STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of complaint investigation survey on 1/19/18 for event ID K9FT11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		2/16/18

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

Electronically Signed | 02/10/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain care in a dignified manner by failing to knock on resident's doors or ask permission to enter rooms for 2 of 13 residents (Resident #26 and Resident #15). Findings included: 1-Record review revealed Resident #26 was admitted to the facility on 5/14/2013 with diagnoses which included Parkinson's Disease and Hypertension. Review of the Annual Minimum Data Set dated 11/11/2017 indicated Resident #26 was moderately cognitively impaired and required extensive assist with all Activities of Daily Living (ADLs). Observations were conducted on 1/18/2018 at 8:30AM, 9:50AM, 10:20AM and 11:30AM of Nursing Assistant (NA) #1 entering Resident #26's room without knocking, announcing entrance or asking permission to enter the room. An interview was conducted with NA #1 on 1/18/2018 at 2:30PM. NA #1 indicated awareness of the need to knock prior to entering residents' rooms. NA #1 stated he must have forgotten to	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain care in a dignified manner by failing to knock on residents doors or ask permission to enter rooms for 2 of 13 residents. The facility administrator and residents have the expectation that all employees must knock on the resident's door and ask permission prior to entering the room. 2. Procedure for implementing the acceptable plan of correction.	

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F 550	Continued From page 2 knock. An interview was conducted with the Director of Nursing (DON) on 1/18/2018 at 2:43PM. The DON stated the expectation was for all staff to knock prior to entering residents' rooms. 2-Record review revealed Resident #15 was admitted to the facility on 4/5/2012 with diagnoses which included Congestive Heart Failure and Chronic Kidney Disease. Review of the most recent comprehensive Minimum Data Set (MDS) for a significant change dated 10/19/2017 revealed Resident #15 was moderately cognitively impaired and required extensive assistance with all his Activities of Daily Living (ADLs). Observations were conducted on 1/18/2018 at 8:30AM, 9:50AM, 10:20AM and 11:30AM of Nursing Assistant (NA) #1 entering Resident #15's room without knocking, announcing entrance or asking permission to enter the room. An interview was conducted with NA #1 on 1/18/2018 at 2:30PM. NA #1 indicated awareness of the need to knock prior to entering residents' rooms. NA #1 stated he must have forgotten to knock. An interview was conducted with the Director of Nursing (DON) on 1/18/2018 at 2:43PM. The DON stated the expectation was for all staff to knock prior to entering residents' rooms.	F 550	On 02/08/2018 an in-service education was begun to all full time, part time, and as needed staff. Topics included: • All staff must knock on a resident's door prior to entering the room even if the door is open. • All staff must ask permission prior to entering the resident's room. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Assistant Unit Manger or designee will monitor procedures for resident's rights weekly x 2 weeks then monthly x 3 months using the Residents rights/privacy Quality Assurance monitor. Monitoring will include auditing staff for knocking and asking permission to enter a resident's room prior to entering. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy,	

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F 550	Continued From page 3	F 550	Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		2/16/18

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F 584	Continued From page 4 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to maintain a safe environment for residents by not monitoring and maintaining hot water temperatures at or below 116 Fahrenheit (F) in 7 of 10 bathrooms checked for hot water temperatures (rooms 103, 202, 204, 205, 212, 412, 405) over 3 halls. Findings included: A review of the medical record revealed Resident #28 was admitted 9/22/2017 with diagnoses of stroke, epilepsy, anxiety and depression. The 14 day Minimum Data Set (MDS) date 10/6/2017 noted the resident to be cognitively intact and needed extensive assistance for all Activities of Daily Living with the physical help of one to two persons. On 1/16/2018 at 3:10 PM, the hot water in the bathroom of Resident #28 was found to be very hot. At 3:35 PM the Maintenance Director checked the hot water in Resident #28's bathroom sink with his calibrated thermometer and it registered 138.6 F. The Maintenance	F 584	F584 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain safe hot water temperature at or below 116 degrees F in 7 of 10 bathrooms. On 01/17/2018 the maintenance director was in the process of correcting the hot water temperature when it was discovered to be greater than 116 degrees F. The Maintenance Director was able to adjust the hot water temperatures to below 116 degrees F. On 01/18/2018 the maintenance director adjusted the hot water temperature to below 116 degrees F. The Director of Nursing began in-servicing all nurses and nurse aides to test water on their wrist prior to using the water and in-serviced alert residents to turn on both hot and cold water at the same time. In-service education will be completed by 02/16/2018.	

