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	345447	A. BUILDING _____ B. WING _____	10/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair 1 of 6 sets of smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (E Hall) and failed to repair a shower door with broken and splintered laminate and wood on the lower edges of the door on 1 of 4 occupied resident hallways (E hall). The facility also failed to repair the main door leading into A hall (secured unit) with broken and splintered laminate and wood on the lower edges of the door on 1 of 4 occupied resident hallways, failed to repair 1 resident room door which made a loud scraping sound when closed (resident room #145) and failed to repair 5 resident room doors with broken and splintered laminate and wood on the lower edges of the doors (resident room #155, #156, #143, #151, #136) for 5 of 54 resident room doors on 4 occupied resident hallways. The facility also failed to repair a light in the bathroom of resident bathroom in 1 of 54 resident rooms (resident room #160), failed to repair floor molding pulled away from the wall in the hallway next to resident room #160 on 1 of 4 occupied resident hallways, failed to remove a toilet lid with chipped edges on the top right corner in 1 resident bathroom (#136) that was rough to touch in 1 of 54 resident rooms, failed to remove dark brown stains from under faucets at sinks in resident bathrooms (room #133, #101, #105) in 3 of 54 resident rooms and failed to label and properly store resident care equipment in 3	F 253	1) After an internal root cause analysis was done, it was determined that an effective system was not in place to identify housekeeping and maintenance issues. While numerous physical plant issues were under a performance action plan for repairs, the IDT team did not document detailed observations during room rounds to determine that resident care equipment was not being labeled per policy. The E Hall smoke door wood and laminate was repaired by the Maintenance Director on 10.16.2017 The E Hall shower door laminate and wood has was repaired by the Maintenance Director on 10.16.2017. The A-Hall entry door wood and laminate was repaired by the Maintenance Director on 10.16.207. Room # 145 door was planed to close without dragging by the Maintenance Director on 10.17.2017. Resident rooms #155. #156, #143, #151, and #136 door(s) wood and laminate were repaired by the Maintenance Director on 10.18.2017. The bathroom light in room #160 was replaced by the Maintenance Director on 10.13.2017. The hallway molding outside Resident room #160 was repaired by the Maintenance Director on 10.16.2017. Resident room #136 toilet lid was replaced by the Maintenance Director on	11/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2017

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F 253	Continued From page 1 shared bathrooms (room #149, #152, #158) on 2 of 4 resident halls. Findings included: 1. Observations on 10/11/17 at 2:19 PM revealed a smoke prevention door on the left side when entering the E hall with broken and splintered laminate and wood on the lower edges of the door that was rough to touch. Observations on 10/12/17 at 4:42 PM revealed a smoke prevention door on the left side when entering the E hall with broken and splintered laminate and wood on the lower edges of the door that was rough to touch. Observations on 10/13/17 at 10:06 AM revealed a smoke prevention door on the left side when entering the E hall with broken and splintered laminate and wood on the lower edges of the door that was rough to touch. 2. Observations on 10/11/17 at 2:20 PM revealed a shower room door on E hall with rough edges on the lower half of the door. Observations on 10/13/17 at 10:05 AM revealed a shower room door on E hall with rough edges on the lower half of the door. Observations on 10/13/17 at 2:23 PM revealed a shower room door on E hall with rough edges on the lower half of the door. 3. Observations on 10/10/17 at 11:15 AM revealed the main door of the A hall (secured unit) had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. Observations on 10/13/17 at 10:21 AM revealed the main door of the A hall (secured unit) had broken and splintered laminate on the edges of	F 253	10.18.2017. Resident rooms #133, #101 and #105 bathroom faucets were cleaned by the Housekeeping Manager on 10.20.2017. Resident care equipment in rooms #149, #152, #158 was removed by the Director of Clinical Services on 10.12.2017. 2) Observations of resident area doors, bathroom lights and fixtures, personal items unlabeled and not bagged were initiated on 11.03.2017 by the Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping. Issues identified were addressed and/or scheduled for repairs. 3) The Director of Clinical Services and the Executive Director re-educated staff on 11.02-11.03.2017 regarding reporting issues with resident area doors, bathroom lights and fixtures as well as unlabeled, non bagged personal items in resident room□s by filling out work order for areas identified or ensuring the personal item is labeled with the residents name. The Interdisciplinary Team including but not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping to perform Quality Improvement Monitoring of resident area doors, bathrooms lights and fixtures and hallways to identify items in need of repair 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one	

