STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey conducted on 11/16/17. Event ID# 9H4P11. A recertification and complaint investigation survey was conducted from 11/13/17 through 11/16/17. Past-noncompliance was identified at: CFR 483.25 at tag F323 at a scope and severity J The tags F323J constituted Substandard Quality of Care. An extended survey was conducted. Current tags were cited.	F 000		12/18/17
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (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 record review, observations, resident and staff interviews, the facility failed to properly sanitize privacy curtains for 9 out of 32 privacy curtains observed for cleanliness. Findings included: 1. An observation of the 100 hall was completed on 11/14/2017 between 3:00 PM and 3:12 PM. a. Room 101A privacy curtain was noted to have a brown stain and a brown, solid substance	F 253	F253 On 12/5/17, privacy curtains in rooms 101b, 106a, 201a, 204a+b, 209b, 402a, 405a+b, 407b, 502a+b, 508a and 604a were removed and washed by housekeeping. Clean privacy curtains were replaced in all rooms listed above on 12/5/17 by housekeeping. ON 12/5/17, privacy curtains throughout the facility were audited for stains and being soiled by the housekeeping manager. Those that were found to be either soiled or stained were removed from the rooms and washed by housekeeping. Clean privacy curtains were then replaced by housekeeping on 12/5/17 in each room. On 12/7/17, the housekeeping manager and the housekeeping staff were re-educated by the housekeeping District Manager on the daily procedure for ensuring clean and unstained privacy curtains. The re-education also included validating the cleaning schedule for privacy curtains. Any newly hired housekeeping staff will receive this in-service during orientation. The facility housekeeping manager will audit 2 rooms from each unit weekly for clean privacy curtains for four weeks, then weekly for 2 months. The Housekeeping Manager will report the findings of these audits to the facility Quality Assurance and Performance Improvement committee weekly for 4 weeks then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/13/17

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

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F 253	Continued From page 1 on the curtain. The facility Housekeeping Deep Clean Schedule/Privacy Curtain Cleaning Schedule was reviewed for November 2017. It was noted that room 101 was scheduled for a deep cleaning on November 1, 2017. b. Room 101B privacy curtain was noted to have a red colored stain. Room 101 was scheduled for a deep cleaning on November 1, 2017. c. Room 106A privacy curtain was noted to have scattered brown stains. Room 106 was scheduled for a deep cleaning on November 8, 2017. 2. The 200 hall observation was completed on 11/14/2017 between 3:13 PM and 3:24 PM. a. Room 201A privacy curtain was noted to have a brown/yellow stain in the middle of the curtain. The facility Housekeeping Deep Clean Schedule/Privacy Curtain Cleaning Schedule was reviewed for the months of October and November 2017. Room 201 was scheduled for a deep cleaning on November 15, 2017. b. Room 204A privacy curtain was noted to have scattered brown stains. Room 204 was scheduled for a deep cleaning on October 19, 2017. c. Room 204B was noted to have solid brown matter on the privacy curtain. Room 204 was scheduled for a deep cleaning on October 19, 2017. d. Room 209B privacy curtain was noted to have solid brown matter on the privacy curtain. Room 209 was scheduled for a deep cleaning on October 26, 2017. 3. The 400 hall was observed on 11/14/2017 between 3:25 PM and 3:33 PM.	F 253		

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F 253	Continued From page 2 a. Room 402A privacy curtain was noted to have scattered brown stains. The facility Housekeeping Deep Clean Schedule/Privacy Curtain Cleaning Schedule was reviewed for the months of October and November 2017. Room 402 was scheduled for a deep cleaning on November 9, 2017. b. Room 405A privacy curtain was noted to have scattered dark brown stains. . Room 405 was scheduled for a deep cleaning on November 14, 2017. c. Room 405B privacy curtain was noted to have scattered yellow stains. . Room 405 was scheduled for a deep cleaning on November 14, 2017. d. The privacy curtain in room 407B was noted to be tied back with a plastic grocery bag and scattered light brown stains were noted on the privacy curtain. Room 407 was scheduled for a deep cleaning November 16, 2017. 4. The 500 hall was observed on 11/14/2017 from 3:34 PM to 3:44 PM. a. Room 502B was observed on 11/13/2017 at 12:27 PM and the privacy curtain was noted to have dark brown stains. Room 502A privacy curtain was noted to be stained with scattered, light brown stains during the observation on 11/14/2017 at 3:34 PM. The facility Housekeeping Deep Clean Schedule/Privacy Curtain Cleaning Schedule was reviewed for the months of October and November 2017. Room 502 was scheduled for a deep cleaning on November 2, 2017. b. Room 508A privacy curtain was noted to have scattered light brown stains. Room 508 was scheduled for a deep cleaning on November 10, 2017.	F 253		