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F 584	Continued From page 5 Director said "I have been dealing with this for a week." The Maintenance Director stated he takes water temperatures in a few rooms on each hall every week and had found a few high temperatures on the 100 hall. The Maintenance Director indicated he was going to lower the temperature of the water and left the room. On 1/16/2018 at 4:08 PM the bathroom sink temperatures were checked in other rooms and were found as: Room 212 was 118 F. Room 205 was 132 F. Room 204 was 134 F. On 1/16/2018 at 4:12 PM the bathroom sink temperatures were checked as follows: Room 202 was 130 F. Room 412 was 140 F. Room 405 was 128 F. On 1/16/2018 at 5:50 PM the Maintenance Director checked the temperature of the hot water in Resident #28's bathroom with his calibrated thermometer and it was 111.7 F. On 1/17/2018 at 9:30 AM, the hot water in Resident # 28's bathroom was noted to be very hot. The Maintenance Director was paged to check the actual water temperature. The Maintenance Director checked the temperature at 10:30 AM to be 99.7 F. The Maintenance Director stated the temperature was a little low and he was still dealing with the issue. On 1/17/2018 at 11:00 AM NA #1 was interviewed and stated she had found hot water she considered too hot in resident's bathrooms. NA #1 indicated she was careful about running the hot water. On 1/18/2018 at 10:48 AM the Maintenance	F 584	2. Procedure for implementing the acceptable plan of correction. In-service education was provided to the Maintenance Director on 1/18/2018 by the Administrator. Topics included: • Hot water should be tested weekly and entered into TELS Team Electronic Library System (Building Management System for Senior Living) • Always follow the manufacturer guidelines for calibration to ensure accurate readings • To test water: Use a hand thermometer, turn on hot water faucet and hold thermometer under water for 30 seconds, read and record temperature and turn off faucet • If water registers above 116 degrees F then adjust the temperature until the correct measurements are obtained. • Document your corrective actions and re-measurement. • If you are not able to adjust the temperature to less than 116 degrees F then notify staff and alert residents not to use the affected area and notify the administration. Corrective action should be initiated immediately. Document in-service to staff and obtain signatures. • Notify the administrator of all readings that are above 116 degrees F. On 02/08/2018 the Director of Nursing began In-service education to all full time, part time, and as needed staff nurses and nurse aides on how to test water for temperature for resident and staff safety. Education will be completed by	

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F 584	Continued From page 6 Director checked the hot water in Resident #28's bathroom to be 97.8 F. On 1/19/2018 at 9:55 AM, in an interview, the Maintenance Director stated when he checked the temperature on 1/16/2018 in Resident #28's bathroom, he went to adjust the temperatures for the mixing valve. The Maintenance Director stated he did not tell anyone, nor did he shut off the water because he was working on it. The Maintenance Director also said that he had been working with the boiler and the meter for a week prior to finding that high temperature, and the Administrator was aware of a problem with the meter. In an interview, on 1/19/2018 at 10:55 AM, the facility Administrator stated when he found out about the water being too hot, the staff were reeducated about finding water that was too hot. When asked for the documentation of the reeducation the Administrator stated it was not a formal in-service with staff signatures, the staff "huddled" with the Nursing Assistants (NAs)and told them they should check the water and if it was too hot to notify their supervisor. The Administrator noted the alert and oriented residents were told not to turn on the hot water only. The Administrator indicated that temperature checks would be done daily until two weeks of consistently acceptable temperatures were recorded. The Administrator stated his expectation was the water temperatures would be safe. On 1/19/2018 at 11:08 AM, NA #2 stated he had worked on 1/15/2018 and 1/17/2018, but had not been told anything about being careful with the hot water.	F 584	02/16/2018. Topics included: Testing water on the inner arm before using it on a patient is the proper way to test the temperature. If it feels too hot or turns your skin red then do not use it on the patient and notify the maintenance staff immediately by contacting them directly if they are in the facility or if it is after hours by paging them. If you are not able to contact maintenance then notify your nurse on call for further instructions. The following procedure is to be followed for testing hot water temperatures by hand prior and during patient showering, whirlpools or using sinks. 1. Turn water in desired location on. Allow water to run 3 minutes prior to testing with hand. Note: While waiting for water to run, you can use this time to gather supplies, etc. 2. Note if there is any steam present. After 3 minutes, place your wrist or inner arm under the flow of water for 5-8 seconds and test the temperature of the water. If the temperature is in question, use the thermometer (located at each nurses station) supplied to test the water temp. Do this by placing the thermometer under the flow of water and wait for the reading to stabilize. If the temp is greater than 116 degrees F., then notify maintenance and your nurse supervisor. Do not use the water. 3. Proceed with the bath if after the hand or thermometer test is completed and temperature is safe. Note: When giving a shower, you are to periodically do the	