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F 253	Continued From page 2 the lower half of the doors that were rough to touch. Observations on 10/13/17 at 2:54 PM revealed the main door of the A hall (secured unit) had broken and splintered laminate on the edges of the lower half of the doors that were rough to touch. 4. Observations on 10/10/17 at 3:00 PM revealed resident room door #145 made a loud scraping sound under the door when closed. Observations on 10/11/17 at 9:57 AM revealed resident room door #145 made a loud scraping sound under the door when closed. Observations on 10/13/17 at 2:31 PM revealed resident room door #145 made a loud scraping sound under the door when closed. 5. a. Observations on 10/11/17 at 2:18 PM revealed resident room door #155 had broken and splintered edges on the lower half of the door that were rough to touch. Observations on 10/13/17 at 10:07 AM revealed resident room door #155 had broken and splintered edges on the lower half of the door that were rough to touch. Observations on 10/13/17 at 2:25 PM revealed resident room door #155 had broken and splintered edges on the lower half of the door that were rough to touch. b. Observations on 10/11/17 at 2:19 PM revealed resident room door #156 had broken and splintered edges on the lower half of the door that were rough to touch. Observations on 10/13/17 at 10:11 AM revealed resident room door #156 had broken and splintered edges on the lower half of the door that were rough to touch.	F 253	year. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of unlabeled/non bagged items in residents rooms 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year. The Maintenance Director and Housekeeping Director will be responsible for correction of reported concerns. 4) The Executive Director will be responsible for implementing this plan of correction. The Executive Director introduced the plan of correction to the QAPI committee on 11/3/17. The results of the Quality Improvement Monitoring are to be reported to the QAPI Committee by the Maintenance Director and Housekeeping Director. Quality Improvement Monitoring schedule may be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver.	

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Observations on 10/13/17 at 2:25 PM revealed resident room door #156 had broken and splintered edges on the lower half of the door that were rough to touch.

c. Observations on 10/11/17 at 2:20 PM revealed resident room door #143 had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/13/17 at 10:11 AM revealed resident room door #143 had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/13/17 at 2:29 PM revealed resident room door #143 had broken and splintered edges on the lower half of the door that were rough to touch.

d. Observations on 10/11/17 at 2:22 PM revealed resident room door #151 had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/13/17 at 10:12 AM revealed resident room door #151 had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/13/17 at 2:33 PM revealed resident room door #151 had broken and splintered edges on the lower half of the door that were rough to touch.

e. Observations on 10/11/17 at 2:26 PM revealed resident room door #136 had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/13/17 at 10:20 AM revealed resident room door #136 had broken and splintered edges on the lower half of the door that were rough to touch.

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Observations on 10/13/17 at 2:43 PM revealed resident room door #136 had broken and splintered edges on the lower half of the door that were rough to touch.

6. Observations on 10/11/17 at 2:16 PM revealed the light in the bathroom of resident room #160 was blinking off and on.
Observations on 10/12/17 at 4:46 PM revealed the light in the bathroom of resident room #160 would not turn on when the light switches were turned on.
Observations on 10/13/17 at 10:10 AM revealed the light in the bathroom of resident room #160 would not turn on when the light switches were turned on.

7. Observations on 10/13/17 10:09 AM revealed the floor molding in the hallway next to resident room #160 was pulled away from the wall and was sticking outward toward the hall.
Observations on 10/12/17 4:47 PM revealed the floor molding in the hallway next to resident room #160 was pulled away from the wall and was sticking outward toward the hall.
Observations on 10/13/17 2:26 PM revealed the floor molding in the hallway next to resident room #160 was pulled away from the wall and was sticking outward toward the hall.

8. Observations on 10/11/17 at 2:26 PM revealed the lid of the toilet in the bathroom of resident room #136 was chipped and rough to the touch at the right corner of the lid.
Observations on 10/13/17 at 10:20 AM revealed the lid of the toilet in the bathroom of resident room #136 was chipped and rough to the touch at the right corner of the lid.
Observations on 10/13/17 at 2:43 PM revealed

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the lid of the toilet in the bathroom of resident room #136 was chipped and rough to the touch at the right corner of the lid.