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F 253	Continued From page 3 5. The 600 hall was observed from 3:45 PM until 3:54 PM. a. Room 604A privacy curtain was noted to have solid brown matter flecked on it. The facility Housekeeping Deep Clean Schedule/Privacy Curtain Cleaning Schedule was reviewed for the months of October and November 2017. Room 600 was scheduled for a deep cleaning on November 16, 2017. The 100 hall was observed on 11/16/2017 at 8:46 AM and it was noted the stains on privacy curtains for room 101B and 106A remained stained. The 200 hall was observed on 11/16/2017 at 8:52 AM and it was noted the privacy curtains for rooms 201A and 204A remained stained. The 400 hall was observed on 11/16/2017 at 9:09 AM. Room 407B privacy curtain remained stained. The 500 hall was observed on 11/16/2017 at 9:19 AM. Rooms 502A, 502B, and 507B remained stained. The 600 hall was observed on 11/16/2017 at 9:29 AM. Room 604A privacy curtain was noted to have solid brown flecks on the curtain. An observation of the privacy curtains in rooms was made with the Housekeeping District Manager on 11/16/2017 at 2:02 PM. He noted the appearance of the stains in rooms 201A, 407 B and the solid material on 604B privacy curtain. Resident #98 was interviewed on 11/13/2017 at 12:27 PM and she reported she didn ' t know	F 253		

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F 253	Continued From page 4 what the stain on the privacy curtain could be and did not remember the housekeeping staff taking down the curtains to be washed. An interview with Resident #110 on 11/13/2017 at 3:07 PM and he noted the dark brown stains were from a wound on his right ankle that bled when the wound care physician provided treatment. Resident #110 reported the stains had been on the privacy curtain "for at least a month" and he had asked staff to remove the curtain and wash it. An interview was conducted with Resident #57 on 11/14/2017 at 3:30 PM and she reported the privacy curtain had been tied back with the plastic grocery sack since she moved into the room "almost a year ago." An interview was conducted with Housekeeper #1 on 11/15/2017 at 11:08 AM. She reported if a housekeeper noticed stains on a privacy curtain, the housekeeper would notify the housekeeping manager by writing a report and request the curtain to be washed. The housekeeper went on to explain that they had a schedule for deep cleaning rooms and the privacy curtains were checked for stains during a deep clean of the room. An interview was conducted with Housekeeper #2 on 11/16/2017 at 9:24 AM. She reported that the privacy curtains are checked daily for stains or dirt and she would notify the department manager if a privacy curtain needed to be changed or washed. The Housekeeping manager was interviewed on 11/16/2017 at 9:29 AM. He reported the facility	F 253		