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F 584	Continued From page 7 On 1/19/2018 at 11:11 AM, NA #3 stated he had been told to be careful with the hot water and if it was very hot to notify his supervisor. On 1/19/2018 at 11:14 AM, NA #4 stated she had been told to check the hot water to make sure it was not too hot.	F 584	hand test throughout the shower. Example: If giving a 3-minute shower, you should recheck the water by doing the hand test approximately half way through. 4. When giving a whirlpool, do the hand test, fill the whirlpool up, then do the hand test again prior to placing the patient in the water. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Maintenance Directors and all nursing staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Daily 01/17/2018 thru 01/31/208 the maintenance director tested hot water temperatures to ensure compliance. The Administrator will monitor TELS Team Electronic Library System (Building Management System for Senior Living) weekly for 2 weeks and monthly for 3 months for recording of water temperatures and corrective actions taken if temperatures are noted >116 degrees F. Any negative findings will immediately be addressed. In addition to this, the administrator will randomly test 5 resident area water temperatures weekly for 2 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action	

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F 584	Continued From page 8	F 584	initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide supervision for meals as recommended by the Speech Therapist for 1 of 1 residents reviewed which resulted in the failure to monitor the resident for aspiration during meal consumption (Resident # 26). Findings included: Record review revealed Resident #26 was	F 684	F684 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to provide supervision for meals as recommended by the Speech Therapist for 1 of 1 resident. On 01/18/2018 the supervised dining room list was updated to include resident #26 by the Director of Nursing.	2/16/18

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F 684	Continued From page 9 admitted on 5/14/2013 with diagnoses which included Parkinson's Disease and Hypertension. Review of the Annual Minimum Data Set dated 11/11/2017 indicated Resident #26 was moderately cognitively impaired and required extensive assist with all Activities of Daily Living (ADLs). Review of Resident #26's Care Plan updated 12/13/2017 revealed the resident to be at a nutritional risk due to a mechanically altered and therapeutic diet. Interventions included: -All staff to be informed of resident's special dietary and safety needs. -Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris. -Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly -Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth -Observe me for shortness of breath, choking, labored respirations, lung congestion -Resident to eat only with supervision Review of the updated Kardex (a communication tool the facility used to communicate resident's needs) revealed Resident #26 required supervision with all meals. On 1/18/2018 at 8:30AM, Resident #26 was observed sitting up in bed with the over-bed table across his lap. The resident's breakfast tray was on the over-bed table and the resident was	F 684	2. Procedure for implementing the acceptable plan of correction. The Assistant Unit Managers will audit all current residents' charts to review for orders stating the resident must be supervised with meals and will ensure the order is set up to fire to the eMAR for nurses to sign off at each meal. This will be complete by 02/16/2018. Based on this audit, residents identified as needing supervision will have a supervised meals task fired to POC (Point of Care Documentation) by the Assistant Unit Manager who will also ensure all care plans and kardex reflect any supervision ordered for meals. This will be complete on 02/16/2018. On 02/08/2016 the Director of Nursing began in-service education to all (full time, part time and as needed) nurses and nurse aides. Education will be completed by 02/16/2018. Topics included: • Supervision of meals means that a nurse aide, nurse or trained feeding assistant must be present during the resident's entire meal. • How to know when a resident requires supervision of meals. • How to document that resident received the supervision. • When a new recommendation from Speech Therapist is received for supervision of meals, the Assistant Unit Manger will enter the order and set it up to fire to the eMAR for all meals, care plan the required supervision, add to kardex and task to the nurse aides. This information has been integrated into	

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F 684	Continued From page 10	F 684		

eating. There was no staff member in the room. A continual observation was made of Resident #26 on 1/18/2018 from 9:50AM to 10:20AM. At 9:50AM, Nursing Assistant (NA) #1 entered the room and asked the resident if he was ready to get up. The resident shook his head no and lifted his fork. NA#1 left the room and left the resident in the same position eating breakfast. NA #1 entered the room again at 10:20AM, removed the resident's breakfast tray and left the room.

An interview was conducted with the facility Speech Therapist (ST) on 1/18/2018 at 11:15AM. The ST indicated Resident #26 was discharged from speech therapy services on 10/12/2107 with instructions/recommendations fir the staff to assist and supervise meals, provide verbal cues as needed to use swallow strategies to decrease the resident's aspiration risk. The ST indicated she provided in house training for the staff. The ST produced an In-Service Training Form dated 9/20/2017 for Resident #26 which included a swallowing strategy handout for staff. Attached to the In-Service form was a signature sheet dated 9/20/2017 and NA #1's signature was observed on the signature sheet.