9. a. Observations on 10/11/17 at 2:26 PM in the bathroom of resident room #133 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 10:18 AM in the bathroom of resident room #133 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 2:39 PM in the bathroom of resident room #133 revealed brown stains under the faucet of the sink.

b. Observations on 10/10/17 at 11:12 AM in the bathroom of resident room #101 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 10:23 AM in the bathroom of resident room #101 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 2:46 PM in the bathroom of resident room #101 revealed brown stains under the faucet of the sink.

c. Observations on 10/11/17 at 11:12 AM in the bathroom of resident room #105 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 10:24 AM in the bathroom of resident room #105 revealed brown stains under the faucet of the sink.
Observations on 10/13/2017 at 2:47 PM in the bathroom of resident room #105 revealed brown stains under the faucet of the sink.

During an interview and tour on 10/13/17 at 2:07 PM the Manager of Housekeeping and Laundry explained she had only been in her position for 2 weeks. She stated she was responsible for housekeepers and cleaning in the facility and they

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had a cleaner they routinely used to clean bathrooms. She further stated they had a product they could use to clean stains in bathrooms and they also had a product that was rough to get most of the stains off sinks in resident bathrooms but keeping bathrooms clean made it easier to keep stains from occurring. She confirmed the stains under faucets at resident sinks were rust stains and needed to be cleaned or replaced.

During an interview and environmental tour on 10/13/17 at 2:12 PM, the Maintenance Director stated he had no major projects or renovation projects planned but they were just trying to upkeep resident rooms. He explained they utilized a work order system and there were paper slips at the nurse's station for staff to fill out. He stated staff were supposed to put them in the box and he checked them throughout the day. He also stated a lot of times staff came up to him in the hall and told him of repairs that needed to be made. He explained he reviewed the work order system with new staff in orientation and he encouraged staff to fill out work orders for anything that needed to be repaired. He stated he made rounds throughout the day and confirmed housekeepers could fill out work orders if they saw something that needed to be fixed. He further stated he had not received work orders regarding the concerns observed during the environmental tour.

During an interview on 10/13/17 at 3:14 PM, the Administrator stated the Maintenance Director was the only staff in the maintenance department and he had to keep up with work orders but his work was only as good as the information he was given. She stated it was their priority for safety concerns to be repaired first and they were

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working hard to self-identify problems and make repairs.

10. a. Observations in the shared bathroom for room 149 on 10/11/17 at 9:07 AM revealed an unlabeled and uncovered bath basin resting on top of the toilet tank.

Observations in the shared bathroom for room 149 on 10/12/17 at 9:05 AM revealed an unlabeled and uncovered bath basin resting on the bathroom floor in between the toilet and sink.

Observations in the shared bathroom for room 149 on 10/13/17 at 10:15 AM revealed an unlabeled and uncovered bath basin resting on the bathroom floor in between the toilet and sink.

b. Observations in the shared bathroom for room 152 on 10/10/17 at 12:24 PM revealed an unlabeled and uncovered bed pan resting on the wall mounted bar.

Observations in the shared bathroom for room 152 on 10/13/17 at 10:10 AM revealed an unlabeled and uncovered bed pan resting on the bathroom floor.

c. Observations in the shared bathroom for room 158 on 10/10/17 at 11:43 AM revealed an unlabeled bed pan hanging from the wall mounted bar in an unlabeled plastic bag. Further observation revealed an unlabeled and uncovered bedside commode bucket sitting on the bathroom floor underneath the sink.

Observations in the shared bathroom for room 158 on 10/12/17 at 9:20 AM revealed an unlabeled bed pan hanging from the wall

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F 253	Continued From page 8 mounted bar in an unlabeled plastic bag. Further observation revealed an unlabeled and uncovered bedside commode bucket sitting on the bathroom floor underneath the sink. Observations in the shared bathroom for room 158 on 10/13/17 at 10:20 AM revealed an unlabeled bed pan hanging from the wall mounted bar in an unlabeled plastic bag. Further observation revealed an unlabeled and uncovered bedside commode bucket sitting on the bathroom floor underneath the sink. During a tour and interview with the Director of Clinical Services on 10/13/17 at 10:55 AM she acknowledged the bed pans, wash basin and bedside commode bucket stored in the shared bathrooms for rooms 149, 152 and 158 were not labeled with the residents' name and had all been stored inappropriately. She indicated the bed pans and wash basin stored in the bathrooms should be labeled with the resident's name and individually covered. She further indicated the bedside commode bucket should have been removed and not stored in the shared bathroom since it was not being used. The DCS stated it was her expectation that all resident personal care equipment would be labeled with the resident's name and stored appropriately.	F 253		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		11/7/17

