & 4/8/2017

F278: 100% audit completed on 4/21/17 and 4/22/2017 of all active residents for the most recent MDS assessment was conducted by Regional MDS consultant #1, Regional MDS consultant #2, MDS Nurse #1, MDS Nurse #2 and/or MDS Nurse #3 to ensure all active diagnoses were coded appropriately in section I of MDS. 19 Other residents noted with inaccurate coding in section I. Modifications/corrections were done to Minimum Data Set as indicated per Resident Assessment Instrument (RAI) guidelines on 4/22/2017 to 4/27/2017 by MDS Nurse #1, MDS Nurse #2 and/or MDS Nurse #3.

F353: Facility staffing pattern re-assessed by the Regional nurse consultant #2, and the Assistant Administrator on 4/12/2017, to determine opportunities to maximize direct care nursing hours, to meet resident□s individual needs. This audit identified opportunities for improvement, including lack of enforcement on attendance policy, employee call out protocol as well as lack on on-call schedule to cover when another nursing employee is unable to report to work, to ensure continuous quality of care with

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sufficient nursing staff.
100% audit of all active resident□s with wound care orders completed by the Regional nurse Consultant #2, and the treatment nurse to ensure that Physicians orders matched the treatment administration records record on 4/12/17, as well as the documentation for completion of such orders are noted in resident□s record per order and to include Saturdays and Sundays

100% of all active residents with pressure ulcers were assessed by Treatment nurse and by Certified wound nurse from sister facility on 4/21/2017. No pressure ulcers were noted to have deteriorated from their previous documented assessment.

32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear.

100% audit of all fall care plans for active residents completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1 to determine if any intervention put in place was implemented and communicated to the nurse aides appropriately. Findings of this audit was documented on fall intervention audit tool. No functional documented process of communication identified to be in place for communication to nurse□s aides, thus, 100% of other residents with interventions

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F 520	Continued From page 99	F 520	to be implemented by nurse□s aide had a potential to affected by this alleged non compliance F371 100% audit of all food storage areas inspected by dietary Manager and/or Registered Dietician 3/27/2017 to identify any other open item that is unsealed and/or not sored appropriately. No other items identified as being inappropriately stored. 100% of dietary staff working on duty on 3/27/2017, re-educated by the Dietary manager on the importance of wearing hair cover and/or beard guard while preparing resident□s meals. All other employees noted to have hair cover and/or beard guard while preparing residents□ meal on 3/27/2017 100% inspection of all ceiling vents in the kitchen audited by Dietary Manager and/or Registered Dietician on 3/27/2017to identify its cleanliness. No other ceiling vent in the Kitchen noted to be unclean or with dust. 100% inspection of all storage carts completed on 3/27/2017 by the Dietary Manager and/or Registered Dietician to identify any other cart that needs to be cleaned and sanitized. No other dietary storage cart noted to be unclean 100% inspection of all meal trays completed by the dietary Manager and/or Registered Dietician on 3/29/2017, 7 other meal trays noted with cracks and/or exposed metal edges. Those seven trays ware discarded immediately by the Dietary Manager and/or Registered Dietician.	

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F 520	Continued From page 100	F 520	100% of all resident meal wares including plates, cups, glasses, spoon and forks rewashed on 3/29/2017 by Dietary aides to ensure cleanliness and sanitation. After being, dish wares allowed to air dry, no other dishware noted to be unclean. 100% inspection of all surfaces used for dish ware air drying process inspected by Dietary Manager and the Registered Dietician on 3/29/2017 to ensure no other surface can potentially obstruct air drying process. All other storage surfaces identifies as being capable of allowing dishes to air dry with no obstruction. F456 32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other lift pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear and tear Systemic Changes: Effective 4/27/2017, the Regional clinical consultant #2 implemented the revised quality assurance performance improvement plan process to ensure that the facility remains in substantial compliance. Effective 4/27/2017, the quality assurance committee will incorporate all cited deficiencies in a QAPI meeting monthly from one annual survey to another and review the areas previously cited to ensure the plan of action put in place is accurately followed. The QAPI committee will make alteration of such plan as	

