STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 05/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	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		5/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2017

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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 resident and staff interviews, and facility record review, the facility failed to promptly resolve a grievance for 1 of 3 sampled residents related to receiving assistance with 2 showers per week for 2 weeks (Resident #23). Resident #23 was admitted to the facility on 12/29/16. Diagnoses included left thigh fracture and chronic pain syndrome, among others. Review of an admission MDS assessment and Care Area Assessment dated 1/5/17 revealed Resident #23 was assessed with clear speech, able to understand and be understood, intact cognition, very important to be involved in decisions about bathing preferences, and required total staff assistance of 2 persons with personal hygiene due to impaired mobility from the thigh fracture/chronic pain. On 4/30/17 at 11:33 AM, Resident #23 was interviewed and stated that he had not received a shower in 2 weeks. Resident #23 further stated that staff provided him with a wash cloth to wash his face, "but that's it." He revealed that he had spoken to the social worker assistant (SWA) several times regarding this, "but it had not helped."	F 166	F 166 What measures did the facility put in place for the resident affected: On 5/24/17 resident #23 was interviewed by the social worker to discuss concern related to shower schedule. Resident #23 is satisfied with receiving two showers per week What measures were put in place for residents having the potential to be affected: On 5/24/17 the director of social work reviewed all resident concerns for the past thirty days to ensure residents and/or the resident RP are satisfied with the resolution and follow-up. Any areas of concern were addressed immediately. What systems were put in place to prevent the deficient practice from reoccurring: On 5/24/17, the administrator initiated an in-service for the administrative staff on Follow Up to Resident Concerns which	

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F 166	Continued From page 3 Review of the facility's April 2017 Grievance Log revealed Resident #23 filed 2 grievances, dated 4/19/17 and 4/26/17 related to not receiving showers as scheduled. Review of the grievances revealed they were received by the SWA. There was no documentation of resolution to these grievances. Review of the shower schedule on 4/30/17 at 11:50 AM revealed that the week of 4/16/17 - 4/22/17, Resident #23 was scheduled to receive showers on Wednesday/Friday during the 7AM - 3PM shift. The current shower schedule, revised 4/23/17, revealed Resident #23 was scheduled to receive showers on Monday/Thursday during the 7AM - 3PM shift. Review of the shower log revealed it was blank regarding Resident #23's receipt of a shower from 4/16/17 - 4/30/17. An interview on 5/1/17 at 11:45 AM with Nursing Assistant (NA) #1 revealed she typically worked with Resident #23 on the 7AM - 3PM shift. NA #1 stated Resident #23 used to receive showers on Wednesdays/Fridays until the shower schedule changed the week of 4/23/17. NA #1 stated that Resident #23 was currently scheduled to receive his showers on Mondays/Thursdays. NA #1 further stated that she was the assigned NA for Resident #23 the last few weeks, but the days she was his assigned NA were not the days he was scheduled to receive a shower. Review of the NA assignment and shower schedule during the interview, revealed NA #1 was the assigned NA for Resident #23 on the following days that he was scheduled to receive a shower or requested a shower, but did not receive a shower: Friday, 4/21/17 Monday, 4/24/17 Wednesday, 4/26/17	F 166	included: 1) When addressing resident concerns, you must include detailed information for resolution of concern to include a date and 2) Any needed audits or observations to support monitoring should be documented. This in-service was completed 5/25/17. All newly hired administrative staff will receive the Follow Up to Resident Concerns in-service during new employee orientation. How the facility will monitor systems put in place: The Administrator and/or DON will review resident concerns weekly for six months to ensure concern have been addressed and the resolution reviewed with the resident/RP in a timely manner to include a written response on the concern form to include details of the follow up that occurred with a date. The QI nurse will present all findings at the monthly QI committee meeting for six months. The QI committee will review the minutes of the resident council meeting monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for six months for further recommendations and oversight.	

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Continued interview with NA #1 revealed, she could not recall why she did not provide Resident #23 a shower on Friday, 4/21/17 (a scheduled shower day) and on Monday, 4/24/17 she stated that she was not aware that the shower scheduled changed and this was his current scheduled shower day. NA #1 also stated that on Wednesday, 4/26/17, Resident #23 requested a shower according to his previous shower schedule, but because the shower schedule had changed and Wednesdays was no longer his scheduled shower day, NA #1 stated she did not provide Resident #23 with a shower that day as he requested, but rather told him that he would receive a shower the next day (Thursday, 4/27/17).

An interview on 5/1/17 at 2:45 PM with the Director of Nursing (DON) revealed the facility implemented a new shower schedule on 4/23/17 to balance the NA work load. The DON stated she was made aware that Resident #23 expressed that he was not getting 2 showers per week as requested. The DON stated that she expected residents to receive at least 2 showers per week or to receive showers per their preference. The DON also stated that if a resident requested a shower on a day that a shower was not scheduled for that resident, a shower should still be provided or discussed with the resident when a shower could be given. The DON stated she reviewed the shower log, but had no further documentation that Resident #23 received 2 showers per week during the weeks of 4/16/17 - 4/30/17.

An interview on 5/3/17 at 11:45 AM with the SWA revealed Resident #23 voiced 2 concerns, dated

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4/19/17 and 4/26/17, that he had not received 2 showers for each of those weeks. The SWA stated that when she received the grievances, she advised the assigned NA to provide him a shower the day each grievance was filed (4/19/17 and 4/26/17), but now understands that on 4/26/17, NA #1 did not provide the shower as directed, she stated that she should have followed up to ensure the shower was given.

During an interview on 5/3/17 at 11:54 AM, the Administrator stated Resident #23 should get a shower on a day he asks, even if it not scheduled. The Administrator further stated that the facility had identified assistance/provision of showers as a quality improvement issue several months ago with ongoing auditing/monitoring. The Administrator stated that Resident #23 filed a grievance on 4/19/17 regarding showers and received a shower that day. She also stated that Resident #23 then filed another grievance on 4/26/17 and NA #1 was instructed to shower him, "but it appears that she is saying she did not shower him."

An interview on 5/3/17 at 12:59 PM with NA #3 revealed that she was aware Resident #23 expressed that he was not getting 2 showers per week. NA #3 stated she assisted Resident #23 with a shower on Thursday, 4/27/17, as directed because he filed a grievance on 4/26/17 regarding not receiving 2 showers per week.

A telephone interview was conducted on 5/03/17 at 1:41 PM with NA #4 and revealed she was made aware that Resident #23 expressed he was not receiving 2 showers per week. NA #4 stated she was his assigned NA a few times, but was not aware of the shower schedule and so she did

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F 166	Continued From page 6 not assist him with a shower a few times because of that. NA #4 stated she was the assigned NA for Resident #23 on Monday, 4/24/17, but that she did not assist him with a shower that day because she was not aware that it was his scheduled shower day. NA #4 stated that the shower schedule changed the week of 4/23/17, but she was not aware of the new schedule and so Resident #23 filed a grievance because he did not receive 2 showers that week.	F 166		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility record review, the facility failed to provide 1 of 4 sampled residents with 2 showers per week for 2 weeks as requested (Resident #23). Resident #23 was admitted to the facility on 12/29/16. Diagnoses included left thigh fracture	F 242	F 242 What measures did the facility put in place for the resident affected: On 5/3/17, the corporate facility consultant interviewed Resident #23 related to	6/7/17

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and chronic pain syndrome, among others.

Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 4/6/17 revealed the status of completion was recorded as "In Progress".

Review of an admission MDS assessment and Care Area Assessment dated 1/5/17 revealed Resident #23 was assessed with clear speech, able to understand and be understood, intact cognition, very important to be involved in decisions about bathing preferences, and required total staff assistance of 2 persons with personal hygiene due to impaired mobility from the thigh fracture/chronic pain.

Review of a care plan, revised 1/10/17, revealed Resident #23 required the physical assistance of staff to restore/maintain the maximum function for self-sufficiency related to personal hygiene/bathing. Staff were to assist and encourage Resident #23 to participate in personal hygiene/bathing and to honor his bathing preferences.

On 4/30/17 at 11:33 AM, Resident #23 was interviewed and stated that he had not received a shower in 2 weeks. Resident #23 further stated that staff provided him with a wash cloth to wash his face, "but that's it." He revealed that he had spoken to the social worker assistant (SWA) several times regarding this, "but it had not helped."

Review of the facility's April 2017 Grievance Log revealed Resident #23 filed 2 grievances, dated 4/19/17 and 4/26/17 related to not receiving showers as scheduled. Review of the grievances

receiving 2 showers per week as requested.

On 5/3/17, the assigned nursing assistant assisted Resident #23 with a shower.

On 5/4/17, the corporate facility consultant offered Resident #23 a shower. On 5/4/17, Resident #23 declined a shower on 5/4/17 stating he had received a shower on 5/3/17.

On 5/4/17, the corporate facility consultant updated the facility shower schedule. The updated shower schedule includes Resident #23□s requested 2 showers per week.

On 5/19/17, the social worker asked Resident #23 how it was going and if Resident #23 got two showers that week. Resident #23 stated It is getting better and confirmed he got 2 showers as requested that week.

On 5/22/17, Resident #23□s electronic health record reflected Resident #23 received a shower on 5/15/17 and 5/19/17.

On 5/22/17, the director of social services interviewed Resident #23 regarding bathing. Resident #23 stated he is getting two showers per week as requested. The director of social services also completed an updated Bathing Preference Questionnaire for Resident #23 which again reflected Resident #23□s desire for 2 showers each week.