An interview was conducted with NA #1 on 1/18/2018 at 2:30PM. NA #1 revealed Resident #26 was on his regular assigned hall and he was familiar with the care needed. NA # 1 indicated Resident #26 needed cueing to eat. NA #1 stated he recalled the in-service for Resident #26 on how to assist with meals but that was a long time ago. NA #1 indicated the resident did not have to be supervised for meals anymore. NA #1 stated there was not anything in the computer or written anywhere which provided updated care instructions and any changes in care was just

the standard orientation training and in the required in-service refresher courses for all Nurses, nurse aides, and Trained Feeders and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Assistant Unit manager or designee will monitor supervision of designated residents during meals daily Monday thru Friday for 2 weeks then monthly for 3 months using the Residents Supervision Quality Assurance monitor. Monitoring will include ensuring a nurse, nurse aide, or trained feeding assistant are present during the meal for the resident designated. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate.
Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.
4. The title of the person responsible for implementing the plan of correction.

The Administrator is responsible for implementation and completion of the acceptable plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

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F 684	Continued From page 11 passed on from shift to shift. NA #1 indicated he popped in on the resident and cued him to eat most of the time. NA #1 revealed he did not cue the resident for breakfast and stated he did not know why. An interview was conducted with the Director of Nursing (DON) on 1/18/2018 at 2:43PM. The DON stated the expectation was staff would check the Kardex every shift for updated care instructions and needs so the staff would have the most recent care needs. The DON also stated the expectation was for Resident #26 to be supervised for meals per the ST recommendations.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to maintain safe hot water temperatures at or below 116 Fahrenheit (F) in 7 of 10 bathrooms checked for hot water temperatures (rooms 103, 202, 204, 205, 212, 412, 405) over 3 halls. Findings included: A review of the medical record revealed Resident #28 was admitted 9/22/2017 with diagnoses of	F 689	F689 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain safe hot water temperature at or below 116 degrees F in 7 of 10 bathrooms. On 01/17/2018 the maintenance director was in the process of correcting the hot water temperature when it was discovered	2/16/18

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F 689	Continued From page 12 stroke, epilepsy, anxiety and depression. The 14 day Minimum Data Set (MDS) date 10/6/2017 noted the resident to be cognitively intact and needed extensive assistance for all Activities of Daily Living with the physical help of one to two persons. In an interview, on 1/16/2018 at 3:05 PM, Resident #28 stated she had not noticed the hot water in the bathroom being very hot. The hot water was turned on and was found to be very hot. At 3:35 PM the Maintenance Director checked the hot water in Resident #28's bathroom sink with his calibrated thermometer and it registered 138.6 F. The Maintenance Director said "I have been dealing with this for a week." The Maintenance Director stated he usually checked temperatures in a few rooms on each hall in the facility each week and had found a few high temperatures and adjusted the valve. The Maintenance Director stated he was going to lower the temperature of the water and left. On 1/16/2018 at 4:01 PM the bathroom sink temperatures were checked as follows: Room 220 was 110 F. Room 217 was 110 F. Room 214 was 112 F. On 1/16/2018 at 4:08 PM the bathroom sink temperatures were checked as follows: Room 212 was 118 F. Room 205 was 132 F. Room 204 was 134 F. On 1/16/2018 at 4:12 PM the bathroom sink temperatures were checked as follows: Room 202 was 130 F.	F 689	to be greater than 116 degrees F. The Maintenance Director was able to adjust the hot water temperatures to below 116 degrees F. On 01/18/2018 the maintenance director adjusted the hot water temperature to below 116 degrees F. The Director of Nursing began in-servicing all nurses and CNA's to test water on their wrist prior to using the water and in-serviced alert residents to turn on both hot and cold water at the same time. Education will be completed by 02/16/2018. 2. Procedure for implementing the acceptable plan of correction. In-service education was provided to the Maintenance Director on 1/18/18 by the Administrator. Topics included: • Hot water should be tested weekly and entered into TELS Team Electronic Library System (Building Management System for Senior Living) • Always follow the manufacturer guidelines for calibration to ensure accurate readings • To test water: Use a hand thermometer, turn on hot water faucet and hold thermometer under water for 30 seconds, read and record temperature and turn off faucet • If water registers above 116 degrees F then adjust the temperature until the correct measurements are obtained. • Document your corrective actions and re-measurement. • If you are not able to adjust the temperature to less than 116 degrees F then notify staff and alert residents not to use the affected area and notify the	