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F 520	Continued From page 101	F 520	deemed appropriate to ensure that the facility remains in substantial compliance. Effective 4/27/2017 House Keeping/Laundry Supervisor re-established a cleaning assignment for housekeeping staff on duty to ensure each resident room is cleaned and sanitized in a daily basis. Effective 4/27/2017, revised deep cleaning schedule put forth by the house keeping/Laundry supervisor for each room to be deep cleaned once monthly, By the Housekeeping staff. Effective 4/27/2017 a maintenance work book will be placed at each nursing station where any maintenance issue(s) can be recorded by any staff member. Maintenance supervisor or assistant maintenance supervisor will check these books daily (Monday to Friday). Any maintenance needs on the week-end that requires immediate attention, a maintenance supervisor or assistant maintenance supervisor will be contacted by staff on duty. 100% of active facility House Keeping and laundry employees received additional training on cleaning and disinfecting of floors and surfaces after blood or body fluid spills and contamination. This education was completed by Housekeeping/Laundry Supervisor and/or Quality assurance nurse. This education was initiated on 4-6-2017 for all active housekeeping and laundry employees, to	

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F 520	Continued From page 102	F 520	include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any house keeping/Laundry staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new house keeping/laundry employees effective 4/27/17 and also will be provided annually. 100% of active facility employees will be educated on the new maintenance request log and Procedure to request any maintenance needs by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This education was initiated on 4-6-2017 for all active employees to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and will be provided annually. F278: Effective 4/27/2017, MDS nurse #1, MDS nurse #2 and/or MDS nurse #3 will review each resident□s physician-documented diagnosis, completed by Medical Doctor, a nurse practitioner, or physician assistant, in the last 60 days of the assessment reference date (ARD). The source of this review include each resident□s physician progress notes, the most recent history and physical, discharge summaries, and or diagnosis listed in each resident□s	

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medication and/or treatment signed and with a date falls in the last 60 days of ARD. Once a diagnosis is identified as documented in the last 60 days, MDS Nurse #1, MDS nurse #2 and/or MDS nurse #3 will determine if the diagnosis is active. (Active diagnosis are those that affect the resident□s functioning or plan of care during the last 7 days, for all diagnosis except, Item I2300 Urinary Tract Infection (UTI), which has specific coding criteria and does not use the active 7-day look back period). MDS nurse will then code the diagnosis in section I of that resident□s MDS assessment when the criterion above are met. UTI will be coded by MDS nurse #1, #2, and/or #3 when determined to be active based on RAI guidelines for UTI assessment and coding.

Effective 4/27/17 prior to submission, MDS Nurse #1, #2, and or #3 and/or MDS Nurse #2 (Whomever is not signing off section I, on the assessment) will review completed MDS assessment to ensure accurate coding of diagnosis in Section I per RAI guidelines. Any assessment noted with inaccurate coding in Section I, Modifications/corrections will be done to Minimum Data Set as indicated per RAI guidelines promptly by MDS Nurse #1, #2, and or #3.

MDS nurse #1, MDS 2 and/or MDS #3 re-educated by MDS Consultant #1 on proper ways of coding MDS assessment, specifically section I on 4/6/2017 This

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F 520	Continued From page 104	F 520	education is also added to new hire process for all MDS nurses 4/27/17 and also will be provided annually. F353: Effective 4/27/2017, open position for all classification of nursing staff, Registered nurses, Licensed Practical Nurses and/or nursing aides will be posted on a worldwide staffing advertisement websites for easier attraction of new hires. When such needs arise, the Human Resources will coordinate the posting of such positions. Effective 4/27/2017 Human resource department will conduct job fail at least once quarterly for recruiting staff. New incentive program that aide of staff recruitments put in place effective 4/27/2017. Facility will utilize agency staff as the last resort to ensure sufficient number is staff is maintained effective 4/27/2017 Effective 4/27/2017, any call-in, (nursing employee unable to report to work), for any nursing staff will be reported to the Director of nursing and to the staffing coordinator so replacement can be made for call ins to assure adequate staffing is maintained to meet the need of each resident. Each employee is expected to contact the facility at the minimum of two hours before the beginning of their shift if will be unable to come to work. Director of Nursing will oversee the assurance of sufficient staff in the facility. Effective 4/27/2017, staff development coordinator will ensure that each nursing staff has appropriate competencies and skill set to provide nursing and related	

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F 520	Continued From page 105	F 520	services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Effective 4/27/2017, each resident treatment is rendered per physician order. On- coming nurse will check treatment records for omissions prior to accepting cart form previous shift nurse. On- coming Nurse will not accept cart until treatments are completed or reconciled. 100% of licensed nurses employed by the facility ware re-educated on ensuring treatment orders are rendered per physician order, completed on the frequency ordered and documented on each resident treatment administration record. This education also covered on what to do when a pressure ulcer is identified and documentation for residents who refuse their wound care treatment to be done. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all licensed nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nursing staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new licensed nurses effective 4/27/17 and also will be provided annually.	