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F 242	Continued From page 8 revealed they were received by the SWA. Review of the shower schedule on 4/30/17 at 11:50 AM revealed that the week of 4/16/17 - 4/22/17, Resident #23 was scheduled to receive 2 showers per week on Wednesday/Friday during the 7AM - 3PM shift. The current shower schedule revealed Resident #23 was scheduled to receive 2 showers per week on Monday/Thursday during the 7AM - 3PM shift, a revised schedule that began on 4/23/17. Review of the shower log revealed it was blank regarding Resident #23's receipt of a shower from 4/16/17 - 4/30/17. On 5/1/17 at 11:30 AM Resident #23 was observed returned to his room from the shower room by nurse aide (NA) #1. Resident #23 stated "This was my first shower in about 2 weeks." An interview on 5/1/17 at 11:45 AM with NA #1 revealed she typically worked with Resident #23 on the 7AM - 3PM shift. NA #1 stated that she had just assisted Resident #23 with a shower because he reported to staff that he was not receiving 2 showers per week and she was instructed by the director of nursing (DON) to give him a shower that day. NA #1 stated Resident #23 used to receive showers on Wednesdays/Fridays until the shower schedule changed the week of 4/23/17. NA #1 stated that Resident #23 was currently scheduled to receive his showers on Mondays/Thursdays. NA #1 further stated that she was the assigned NA for Resident #23 the last few weeks, but the days she was his assigned NA were not the days he was scheduled to receive a shower. Review of the NA assignment and shower schedule during the interview, revealed NA #1 was the assigned	F 242	What measures were put in place for residents having the potential to be affected: On 5/22/17, the corporate facility consultant audited 100% of resident Bathing Preference Questionnaires to verify all current residents had a Bathing Preference Questionnaire sheet completed. The bathing preference sheet includes what type of bath (shower, full bed bath, or other) and how many times per week the resident prefers to be bathed. Two residents did not have a resident Bathing Preference Questionnaire completed on file. On 5/22/17, the social worker interviewed the two residents and completed a Bathing Preference Questionnaire. As of 5/22/17, 100% of current residents have a Bathing Preference Questionnaire sheet completed. The Bathing Preference Questionnaire binder is maintained in the social worker office. On 5/23/17, the corporate facility consultant audited the shower schedule to ensure all the facility□s current resident rooms are represented on the shower schedule and the schedule reflects each resident□s preferred type of bath (shower, full bed bath, or other) and the number of times per week the resident prefers to be bathed. The corporate facility consultant updated the shower schedule, adding On 5/23/17, the corporate MDS consultant	

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F 242	Continued From page 9 NA for Resident #23 on the following days that he was scheduled to receive a shower or requested a shower, but did not receive a shower: Friday, 4/21/17 Monday, 4/24/17 Wednesday, 4/26/17 Continued interview with NA #1 revealed, she could not recall why she did not provide Resident #23 a shower on Friday, 4/21/17 (a scheduled shower day) and on Monday, 4/24/17 she stated that she was not aware that the shower scheduled changed and this was his current scheduled shower day. NA #1 also stated that on Wednesday, 4/26/17, Resident #23 requested a shower according to his previous shower schedule, but because the shower schedule had changed and Wednesdays was no longer his scheduled shower day, NA #1 stated she did not provide Resident #23 with a shower that day as he requested, but rather told him that he would receive a shower the next day (Thursday, 4/27/17). An interview on 5/1/17 at 2:45 PM with the Director of Nursing (DON) revealed the facility implemented a new shower schedule on 4/23/17 to balance the NA work load. The DON stated she was made aware that Resident #23 expressed that he was not getting 2 showers per week as requested and that she advised NA #1 to provide him a shower on Monday, 5/1/17. The DON stated that she expected residents to receive at least 2 showers per week or to receive showers per their preference. The DON also stated that if a resident requested a shower on a day that a shower was not scheduled for that resident, a shower should still be provided or	F 242	audited 100% of the Bathing Preference Questionnaires, comparing the questionnaire preference to the resident care plan and care guide. The MDS consultant updated several resident care plans and care guides to reflect resident bathing preferences. What systems were put in place to prevent the deficient practice from reoccurring: On 5/23/17, the staff development coordinator began a new employee orientation. The new employee orientation will ensure additional supervisors, nurses, and nursing assistants will be available to provide services honoring residents□ self-determination-right to make choices, including providing bathing/showers twice weekly as requested by Resident #23. On 5/24/17, the corporate facility consultant initiated an in-service with admissions, social services, and nursing departments related to the resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident to include the facility providing showers as requested on the resident□s Bathing Preference Questionnaire. The in-service will be 100% complete by 6/7/17. All newly hired staff and agency staff will receive this shower in-service during new employee orientation. On 5/24/17, the director of nursing, staff	

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discussed with the resident when a shower could be given. The DON stated she reviewed the shower log, but had no further documentation that Resident #23 received 2 showers per week during the weeks of 4/16/17 - 4/30/17.

During an interview on 5/3/17 at 11:54 AM, the Administrator stated Resident #23 should get a shower on a day he asks, even if it was not scheduled. The Administrator further stated that the facility had identified assistance/provision of showers as a quality improvement issue several months ago with ongoing auditing/monitoring. The Administrator stated that Resident #23 filed a grievance on 4/19/17 regarding showers and received a shower that day. She also stated that Resident #23 then filed another grievance on 4/26/17 and NA #1 was instructed to shower him, "but it appears that she is saying she did not shower him."

An interview on 5/3/17 at 12:59 PM with NA #3 revealed that she was aware Resident #23 expressed that he was not getting 2 showers per week. NA #3 stated she assisted Resident #23 with a shower on Thursday, 4/27/17, as directed because he filed a grievance on 4/26/17 regarding not receiving 2 showers per week.

A telephone interview was conducted on 5/03/17 at 1:41 PM with NA #4 and revealed she was made aware that Resident #23 expressed he was not receiving 2 showers per week. NA #4 stated she was his assigned NA a few times, but was not aware of the shower schedule and so she did not assist him with a shower a few times because of that. NA #4 stated she was the assigned NA for Resident #23 on Monday, 4/24/17, but that she did not assist him with a shower that day because

scheduler, social services director, MDS nurse, treatment nurse, and/or corporate consultant began twice weekly review of a Bath Type report. The review of the Bath Type report is to ensure residents, including Resident #23 are receiving showers twice weekly as requested or as indicated on the Bathing Preference Questionnaire. The review will be documented by the reviewers initials and date review noted on the Bath Type report. Any residents not getting bathed/showered as requested will immediately be offered a bath type of the resident s preference and it will be documented in the electronic health record. This review of the Bath Type report will continue for a period of three months to prevent the deficient practice from reoccurring, allowing the new staff opportunity to get used to the bathing/shower routine. Any issues will be immediately addressed and brought to the attention of the director of nursing.

On 5/24/17, the director of nursing placed the bathing preference-based shower schedule in the two shower rooms (spas) and posted it also at the nurse station (charting room). The posting of the bathing preference-based shower schedule in the shower rooms (spas) and at the nurse station will assist in communicating to the nursing assistants what days the residents have chosen for bathing, based on the Bathing Preference Questionnaire.

On 5/30/17, the director of nursing

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F 242	Continued From page 11 she was not aware that it was his scheduled shower day. NA #4 stated that the shower schedule changed the week of 4/23/17, but she was not aware of the new schedule and so Resident #23 filed a grievance because he did not receive 2 showers that week.	F 242	implemented the use of a new daily staff assignment sheet. The new daily assignment sheet will include room numbers of residents who have requested to have a bath/shower on that day, based on their Bathing Preference Questionnaire. The new daily staff assignment sheet is expected to improve communication to the nursing assistants of resident requested showers. The new daily staff assignment sheet will also allow the nurses to follow-up with the nursing assistants to ensure resident choices are honored, including Resident #23 being assisted with 2 showers per week. How the facility will monitor systems put in place: On 5/23/17, resident shower preferences began being audited by the social services worker, social services director, treatment nurse, nurse supervisor, and/or corporate nurse consultant to ensure residents are receiving showers according to their preference. The audit will be documented on shower audit tool. The shower audit tool will be completed for 5 residents daily 5 x per week x 4 weeks, then 5 residents weekly x 4 weeks , then 5 residents monthly x 2 months. The monthly Quality Improvement (QI) Committee will review the results of the audits monthly x 6 months with recommendation and follow up, as needed or appropriate, for continued compliance in this area and to determine	

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F 242	Continued From page 12	F 242		
			the need for and or/ frequency of continued QI monitoring.	
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the Minimum Data Set (MDS) assessment, the facility failed to complete a comprehensive admission MDS assessment within 14 days of admission to the facility for 1 of 3 sampled residents reviewed (Resident #120). Resident #120 was admitted to the facility on 4/1/17. On 5/1/17 a review of an admission MDS assessment dated 4/8/17 revealed the status of sections A, B, E, G, GG, H, I, J, K, L, M, N, P and V as "In Progress." The status of sections C, D, F and Q were coded as "Complete." The admission MDS assessment for Resident #120 was still	F 273	F 273 What measures did the facility put in place for the resident affected: On 5/9/2017 the admission Minimum Data Set (MDS) for resident #120 with the ARD 4/8/2017 was completed by the Corporate RAI/Reimbursement Auditor. The assessment was transmitted and accepted on 5/10/2017. What measures were put in place for residents having the potential to be affected: On 5/24/17 an audit was completed by the	6/7/17

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F 273	Continued From page 13 incomplete 30 days after admission. An interview with the Resident Assessment Instrument (RAI) Reimbursement Auditor (corporate consultant) and review of the admission MDS for Resident #120 occurred on 05/03/17 at 10:29 AM. During the interview the RAI Reimbursement Auditor stated that she had provided the facility with MDS assistance over the prior 4 weeks because some MDS assessments were incomplete. The RAI Reimbursement Auditor stated that the facility was in the process of hiring a full-time MDS Coordinator and currently had 2 part-time MDS Coordinators. She confirmed that the admission MDS dated 4/8/17 for Resident #120 was incomplete and that the facility was currently working on MDS assessments with the most current due date to prevent being late on further assessments. She stated that the current MDS assessments that were late would remain late until the facility could get caught up. During an interview on 5/3/17 at 11:54 AM, the Administrator stated the facility was currently behind on the completion of some MDS assessments due to staff turnover in that department. The Administrator stated that the facility currently had 2 part-time MDS Coordinators, was in the process of hiring a full-time MDS Coordinator and was currently using corporate support in order to get caught up on the MDS assessments that were late.	F 273	facility Corporate RAI/Reimbursement Auditor using the MDS in progress list and MDS scheduler to identify late admission assessments. No late assessments were identified. What systems were put in place to prevent the deficient practice from reoccurring: On 5/23/17 & 5/24/17 the MDS nurses were in-serviced by the Corporate RAI/Reimbursement Auditor related to the timely completion of MDS assessments to include admission assessments per the RAI manual. How the facility will monitor systems put in place: On 5/30/17, the director of nursing (DON), assistant director of nursing (ADON), administrator, and/or a corporate consultant began monitoring began monitoring the MDS admission assessments to ensure all parts of assessments are completed on or before due date using the MDS completion assessment tool. The audit will be completed weekly for 12 weeks then monthly for 3 months. The administrator and/or DON will present all findings from the MDS completion assessment tool at the monthly QI committee. The monthly QI committee will review the results of the MDS completion audit tool monthly for 6	