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F 689	Continued From page 13 Room 412 was 140 F. Room 405 was 128 F. On 1/16/2018 at 5:50 PM the Maintenance Director checked the temperature of the hot water in Resident #28's bathroom with his calibrated thermometer and it was 111.7 F. On 1/17/2018 at 9:30 AM, the hot water in Resident # 28's bathroom was noted to be very hot. The Maintenance Director was paged to check the actual water temperature. The Maintenance Director checked the temperature at 10:30 AM to be 99.7 F. The Maintenance Director stated the temperature was a little low and he was still dealing with the issue. On 1/17/2018 at 11:00 AM NA #1 was interviewed and stated she had found hot water she considered too hot in resident's bathrooms. NA #1 indicated she was careful about running the hot water. On 1/18/2018 at 10:48 AM the Maintenance Director checked the hot water in Resident #28's bathroom to be 97.8 F. On 1/19/2018 at 9:55 AM, in an interview, the Maintenance Director stated when he checked the temperature on 1/16/2018 in Resident #28's bathroom, he went to adjust the temperatures for the mixing valve. The Maintenance Director stated he did not tell anyone, nor did he shut off the water because he was working on it. The Maintenance Director also said that he had been working with the boiler and the meter for a week prior to finding that high temperature, and the Administrator was aware of a problem with the meter.	F 689	administration. Corrective action should be initiated immediately. Document in-service to staff and obtain signatures. • Notify the administrator of all readings that are above 116 degrees F. On 02/08/2018 the Director of Nursing began In-service education to all full time, part time, and as needed staff nurses and nurse aides on how to test water for temperature for resident and staff safety. This education will be completed by 02/16/2018. Topics included: Testing water on the inner arm before using it on a patient is the proper way to test the temperature. If it feels too hot or turns your skin red then do not use it on the patient and notify the maintenance staff immediately by contacting them directly if they are in the facility or if it is after hours by paging them. If you are not able to contact maintenance then notify your nurse on call for further instructions. The following procedure is to be followed for testing hot water temperatures by hand prior and during patient showering, whirlpools or using sinks. 5. Turn water in desired location on. Allow water to run 3 minutes prior to testing with hand. Note: While waiting for water to run, you can use this time to gather supplies, etc. 6. Note if there is any steam present. After 3 minutes, place your wrist or inner arm under the flow of water for 5-8 seconds and test the temperature of the water. If the temperature is in question,	

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	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

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F 689	Continued From page 14 In an interview, on 1/19/2018 at 10:55 AM, the facility Administrator stated when he found out about the water being too hot, the staff were reeducated about finding water that was too hot. When asked for the documentation of the reeducation the Administrator stated it was not a formal in-service with staff signatures, the staff "huddled" with the Nursing Assistants (NAs)and told them they should check the water and if it was too hot to notify their supervisor. The Administrator noted the alert and oriented residents were told not to turn on the hot water only. The Administrator indicated that temperature checks would be done daily until two weeks of consistently acceptable temperatures were recorded. The Administrator stated his expectation was the water temperatures would be safe. On 1/19/2018 at 11:08 AM, NA #2 stated he had worked on 1/15/2018 and 1/17/2018, but had not been told anything about being careful with the hot water. On 1/19/2018 at 11:11 AM, NA #3 stated he had been told to be careful with the hot water and if it was very hot to notify his supervisor. On 1/19/2018 at 11:14 AM, NA #4 stated she had been told to check the hot water to make sure it was not too hot.	F 689	use the thermometer (located at each nurses station) supplied to test the water temp. Do this by placing the thermometer under the flow of water and wait for the reading to stabilize. If the temp is greater than 116 degrees F., then notify maintenance and your nurse supervisor. Do not use the water. 7. Proceed with the bath if after the hand or thermometer test is completed and temperature is safe. Note: When giving a shower, you are to periodically do the hand test throughout the shower. Example: If giving a 3-minute shower, you should recheck the water by doing the hand test approximately half way through. 8. When giving a whirlpool, do the hand test, fill the whirlpool up, then do the hand test again prior to placing the patient in the water. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Maintenance Directors and all nursing staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Daily 01/17/2018 thru 01/31/208 the maintenance director tested hot water temperatures to ensure compliance. The Administrator will monitor TELS Team Electronic Library System (Building	

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F 689	Continued From page 15	F 689	Management System for Senior Living) system weekly for 2 weeks and monthly for 3 months for recording of water temperatures and corrective actions taken if temperatures are noted >116 degrees F. Any negative findings will immediately be addressed. In addition to this, the administrator will randomly test 5 resident area water temperatures weekly for 2 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		2/16/18

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	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 16 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an abnormal involuntary movement scale assessment for 1 of 3 residents reviewed (Resident #53). Findings included: Record review revealed Resident #53 was admitted to the facility on 12/4/2017 with	F 756	F756 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 2 residents. On 01/19/2018, the AIMS was completed	

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LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