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F 520	Continued From page 106	F 520	Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident□s individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident□s evaluation by healthcare professional documented on resident plan of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines. Effectively 4/27/2017; Resident□s Care Cards were initiated as a communication tool to alert nurse□s aides of appropriate method to transfer each resident together with minimum number of staff required for the Activity of daily Living (ADL), specifically transfer to take place. Care Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse□s aides. This include but not limited to fall interventions such as bed in low position, fall mat on floor and/or Chair/bed alarm. Three ring binders titled Care Cards places at each nurse□s station for easy access by the nurse□s aides. This process was put in place with the collaboration among the Regional Clinical Consultant #2, Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse, MDS Coordinator #1, MDS Coordinator #2, MDS coordinator #3 and the Staff Development Coordinator	

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F 520	Continued From page 107	F 520	100% active residents in facility were re-assessed for individualized care needs. This re-assessment was completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1, Director of nursing and/or Assistant Director of nursing. Appropriate intervention was put in place and added to each resident□s care card. Effective 4/27/2017 Care cards will be initiated on admission by the admitting nurse and updated at least quarterly and with any change in treatment plan, related to resident□s direct care and safety, by the hall nurses and/or interdisciplinary care plan team. Interventions to be carried out by nursing aides will be added to be part of each resident care cards. 100% of nursing staff, to include licensed nurses and nurse□s aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware	

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F 520	Continued From page 108	F 520	educated on how to access, the care cards and how to obtain information from such. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. F371 Effective 4/27/2017 A new Dietary Manager was hired and trained and will oversee dietary services, sanitation, food storage and employee practices to ensure compliance. Root cause of such alleged compliances concluded to be staff training and managerial supervision. Effective 4/27/2017, A cook on duty is designated to work as a Kitchen supervisor on duty. On the absence of the dietary manager, the cook on duty will oversee kitchen sanitation, proper storage of foods, ensuring dish wares are allowed to air dry, cleanness of dishware before use, employee compliance with wearing beard guard and hair cover while preparing resident food as well as ensuring any dish wares not in good repair are removed out of circulation immediately. 100% of dietary employees, to include cooks and dietary aides ware re-educated	

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F 520	Continued From page 109	F 520	on proper storage of food in all food storing location to include but not limited to freezer, Walk-in refrigerator, reach in refrigerator and dry storage food, proper use of beard guards & hair cover while preparing residents food, proper cleaning of the ceiling vents and the proper way to clean storage carts for meal trays. This re-education also covered and emphasized on proper technique to clean and store plates and glasses to allow air drying as well as how to identify damaged trays for disposal, and notifying Dietary Manager so that replacements could be ordered. This education provided by Dietary Manager and/or Registered Dietician. This educated was initiated on 3/27/2017 for all dietary staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any dietary staff not educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. F456 Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident s individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of residents. When using mechanical lift, at least 2 person will assists each resident, unless resident s evaluation by healthcare professional documented on resident plan of care indicate resident could be	

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F 520	Continued From page 110	F 520	transferred by one person assist with mechanical lift, per manufacturer guidelines. 100% of nursing staff, to include licensed nurses and nurse s aides ware in-serviced on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanical lift transfer, unless the plan of care states otherwise, removing any pads that were broken, frayed or in poor condition out of circulation and notifying central supply and/or nurse administrative staff (DON, ADON, QA nurse, supervisor, and/or Staff development coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revise the care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information from such. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all nursing staff to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any staff not educated by	

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F 520	Continued From page 111	F 520	4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annually. Regional Clinical Director #1 re-educated the Quality Assurance committee on the revised process necessary to identify quality deficiencies in the facility and how to establish plans to ensure such non-compliance will not re-occur. This re-education was rendered on 4/25/2017 to The Administrator, Director of Nursing, Quality Assurance nurse, Social services, MDS nurses, Activity coordinators, Staffing clerk, who is also a certified nursing aide and Central supply clerk was some of the educated QAPI committee members. Monitoring Process: Effective 4/27/2017, the administrator will monitor the compliance of the quality assurance committee incorporation of all cited deficiencies in a QAPI meeting monthly from one annual survey to another and review the areas previously cited to ensure the plan of action put in place is accurately followed. This monitoring process will be dome monthly x 6 months or until the pattern of compliance is maintained. Effective 4/27/17 Director of nursing, Assistant Director of Nursing, and/or Maintenance supervisor will review the maintenance request books weekly x 4	

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weeks, then monthly x 3 months on all halls to assure service requests had been followed up appropriately.