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F 253	Continued From page 5 used a rotating schedule to deep clean rooms. He further reported the housekeepers would notify him if a privacy curtain needed to be washed. An interview was conducted with the District Housekeeping Manager on 11/16/2017 at 10:02 AM. He explained the deep cleaning schedule for the resident rooms. He reported he was not aware there was an issue with the privacy curtains. The District Housekeeping manager was interviewed on 11/16/2017 at 2:02 PM. He reported that privacy curtains become soiled very easily. He reported it was his expectation the Housekeeping manager would audit the privacy curtains for cleanliness and remove soiled curtains to be washed on a daily basis and that housekeepers would continue to report soiled privacy curtains to the housekeeping manager. The Administrator and the facility consultant were interviewed on 11/16/2017 at 4:00 PM and the Administrator reported it was his expectation that the privacy curtains would be washed when they were soiled and that housekeeping would monitor the cleanliness of the privacy curtains daily.	F274		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (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	F 253 F 274	Resident #95 had a Significant Change Assessment completed by the Resident Care Management Director (RCMD) on 11/28/17. The assessment revealed that resident #95 did have a significant change of condition. The IDT Team reviewed the change and then updated Resident #95's Care Plan to reflect the significant change. An audit was completed on 11/15/17 by the RCMD dating back to 3/27/17 to identify other residents possibly affected by this deficient practice. A significant change of condition MDS has been completed by the RCMD and IDT Team on any affected resident. The RCMD re-educated the MDS Coordinator on the RAI Guidelines for significant change of condition assessment on 11/15/17. The IDT clinical team was also re-educated by the RCMD on the RAI Guidelines for significant change of condition assessment on 12/12/17. The IDT team (consisting of the DON, ADON, other clinical managers, RCMD) will review the 24 hour report and physician orders from the previous day Monday thru Friday for 30 days to ensure residents with significant changes and their plan of care are captured on the MDS assessment if appropriate. The DON or designee will review 2 of the previous weeks MDS's to assure that any significant change of condition is captured on the MDS. These reviews will be weekly for 4 weeks then bi-monthly for 2 months. The findings from these audits will be reported by the DON to the Quality Assurance and Performance Improvement Committee weekly for 4 weeks then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 274	Continued From page 6 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 observations, record review and staff interview, the facility failed to complete a Significant Change in Status Assessment for 1 of 4 sampled residents (Resident #95) who experienced a change in condition. The findings included: Resident #95 re-entered the facility on 7/5/17, with diagnoses including muscle weakness, osteoarthritis, and dementia. The admission Minimum Data Set (MDS) dated 7/12/17, indicated the resident was moderately cognitively impaired and had impaired range of motion in one upper extremity. The MDS specified the Resident #95 required limited assistance with bed mobility and dressing. The quarterly MDS dated 10/5/17 had range of motion limitations in the upper and lower extremities on one side of her body, and required extensive assistance from staff for bed mobility and dressing. During an interview on 11/15/17 at 10:48 AM, Resident #95's assessments were reviewed with the MDS nurse. The MDS nurse compared the differences in coding between the time of the comprehensive assessment on 7/12/17 and the quarterly assessment on 10/5/17. The MDS nurse	F 274	F274 Resident #95 had a Significant Change Assessment completed by the RCMD on 11/28/17. The assessment revealed Resident #95 did have a significant change of condition. The IDT Team reviewed the change and then updated Resident #95 Care Plan to reflect the significant change. An audit was completed on 11/15/17 by the RCMD dating back to 3/27/17 to identify other residents possibly affected by the deficient practice. A significant change of condition MDS has been completed by the RCMD and IDT Team on any affected resident. The RCMD re-educated the MDS Coordinator on the RAI Guidelines for significant change of condition assessment on 11/15/17. The IDT Clinical Team was also re-educated by the RCMD on the RAI Guidelines for significant change of condition assessment on 12/12/17. The IDT Team (consisting of DON, ADON, other Clinical Managers, RCMD) will review the 24 hour report and physician orders from the previous day Monday through Friday for 30 days to ensure residents with significant changes and their plan of care are captured on the MDS assessment if appropriate. The DON or designee will review 2 of the previous week's MDS's to assure any significant change of condition is captured on the MDS. These reviews will be weekly for 4 weeks, the bi weekly for 2 months. The findings from these audits will be reported by the DON to the Quality Assurance and Performance Improvement Committee weekly for 4 weeks then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 274	Continued From page 7 indicated the change in activities of daily living and range of motion met the definition, and a significant change in status assessment should have been completed after the MDS in October. The MDS nurse stated the different staff disciplines would meet and discuss residents, but the MDS nurses would not be aware of a change in status unless it was brought to their attention. On 11/15/17 at 12:45 PM, Resident #95 was observed in bed and appeared to be asleep. The resident was wearing a left hand splint. During an interview on 11/16/2017 at 3:07 PM, the Director of Nursing said she expected that a comprehensive MDS be initiated for changes in resident status as per the MDS guidelines.	F 274		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 Resident #107 Quarterly Assessment dated 11/2/17 was reviewed by the Resident Care Management Director (RCMD) and a modification was completed to reflect the change in the range of motion of the resident. An audit on 12/8/17 by the RCMD of the Residents for the last 30 that had a MDS completed were reviewed to ensure section G of the MDS under functional limitations in range of motion to ensure that any resident with limitations in range of motion were accurately coded. Over the next quarterly cycle the RCMD will review all other residents to ensure any resident with function limitations in range of motion is captured appropriately. The District Director of Care Management will complete reeducation of the MDS staff on 12/18/17 on section G under functional limitations of the RAI guidelines to ensure accurate coding of the resident range of motion status. The DON or designee will review 2 of the previous weeks MDS assessments for accuracy for 4 weeks, then 4 per month thereafter for 2 months. The DON will bring these findings to the Quality Assurance and Improvement Committee weekly for 4 weeks then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to assure continued compliance.	

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F 278	Continued From page 8 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide accurate assessments for 1 of 35 (Residents #107) residents observed. Resident #107 had a right wrist contracture and the Quarterly Minimum Data Set Assessment dated 11/2/17 stated she had no functional limitations to the upper extremities. The findings included: Review of Resident #107's medical record revealed diagnoses of Alzheimer's Dementia, Anxiety and Behaviors. Review of Resident #107's Admission Minimum Data Set Assessment dated 4/5/17 indicated she was severely cognitively impaired. The Admission Minimum Data set also revealed Resident #107 had functional limitations for both upper and lower extremities on both sides.	F 278		

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F 278	Continued From page 9 Review of Resident #107's physician's orders revealed an order for right resting hand splint dated 5/4/17. Review of Resident #107's Quarterly Minimum Data Set Assessment dated 11/2/17 indicated she was moderately cognitively impaired. The Quarterly Minimum Data Set Assessment further revealed the resident had no functional limitation to the upper extremities and impairment on both sides on the lower extremities. On 11/14/17 at 9:32 am Resident #107 was observed in her wheelchair at the nurses' station. Resident #107 had both of her hands in her lap and a contracture was noted to the right hand and wrist, and there was no splint in place. On 11/15/17 at 2:46 pm the Minimum Data Set Nurse stated there was an error to the Quarterly Minimum Data Set Assessment dated 11/2/17 and the resident had a contracture to her right hand that was not coded on the assessment. On 11/16/17 at 4:56 pm the Director of Nursing stated she wasn't aware of the inaccurate assessment of Resident #107 and her expectations are the Minimum Data Set Assessments would be accurately coded for all residents.	F 278	F279 On 11/15/17 the Resident Care Management Director (RCMD) corrected the Care Plan of Resident #107 to reflect the order for a splint. An audit was completed on 11/15/17 by the RCMD and Rehab Director to determine all residents with splints have Care Plans in place. An in-service was given by the Rehab Director to Nursing staff on 11/15/17 to communicate the process for transcribing splint orders to the MAR so that further communication is assured to the IDT Team so that the Care Plans are updated accurately. New employees will receive the same training during their orientation process. Changes in Care Plans will be discussed in morning meeting and a copy of the associated order will be provided to the MDS team for updates to the Care Plan. An audit of Care Plans of residents with splints will be conducted daily for 2 weeks then weekly for 2	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review	F 279	months by the RCMD. The RCMD will bring these findings to the Quality Assurance and Improvement Committee weekly for 4 weeks then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to assure continued compliance.	