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F 281	Continued From page 9 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations and physician and staff interviews the facility failed to follow physician's orders to administer pain medication through a gastrostomy tube (tube inserted through the abdomen into the stomach) when a resident was given the bedtime dosage instead of the daytime dosage of a pain medication for 1 of 1 resident sampled for medication administration through a gastrostomy tube (Resident #52). Findings included: Resident #52 was admitted to the facility 09/09/16 with diagnoses which included chronic pain, difficulty swallowing high blood pressure, chronic lung disease, convulsions, dementia, vitamin D deficiency, depression and anxiety. A review of the most recent significant change Minimum Data Set (MDS) dated 09/20/17 indicated Resident #52 was cognitively intact for daily decision making. The MDS also revealed Resident #52 required supervision for activities of daily living. A review of physician's orders dated 09/14/17 indicated may cocktail (combine) medications. A review of physician's orders dated 10/01/17 through 10/31/17 revealed the following: Gabapentin 400 milligrams (mg) via tube 3 times a day for neuropathy (nerve pain) and pain. Gabapentin 600 mg via tube daily at bedtime for neuropathy and pain. During an observation on 10/12/17 at 11:44 AM	F 281	1) After an internal root cause analysis was done, it was determined that while education regarding medication errors was completed with Nurse #1 upon orientation, Nurse #1 did not follow protocol for medication error reporting and the nurse not following the five rights of medication administration led to the error. The Physician for Resident #52 was notified on 10.12.2017 with no new orders written. Medication error report was completed on 10.12.2017 by the Director of Clinical Services. Nurse #1 was reeducated by the Director of Clinical Services on 10.12.17 on reporting medication errors and on Medication Administration. 2) The Director of Clinical Services completed medication pass observations of Licensed Nurses to observe following the Five Rights of Medication Pass on 10.30.2017 thru 11.06.2017. 3) Licensed Nurses were reeducated by the Director of Clinical Services beginning 10.12.2017 thru 11.6.2017 on policy for medication administration and reporting medication errors. The Director of Clinical Services to perform Quality Improvement Monitoring of Medication Administration five times a week for four weeks, three times a week for four weeks, two times a week for four weeks then monthly thereafter for one year. 4) The Director of Clinical Services will be responsible for implementing this plan of correction. The Director of Clinical	

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F 281	Continued From page 10 Nurse #1 stated she had to give medications to Resident #52 because he was going out of the facility to an appointment. She explained she would give him 12:00 PM and 1:00 PM medications since he would be out of the facility because she could not let him go to the appointment without getting his pain medication. During an observation on 10/12/17 at 11:47 AM Nurse #1 removed a Gabapentin 600 milligrams (mg) tablet from a blister pack medication container and placed it in a plastic pill cup with MAPAP 2 tablets to equal 1,000 mg and Oxycodone 20 mg. She then placed the medications in a plastic sleeve and crushed the medications together, poured the crushed medications into a plastic pill cup and took them into Resident #52's room. Nurse #1 washed her hands and poured water from a plastic container into the cup of crushed medications and mixed them. She then took a plastic syringe out of a plastic bag hanging on a pole next to Resident #52's bed and Resident #52 unclamped the stomach tube. Nurse #1 inserted the tip of the syringe into the tube and poured approximately 30 milliliters (ml) of water into the tube, then poured in the medications mixed with water and then flushed the tube with approximately 30 ml of water. Resident #52 then clamped the tube and Nurse #1 removed the syringe, and left the room and went back to the medication cart. During an interview on 10/12/17 at 12:04 PM Nurse #1 confirmed she gave Resident #52 Gabapentin 600 mg which was his bedtime dose by mistake. She stated she would leave a note for the night shift nurse to let her know to give Gabepentin 400 mg instead of 600 mg so he would get the correct daily dose.	F 281	Servicers introduced the plan of correction to the QAPI committee on 11.3.17. The results of the Quality Improvement Monitoring are to be reported to the QAPI Committee by the Director of Clinical Services. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring schedule may be modified based on findings.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

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F 281	Continued From page 11 During an interview on 10/12/17 at 12:18 PM the Director of Nursing stated it was her expectation for Nurse #1 to notify Resident #52's physician that she had given the night time dose of Gabepentin 600 mg and follow whatever orders they gave. She stated she expected for nurses to follow physicians orders and give medications correctly. During an interview on 10/13/17 at 11:19 AM with a physician who was also the facility Medical Director he stated he had been notified of the medication error yesterday on 10/12/17 when Resident #52 had received Gabapentin 600 mg instead of Gabapentin 400 mg. He stated the medication was still within the therapeutic range so there was no harm. He further stated it was his expectation for nurses to call the physician when there was a medication error and to follow physician's orders and give the correct medication.	F 281		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 322		11/7/17