Effective 4/27/17 Housekeeping supervisor will complete environmental Infection control audits weekly x 4 weeks, then monthly x 3 months on all halls to assure floors and surfaces are cleaned properly.

Results of audits will be reported to Quality assurance performance improvement committee meeting monthly x 4 months by the Housekeeping/laundry supervisor, or until pattern of compliance is achieved. QAPI committee will modify this plan as deemed appropriate to ensure continuous compliance.

Maintenance supervisor and/or Administrator will review maintenance work books to ensure compliance with work orders. This review will be completed weekly x 4 weeks, then monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee.

F278: Effective 4/17/17 MDS Section I reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS

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F 520	Continued From page 113	F 520	assessments weekly for 4 weeks, then 25% of all completed MDS assessments weekly x 4 weeks or until compliance is achieved by MDS nurse #1, #2, and or #3. MDS nurse #1, MDS nurse #2, and/or MDS nurse #3 will present the findings of this audit to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. F353: Effective 4/27/2017, sufficient nursing staffing for past 24 hours and upcoming 24 hours will be discussed in a daily morning meeting (Monday thru Friday), and the week-end supervisor or nurse in-charge will audit staffing pattern on (Saturday & Sundays), to ensure thefacility has sufficient number of staff to meet resident need. Any identified problem during this monitoring process will be addressed promptly to unsure resident care and services is not affected. This review will take place daily for 2 weeks, weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Staffing coordinator, Director of Nursing and/or the assistant administrator will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this plan. Effective 4/27/2017, Assistant administrator will review staffing sheets	

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F 520	Continued From page 114	F 520	for the week to ensure facility had sufficient nursing staffing to meet the need of resident based on determined minimum hours per patient day (PPD) requirements. This review will take place weekly x 12 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Staffing coordinator, Director of Nursing and/or the assistant administrator will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 6 months for any additional monitoring needs or modifications of this plan. Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all treatments records daily (Monday Friday) and the week-end supervisor or nurse in-charge will audit treatment records on (Saturday & Sundays), to ensure they have been completed and signed for as ordered by physician. This review will take place daily for 2 weeks, weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly. Quality assurance nurse will report findings of this audit to facility Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this plan. Effective 4/27/2017, resident care cards will be reviewed by the clinical interdisciplinary team daily (Monday thru Friday), and by the week-end supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 115	F 520		

or nurse in-charge on (Saturday & Sundays), to ensure its presence and accuracy as appropriate. This team will consist of but not limited to the DON, ADON, QA Nurse, SDC, MDS#1, MDS#2, and/or MDS#3. , this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed by the member of the interdisciplinary team promptly. Quality Assurance nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.

Effectively 4/27/2017; Director of nursing, Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all new admission for previous day, daily (Monday thru Friday) and the week-end supervisor or nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review will take place daily (Monday thru Friday) for 4 weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findings noted will be addressed promptly QAPI nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.

Effective 4/27/2017, central supplies clerk or Quality Assurance nurse will inspect the

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F 520	Continued From page 116	F 520	condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement. F371 Effective 4/27/2017 The Registered Dietician, Dietary Manager, designated cook, and or designated dietary aide will monitor compliance with proper food storage all food storing locations, to include but not limited to freezer, Walk-in refrigerator, reach in refrigerator and dry storage food, proper use of beard guards & hair cover while preparing residents food, proper cleaning of the ceiling vents and the proper way to clean storage carts for meal trays. This monitoring will also assure proper technique to clean and store plates & glasses to allow air drying as well as monitoring any damaged trays for disposal. Effective 4/27/2017, This monitoring process will be accomplished, and findings will be documented in a daily Daily Kitchen Rounds Audit Tool and a Sanitation Checklist daily for 2 weeks, then 3 times a week for 2 weeks then weekly times 12 week, then monthly x 6 months afterwards, or until the pattern of compliance is maintained. Effective 4/27/2017 the Dietary Manager or Registered Dietician will report findings	

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F 520	Continued From page 117	F 520	of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement monthly x 6 months, F456: Effective 4/27/2017, central supplies clerk or Quality Assurance nurse will inspect the condition of slings in the facility to determine functionality. Any sling noted in unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance nurse or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement.	