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F 279	Continued From page 10 and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)-	F 279		

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F 279	Continued From page 11 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to develop a care plan with goals and interventions to prevent decline in range of motion in 1 of 2 residents observed. Resident #107 had a right wrist contracture with an order for a right wrist splint without a care plan developed. Review of Resident #107's medical record revealed diagnoses of Alzheimer's Dementia, Anxiety and Behaviors. Review of Resident #107's Admission Minimum Data Set Assessment dated 4/5/17 revealed a Brief Interview for Mental Status score of 3, which indicated she was severely cognitively impaired. The Admission Minimum Data Set Assessment also revealed Resident #107 required extensive assistance of two staff members for bed mobility, transfers, dressing and toileting; total assistance of one staff member for bathing; and limited assistance of one staff member for eating. The Admission Minimum Data set also revealed	F 279		

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F 279	Continued From page 12 Resident #107 had functional limitations for both upper and lower extremities on both sides. Review of Resident #107's physician's orders revealed an order for right resting hand splint dated 5/4/17. Review of the Rehab to Restorative Transition Record dated 7/17/17 revealed NA #2 had been instructed and signed the form. The Rehab to Restorative Transition Record further revealed the resting right hand splint should be on daily for four to six hours; the resident should be checked for redness and skin breakdown; and the splint should be worn seven days a week. Review of Resident #107's Quarterly Minimum Data Set Assessment dated 11/2/17 revealed a Brief Interview for Mental Status score of 9, which indicated she was moderately cognitively impaired. The Quarterly Minimum Data Set further revealed Resident #107 required extensive assistance of two staff members for bed mobility, transfers and toileting; extensive assistance of one staff member for locomotion, dressing, personal hygiene and dressing; and limited assistance of one staff member for eating. The Quarterly Minimum Data Set Assessment further revealed the resident had no functional limitation to the upper extremities and impairment on both sides on the lower extremities. Review of Resident #107's care plan revealed there was no care plan for the ordered right resting hand splint. On 11/14/17 at 9:32 am Resident #107 was observed in her wheelchair at the nurses' station. Resident #107 had both of her hands in her lap and a contracture was noted to the right hand and	F 279		

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F 279	Continued From page 13 wrist and there was no splint in place. On 11/15/17 at 10:37 am NA #1 revealed she was not aware of a scheduled time for Resident #107's right resting hand splint to be applied or removed. She stated NA #2 applies splints and removes them for residents that need them. On 11/15/17 at 11:00 am Nurse #1 stated when residents come off of therapy the restorative person puts their splints on and takes them off, and does range of motion. Nurse #1 was not aware of a schedule for applying or removing Resident #107's right hand splint. On 11/15/17 at 1:56 pm the Rehabilitation Program Director revealed when residents have orders for a splint the Rehabilitation Program Director gives the Director of Nursing a form to inform her what type of splint and how many hours a day the splint should be in place. She also stated the Director of Nursing writes a care plan for each splint and the hours it should be worn. The Rehabilitation Program Director revealed Resident #107 has a splint and was released to Restorative Nursing to manage her splint on 7/17/17. The Rehabilitation Program Director also revealed the right hand contracture had not worsened since Resident #107 was released to Restorative services. On 11/15/17 at 2:05 pm NA #2 revealed she had not been assigned as a Restorative Aide in "a couple of months". She also stated, "There used to be a restorative book we had and therapy would tell us who had a splint and give us a paper telling us how many hours they needed their splint." NA #2 stated when there was no one assigned to restorative then Physical Therapy will	F 279		

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F 279	Continued From page 14 put the splints on. On 11/15/17 at 2:12 pm the Minimum Data Set Nurse revealed she had added the care plan for splints today after she had been made aware there was no care plan in place for the resting right hand splint for Resident #107. On 11/15/17 at 2:16 pm the Director of Nursing stated she did not have any documentation to show there was a process in place for splint placement or monitoring of splints for Resident #107. She stated her expectation was there should be an order for each splint, and each resident with a splint should have a care plan and kardex.	F 279		
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323	F323 The accepted corrected plan of 11/16/17 continues to be monitored through our Quality Assurance and Improvement Committee for 3 months. The committee will review the results and Implement additional interventions as needed to assure continued compliance.	