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F 756	Continued From page 17 diagnoses which included Dementia with behavioral disturbance and Mood Disorder. Record review of the Admission Minimum Data Set (MDS) dated 12/11/2017 indicated Resident #53 was severely cognitively impaired extensive assistance with all Activities of Daily Living (ADLs). Review of the assessments revealed no assessment for the abnormal involuntary movement (AIMs) for possible side effects from the drug. Record review of the December 2017 and January 2018 Physicians orders revealed Resident #53 received Seroquel (an antipsychotic) twice a day. Record review of the initial pharmacy review completed in December 2017 indicated Resident #53 did not have an abnormal involuntary movement scale assessment (AIMS) completed on admission. Record review of the monthly medication pharmacy review dated 1/12/2018 indicated the AIMS was still not in the medical record and listed in the recommendations for the AIMS to be completed. Record review of the Psychiatry Initial Visit note dated 1/16/2018 revealed a recommendation to obtain a current AIMS. An interview was conducted with the Director of Nursing (DON) on 1/19/2018 at 9:53AM. The DON revealed if the resident was on an	F 756	for resident # 53 by the Assistant Unit Manger. 2. Procedure for implementing the acceptable plan of correction. On 02/08/2018, an in-service education was provided to the Director of Nursing and two Assistant Unit Mangers by the Nurse Consultant on the frequency of AIMS testing. Topics included: • New admissions who have antipsychotic drug orders and Reglan and residents in the Facility for whom an antipsychotic drug or Reglan is ordered shall be tested prior to starting the medication, then every 6 months thereafter. This information has been integrated into the standard orientation training and in the required in-service refresher courses for the Director of Nursing and Assistant Unit Mangers and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the completion of AIMs assessment using the AIMs Quality Assurance tool weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing 5 residents who are	

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F 756	Continued From page 18 antipsychotic medication, the Unit Managers completed the AIMS on admission and every 6 months. The DON indicated the facility implemented a new admission checklist which included the need for an AIMS, however the residents admitted prior to the initiation of the new form did not have a system in place to ensure the AIMS were completed. The DON stated the expectation was for residents on antipsychotic medications to have an AIMS completed on admission and every 6 months.	F 756	receiving anti-psychotics or Reglan for completion of an AIMs assessment every 6 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		2/16/18

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	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

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F 761	Continued From page 19 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to dispose of expired medications from two of two medication storage rooms reviewed. Findings included: On 1/18/2018 at 6:05 PM the medication storage room for the 100/200 hall was checked. The refrigerator was noted to have 1 box of single dose vials labeled Pneumovax 23. The box contained 7 single dose vials with the lot number of MO26317 and an expiration date of 11 Jan 2018. The lot and expiration date were also located on the outside of the box. On 1/18/2018 at 6:20 PM the medication storage room for the 300/400 hall was checked. The refrigerator contained 1 box of influenza marked 2017 Afluria. The box was unopened and had a lot number of WT52606 and an expiration date of 03 Jun 2017. In an interview on 1/19/2018 at 10:15 AM, the Director of Nursing stated her expectation was that all expired medications would be disposed of. The facility Administrator was present also and stated his expectation was the same.	F 761	F761 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to dispose of expired medications from 2 of 2 medication storage rooms. On 01/17/2018, the Assistant Unit Manager removed the expired Pneumovax 23 and Influenza from the 2 medication rooms. On 1/22/18, the Central Supply Director audited the two medication rooms for expired medication and expired supplies. 2. Procedure for implementing the acceptable plan of correction. On 2/9/18, the Director of Nursing provided an in-service education to the Central Supply Director. Topics included: • Weekly when stock medications and supplies are shelved in the medication rooms, the Central Supply Director will audit existing stock and medication room refrigerators for expired items. Older stock will be moved to the front of the supply to allow for use before expiration date. This information has been integrated into	

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	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

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F 761	Continued From page 20	F 761	the standard orientation training and in the required in-service refresher courses for Central Supply Director and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Assistant Unit Manger or designee will monitor the completion of Medication Storage Room Quality Assurance tool weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing 100% of all medication rooms for expired medications. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		2/16/18

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F 809	Continued From page 21 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review the facility failed to provide breakfast for resident leaving early for dialysis and failed to offer bedtime snack for 1 of 1 resident (Resident #264) reviewed for dialysis. Findings included: The resident was recently admitted on 1/12/18 for rehabilitation with a diagnosis of Diabetes Mellitus 2 (DM 2), End Stage Renal Disease (ESRD), Anemia, Gastro-Esophageal Reflux Disease (GERD), and fracture of one rib in her left side and on her left ankle. Minimum Data Set (MDS) dated 1/18/18 revealed	F 809	F809 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to provide breakfast for resident leaving early for dialysis and failed to offer bed time snack for 1 of 1 residents. For resident # 264, on 01/18/2018 dietary staff were instructed to prepare a bag of to go breakfast the night prior to dialysis and it is to be placed in the unit nourishment room refrigerator for staff to provide to the resident prior to departure	

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	345468	A. BUILDING _____ B. WING _____	C 01/19/2018

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F 809	Continued From page 22	F 809		

the resident was cognitively intact and could communicate her needs to the staff. The resident needed set up for meals and in need of assistance for transfers. The care plan indicated the resident was scheduled for dialysis on Tuesday, Thursday, and Saturday.