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F 273	Continued From page 14	F 273	months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a significant change comprehensive Minimum Data Set (MDS) assessment within 14 days after a change in nutrition/wound status for 1 of 6 sampled residents (Resident #72). Resident #72 was originally admitted to the facility on 3/25/15. Diagnoses included Alzheimer's dementia and psychotic disorder.	F 274	F Tag 274 late Sig Change MDS assessments What measures did the facility put in place for the resident affected: On 5/3/2017 the Significant Change Minimum Data Set (MDS) for resident #72 with the ARD 4/8/2017 was completed by the Corporate RAI/Reimbursement Auditor. The assessment was transmitted	5/27/17

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F 274	Continued From page 15 A quarterly MDS assessment dated 12/24/16 assessed Resident #72 as requiring the supervision and the physical assistance of 1 staff person with meals, received 100% of her nutrition from a mechanically altered diet and had no ulcers, wounds or skin problems. Review of a Discharge MDS assessment dated 3/15/17 revealed Resident #72 had an unplanned hospital discharge on 3/15/17, but with an anticipated return to the facility. Resident #72 was re-admitted to the facility on 3/22/17 after an acute hospital stay requiring surgery. Review of the hospital discharge summary dated 3/22/17 revealed Resident #72 had a surgically placed percutaneous endoscopic gastrostomy (PEG) tube which required daily dressing changes for the surgical wound and she now received 100% of her nutrition via a tube feeding product. Further medical record review revealed Resident #72 had an unplanned hospital discharge on 3/26/17, due to a change in mental status and was re-admitted to the facility on 4/1/17. A significant change MDS assessment dated 4/8/17 was reviewed and revealed it was coded as "In Progress" but had not been completed within 14 days of the significant changes for Resident #72 (surgical placement of a PEG tube, a change in nutritional status and dressing changes for a surgical wound). During an interview on 5/3/17 at 11:54 AM, the Administrator stated the facility was currently behind on the completion of some MDS	F 274	and accepted on 5/8/2017. What measures were put in place for residents having the potential to be affected: On 5/24/17 an audit was completed by the facility Corporate RAI/Reimbursement Auditor using the MDS in progress list and MDS scheduler to identify late significant change assessments. No late assessments were identified. What systems were put in place to prevent the deficient practice from reoccurring: On 5/23/17 & 5/24/17 the MDS nurses were in-serviced by the Corporate RAI/Reimbursement Auditor related to the timely completion of MDS assessments to include significant change assessments per the RAI manual. How the facility will monitor systems put in place: On 5/30/17, the director of nursing (DON), assistant director of nursing (ADON), administrator, and/or a corporate consultant began monitoring began monitoring the MDS significant change assessments to ensure all parts of assessments are completed on or before due date using the MDS completion assessment tool. The audit will be completed weekly for 12 weeks then monthly for 3 months.	

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F 274	Continued From page 16 assessments due to staff turnover in that department. The Administrator stated that the facility currently had 2 part-time MDS Coordinators, was in the process of hiring a full-time MDS Coordinator and was currently using corporate support in order to get caught up on the MDS assessments that were late. An interview with the Corporate Nurse Consultant and the Resident Assessment Instrument (RAI) Reimbursement Auditor (corporate consultant) occurred on 05/03/17 at 4:21 PM. The interview revealed Resident #72 discharged to the hospital on 3/15/17 and returned to the facility on 3/22/17 with a PEG tube that was surgically placed in the hospital and required dressing changes to the surgical site. The interview also revealed that Resident #72 discharged to the hospital again on 3/26/17 and then returned on 4/1/17, and a significant change MDS dated 4/8/17 was still in progress and had not been completed. During the interview the RAI Reimbursement Auditor stated that she had provided the facility with MDS assistance over the prior 4 weeks because some MDS assessments were incomplete. The RAI Reimbursement Auditor stated that the facility was in the process of hiring a full-time MDS Coordinator and currently had 2 part-time MDS Coordinators. She confirmed that the significant change MDS dated 4/8/17 for Resident #72 was incomplete and that the facility was currently working on MDS assessments with the most current due date to prevent being late on further assessments. She stated that the current MDS assessments that were late would remain late until the facility could get caught up.	F 274	The administrator and/or DON will present all findings from the MDS completion assessment tool at the monthly QI committee. The monthly QI committee will review the results of the MDS completion audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	F 276		6/7/17

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F 276	Continued From page 17 (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the Minimum Data Set (MDS) assessment, the facility failed to complete a quarterly MDS within 3 months of the previous admission MDS assessment for 1 of 6 sampled residents reviewed (Resident #23). Resident #23 was admitted to the facility on 12/29/16. An admission MDS was completed for Resident #23 on 1/5/17. On 5/1/17 review of the most recent quarterly MDS assessment dated 4/6/17 revealed the status of completion was recorded as "In Progress", 118 days after completion of the admission MDS dated 1/5/17. Sections A, C, D, E, G, GG, H, I, J, L and N were all coded as "In Progress" and sections C and K were coded as "Complete." An interview with the Resident Assessment Instrument (RAI) Reimbursement Auditor (corporate consultant) and review of the quarterly MDS for Resident #23 occurred on 05/03/17 at 10:29 AM. During the interview the RAI Reimbursement Auditor stated that she had provided the facility with MDS assistance over the prior 4 weeks because some MDS assessments were incomplete. The RAI Reimbursement	F 276	F 276 What measures did the facility put in place for the resident affected: On 5/15/2017, the quarterly Minimum Data Set (MDS) for resident #23 with the ARD 4/6/2017 was completed by the Corporate MDS Consultant. The assessment was transmitted and accepted on 5/16/2017. What measures were put in place for residents having the potential to be affected: On 5/24/17, an audit was completed by the Corporate RAI/Reimbursement Auditor using the MDS in progress list and MDS scheduler to identify late quarterly assessments. No late assessments were identified. What systems were put in place to prevent the deficient practice from reoccurring: On 5/23/17 & 5/24/17, the MDS nurses were in-serviced by the Corporate RAI/Reimbursement Auditor related to the timely completion of MDS assessments to	

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F 276	Continued From page 18 Auditor stated that the facility was in the process of hiring a full-time MDS Coordinator and currently had 2 part-time MDS Coordinators. She confirmed that the quarterly MDS dated 4/6/17 for Resident #23 was incomplete and that the facility was currently working on MDS assessments with the most current due date to prevent being late on further assessments. She stated that the current MDS assessments that were late would remain late until the facility could get caught up. During an interview on 5/3/17 at 11:54 AM, the Administrator stated the facility was currently behind on the completion of some MDS assessments due to staff turnover in that department. The Administrator stated that the facility currently had 2 part-time MDS Coordinators, was in the process of hiring a full-time MDS Coordinator and was currently using corporate support in order to get caught up on the MDS assessments that were late.	F 276	include quarterly assessments per the RAI manual. How the facility will monitor systems put in place: On 5/30/17, the director of nursing (DON), assistant director of nursing (ADON), administrator, and/or a corporate consultant began monitoring began monitoring the MDS quarterly assessments to ensure all parts of assessments are completed on or before due date using the MDS completion assessment tool. The audit will be completed weekly for 12 weeks then monthly for 3 months. The administrator and/or DON will present all findings from the MDS completion assessment tool at the monthly QI committee. The monthly QI committee will review the results of the MDS completion audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		6/7/17

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F 282	Continued From page 19 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to follow care plan interventions by not having a resident's call bell in reach for for 1 of 5 residents sampled (Resident #78). The Findings included: Resident #78 was admitted to the facility on 12/23/16 with diagnoses that included Parkinson's disease, anxiety, dysphagia, and altered mental status. Review of care plan initiated on 02/07/17 and revised on 04/14/17 read in part, Resident #78 was at risk for falls characterized by history of falls and actual falls with injury related to disease process of Parkinson's disease. The goal of stated care plan was Resident #78 would not sustain further serious injury through next review. Interventions included, keep call light within reach and answer timely. Review of the most recent quarterly minimum data set (MDS) dated 04/01/17 revealed that Resident #78 was able to make herself understood and was severely cognitively impaired. The MDS also revealed that Resident #78 required limited assistance of 1 staff member	F 282	F282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident□s written plan of care 1)On 5/24/17 Resident #78□s care plan and care guide were reviewed and updated by the Minimum Data Set Nurse (MDS) to be accurate and up to date. The resident care plan and care guide includes risk for falls focus with call bell in reach as an intervention. On 5/1/17 resident # 78 was provided with a ding bell to use until call bell was repaired. On 5/1/17 resident # 78□s call bell was repaired by the maintenance director and was functioning properly. 2)On 5/24/17, the corporate consultants began reviewing 100% of the care plans and care guides for all residents identified through the MDS process with fall risk ensuring resident care plans and care guides are up to date including appropriate interventions. The audit will be completed by 5/27/17. All residents with call bell in reach listed as an intervention	

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F 282	Continued From page 20	F 282		

for toileting, bed mobility, and dressing. The MDS also revealed that Resident #78 was occasionally incontinent of bowel and bladder.

An observation on 04/30/17 at 11:27 AM of Resident #78's room revealed, Resident #78 was not present in the room. No call bell was present and there was no other means noted in the room for Resident #78 to contact the nurse's station.

An observation on 04/30/17 at 12:40 PM of Resident #78's room revealed, Resident #78 was up in her wheelchair at bedside. No call bell was present and there was no other means noted in the room for Resident #78 to contact the nurse's station.

An observation on 04/30/17 at 4:16 PM of Resident #78's room revealed, Resident #78 was resting in her bed. No call bell was present and there was no other means noted in the room for Resident #78 to contact the nurse's station.

An observation on 05/01/17 at 10:42 AM of Resident #78's room revealed, Resident #78 was resting in her bed. No call bell was present and there was no other means noted in the room for Resident #78 to contact the nurse's station.

An observation on 05/01/17 at 2:51 PM of Resident #78's room revealed, Resident #78 was resting in her bed. No call bell was present and there was no other means noted in the room for Resident #78 to contact the nurse's station.

An interview with NA #2 was conducted on 05/02/17 at 2:22 PM. NA #2 stated that she routinely cared for Resident #78. NA #2 stated that Resident #78 used her call bell frequently to

were audited by the corporate consultant on 5/24/17 ensuring there was functioning call light within resident reach.

3) On 5/24/17, the staff facilitator began in-servicing a 100% all nurses, medication aides, and nursing assistants related to following resident care plans and care guides to ensure each resident is provided quality care and safety is maintained to include keeping the call light in reach. In-service will be completed by 6/7/17. During orientation of new employees nurses and nursing assistants will continue to be educated on the importance of following residents care plans and care guides and locations of each form.