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F 323	Continued From page 15 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and resident interviews the facility failed to prevent 2 of 5 cognitively impaired residents from exiting the facility unsupervised (Resident #50 and Resident #114). Findings included: A review of the weather for 9-14-17 revealed that the temperature was 77 degrees with no rain. 1A: Resident #50 was admitted to the facility on 8-22-16. The resident was admitted with multiple diagnoses to include above the left knee amputation, history of falls, muscle weakness and alzheimers. A review of resident #50's Minimum Data Set (MDS) dated 7-26-17 revealed that the resident was severely cognitively impaired. The MDS coded the resident as needing extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene, extensive assistance with two people for transfers, supervision with one person for locomotion on the unit in her wheelchair and the resident was coded as a person that would wander out of the building. A review of resident #50's care plan dated	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 16 8-17-17 revealed that the resident had a care plan addressing the residents elopement risk with the following interventions; Staff is to check placement of the wander guard visually every shift, distract the resident from wandering and check the function of the wander guard with electric machine every day. 1B: Resident #114 was admitted to the facility on 9-11-15. The resident was admitted with multiple diagnoses to include dementia, hearing loss, muscle weakness, history of falling, blindness in the right eye and low vision in her left eye. A review of resident #114's Minimum Data Set (MDS) dated 8-24-17 revealed resident #114 had memory problems with moderately impaired decision making abilities. The MDS also revealed the resident needed extensive assistance of one person for bed mobility, dressing, toileting and personal hygiene, supervision with one person for transfers, walking in the corridors, locomotion on and off unit and eating and independent with walking in her room. MDS revealed the resident was not coded for wandering behaviors. A review of the care plan dated 5-30-17 revealed that there was no plan developed for wandering or exit seeking behaviors. A review of the incident report dated 9-14-17 revealed that resident #50 was observed outside in the parking lot. A review of the incident report dated 9-14-17 revealed that resident #114 was observed outside in the parking lot. A review of a written interview by the Rehab	F 323		

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F 323	Continued From page 17 Director dated 9-14-17 revealed that a Physical Therapist Assistant (PTA) saw resident #50 being pushed in her wheel chair by resident #114 outside in the parking lot. The written interview revealed that the PTA went out to the parking lot, checked on the two residents then brought them back inside through the therapy door. An interview with the Rehab Director occurred on 11-15-17 at 10:20am. The Rehab Director stated that she was informed of resident #50 and resident #114 being outside in the parking lot by her Physical Therapy Assistant (PTA). The staff member stated while her PTA went out to escort the residents back into the building she called the Director of Nursing and the Administrator to come escort the residents back to their respective rooms. The Rehab Director stated she believed the residents went out the front door of the facility. An interview with the Physical Therapy Assistant (PTA) occurred on 11-15-17 at 10:25am. The PTA stated he was providing therapy for a resident and happen to glance out the window and saw resident #50 and resident #114 outside in the parking lot. The staff member stated resident #114 was pushing resident #50 in her wheel chair and that this occurred around 2:00pm on 9-14-17. The PTA walked to where the residents were located outside and attempted to ask where they were going but the PTA stated neither resident could answer him. The PTA stated he escorted both residents back into the building. The area from the therapy door, where the residents were brought back into the building, to where they were found was 100 feet. A review of the Director of Nursing's (DON)	F 323		

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investigation dated 9-21-17 revealed that resident #50 was seen in the dining room eating lunch and then next observed, by a staff member, being pushed in her wheelchair by another resident in the parking lot. The report revealed that staff responded and brought the two residents back inside and that the DON and the maintenance director tested resident #50's wander guard and discovered it was not working. The report also revealed that a head to toe assessment was completed for resident #50.

An interview with the Director of Nursing (DON) occurred on 11-15-17 at 3:50pm. The DON stated after she was made aware of resident #50 being out in the parking lot she "immediately" tested resident #50's wander guard with the electric machine. The DON stated the wander guard registered as not working and that she then took the resident to one of the doors that had a wander guard alarm and the wander guard did not work. The DON stated she "immediately" received an order to change the wander guard and placed a new wander guard on the resident.

An interview with resident #50 occurred on 11-15-17 at 9:45am. The resident stated she could not remember the incident. The resident stated she did not go outside. Resident #50's wander guard noted to be present on her right wrist.

An interview with resident #114 occurred on 11-15-17 at 10:00am. Due to residents inability to hear and limited vision it was not possible to ascertain if she remembered being out of the building on 9-14-17.