During an interview with Resident #264 on 1/18/18 at 4 PM, she stated the facility did not offer or provided breakfast (bag meal or meal to go) when she left for dialysis at 5:45 AM this morning (1/18/18). She stated her dialysis was completed at 1:30 PM and was back in the facility at 3:30 PM. She also stated that since she was admitted in the facility, there were times that they didn't provide meals. And for evening snacks, she was only offered one time in the last 6 days. She also stated that she likes receiving bedtime snacks.

Record review on a log for meals provided by the Director of Nursing (DON) from 1/12/18 to 1/18/18 revealed there were no recorded meals for the following dates:
1. 1/13/18 - no breakfast recorded
2. 1/15/18 - no breakfast and lunch recorded
3. 1/16/18 - no breakfast and lunch recorded
4. 1/17/18 - no breakfast recorded
5. 1/18/18 - no breakfast recorded and lunch was marked resident not available.

During an interview with the Unit Supervisor on 1/18/17 at 5:18 PM she stated the nursing staff were responsible upon admission to write the orders for meals and send it to the kitchen. She further stated that the transportation staff was responsible to request the meal to be taken with the resident when they go to dialysis.

from the facility for dialysis on Tuesday, Thursday, and Saturday. For resident #264 a bedtime snack will be offered every evening by the resident's nurse aide.

2. Procedure for implementing the acceptable plan of correction.

Beginning on 02/05/2018, in-service education was provided to all (full time, part time and as needed) nurses, nurse aides, transportation coordinator and dietary staff. Education will be completed by 02/16/2018. Topics included:
- The transportation coordinator will communicate to the applicable nursing staff and dietary when residents have scheduled appointments. A list will be placed at the nurse's station and one will be given to the dietary manager. If the scheduled appointment time will cause the resident to miss a meal the transportation coordinator will note beside the resident name "provide bag meal".
- The dietary staff will be responsible for preparing the bag meal and placing it in the nourishment refrigerator for the resident.
- The nurse aide is responsible for providing the bag meal to the resident prior to leaving the facility.
- Dietary will provide snacks at bed time for all residents. Snacks will be located in the nourishment refrigerator on the unit.
- The nurse aide is responsible for offering a snack to each resident. Documentation in POC (Point of Care documentation) should reflect that the

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F 809	Continued From page 23 An interview with the transportation staff on 1/19/18 at 8:52 AM, she stated she knew the resident's dialysis schedule was changed last Tuesday (1/16/18) but she forgot to request the meal the day before the dialysis appointment for 1/18/18. An interview with the kitchen supervisor on 1/18/19 at 5:25 PM revealed she just found out now that she went out early for dialysis. The kitchen staff usually starts at 6 AM and there was no request for a bag breakfast on 1/17/18 a day before the appointment. An interview with the kitchen manager on 1/19/19 at 10:37 AM she stated there was no request to prepare bag breakfast for this resident on 1/17/18 for 1/18/18 dialysis day. She further stated that she just received the request this morning about the dialysis schedule change for Resident #264. She also indicated that evening snacks were put out in the nursing station around 6-7 PM. The night shift nurse that worked with resident #264 the morning the resident went to dialysis was interviewed via telephone. She stated that resident was offered breakfast on 1/18/19 but refused. The nurse's notes were reviewed from admission 1/12/18 up to 1/19/18 revealed no documentations written of resident's refusal for meals or bedtime snacks. The morning shift Nurse #2 working on 1/18/18 was interviewed on 1/18/18 at 4:43 PM, stated the resident already left before she got in the facility and she didn't know if she had a bag breakfast.	F 809	snack was offered and accepted by the resident, declined, or the resident is a tube feeder. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor meal and snack delivery weekly for 2 weeks then monthly for 3 months using the meal and snack delivery Quality Assurance monitor. Monitoring will include ensuring residents with early morning appointments receive their breakfast trays prior to leaving for the appointment and that residents are offered a bed time snack. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction.	