4)The administrative nurses, DON, staff facilitator, corporate consultant, and/or MDS nurse began utilizing the care plan/guide audit tool on 5/30/17 to ensure care plans and care guides are being followed to include interventions required to assist with management of residents identified with fall risk interventions to include keeping call light in reach. Random audit of 10% of residents will be reviewed weekly x 12 weeks then monthly x 3 months.

5)The monthly QI committee will review results of the audits x 6 months for any trends, actions taken and determine the need for and /or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 21	F 282		

make staff aware of her needs. NA #2 stated Resident #78 would ring her call light if she was wet or wanted to get up out of bed or if she wanted to get back into bed. NA #2 stated that the last thing she does before leaving the residents room is make sure the call light was within reach.

An interview with Medication Aide (MA) #1 was conducted on 05/02/17 at 2:39 PM. MA #1 stated that she routinely cared for Resident #78. MA #1 stated that they had worked extensively with Resident #78 to get her to use the call light. MA #1 stated that Resident #78 would try to get up without using the call light for assistance and would fall frequently. MA #1 stated that after working a lot with Resident #78 she now used her call bell to alert staff that she needed to use the bathroom or that she wanted to get up or be laid down. MA #1 stated that Resident #78 would also ring her call bell to alert staff that she was in pain. MA #1 stated that something happened to her call bell and sometime after her shift ended on 05/01/17 someone had given Resident #78 a bell to use to call for help.

An interview with the interim Director of Nursing (DON) was conducted on 05/02/17 at 4:00 PM. The interim DON stated that Resident #78 used her call bell very frequently to alert staff of her needs. The interim DON stated that all care plan interventions are expected to be followed and she was not sure how Resident #78 was able to call for assistance when she did not have a call bell available to her.

An interview with the Administrator was conducted on 05/02/17 at 4:36 PM. The Administrator stated that all care plans are

the findings and recommendation to the quarterly executive QA committee for further recommendations and oversight.

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F 282	Continued From page 22 expected to be followed and if the call bell is not working then everyone has been trained to give the resident a bell immediately. An interview with Resident #78 was conducted on 05/03/17 at 1:27 PM. Resident #78 stated she used her call bell when she needed to use the restroom or when she wanted to get out of bed. Resident #78 stated that on the evening of 04/30/17 she did not have a call bell and "she just had to wait until staff came into her room." Resident #78 stated that on Monday afternoon 05/01/07 someone had given her a bell to use until they fixed her call bell.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews the facility failed to check a resident for incontinence on the day shift for 1 of 4 residents sampled for activities of daily living (Resident #72). The findings included: Resident #72 was readmitted to the facility on 04/01/17 with diagnoses that included pneumonia, Alzheimer's disease, non-Alzheimer's dementia, depression, and other psychotic disorder other than schizophrenia. Review of the most recent comprehensive	F 312	F 312 What measures did the facility put in place for the residents affected: On 4/30/17, the nursing assistant washed, dried, replaced the brief, put lotion on Resident #72, and changed the bed linen. On 4/30/17, the administrator assigned the department heads to made incontinent rounds every two hours to ensure residents were being attended to and the nursing assistants were providing incontinent care for dependent residents.	5/25/17

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F 312	Continued From page 23 Minimum Data Set (MDS) dated 04/08/17 revealed that Resident #72 was severely impaired for daily decision making and was rarely/never understood. The MDS also revealed that Resident #72 required total assistance of 1 staff member for toileting and was always incontinent of bowel and bladder. Review of the Urinary Incontinence Care Area Assessment (CAA) dated 04/08/17 read in part, that Resident #72 was dependent for toileting tasks and was totally incontinent of bowel and bladder. An interview with Resident #72's family member was conducted on 04/30/17 at 12:30 PM. The family remember reported that she had just came to visit and when she arrived to her family member's room it smelled very strongly of ammonia and urine. The family member was observed taking deodorizing spray from her pocketbook to spray in the room to alleviate the very strong foul odor of urine. The family went on to explain that they had just arrived to the facility and found their family member was incontinent and it appeared that their family member had not been changed in a long time. The family member stated she had pulled the covers back off of Resident #72 and noted a large brown ring on the pad and on the sheet. The family member further stated that the brief was visibly soiled and the pad was also very wet to the touch. The family member had spoken to a member of the facility management team and asked why their family member had been left wet. The facility management team had apologized and offered to provide incontinent care to Resident #72. The family member stated she had declined the help and stated, "If they could not provide the care	F 312	Non-nursing department heads (Activities, accounts payable, accounts receivable, dietary, maintenance, social services) check residents' clothing for cleanliness (dry and unsoiled) and for odors and document on the Administrative Staff/Department Head Rounds Sheet. Nursing department heads (director of nursing, assistant director of nursing, staff facilitator, MDS, quality improvement nurse) check residents' briefs/pull-ups for wetness and/or soiling and document on the Administrative Nursing Rounds Sheet. On 4/30/17, the administrator, director of nursing (DON), and scheduler reviewed the staff assignment sheet and the staff schedule to ensure there was a nursing assistant assigned to assist Resident #72 with incontinent care. On 5/8/17 through 5/19/17, the corporate facility consultants began checking Resident #72 on a daily basis to ensure the facility had provided incontinent care. Resident #72 was dry and had no odor during most checks. When the resident was wet or with odor, the facility consultant obtained immediate assistance to provide incontinent care for Resident #72. On 5/24/17, the corporate facility consultant checked Resident #72 to ensure the facility had provided incontinent care. Resident #72 was clean and dry.	

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F 312	Continued From page 24 before now, I do not need them to do it now." The family member stated that they had started to provide the incontinent care when the Nursing Assistants (NAs) came in and offered to finish and the family member stated that they allowed the staff to provide the care. An observation was made on 04/30/17 at 1:01 PM of the linen and brief that had just been removed from Resident #72. The linen was noted have a large brown ring that started at the top of the sheet and extended more than halfway to the bottom of the fitted sheet. The pad that was on the bed was noted to have a large brown ring that extended to the edges of the pad, the pad was wet to the touch. The brief that Resident #72 had been wearing was visibly soiled and had a very strong smell of ammonia. The brief was heavy to touch and the inner absorbing contents of the brief had bunched together from the excessive moisture. An interview with NA #6 was conducted on 04/30/17 at 1:17 PM. NA #6 stated that she and NA #5 were working together on their assignment and they both were responsible for Resident #72. NA #6 stated that when she arrived for her shift she was assigned to another unit in the facility and 2 staff members had not shown up for work. NA #6 stated that the supervisor had called in 2 other staff members to come and help out so when those staff arrived to work I was reassigned to the unit with Resident #72. NA #6 stated this reassignment occurred at 9:00 AM which was right in the middle of breakfast. NA #6 explained that when she took the assignment for Resident #72 she had to finish passing breakfast trays, assisting residents with eating, and then picking up the dirty trays. After all the breakfast trays had	F 312	What measures were put in place for residents having the potential to be affected: On 4/30/17, the administrator, director of nursing (DON), assistant director of nursing (ADON), treatment nurse, social services director (a nursing assistant), social services assistant (a nursing assistant), activities director, staff facilitator, and/or corporate facility consultants conduct administrative rounds daily, to include monitoring for incontinent care, to ensure the facility is providing incontinent care for dependent residents. The administrator, department heads, hall nurses, and/or corporate consultants also monitor dining rooms and activity rooms on a daily basis, watching for residents needing incontinent care. Non-nursing department heads (activities, accounts payable, accounts receivable, dietary, maintenance, social services) check residents' clothing for cleanliness (dry and unsoiled) and for odors and document on the Administrative Staff/Department Head Rounds Sheet. Nursing department heads (director of nursing, assistant director of nursing, staff facilitator, MDS, quality improvement nurse) check residents' briefs/pull-ups for wetness and/or soiling and document on the Administrative Nursing Rounds Sheet. Any issues of a resident needing incontinent care are immediately addressed by the auditor who will ensure the resident is escorted to their room and assisted by a registered nurse, licensed practical nurse, and/or nursing assistant.	

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F 312	Continued From page 25 been removed NA #6 stated that she and NA #5 had started a round to provide care to the residents. NA #6 stated she had been in Resident #72's room providing care to the roommate when she overheard Resident #72's family get upset because the resident was soiled. NA #6 stated she finished providing care to the roommate and then went to assist Resident #72. NA #6 stated she provided incontinent care to Resident #72 at 12:15 PM and this was the first time she had provided care to Resident #72 since arriving for her shift. NA #6 also stated that Resident #72 should have been changed at 6:30 AM on 3rd shift's last round. NA #6 stated that at 12:15 PM she washed, dried, and put lotion on Resident #72 and replaced her brief and linen. An interview with NA #7 was conducted on 04/30/17 at 1:19 PM. NA#7 stated she had worked 3rd shift and was the only NA on the medical unit which had approximately 55 residents. NA #7 stated that she generally tried to make 2-3 rounds each night on her shift. NA #7 stated last night she was only able to change everyone 1 time and she changed Resident #72 at 2:00 AM and "unfortunately that was the only time I was able to provide any care to Resident #72" on my shift. NA #7 stated that Nurse #2 that was working tried to help as much as she could but she was passing medications and doing other duties. NA #7 stated that if there would have more staff then Resident #72 would have been changed and turned every 2 hours like she was supposed to be. An interview with NA #5 was conducted on 04/30/17 at 1:34 PM. NA #5 stated that she and NA #6 were working together on their assignment and they both were responsible for Resident #72.	F 312	Incontinent rounds findings and corrective actions taken are documented by the non-nursing department heads on the Administrative Staff/Department Head Rounds Sheet and the nursing department heads will document incontinent rounds on the Administrative Nursing Rounds Sheet. What systems were put in place to prevent the deficient practice from reoccurring: On 4/30/17, the administrator, director of nursing (DON), assistant director of nursing (ADON), treatment nurse, social services director (a nursing assistant), social services assistant (a nursing assistant), activities director, staff facilitator, and/or corporate facility consultants conduct daily administrative rounds, to include monitoring for incontinent care, to ensure the facility is providing incontinent care for dependent residents. The administrator, department heads, hall nurses, and/or corporate consultants also monitor dining rooms and activity rooms on a daily basis, watching for residents needing incontinent care. Non-nursing department heads (Activities, accounts payable, accounts receivable, dietary, maintenance, social services) check residents' clothing for cleanliness (dry and unsoiled) and for odors and document on the Administrative Staff/Department Head Rounds Sheet. Nursing department heads (director of nursing, assistant director of nursing, staff facilitator, MDS, quality improvement	