A review of resident #50's head to toe

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F 323	Continued From page 19 assessment dated 9-14-17 revealed that a complete body check was completed with no abnormal findings. A review of the Medication Administration Record (MAR) revealed that resident #50 received her wander guard bracelet on 3-28-17. The MAR further revealed that the wander guard was replaced on 7-13-17. A review of the MAR from 7-13-17 to 9-14-17 revealed documentation that resident #50's wander guard was working properly. The MAR further revealed that the resident received a new wander guard bracelet 9-14-17. A review of the maintenance logs dated 9-12-17 through 9-15-17 revealed that all 5 doors that have the wander guard alarm system were operational. A review of the manufacturers guidelines related to the maintenance and replacement of the wander guard revealed that resident #50's wander guard bracelet was to be replaced every 90 days. An interview with the Nursing Assistant (NA #3) occurred on 11-15-17 at 10:40am. NA #3 stated she remembers she was working on 9-14-17 but denied knowing anything about resident #50 being outside in the parking lot. The staff member also stated she did not remember rendering any type of care or seeing resident #50 after lunch. An interview with nurse #1 occurred on 11-15-17 at 10:45am. Nurse #1 stated she remembered working on 9-14-17 but denied knowing anything about resident #50 being outside in the parking	F 323		

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lot till the next day when she came into work. Nurse #1 stated she was told at that time about the resident being outside and that she needed to make sure she checked on resident #50 more often.

An interview with maintenance personal occurred on 11-15-17 at 1:50pm. Maintenance stated that the only way out of the building during the day was through the front door and that all other doors were locked and needed a key or a code to get out. Maintenance measured from the front door, where resident #50 and resident #114 left the building, to where they were located and the measurement was 446 feet. The distance between where the residents were found and the road was 346 feet. Maintenance stated that resident #50's wander guard bracelet did not work but that he did not know why it was not working and guessed it may have been that the battery died.

An observation of the nurse testing resident #50's wander guard occurred on 11-15-17 at 4:10pm. The nurse explained the procedure as she tested the wander guard and found the wander guard to be working properly.

An interview with the DON occurred on 11-16-17 at 9:31am. The DON stated she expected all residents who have wander guards have them checked for placement and functionality daily.

An interview with the Nursing Assistant (NA #3) occurred on 11-15-17 at 1:40pm. NA #3 stated she remembers she was working on 9-14-17 but denied knowing anything about resident #114 being outside in the parking lot. NA #3 also stated she did not remember rendering any type of care

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F 323	Continued From page 21 or seeing resident #114 after lunch. An interview with the DON occurred on 11-16-17 at 9:31am. The DON stated she expected all residents who have wander guards have them checked for placement and functionality daily. The DON also stated she expected resident #114 to be monitored more closely. An observation of the nurse checking placement and functionality of resident #114's wander guard occurred on 11-16-17 at 2:10pm. The nurse explained the procedure in testing the functionality of the wander guard and that the electric machines light will turn green when the devise is working properly. The result was that resident #114's wander guard was working. The facility provided a plan of correction with a correction date of 9-14-17. The plan of correction included: F323. 1. On 9/14/17 at approximately 2:00pm a Therapist from the Facility's Rehab staff observed, through the Rehab gym window, Resident #50 and Resident #114 in the Facility parking lot. Resident #114 was pushing Resident #50 seated in a wheelchair. The Rehab staff responded immediately and assisted both Residents back into the facility and proceeded directly to the Charge Nurse and reported the event. Nurse #1 completed a head to toe assessment of Resident #50 and Resident #114, noted no injuries and documented this assessment on a nurse's progress note. On 9/14/17, immediately following the event, the Director of Nursing validated the placement and function of the Wander guard for Resident #50. The Facility Maintenance Director and Director of	F 323		

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F 323	Continued From page 22 Nursing took Resident #50 to the front door to test the function of the resident's bracelet located on her right wrist. As the Resident approached the doors it did not activate the Wander guard System to lock the doors. A new bracelet was placed on Resident #50 by the Director of Nursing and when the resident was taken back toward the front door the alarm activated and the door locked. Resident #50 was assessed as being at risk for elopement and identified at risk on 3/28/17, a wander guard was placed for intervention and the care plan was updated. Resident #114 was admitted on 7/1/16, was not assessed a risk for elopement and has no prior history of wandering or exit seeking behaviors and did not use a Wander guard bracelet prior this event. An updated Elopement Assessment was completed for Residents #50 and resident #114 by the Director of Nursing on 9/15/17. Residents #50 and resident #114 were assessed at risk for elopement, care plans were reviewed and revised to include exit seeking behaviors, the Wander guard bracelet was continued for Resident #50 and a Wander guard bracelet was added for Resident #114. The Director of Nursing notified the Responsible Party and Physician for both Resident #50 and resident #114 regarding the event, the follow up assessment, and the plan for increased monitoring that began on 9/14/17. No new Physician's Orders were received. The Facility Medical Director was notified on of the incident on 9/14/17 by the Director of Nursing. 2. An Incident report was completed by Director of Nursing on 9/14/17 and an investigation with	F 323		