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F 322	Continued From page 12 (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations and physician and staff interviews the facility failed to check placement of a gastrostomy tube (tube inserted through the abdomen into the stomach) before administration of medications and water through the tube for 1 of 1 sampled resident for medication administration through a gastrostomy tube (Resident #52). Findings included: Resident #52 was admitted to the facility 09/09/16 with diagnoses which included chronic pain, difficulty swallowing high blood pressure, chronic lung disease, convulsions, dementia, vitamin D deficiency, depression and anxiety. A review of the most recent significant change Minimum Data Set (MDS) dated 09/20/17 indicated Resident #52 was cognitively intact for daily decision making. The MDS also revealed Resident #52 required supervision for activities of daily living. A review of physician's orders dated 09/14/17 indicated may cocktail (combine) medications. A review of physician's orders dated 10/01/17 through 10/31/17 revealed the following:	F 322	1)After an internal root cause analysis was performed, it was determined that the nurse had knowledge of how to properly administer medications through an enteral tube, but due to lack of opportunity to use this knowledge a step was left out of the process. Orientation education and repeat demonstration was completed upon hire, however Nurse #1 failed to follow proper medication administration protocol. The Physician for Resident #52 was notified on 10.12.2017 with no new orders. Nurse #1 was re educated by the Director of Clinical Services on 10.12.17 regarding Medication Administration. 2) The Director of Clinical Services completed medication pass observations of Licensed Nurses to observe following proper method of administering medications 10.30.2017 thru 11.02.2017. 3) Licensed Nurses were reeducated by the Director of Clinical Services beginning on 10.12.2017 thru 11.6.2017 on policy for medication administration and reporting medication errors. The Director of Clinical Services to perform Quality Improvement Monitoring of Medication Administration five times a week for four weeks, three times a week for four weeks, two times a	

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F 322	Continued From page 13 Gabapentin 400 milligrams (mg) via tube 3 times a day for neuropathy (nerve pain) and pain. Gabapentin 600 mg via tube daily at bedtime for neuropathy and pain. MAPAP 500 mg take 2 tabs (1,000 mg) via tube every 6 hours for pain. Oxycodone 20 mg via tube every 4 hours while awake for pain. During continuous observations on 10/12/17 starting at 11:44 AM Resident #52 was located next to a medication cart that was parked in the hallway across from his room talking with Nurse #1. He then went back into his room and Nurse #1 remained at the medication cart. Nurse #1 stated she had to give Resident #52 medications because he was going out for an appointment. She explained she would give him 12:00 PM and 1:00 PM medications since he would be out of the facility because she could not let him go to the appointment without getting his pain medication. Observations continued on 10/12/17 at 11:47 AM and revealed Nurse #1 removed Gabapentin 600 mg, MAPAP 2 tablets to equal 1,000 mg and Oxycodone 20 mg from medication packages and placed them in a plastic sleeve and crushed the medications together. She then poured the crushed medications into a plastic pill cup and took them into Resident #52's room. Nurse #1 washed her hands and poured water from the bathroom sink into a plastic container and then into the cup of crushed medications and mixed them. She then took a plastic syringe out of a plastic bag hanging on a pole next to Resident #52's bed and Resident #52 unclamped the stomach tube. Nurse #1 inserted the tip of the syringe into the tube and then poured approximately 30 milliliters (ml) of water into the	F 322	week for four weeks then monthly thereafter for one year. 4) The Director of Clinical Services will be responsible for implementing this plan of correction. The Director of Clinical Servicers introduced the plan of correction to the QAPI committee on 11.6.17. The results of the Quality Improvement Monitoring are to be reported to the QAPI Committee by the Director of Clinical Services. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring schedule may be modified based on findings.	