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F 312	Continued From page 26 NA #5 stated that when she arrived for her shift she was assigned to another unit in the facility and 2 staff members had not shown up for work. NA #5 stated that the supervisor had called in 2 other staff members to come and help out so when those staff arrived to work I was reassigned to the unit with Resident #72. NA #5 stated this reassignment occurred at 9:00 AM which was right in the middle of breakfast. NA #5 explained that when she took the assignment for Resident #72 she had to finish passing breakfast trays, assisting residents with eating, and then picking up the dirty trays. After all the breakfast trays had been removed NA #5 stated that she and NA #6 had started a round to provide care to the residents. NA #5 stated she had been in Resident #72's room providing care to the roommate when she overheard Resident #72's family get upset when the resident was soiled. NA #5 stated she finished providing care to the roommate and then went to assist Resident #72. NA #5 stated that when she went to assist Resident #72 the room smelled very strongly of ammonia and urine. NA #5 stated that she assisted Resident #72 with incontinent care at 12:15 PM and that was the first time she had provide care to Resident #72 since arriving for her shift. NA #5 stated that Resident #72 should have been changed at 6:30 AM on 3rd shift ' s last round. NA #5 stated that when she changed Resident #72 there was a large brown ring that went from the pad to the sheet and then to the mattress. NA #5 stated that the ring started at Resident #72's neck and extended down to her knees. NA #5 stated that Resident #72's brief was soaked and was heavy to the touch. An attempt to speak to Nurse #2 was unsuccessful on 05/01/17 at 12:56 PM.	F 312	nurse) check residents' briefs/pull-ups for wetness and/or soiling and document on the Administrative Nursing Rounds Sheet. Any issues of a resident needing incontinent care is immediately addressed by the auditor who will ensure the resident is escorted to their room and assisted by a registered nurse, licensed practical nurse, and/or nursing assistant. Incontinent rounds findings and corrective actions taken are documented by the non-nursing department heads on the Administrative Staff/Department Head Rounds Sheet and the nursing department heads will document incontinent rounds on the Administrative Nursing Rounds Sheet. On 5/17/17, the administrator, director of nursing, and corporate consultants received consultation from the Quality Improvement Organization (QIO). On 5/22/17, ongoing through 5/30/17, the staff facilitator continued providing orientations for new registered nurses (RNs), licensed practical nurses (LPNs), medication aides, nursing assistants, and geriatric care assistants (GCAs) to ensure there is enough staff, even when staff members do not show up to work, to provide incontinent care for dependent residents, including Resident #72. On 5/24/17, the corporate facility consultant reviewed the daily staffing assignment to ensure all the facility's current resident rooms are represented in the staffing assignments. Because	

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F 312	Continued From page 27 An interview with the interim Director of Nursing (DON) was conducted on 05/02/17 at 4:03 PM. The interim DON stated that incontinent care should be provided at least every 2 hours and as needed. The interim DON stated that she expected Resident #72 to be checked and changed every 2 hours through the night and then 1st shift should have provided care to her by 8:00 AM. The interim DON stated "it is disturbing to me that Resident #72 had no incontinent care or ADL care provided to her by 12:00 PM." An interview with Administrator was conducted on 05/02/17 at 4:42 PM. The administrator stated that she expected Resident #72 to be changed every 2 hours and as needed. The administrator stated that it was not acceptable to only change the resident's once a shift. The Administrator stated that she also expected the nurses that were on duty to help as needed with providing care to the residents.	F 312	multiple staff expressed concern over being able to read/understand/adjust the assignment sheet, especially when staff members do not show up to work, “poor communication” was identified as a root cause for not providing incontinent/ADL care for dependent residents, including Resident #72 on 4/30/17. On 5/25/17, the administrator began review and discussion of the administrative rounds tool in the daily department head meeting and DON began review and discussion of the administrative nurse rounds tool in the daily clinical meeting. Both rounds tools include checking the resident for cleanliness (wetness, soiled) and odors. The purpose of reviewing and discussing the administrative rounds tool and the administrative nursing rounds tool during the daily meetings, rather than independent review only by the administrator and DON, is to improve communication within and between the administrative operational team and the nursing clinical teams. Improved communication will promote improved coordination of resident-centered care, including incontinent care, for dependent residents. On 5/31/17, the director of nursing (DON) and staff facilitator initiated an in-service for all RNs, LPNs, medication aides, and nursing assistants on providing incontinent care for dependent residents. The focus of the in-service is the importance of communication during	

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F 312	Continued From page 28	F 312	change of shift, when assignments are changed, and if provision of assistance with incontinent care/ADLs is not being provided as scheduled; communication must include verbal and written communications “up-down and down-up” to ensure dependent residents are assisted with incontinent care. This in-service will be completed on 6/7/17. After 6/7/17, no RN, LPN, medication aide, or nursing assistant will be allowed to work until the incontinent care in-service is completed. This incontinent care in-service will be incorporated into new employee orientation. On 6/1/17, the administrator, director of nursing (DON), assistant director of nursing (ADON), quality improvement (QI) nurse, treatment nurse, MDS nurse, nurse supervisor, charge nurse, social services director (a nursing assistant), social services assistant (a nursing assistant), activities director, staff facilitator, and/or corporate facility consultants conduct will conduct Shift incontinent rounds twice each shift to ensure the facility is providing incontinent care for dependent residents. Any issues of a resident needing incontinent care is immediately addressed by the auditor who will ensure the resident is escorted to their room and assisted by a registered nurse, licensed practical nurse, and/or nursing assistant. Shift incontinent rounds findings and corrective actions taken are documented by the Shift Incontinent Rounds Sheet for four weeks. The Shift Incontinent Round Sheet will be completed and turned in to the director of	

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F 312	Continued From page 29	F 312	nursing. The director of nursing will review the Shift Incontinent Round Sheets five times weekly at the clinical meeting for four weeks. How the facility will monitor systems put in place: Using, the quality improvement (QI) Audit Tool the administrator, DON, assistant director of nursing, quality improvement (QI) nurse and/or the nursing supervisor will review the resident concerns monthly summary, the administrative rounds tools, the administrative nursing rounds tools, the Shift Incontinent Round Sheets, and the daily staffing sheets, to identify any trends and/or patterns related to provision of incontinent/ADL care for dependent residents. The administrator and/or DON will ensure any issues of failure to provide incontinent care for a dependent resident will result in retraining and additional monitoring. Findings and results of the QI tools will be reviewed by the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care, including incontinent care, through developing communication. As recommended by QIO, utilization of the cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) will help the facility uncover the real causes for resident care	

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F 312	Continued From page 30	F 312	process failures, including incontinent care for dependent residents. Once the communication is opened up to identify factors causing nonconformance, the administrator and/or DON will present the monthly QI committee recommendations to the quarterly executive QAA committee for additional recommendations for monitoring and continued compliance. The QAA committee will continue consulting with the QIO until substantial compliance is achieved.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 315		5/27/17

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F 315	Continued From page 31 demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews, nurse practitioner, and staff interviews the facility failed to respond to a urinalysis and culture that was positive for 2 microorganisms for 1 of 3 residents with an indwelling catheter (Resident #69). The findings included: Resident #69 was admitted to the facility on 10/23/15 with diagnoses that included cerebral vascular accident with hemiplegia, dysphagia, diabetes mellitus, and peripheral vascular disease. Review of the most recent quarterly Minimum Data Set (MDS) dated 04/13/17 revealed that Resident #69 was severely impaired for daily decision making. The MDS also revealed that Resident #69 required total assistance with toileting and was always incontinent of bowel. The MDS further revealed that Resident #69 had an indwelling catheter and 1 Stage 4 pressure ulcer.	F 315	F 315 No Catheter, Prevent UTI, Restore Bladder What measures did the facility put in place for the residents affected: On 3/21/17, the staff nurse collected Resident #69's urine specimen. On 3/25/17, the laboratory received Resident #69's urine specimen. On 3/25/17, the laboratory results for Resident #69's urine specimen were available in the electronic laboratory reporting system. On 3/27/17, the staff nurse collected Resident #69's urine specimen. On 3/27/17, the laboratory received Resident #69's urine specimen. On 3/27/17, the laboratory results for Resident #69's urine specimen were available in the electronic laboratory reporting system. On 4/2/17, the nurse called the on-call physician regarding Resident #69's urine culture and sensitivity report. On 4/3/17, Resident #69's physician/nurse	

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F 315	Continued From page 32 Review of a physician's order dated 03/20/17 read in part, urinalysis with culture and sensitivity. Review of a laboratory result of the urinalysis for Resident #69 dated 03/25/17 indicated that the collection of the specimen was 03/21/17 and it was received at the laboratory on 03/25/17. The urinalysis was noted to be positive and was noted to grow 2 microorganisms. The microorganisms were Escherichia coli which was extended spectrum beta lactamase (ESBL) (resistant to commonly used antibiotics) and proteus mirabilis. The sensitivity indicated that the microorganisms were resistant to Levaquin (antibiotic) and most susceptible to amikacin (antibiotic). Review of a laboratory results of urinalysis for Resident #69 dated 03/27/17 indicated the specimen was collected on 03/27/17 and received at the laboratory on 03/27/17. The urinalysis was noted to be positive and was noted to grow 2 microorganisms. The microorganisms were Escherichia coli which was extended spectrum beta lactamase (ESBL) (resistant to commonly used antibiotics) and proteus mirabilis. The sensitivity indicated that the microorganisms were resistant to Levaquin and most susceptible to amikacin. Review of a nurse's note dated 04/02/17 at 8:11 PM read, call placed to on call physician about urine culture and sensitivity report. To return call. Signed by Nurse #3. Review of a physician order dated 04/02/17 read, isolation/contact precautions for ESBL. Review of a physician order dated 04/02/17 read,	F 315	practitioner ordered an antibiotic to be given and contact precautions. On 4/3/17, the nurse notified Resident #69's responsible party. What measures were put in place for residents having the potential to be affected: On 4/3/17, the staff facilitator initiated an in-service for 100% of nurses regarding 1) the physician must be notified when an abnormal laboratory result is received and 2) notification of the physician must be documented in the medical record with any new orders. On 4/3/17, the corporate facility consultant initiated a 4-point plan titled MD Notification of Abnormal Labs. The 4-point plan included corrective action for Resident #69, corrective action for other residents in the facility, measures put into place to prevent recurrence, and measures to monitor for sustained improvements. On 5/3/17, the director of nursing and corporate facility consultants met to perform a root cause analysis using the "5-Whys" process. Communication as evidence by lack of information and lack of access to electronic health records was determined to be the root cause of why the facility failed to respond to a urinalysis and culture that was positive for two microorganisms. On 5/9/17, the corporate facility consultant began assisting facility registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs) with accessing the electronic health record and electronic	