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F 809	Continued From page 24 The Nursing Aide (NA) #5 that worked during night shift was called via telephone twice on 1/18/19 and was unsuccessful. Her telephone number was restricted and didn't go through. The DON stated she got the same call restriction when she tried to call on 1/19/18. All three NA's (NA #6, #7, #8) working at the time the meal logs were missing were interviewed via telephone on 1/19/18 and all stated they don't remember the details what happened at that time. The meal logs were the only way they can remember what was consumed by the resident. During the interview with the DON on 1/18/19 she stated that a bag meal for dialysis should be requested a day before and sent out with the resident. She further stated that the breakfast that was not sent with the resident was unacceptable. She stated that the evening snacks were usually distributed around 7-8 PM.	F 809	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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.	F 865		2/16/18

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F 865	Continued From page 25 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions placed to ensure the facility was free of accident hazards. This deficiency was cited on February 9, 2017 following a recertification and complaint survey and subsequently recited on January 19, 2018 on the current recertification survey. The repeat deficiency was in the area of safe/clean/comfortable/homelike environment (F584). This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: 483.10 Resident Rights: Based on observations, staff and resident interviews, and record review, the facility failed to maintain safe hot water temperatures at or below 116 Fahrenheit (F) in 7 out of 10 bathrooms checked for hot water temperatures (rooms 103, 202, 204, 205, 212, 412, and 405) over 3 halls. During the previous recertification survey of	F 865	F865 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's Quality Assurance Committee (QA) failed to maintain the implemented procedures and monitor these interventions placed to ensure the facility was free of accident hazards. The re-citing of F371 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. On 01/17/2018 the maintenance director was in the process of correcting the hot water temperature when it was discovered to be greater than 116 degrees F. The Maintenance Director was able to adjust the hot water temperatures to below 116 degrees F. On 01/18/2018 the maintenance director adjusted the hot water temperature to below 116 degrees F. The Director of Nursing began in-servicing all nurses and CNA's to test water on their wrist prior to using the water and in-serviced alert residents to turn on both hot and cold water at the same time. Education will be completed by 02/16/2018. The administrator ensured that daily 01/17/2018 thru 01/31/208 the maintenance director tested hot water	

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F 865	Continued From page 26 2/9/17 this regulation was cited for failure to remain free of accident hazards when staff failed to use the assigned total lift to transfer a resident which resulted in an injury. An interview was conducted with the Administrator on 1/19/18 at 12:30 pm. The Administrator stated that the QA Committee met monthly and included himself, the Director of Nursing (DON), the Medical Director (MD), and all the department heads. Concerns noted during audits and reports from staff or family members were brought to the committee meetings and from there they would be incorporated into the program.	F 865	temperatures to ensure compliance and compliance was reached as indicated by water temperatures at 116 degrees F or below. 2. Procedure for implementing the acceptable plan of correction. In-service education was provided to the Maintenance Director on 01/18/2018 by the Administrator. Topics included: • Hot water should be tested weekly and entered into TELS Team Electronic Library System (Building Management System for Senior Living) • Always follow the manufacturer guidelines for calibration to ensure accurate readings • To test water: Use a hand thermometer, turn on hot water faucet and hold thermometer under water for 30 seconds, read and record temperature and turn off faucet • If water registers above 116 then adjust the temperature until the correct measurements are obtained. • Document your corrective actions and re-measurement. • If you are not able to adjust the temperature to less than 116 then notify staff and alert residents not to use the affected area and notify the administration. Corrective action should be initiated immediately. Document in-service to staff and obtain signatures. • Notify the administrator of all readings that are above 116. On 02/07/2018, the Administrator was in-serviced by the Clinical Nurse	

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F 865	Continued From page 27	F 865	Consultant to ensure that when water temperatures are noted or reported to be above 116 degrees F that the following measures are immediately taken and documented including in-services of staff and residents. The administrator is also to notify the Regional Director for hot water temperatures that are noted above 116 degrees F that are not able to be immediately corrected. • Hot water should be tested weekly and entered into TELS (Team Electronic Library System Building Management System for Senior Living) • Always follow the manufacturer guidelines for calibration to ensure accurate readings • To test water: Use a hand thermometer, turn on hot water faucet and hold thermometer under water for 30 seconds, read and record temperature and turn off faucet • If water registers above 116 then adjust the temperature until the correct measurements are obtained. • Ensure corrective actions and re-measurement are documented. • If you are not able to adjust the temperature to less than 116 then notify staff and alert residents not to use the affected area and notify the administration. Corrective action should be initiated immediately. All in-services must be documented and ensure all applicable staff receive the in-service. • The administrator is notified of all readings that are above 116.	

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F 865	Continued From page 28	F 865	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Maintenance Directors and Administrators and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor TELS Team Electronic Library System (Building Management System for Senior Living) system weekly for 2 weeks and monthly for 3 months for recording of water temperatures and corrective actions taken if temperatures are noted >116 degrees F. Any negative findings will immediately be addressed. In addition to this, the administrator will randomly test 5 resident area water temperatures weekly for 2 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction.	

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F 865	Continued From page 29	F 865	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	