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F 323	Continued From page 23 root cause analysis was completed by the Director of Nursing on 9/14/17. Resident #50 had been identified as possible risk for elopement on 3/28/16 and a Wander guard bracelet was initiated. Resident #50's medical record revealed that the bracelet was last changed on 7/13/17 and scheduled to be changed every 90 days, due on 10/13/17. The treatment record for July, August and September revealed that the residents bracelet had been checked for placement and function by the Charge Nurse, daily as ordered by the Physician with no discrepancies noted. Staff interviews were conducted to validate the procedure for checking placement and function of the Wander guards. On 9/14/17 Incident and Accident reports from the last 90 days were reviewed by the Director of Nursing and Administrator and it was determined there were no other unsupervised exits reported for Resident #50. There were no other unsupervised exits reported for other residents assessed at risk for elopement during the last 90 days. To the knowledge of Facility Staff and Leadership, Resident #50 has had no other instances of exiting the facility without supervision prior to 9/14/17. The Maintenance Director completed a review of the Wander guard System including validation of properly functioning Wander guard keypads and alarms for all Facility doors on 9/14/17 and again on 9/15/17. This validation is completed by utilizing a functioning Wander guard bracelet to validate that each door locks when the bracelet is within 5 feet and alarms when the bracelet crosses the threshold. The Maintenance Director or Administrator will continue to monitor the Wander guard System for all facility doors daily and document on the Wander guard Log maintained in the Director of Nursing Office. This	F 323		

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F 323	Continued From page 24 daily monitoring will continue for 90 days and be re-evaluated for effectiveness by the Administrator and Maintenance Director, this is an ongoing facility process that will continue. The Director of Nursing and Nurse Managers completed an audit of all current residents with Wander guard bracelets and validated placement and function of each device on 9/14/17 immediately following the event to ensure all other devices were functioning properly. 6 Residents were reviewed and no other discrepancies were identified. On 9/15/17 the Director of Nursing and Nurse Managers conducted an audit of all current residents at risk for elopement to include a review of current Elopement Assessments for accuracy, validation of Wander guard bracelet placement and operation as required, validation of Physician's Orders to include checking placement of current Wander guards every shift and function of current Wander guards daily. Elopement care plans were reviewed and validated on 9/15/17 by the Nurse Managers. 3. On 9/14/17 The Director of Nursing and Nurse Managers re-educated all current Facility Staff regarding the resident identified at risk for elopement. The education included monitoring the whereabouts of residents who are at risk for elopement, action to take if a resident exhibits exit seeking behavior, checking function and placement of the Wander guard bracelet and action to take if Wander guard bracelet is not in placement or not properly functioning. No staff shall work after 9/15/17 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 9/15/17. The Director of Nursing and Nurse Managers will	F 323		

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	345011	A. BUILDING _____ B. WING _____	11/16/2017

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F 323	Continued From page 25 monitor the placement and function of the Wander guard bracelets for 5 random residents with bracelets 3 times per week for 12 weeks, in addition to the daily check of the function and placement conducted by the Charge Nurse. The Director of Nursing and Nurse Managers will validate weekly that Wander guard bracelets are change per orders according to the manufacturer recommendations and this change will be tracked and documented on the MAR. Residents identified at risk for elopement will have their location monitored twice per shift by the Charge Nurse and this will be documented on the MAR. The Director of Nursing and Nurse Managers will validate these location checks for 5 random residents at risk for elopement 3 times per week for 12 weeks. Any opportunities identified will be corrected and reported to the Director of Nursing and Administrator immediately. The Director of Nursing and Nurse Managers will review new admissions and readmission daily and review the 24 hour report during the Clinical Morning Meeting to validate accurate elopement assessments and care plans as required. The Director of Nursing and Nurse Managers will review current residents assessed at risk for elopement monthly to validate accurate assessments and care plans. The Maintenance Director or Administrator will continue to monitor the Wander guard System for all facility doors daily and document on the Wander guard Log maintained in the Director of Nursing Office. This daily monitoring will continue for 90 days and be re-evaluated for effectiveness by the Administrator and Maintenance Director, this is an ongoing facility process that will continue The Administrator is responsible for the implementation of the plan of correction.	F 323		

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F 323	Continued From page 26 The facility alleges compliance with F323 on 9/15/17. The corrective action plan was validated on 11-16-17 at 5:00pm Validation included reviewing the educational material and roster for the in-service related to elopement risk behaviors and wander guards. Validation included interviews with randomly chosen staff in different service areas which validated recent education on elopement behaviors, what to do if they notice these behaviors, placement and functionality of the wander guard and who to contact if the wander guards are missing or not working and having staff demonstrate how to test the wander guard on those residents that currently have this devise. On 9-15-17 the facility began auditing the 6 residents that had wander guards for wandering behaviors and the placement and functionality of their wander guards. No further issues had occurred.	F 323		
F 371 SS=D	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371	F371 The 2 male staff members were in-serviced on 11/13/17 on the proper use of facial hair covering while handling and serving food to residents by Food Service Manager (FSM). On 11/13/17 the kitchen staff was observed by the FSM to assure that no other staff had uncovered facial hair. The observation did not reveal any uncovered facial hair. On 12/11/17, the Food Service Manager in-serviced the dietary staff on the proper use of hair covering nets for beards, moustaches and hair. The Food Service manager will monitor the dietary staff weekly for the proper use of hair nets for four weeks, then weekly for 2 months. The Dietary District Manager will audit dietary staff for proper hair covering weekly for 4 weeks, then monthly for 2 months. The Food Service Manager and District Manager will report the findings of these audits to the facility Quality Assurance and Performance Improvement Committee weekly for 4 weeks, then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 371	Continued From page 27 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the male dietary staff failed to use facial hair covering while handling and serving food to residents 2 out of 4 meals observed. Findings included: An observation of the kitchen and the staff occurred on 11-13-17 at 10:00am. 2 male staff members in the kitchen were noted not to have their mustaches covered and the dietary manager was noted not to have any of his facial hair covered. An observation of lunch being served in the main dining room occurred on 11-13-17 from 12:00pm to 12:30pm. One of the male kitchen staff was noted to bring out 3 trays, lifting the lid off the main dish and handing it to the dining room staff without having his mustache covered. The dietary manager was also noted to be delivering trays to	F 371		