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F 315	Continued From page 33 start Levaquin 500 milligrams (mg) via gastrostomy tube (GT) daily for 7 days. Diagnoses +Escherichia coli and + pseudomonas aeruginosa. On contact precautions. Review of a physician order dated 04/03/17 read, discontinue Levaquin 500 mg. Start amikacin 250 mg inter-muscular for 7 days for ESBL urinary tract infection. Review of nurse's note dated 04/03/17 at 9:42 AM read in part, informed that Resident #69's urinalysis and culture and sensitivity were positive for Escherichia coli and Pseudomonas A, as confirmed by morning charge nurse via e-laboratory system. On call was notified and return call was pending. Nurse returned call and was notified of the positive urinalysis and culture and sensitivity and was also informed of microorganism's resistance and susceptibility to list of antibiotics and stated she would clarify with the doctor and return call. Nurse called back and gave new order to start Levaquin 500 mg via GT. First dose was given. Family was notified and report was given to oncoming nurse. Signed Nurse #2. An attempt to interview Nurse #2 on 05/01/17 at 12:56 PM was unsuccessful. An interview with the Nurse Practitioner (NP) was conducted on 05/01/17 at 4:01 PM. The NP stated Resident #69's family was concerned because his they felt like his urine was cloudy and wanted a urinalysis done. The NP stated that Resident #69 had a chronic indwelling catheter due to his stage 4 wound and he was "colonized" (when a patient has no symptoms of infection but significant numbers of bacteria have colonized	F 315	laboratory system, as appropriate for their job title. On 5/25/17, the director of nursing and staff facilitator initiated an in-service for 100% of nurses regarding 1) the timely collection of specimens for laboratory analysis, including urine specimens, 2) monitoring closely the electronic laboratory system for results, 3) prompt (within the shift) notification of the physician and response to a positive laboratory result, including a positive urinalysis and culture, 4) documenting notification of the physician, responsible party, new orders, and actions taken to including isolation precautions, 5) contacting the appropriate support system and/or supervisor if the nurse has difficulty accessing the electronic health record and electronic laboratory systems. On 6/7/17, the in-service will be 100% completed. After 6/7/17, no nurse will be allowed to work until this laboratory process in-service is completed. The laboratory process in-service will be added to new employee orientation for nurses. On 5/31/17, the corporate facility consultant completed a 100% audit of the past 14 days to verify the physician and/or nurse practitioner was notified of abnormal laboratory results and any new orders were implemented. What systems were put in place to prevent the deficient practice from reoccurring: Beginning 6/7/16, the assistant director of nursing, quality improvement nurse (QI) nurse, staff facilitator, nurse supervisor,	

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F 315	Continued From page 34 the urinary tract) and generally his urinalysis came back positive. We don't usually treat 1 microorganism but this urinalysis came back with 2 microorganisms and that was why Resident #69 was treated. One of the microorganisms was ESBL and that was why he was placed on isolation precautions. The NP stated when she reviewed the urinalysis and culture report she discontinued the Levaquin because the microorganism was resistant to that antibiotic and started amikacin which was the most susceptible for the microorganism. The NP stated that recently the facility has had an increase in new staff and agency staff and they have had trouble getting access to the electronic medical record. The NP stated the lab specimen was collected and sent to the laboratory and then when it was completed it "sat in the electronic medical record until there was trigger to look at the results." The NP also stated "that the treatment of the urinalysis would not have been any different if the report would have been called to her sooner and she felt like there was no harm to Resident #69 in taking so long to get the appropriate treatment to him." If anything the NP stated she would like to treat Resident #69 "less for his safety." The NP also stated that her expectation was that if a urinalysis was ordered during the day the night shift would obtain the specimen and the laboratory would pick it up tomorrow and report it out the same day. "The NP also stated she expected much more timely reporting of laboratory reports to her so treatment could be initiated more timely. " An interview with Nurse #3 was conducted on 05/01/17 at 5:40 PM. Nurse #3 stated that she only worked at the facility on the weekends and each nurse was supposed to follow up on labs	F 315	evening charge nurse, treatment nurse, and/or corporate facility consultant will utilize the “Laboratory Audit” tool weekly, for six months to validate laboratory orders are carried out timely and results are reported timely to the physician and/or nurse practitioner. The director of nursing and/or administrator will review the completed “Laboratory Audit” tool to ensure proper collection of specimens for laboratory analysis and the results are promptly reported to the physician and/or nurse practitioner. The director of nursing and/or administrator will initial the bottom right corner of the laboratory audit tool with the date for a period of six months. The administrator and/or DON will ensure any issues of failure to respond to a positive urinalysis and culture will result in retraining and additional monitoring. How the facility will monitor systems put in place: The director of nursing will present the results and findings of the Laboratory Audit QI tool to the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care, including responding to positive laboratory results, through developing communication. As recommended by QIO, utilization of the cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) was used to help the facility uncover the real cause(s) for the laboratory process failure:	

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that were drawn on their residents. Nurse #3 stated that Resident #69 had an order for a urinalysis and culture and sensitivity and Resident #69's family asked me to see if the results were back yet. Nurse #3 stated that she researched the laboratory report and discovered that Resident #69 had a urinary tract infection and I called the on call physician and started the antibiotic and placed the resident on isolation at that time. Nurse #3 stated that the "lab report was present in the electronic medical record but no one had followed up on it until the family asked me to." Nurse #3 stated that after she spoke to the on call physician she did call Resident #69's family and made them aware of the new orders.

An interview with interim Director of Nursing (DON) was conducted on 05/02/17 at 4:20 PM. The interim DON stated that she has been working at the facility for 2 weeks. The interim DON stated that since she has been at the facility she has been following up on the laboratory reports. The interim DON stated she printed off the laboratory reports each day and made sure the physician was aware of the results. The interim DON was not sure what happened with this laboratory report because she was not at the facility at that time. The interim DON stated that her expectation was that all laboratory specimens were collected and taken to the laboratory for processing, and as soon as the results were available the physician and family were immediately notified.

An interview with the Administrator was conducted on 05/02/17 at 4:54 PM. The Administrator stated that her expectation was that as soon as the laboratory results were in the electronic medical record the physician should

communication: lack of nurse communication with the electronic laboratory system related to no access. Communication in the form of access to electronic laboratory results is identified and addressed. The QI and QAA committees will continue to monitor the laboratory systems to identify other factors causing the failure to respond to a urinalysis and culture, ensuring continued compliance. The DON will present the monthly QI committee recommendations to the quarterly executive QAA committee for additional recommendations for monitoring and continued compliance. The QAA committee will continue consulting with the QIO until substantial compliance is achieved.

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F 315	Continued From page 36 have immediately been notified and treatment and isolation initiated.	F 315		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		5/25/17

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F 441	Continued From page 37 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 record reviews, nurse practitioner, and staff interviews the facility failed to implement isolation precautions for a resident diagnosed with a urinary tract infection that required isolation for 1 of 4 residents sampled (Resident #69). The Findings included:	F 441	F 441 Infection Control What measures did the facility put in place for the residents affected: On 3/21/17, the staff nurse collected Resident #69's urine specimen. On 3/25/17, the laboratory received Resident #69's urine specimen. On 3/25/17, the	

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F 441	Continued From page 38 Review of the "Infection Control Program" policy dated 09/2014 read in part, transmission based precautions will be utilized for known or suspected infections for which the route of transmission and/or prevention is known. Contact precautions in addition to standard precautions should be used for resident with known or suspected with microorganisms that are easily transmitted by direct or indirect contact. The policy also indicated that multidrug-resistant organisms, infections, or colonization that include extended spectrum beta lactamase (ESBL) would require standard or contact isolation. The guidance of ESBL stated "contact precautions recommended in setting with evidence of ongoing transmission, acute care settings with increased risk for transmission or wound that cannot be contained by dressings." Review of a physician's order dated 03/20/17 read in part, urinalysis with culture and sensitivity. Review of a laboratory result of the urinalysis for Resident #69 dated 03/25/17 indicated that the urinalysis positive and was noted to grow 2 microorganisms. The microorganisms were Escherichia coli which was extended spectrum beta lactamase (ESBL) (resistant to commonly used antibiotics) and proteus mirabilis. Review of a nurse's note dated 04/02/17 at 8:11 PM read, call placed to on call physician about urine culture and sensitivity report. To return call. Signed by Nurse #3. Review of a physician order dated 04/02/17 read, isolation/contact precautions for ESBL. An interview with the Nurse Practitioner (NP) was	F 441	laboratory results for Resident #69's urine specimen were available in the electronic laboratory reporting system. On 3/27/17, the staff nurse collected Resident #69's urine specimen. On 3/27/17, the laboratory received Resident #69's urine specimen. On 3/27/17, the laboratory results for Resident #69's urine specimen were available in the electronic laboratory reporting system. On 4/2/17, the nurse called the on-call physician regarding Resident #69's urine culture and sensitivity report. On 4/2/17, the nurse implemented contact precautions for Resident #69 diagnosed with a urinary tract infection that required isolation. On 4/3/17, Resident #69's physician/nurse practitioner ordered an antibiotic to be given and contact precautions. On 4/3/17, the nurse notified Resident #69's responsible party. What measures were put in place for residents having the potential to be affected: On 4/2/17, the nurse implemented contact precautions for Resident #69 diagnosed with a urinary tract infection that required isolation. On 4/3/17, the staff facilitator initiated an in-service for 100% of registered nurses (RNs) and licensed practical nurses (LPNs) regarding 1) the physician must be notified when an abnormal laboratory result is received and 2) notification of the physician must be documented in the medical record with any new orders. On 4/3/17, the corporate facility consultant	

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F 441	Continued From page 39	F 441		

conducted on 05/01/17 at 4:01 PM. The NP stated Resident #69's family was concerned because his they felt like his urine was cloudy and wanted a urinalysis done. The NP stated that "because one of the microorganisms was ESBL we were required to place him on isolation precautions." The NP also stated she expected much more timely reporting of laboratory reports to her so isolation could have been initiated more timely.