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F 322	Continued From page 14 tube which flowed through the tube by gravity, then poured in the medications mixed with water and then flushed the tube with approximately 30 ml of water. Resident #52 then clamped the tube and Nurse #1 removed the syringe, rinsed it in the bathroom sink and placed it back in the plastic bag hanging on the pole next to Resident #52's bed and left the room and went back to the medication cart. When asked about checking for placement of the tube, Nurse #1 stated she had checked placement of the tube earlier that morning. During an interview on10/12/17 at 12:18 PM the Director of Nursing (DON) stated it was her expectation for Nurse #1 to check for placement of the tube according to their policy. During a follow up interview on 10/12/17 at 2:30 PM the DON stated she had reviewed their policy and it was her interpretation that the nurse should check for placement of the gastrostomy tube before administration of medications in the tube. She further stated the nurse could check for placement either with air or water to confirm placement of the tube. During an interview on10/13/17 at 11:19 AM with Resident #52's physician who was also the Medical Director he stated he thought the facility had a protocol in place for checking placement of gastrostomy tubes. He further stated it was his expectation for nurses to check for placement of the tube before they administered medications through it.	F 322		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		11/7/17

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F 520	Continued From page 15 (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for	F 520		

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F 520	Continued From page 16 sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident 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 July of 2016. This was for a recited deficiency which occurred in July of 2016 and on the current recertification survey. The deficiency was in the area of maintenance and housekeeping. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F 253 Maintenance and Housekeeping: Based on observations and staff interviews the facility failed to repair 1 of 6 sets of smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (E Hall) and failed to repair a shower door with broken and splintered laminate and wood on the lower edges of the door on 1 of 4 occupied resident hallways (E hall). The facility also failed to repair the main door leading into A hall (secured unit) with broken and splintered laminate and wood on the lower edges of the door on 1 of 4 occupied resident hallways, failed to repair 1 resident room door which made a loud scraping sound when closed (resident room #145) and failed to repair 5 resident room doors with broken and splintered laminate and wood on the lower edges of the doors (resident room #155, #156, #143, #151,	F 520	1) Facility has QAPI committee in place and implements plans for improvement and monitors and revises as needed through the QAPI process. The current performance improvement plan hadn□t been updated to include new issues for correction. 2) The RDCS will re-educate the interdisciplinary team members on regulation F520 and the facility□'s policy and procedures for Quality Assurance Performance Improvement on 11.6.17. Observations of resident area doors, bathroom lights and fixtures, hallways and personal items unlabeled and not bagged was completed 11.3.2017 and ongoing by the Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping. Issues identified were addressed. 3) The Director of Clinical Services and the Executive Director re-educated staff on 11.2-11.3.2017 regarding reporting issues with resident area doors, bathroom lights and fixtures, hallways and unlabeled, non bagged personal items in resident room□s by filling out work order for areas identified. The Interdisciplinary Team including but not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping to perform Quality	

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F 520	Continued From page 17 #136) for 5 of 54 resident room doors on 4 occupied resident hallways. The facility also failed to repair a light in the bathroom of resident bathroom in 1 of 54 resident rooms (resident room #160), failed to repair floor molding pulled away from the wall in the hallway next to resident room #160 on 1 of 4 occupied resident hallways, failed to remove a toilet lid with chipped edges on the top right corner in 1 resident bathroom (#136) that was rough to touch in 1 of 54 resident rooms, failed to remove dark brown stains from under faucets at sinks in resident bathrooms (room #133, #101, #105) in 3 of 54 resident rooms and failed to label and properly store resident care equipment in 3 shared bathrooms (room #149, #152, #158) on 2 of 4 resident halls. During the recertification survey of 10/13/17, the facility was recited for F 253 for failure to repair broken and splintered laminate and wood on the lower edges of smoke prevention/fire doors, shower door, hallway door, and resident room doors. The facility also failed to repair a light in a resident's bathroom, failed to repair floor molding in a resident's room, failed to remove dark brown stains from under the sinks in residents bathrooms, failed to remove a chipped toilet lid in a resident's bathroom and failed to label and properly store resident care equipment. During the July 2016 recertificataion survey, F 253 was originally cited for failure to repair resident doors, smoke prevention doors, a cracked vinyl hand rail in the main hallway, stained grout around the base of toilets, and baseboard in a resident's bathroom on the locked dementia unit. During an interview on 10/13/17 at 3:14 PM the Administrator stated after the previous survey, they have worked hard to self-identify areas that	F 520	Improvement Monitoring of resident area doors, bathrooms lights, toilet lids and hall ways to identify items in need of repair 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of unlabeled/non bagged items in residents rooms 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year. The Maintenance Director and Housekeeping Director will be responsible for correction of reported concerns. 4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11.03.2017. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services or designee in DCS absence. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule may be modified based on findings.	

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F 520	Continued From page 18 needed to be fixed. She added they have put environmental performance improvement plans into place that "have no end date" because there will always be things that needed to be repaired. The Administrator stated that as a facility they were committed to continuing a root cause analysis of the issues in an effort to improve the overall system.	F 520		