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F 371	Continued From page 28 the halls without his beard or mustache covered. An observation of the kitchen staff occurred on 11-14-17 at 11:55am. The dietary manager was noted to have his beard and mustache covered while serving 3 plates of food however, the other 2 male kitchen staff preparing the meal did not have their mustaches covered. An interview with the dietary manager occurred on 11-14-17 at 12:00pm. The dietary manager stated "the guards fall down sometimes". The dietary manager stated he would remind his staff to keep the guard over their mustache. An interview with the Administrator occurred on 11-16-17 at 4:04 pm. The Administrator stated he expected the male staff in the kitchen keep their beards and mustaches covered.	F 371	F460 On 12/5/17, privacy curtains in rooms 102B, 106B, 110B, 206A, 209A, 210A, 402A, 403B, 407A, and 507B were removed by housekeeping. The privacy curtains listed above were then replaced with privacy curtains wide enough to provide total visual privacy by housekeeping.	
F 460 SS=D	BEDROOMS ASSURE FULL VISUAL PRIVACY CFR(s): 483.90(e)(1)(iv)-(v) (e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; (e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to provide full visual privacy with privacy curtains that were not wide enough to extend around the resident ' s bed for 10 out of 32 privacy curtains observed.	F 460	On 12/5/17, privacy curtains throughout the facility were audited by housekeeping, for proper width to provide total visual privacy. Those that were found to not provide complete visual privacy were removed by housekeeping and replaced by privacy curtains that provide total visual privacy. On 12/7/17, the housekeeping manager and staff were re-educated by the housekeeping District Manager on the procedure for ensuring privacy curtains in resident rooms provided complete visual privacy at all times. The monitoring of proper size privacy curtains was on the cleaning schedule. The facility housekeeping manager will audit 2 resident rooms weekly for proper size privacy curtains then for 4 weeks, then weekly for 2 months. The housekeeping District Manager will audit random 4 resident rooms for proper size privacy curtains weekly for 4 weeks, then monthly for 2 months. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 460	Continued From page 29 Findings included: An observation of the 100 hall was completed on 11/14/2017 between 3:00 PM and 3:12 PM. Rooms 102B, 106B and 110B privacy curtains were not wide enough to extend completely around the bed and provide the resident with full visual privacy. The curtains hanging were half the length of the track and left an open space of more than two feet wide. The 200 hall observation was completed on 11/14/2017 between 3:13 PM and 3:24 PM. Rooms 206A, 209A and 210A privacy curtains were not wide enough to extend fully around the bed and provide the resident with full visual privacy. The curtains hanging were half the length of the track and left an open space of more than two feet wide when extended fully. The 400 hall was observed on 11/14/2017 between 3:25 PM and 3:33 PM. Rooms 402A, 403B and 407A privacy curtains were not wide enough to extend completely around the bed and provide the resident with full visual privacy. The curtains hanging were half the length of the track and left an open space of more than two feet wide when extended completely. The 500 hall was observed on 11/14/2017 from 3:34 PM to 3:44 PM. Room 507B privacy curtain was not wide enough to extend fully around the bed and provide the resident with full visual privacy. The curtains hanging were half the length of the track and left an open space of more than two feet wide when extended fully. NA #3 was interviewed on 11/16/2017 at 9:15 AM. She reported she would move the curtains	F 460		

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F 460	Continued From page 30 around to provide as much privacy as possible, but if the curtains were not wide enough to go all the way around the bed, she would ask the roommate to leave, or if the roommate had company, ask the visitors to exit the room. The Housekeeping Manager and the District Housekeeping Manager were interviewed on 11/16/2017 at 9:29 AM. The District Manager reported the wider curtains were heavier than the short curtains and the wider curtains were to be hung on the A-side bed, closest to the door. They were not aware some privacy did not provide full visual privacy. The District Housekeeping Manager was interviewed on 11/16/2017 at 2:02 PM. He reported it was his expectation the nursing or housekeeping staff would identify and report privacy curtains that did not fully extent around the bed to provide the resident with full visual privacy to be changed by the Housekeeping Manager. The Administrator and the facility consultant were interviewed on 11/16/2017 at 4:00 PM and the Administrator reported it was his expectation that the privacy curtains would provide full visual privacy of the resident and would be corrected if the curtain of incorrect width was hanging.	F 460		