An interview with Nurse #3 was conducted on 05/02/17 at 3:57 PM. Nurse #3 stated that on 04/02/17 Resident #69's family asked me to follow up on the urinalysis that was done on 03/20/17 and when I reviewed his medical record I discovered that he had urinary tract infection that contained ESBL. Nurse #3 stated that she went ahead and called the on call physician and was given a verbal order for antibiotic and contact isolation for the ESBL. She reported that residents that required contact isolation were identified by a sign on the door and the correct personal protective equipment (PPE) on the outside of their door. Nurse #3 stated that isolation precaution should have been initiated when the urinalysis and culture came back on 03/25/17 and showed the ESBL. She added that on 04/01/17 all care provided to Resident #69 included incontinent care, catheter care, wound care, and medication administration was provided without the appropriate PPE.

An interview with the Director of Housekeeping (DOH) was conducted on 05/03/17 at 11:25 AM. The DOH stated that each resident room was cleaned each day using a 3/5/7 step process. The process included cleaning the room vertically and horizontally and emptying the trash. The DOH

initiated a 4-point plan titled MD Notification of Abnormal Labs. The 4-point plan included corrective action for Resident #69, corrective action for other residents in the facility, measures put into place to prevent recurrence, and measures to monitor for sustained improvements.
On 5/3/17, the director of nursing and corporate facility consultants met to perform a root cause analysis using the "5-Whys" process. Communication as evidence by lack of information and lack of access to electronic health records was determined to be the root cause of why the facility failed to respond to a urinalysis and culture that was positive for two microorganisms.
On 5/9/17, the corporate facility consultant began assisting facility registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs) with accessing the electronic health record and electronic laboratory system, as appropriate for their job title.
On 5/25/17, the director of nursing and staff facilitator initiated an in-service for 100% of RNs and LPNs regarding the current assigned nurse's responsibility for 1) the timely collection of specimens for laboratory analysis, including urine specimens, 2) monitoring closely the electronic laboratory system for results, 3) prompt (within the shift) notification of the physician and response to a positive laboratory result, including a positive urinalysis and culture, 4) documenting notification of the physician, responsible party, new orders, and actions taken to

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F 441	Continued From page 40 stated this process was used every day for every room. He further stated that this process was also used for rooms that where on isolation precautions, except that those rooms were cleaned last. Before the isolation rooms were cleaned we always change our mop water and use fresh rags for wiping the room down. The house keepers where aware of which rooms were on isolation precautions by the sign that was posted on the door of the room. When the house keeping staff see the sign they know they have to gown and glove before cleaning the room and obtain clean water and rags. The DOH stated if there was no sign on the door indicating isolation precautions then they treated the room as a regular room and proceed to clean it like they normally would. An interview with interim Director of Nursing (DON) was conducted on 05/02/17 at 4:20 PM. The interim DON stated that when the urinalysis results were obtained and Resident #69 was positive for ESBL, Resident #69 should have immediately been placed on isolation precautions and a sign placed on his door and the correct PPE made available to staff and visitors. The interim DON stated that Resident #69 was in a private room but the staff that was emptying his catheter should have worn a gown and gloves and if they provided any care to Resident #69 included incontinent care, wound care, catheter care, or medication administration then they should have had on a gown and gloves. An interview with the Administrator was conducted on 05/02/17 at 4:54 PM. The Administrator stated that her expectation was that as soon as the laboratory results were available the physician was notified and isolation	F 441	including initiating isolation precautions, 5) contacting the appropriate support system and/or supervisor if the nurse has difficulty accessing the electronic health record and electronic laboratory systems. It is the on duty RN's or LPN's responsibility to initiate contact precautions as ordered by the physician. On 6/7/17, the in-service will be 100% completed. After 6/7/17, no nurse will be allowed to work until this laboratory process in-service is completed. The laboratory process in-service will be added to new employee orientation for nurses. On 5/31/17, the corporate facility consultant completed a 100% audit of the past 14 days to verify the physician and/or nurse practitioner was notified of abnormal laboratory results and any new orders were implemented to include implementation of isolation precautions. What systems were put in place to prevent the deficient practice from reoccurring: Beginning 6/7/16, the assistant director of nursing, quality improvement nurse (QI) nurse, staff facilitator, nurse supervisor, evening charge nurse, treatment nurse, and/or corporate facility consultant will utilize the "Laboratory Audit" tool weekly, for six months to validate laboratory orders are carried out timely and results are reported timely to the physician and/or nurse practitioner to include implementation of isolation precautions. The director of nursing and/or administrator will review weekly the completed "Laboratory Audit" tool to	

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F 441	Continued From page 41 precautions initiated.	F 441	ensure proper collection of specimens for laboratory analysis and the results are promptly reported to the physician and/or nurse practitioner. The director of nursing and/or administrator will initial the bottom right corner of the laboratory audit tool with the date for a period of six months. The administrator and/or DON will ensure any issues of failure to implement isolation precautions for a resident diagnosed with a urinary tract infection that required isolation. How the facility will monitor systems put in place: The director of nursing will present the results and findings of the Laboratory Audit QI tool to the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care, including responding to positive laboratory results, through developing communication. As recommended by QIO, utilization of the cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) was used to help the facility uncover the real cause(s) for the laboratory process failure: communication: lack of nurse communication with the electronic laboratory system related to no access. Communication in the form of access to electronic laboratory results is identified and addressed. The QI and QAA committees will continue to monitor the laboratory systems at the monthly and quarterly meetings for six months to	

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F 441	Continued From page 42	F 441	identify other factors causing the failure to respond to a urinalysis and culture, ensuring continued compliance. The DON will present the monthly QI committee recommendations to the quarterly executive QAA committee for additional recommendations for monitoring and continued compliance. The QAA committee will continue consulting with the QIO until substantial compliance is achieved.	
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to provide a resident with the means to contact the nursing station for 30 hours for 1 of 6 sampled residents (Resident #78). The findings included: Resident #78 was admitted to the facility on 12/23/16 with diagnoses that included Parkinson's disease, anxiety, dysphagia, and altered mental status.	F 463	F 463 Resident Call System What measures did the facility put in place for the residents affected: On 4/30/17, the facility volunteer turned gave Resident #78's call light cord to the facility nursing assistant (NA). A replacement call cord or call bell was not immediately provided to Resident #78. On 5/1/17, the nursing assistant reported someone had given Resident #78's a bell to use to call for help. On 5/2/17, the maintenance director	5/25/17

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F 463	Continued From page 43 Review of the most recent quarterly minimum data set (MDS) dated 04/01/17 revealed that Resident #78 was able to make herself understood and was severely cognitively impaired. The MDS also revealed that Resident #78 required limited assistance of 1 staff member for toileting, bed mobility, and dressing. An observation on 04/30/17 at 11:25 AM of a facility volunteer was made. The facility volunteer was observed to hand Nursing Assistant (NA) #5 Resident #78's call cord and told NA #5 that Resident #78 had pulled the cord out of the wall. The call cord was noted to have the electrical wires exposed at one end and was missing the end piece that connected the call cord to the wall. An observation on 04/30/17 at 11:27 AM of Resident #78's room was made. The end of the call cord that was given to NA #5 was noted to be in the wall with no call cord available to Resident #78. There was no other means noted in the room for Resident #78 to contact the nurse's station. An observation on 04/30/17 at 12:40 PM of Resident #78's room was made. The end of the call cord that was given to NA #5 earlier on the shift was noted to be in the wall with no call cord available to Resident #78. There was no other means noted in the room for Resident #78 to contact the nurse's station. An observation on 04/30/17 at 4:16 PM of Resident #78's room was made. The end of the call cord that was given to NA #5 earlier on the shift was noted to be in the wall with no call cord available to Resident #78. There was no other means noted in the room for Resident #78 to	F 463	became aware of Resident #78's call light cord not working and immediately replaced the call light cord in Resident #78's room. What measures were put in place for residents having the potential to be affected: On 5/2/17, the maintenance director completed a 100% audit of all facility resident rooms to ensure there was a functioning call light cord. The audit revealed no other missing or malfunctioning call light cords in resident rooms. On 5/3/17, the administrator, maintenance director, other department heads and corporate facility consultants met during the morning department head meeting to perform a root cause analysis using the "5-Whys" process. "Communication" as evidence by lack of information to new staff and lack of access to an extra call light cord was determined to be the root cause of why the facility failed to provide a means for Resident #78 to contact the nurse station On 5/30/17, the administrator and staff facilitator initiated an in-service for 100% of facility staff regarding call cords. The in-service covers 1) the regulation F 463, 483.90(g)(2) Resident Call System-Room/Toilet/Bath, 2) all residents must have means to contact the nursing station, 3) if the call cord does not work, there is an extra call cord in the nurse station, 4) if promptly replacing the call cord does not correct the problem, provide the resident with a tap bell, 5) tap	

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F 463	Continued From page 44 contact the nurse's station. An observation on 05/01/17 at 10:42 AM of Resident #78's room was made. The end of the call cord that was given to NA #5 on 04/30/17 was noted in the wall with no call cord available to Resident #78. There was no other means noted in the room for Resident #78 to contact the nurse's station. An observation on 05/01/17 at 2:51 PM of Resident #78's room was made. The end of the call cord that was given to NA #5 on 04/30/17 was noted in the wall with no call cord available to Resident #78. There was no other means noted in the room for Resident #78 to contact the nurse's station. An interview with NA #5 was conducted on 05/01/17 at 2:51 PM. NA #5 stated that she have given the call cord that the facility volunteer had handed to her on 04/30/17 to Nurse #1. NA #5 stated that she was not sure what Nurse #1 had done with the call cord. NA #5 further stated that Resident #78 used her call bell frequently to alert staff that she needed to be changed or she wanted to go to bed or get out of bed. An interview with Nurse #1 was conducted on 05/02/17 at 12:01 PM. Nurse #1 stated she was agency staff that recently started coming to the facility to work. Nurse #1 stated that NA #5 did not hand her a call cord and this was the first she had been made aware that Resident #78 did not have a means to contact the nursing station. Nurse #1 stated that if NA #5 would have handed her a call cord she would have either fixed the call cord or given Resident #78 a bell to use.	F 463	bells are promptly provided at the nurse station and shall be distributes to resident(s) when the call cord and/or call bell system is not functioning properly, 6) when the call cord and/or call light is not working, in addition to providing a means to contact the nursing station, the staff person identifying the problem will notify their supervisor and 7) when the call cord and/or call light is not working, the staff person will complete a work order form. The work order form white copy will go to the maintenance department and the yellow copy to the administrator. This call light in-service will be provided to all new staff during new employee orientation and agency staff prior to working a shift in the facility. What systems were put in place to prevent the deficient practice from reoccurring: Beginning 5/30/17, the maintenance director, housekeeping supervisor, assistant director of nursing, quality improvement nurse (QI) nurse, staff facilitator, nurse supervisor, evening charge nurse, treatment nurse, and/or corporate facility consultant will utilize the call light audit tool weekly, for six months to validate the facility has provided each resident with the means to contact the nursing station and any negative results are immediately corrected by providing a means for the resident to contact the nursing station (new call cord, tap bell, or other). The administrator, director of nursing, and/or corporate consultant will review	

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An interview with NA #2 was conducted on 05/02/17 at 2:22 PM. NA #2 stated that she routinely cared for Resident #78. NA #2 stated that Resident #78 used her call bell frequently to make staff aware of her needs. NA #2 stated Resident #78 would ring her call light if she was wet or wanted to get up out of bed or if she wanted to get back into bed.

An interview with Certified Medication Aide (CMA) #1 was conducted on 05/02/17 at 2:39 PM. CMA #1 stated that she routinely cared for Resident #78. CMA #1 stated that Resident #78 used her call bell to alert staff that she needed to use the bathroom or that she wanted to get up or be laid down. CMA #1 stated that Resident #78 would also ring her call bell to alert staff that she was in pain. CMA #1 stated that something happened to her call bell and sometime after her shift ended on 05/01/17 someone had given Resident #78 a bell to use to call for help.

An interview with the Director of Maintenance (DM) was conducted on 05/02/17 at 2:48 PM. The DM stated that if anything was broken or needed repaired a work order would be filled out and either given to him or put in the box on his office door and he would follow up within 48 hours. The DM stated that he had not received any work order on Resident #78's call cord and had no idea anything was wrong with it. The DM grabbed a call cord and immediately went to Resident 78's room and replaced the call cord and then verified the call bell was working properly.

An interview with the interim Director of Nursing (DON) was conducted on 05/02/17 at 4:00 PM. The interim DON stated that Resident #78 used

weekly the completed call light audit tool to ensure there is a means for every resident to contact the nursing station. The administrator, director of nursing, and/or corporate consultant will initial the bottom right corner of the call light audit tool with the date for a period of six months.
Beginning 6/1/17, the administrator will include in the daily department head meetings review of the results of the administrative rounds performed by the department heads. The administrative rounds are recorded on the administrative rounds tool, to include the proper functioning of the call light system. The review at the department head meeting will include making sure 1) all residents have means to contact the nursing station, 2) if the call cord did not work, an extra call cord was used, 3) if promptly replacing the call cord did not correct the problem, the resident was provided with a tap bell, 4) tap bell(s) was promptly provided to resident(s) when the call cord and/or call bell system is not functioning properly, 5) when the call cord and/or call light was not working the staff person identifying the problem notified their supervisor and 6) when the call cord and/or call light was not working, the staff person completed a work order form. The work order form white copy went to the maintenance department and the yellow copy to the administrator, 7) maintenance staff completed the work order and gave the completed work order copy to the administrator as documentation that the call cord/call light was repaired and the

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F 463	Continued From page 46 her call bell very frequently to alert staff of her needs. The interim DON stated that if Resident #78's call bell was not functioning properly then a work order should have been completed and the staff should have given her a bell to use to alert staff of her needs. The interim DON stated she was not aware that Resident #78's call bell was not working properly or that she needed another call cord. An interview with the Administrator was conducted on 05/02/17 at 4:36 PM. The Administrator stated that when the volunteer handed NA #5 the broken call cord, NA #5 should have written a work order and provided Resident #78 with a bell to call for assistance. The Administrator stated she was unaware that the call bell was not working properly and she certainly would have wanted to have been made aware of the issue. An interview with Resident #78 was conducted on 05/03/17 at 1:27 PM. Resident #78 stated she used her call bell when she needed to use the restroom or when she wanted to get out of bed. Resident #78 stated that on the evening of 04/30/17 she did not have a call bell and "she just had to wait until staff came into her room" to help me. Resident #78 stated that on Monday afternoon 05/01/07 someone had given her a bell to use until they fixed her call bell.	F 463	resident has means to contact the nursing station. The administrator will ensure any issues of failure to provide a resident will the means to contact the nursing station will be addressed through additional root cause analysis, process correction, training, and monitoring. How the facility will monitor systems put in place: The maintenance director or administrator will present the results and findings of the call light cord audits to the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care, including the provision of the means to contact the nursing station, through developing communication. As recommended by QIO, utilization of the cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) was used to help the facility uncover the real cause(s) for the call light cord process failure: communication: lack of nurse communication with the maintenance director to provide the means for residents to contact the nursing station. Communication in the form of using verbal communication during department head meetings and written work order forms to ensure the facility provides residents with the means to contact the nursing station. The QI and QAA committees will continue to monitor the call light systems to identify other factors	

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F 463	Continued From page 47	F 463	causing the failure to communication call light system failures. The administrator and/or maintenance director will present the monthly QI committee recommendations to the quarterly executive QAA committee for additional recommendations for monitoring and continued compliance. The QAA committee will continue consulting with the QIO until substantial compliance is achieved.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and	F 520		5/27/17

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F 520	Continued From page 48 (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 implemented procedures and monitor these interventions that the committee put into place in March 2017 following a recertification and complaint survey and subsequently recited in May 2017 on the current follow up and complaint survey. The repeat deficiencies are in the areas of resident neglect (F224), allow residents to make choices (F242), activities of daily living (F312), sufficient nursing staff (F353), and Administration (F490). These deficiencies were recited during the facility's current follow up and complaint survey. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The Findings included: This tag is cross referred to:	F 520	F 520 On 5/9/17, the monthly QI Committee held a meeting. The administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, social workers, medical records, dietary manager and housekeeping supervisor will attend monthly QI Committee meetings on an ongoing basis and will assign additional team members as appropriate. Using the “5 Whys” root cause analysis process, the QI Committee was able to determine “communication” is a key factor in the deficient practice areas of 1) resident neglect, 2) allowing residents to make choices, 3) activities of daily living, 4) sufficient nursing staff, and 5) administration. On 5/17/17, the administrator, director of nursing, and corporate consultants	

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F 520	Continued From page 49 1a). F224: Neglect: Based on observations, record reviews, family and staff interviews the facility neglected to provide incontinent care for a dependent resident for 1 of 3 residents sampled (Resident #72). During the complaint survey of 03/30/17, this regulation was cited for neglecting to feed and provide incontinence care for dependent residents for 4 of 6 sampled residents (Resident #4, #5, #6, and #7). During the current complaint survey of 05/03/17, this regulation was cited for neglecting to provide incontinent care for a dependent resident. 1b). F242: Allow residents to make choices: Based on observation, resident and staff interviews, and facility record review, the facility failed to provide 1 of 4 sampled residents with 2 showers per week for 2 weeks as requested (Resident #23). During the recertification and complaint survey of 03/10/17, this regulation was cited for failure to provide showers according to the preference of the resident for 1 of 3 sampled residents who reviewed for choices (Resident #57). During the current compliant survey of 05/03/17, this regulation was cited for failure to provide 2 showers per week as the resident requested. 1c). F312: Activities of Daily Living: Based on observations, record reviews, family and staff interviews the facility failed to check a resident for incontinence on the day shift for 1 of 4 residents sampled for activities of daily living (Resident	F 520	received consultation from the Quality Improvement Organization (QIO). On 5/18/17, the facility administrator in-serviced the department heads (DON, MDS nurse, treatment nurse, maintenance director, dietary manager, social workers, medical records, dietary manager and housekeeping supervisor) related to the appropriate functioning of the QAA Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. As of 5/19/17, after the administrator's QAA in-service, the monthly QI Committee began identifying other areas of quality concern through the QA review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern log. The quarterly Executive QAA Committee, to include the medical director, will meet at a minimum of quarterly. The quarterly Executive QAA Committee, including the medical director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. Findings and results of the QI tools will be reviewed by the monthly QI committee	

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F 520	Continued From page 50 #72). During the recertification and complaint survey of 03/10/17, this regulation was cited for failing to provide assistance with shaving, nail care, and dressing for 1 of 10 sampled residents (Resident #74). During the complaint survey of 03/30/17, this regulation was cited for failure to provide incontinent care, showers, bed baths, and oral care as needed for 1 of 6 residents (Resident #9) reviewed for activities of daily living. During the current complaint survey of 05/03/17, this regulation was cited for failure to check a resident for incontinence care on the day shift. 1d). F353: Sufficient Nursing Staff: Based on observations, record reviews, and staff interviews the facility failed to have sufficient quantity of staff to ensure a dependent resident was provided incontinent care for 1 of 3 sampled residents (Resident #72). During the complaint survey of 03/30/17, this regulation was cited for failure to have sufficient quantity of staff to monitor a resident at risk for falls; the resident fell and was injured for 1 of 4 sampled residents (Resident #2); and the facility failed to have sufficient quantity of staff to ensure dependent residents were fed and provided incontinence care for 4 of 7 sampled residents (Resident #4, #5, #6, and #7). The facility also failed to have sufficient quantity of staff to have a Registered Nurse function fulltime as a Director of Nursing. During the current complaint survey 05/03/17, this	F 520	and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care through developing communication processes. As recommended by QIO, utilization of the cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) will help the facility uncover the real causes for resident care process failures, including: 1) resident neglect, 2) allowing residents to make choices, 3) activities of daily living, 4) sufficient nursing staff, and 5) administration. The Executive QAA Committee will validate the facility's progress in correction of deficient practices or identify concerns. The quarterly Executive QAA Committee meeting agenda, resulting plans of corrections, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions. The administrator or DON will report back to the Executive QAA Committee at the next scheduled quarterly meeting.	

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regulation was cited for failure to have sufficient quantity of staff to ensure a dependent resident was provided incontinent care.

An interview was conducted with the Administrator on 05/03/17 at 3:48 PM. She explained that the Quality Assurance (QA) committee consisted of herself, the Director of Nursing, all department heads, pharmacy consultant, and medical director and they met monthly. The Administrator stated they have had a lot of discussion about recent survey results and ways they can achieve substantial compliance. The team was reviewing all the monitoring tools and audits to help guide us in the areas that we remain out of compliance with. The Administrator stated that the audits have "looked good and are showing improvement." She further explained that one of the biggest barriers to achieving substantial compliance is difficult families and the lack of consistent assignments. Another obstacle we face is holding the current employees to a standard and holding them accountable for their performance and being able to use disciplinary action when needed. She also added that they have been using the process of Plan-Do-Study-Act and root cause analysis for any continued non-compliance.