STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 04/07/2018

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UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey of 4/7/18. Event ID# KOJ711. 4/27/18. The 2567 was amended because an error was discovered at tag F697	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		5/1/18

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

Electronically Signed | 04/27/2018

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F 561	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to consider the resident's desire for side rails or an alternative device for 1 of 23 residents, Resident #33, who requested side rails for repositioning in bed and transferring to and from the bed. Findings Included: Record Review for Resident #33 revealed she was admitted to the facility on 3/10/19 with diagnoses of loss of muscle coordination, inflammation of the muscles, major depressive disorder, anxiety, and insomnia. Resident #33's most recent Minimum Data Set Annual Assessment on 10/26/17 revealed she required limited assistance with bed mobility, and extensive assistance with transfers to and from bed and chair, eating, and toileting. The assessment also revealed Resident #33 had no limitation of range of motion on her upper or lower extremities, and she used a walker and wheelchair for locomotion. A review of Resident #33's most recent Quarterly Minimum Data Set (MDS) Assessment dated 1/24/18 revealed she required limited assistance with bed mobility, transfers to and from the bed and chair, eating, and toileting. The Quarterly MDS Assessment also revealed Resident #33 had no functional limitations of range of motion on her upper or lower extremities, and she used a walker and wheelchair for locomotion. A Side Rail Use and Alternative Review Form dated 1/21/18 revealed Resident #33 desired to	F 561	The plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correction conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. Root Cause Analysis Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that the facility did not follow policy and procedure for providing an alternative to the side rails for repositioning in bed and transfers. Immediate Action Resident #31 was screened by therapy for an appropriate repositioning in bed and transfer device on 4/20/18. A side rail use and alternative review form was completed on 4/20/18 by the ADHS. Resident declined alternative. Identification of Others On 4/25/18 interviews were conducted with all alert and oriented residents to determine who may want an assistive devise to assist with transfers and repositioning in bed by members of the administrative team. . If a need or request	

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F 561	Continued From page 2 have her side rails raised while in bed. The assessment stated the side rails were not indicated at this time, but no alternative was listed. The Side Rail Use and Alternative Review Form also revealed Resident #33 used side rails for positioning and the side rails helped her to rise form lying down to sitting and/or standing position. On 4/3/18 at 3:11 pm during an interview with Resident #33 she stated the facility removed her side rails and did not replace them or give her an alternative when she requested they be placed back on her bed. Resident #33 stated she used the side rails for repositioning in bed and transferring to and from her bed and electric wheelchair. During the interview Resident #33 demonstrated how she would use the side rails to assist her with transfers. She was unsteady during the transfer and grasped the mattress to keep her balance. On 4/4/18 at 2:26 pm an interview with Nurse Aide #4 revealed she didn't know why all the side rails were removed and they don't use them anymore. She stated several residents were upset because they wanted their side rails but they did not give them back. On 4/4/18 at 2:29 pm an interview with Nurse #1 revealed she was informed side rails were removed per corporate office decision. She stated there were a couple of residents that had the smaller bars on their beds for repositioning. She stated Resident #33 didn't need the side rails for positioning. On 4/6/18 at 3:50 pm an interview with the Assistant Director of Nursing revealed it was a	F 561	was present a therapy screen will be conducted. No other residents were identified. Systemic Changes Effective 4/27/18, 100% of staff were educated by the Assistant Director of Nursing and/or the Executive Director on Resident□s Rights and Resident□s Choice. Any resident identified requiring an assistive device for repositioning and transfers will be addressed with an alternative. A therapy screen will be conducted on all residents requiring positioning devices for repositioning or transfers. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process. Monitoring The Director of Nursing/Assistant Director of Nursing/Unit Manager will monitor during clinical meeting 5 days per week (Monday-Friday) that all new admissions who request a side rail or positioning device or residents with change in mobility will be assessed for the need of repositioning and transfer devices. This monitoring will be conducted daily for 4weeks, then weekly x 4 weeks and then monthly thereafter. Findings will be reported to monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modification until a pattern of compliance is achieved.	

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F 561	Continued From page 3 corporate decision to remove all the side rails. She stated the residents were given alternatives such as smaller mobility aids and trapeze bars instead of regular side rails. She stated Resident #33 parked her electric wheelchair against the bed and used it to aide in transferring. On 4/7/18 at 3:20 pm an interview with the Administrator revealed her expectation was the facility would allow Resident #33 an alternative to side rails if they wanted side rails and provide the safest solution. On 4/7/18 at 3:25 pm an interview with the Director of Nursing revealed her expectation would be the residents would be kept safe and the most appropriate intervention would be used to assist Resident #33 with bed mobility and transfers. The Director of Nursing stated the facility would allow alternatives to side rails and the safest alternative should be used.	F 561		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		5/1/18

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F 582	Continued From page 4 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 582	F 582	

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F 582	Continued From page 5 facility failed to provide facility residents with CMS-10055 Skilled Nursing Advanced Beneficiary Notice (SNFABN) prior to discharge from Medicare services for two of three residents reviewed for discharge documentation (Resident #81 and #198). Findings included: 1. Resident #81 was admitted to the facility on 3/2/2018. A review of the medical record for Resident #81 revealed a CMS 10123 NOMNC (Notice of Medicare non-coverage) letter had been signed by Resident #81 on 3/19/2018. Therapy services were scheduled to end on 3/21/2018 for Resident #81. A review of the chart revealed a CMS-10055 SNFABN had not been provided to Resident #81. The Administrator was interviewed on 4/7/2018 at 4:43 PM. She reported the social worker was responsible for getting the forms signed by the resident when their Medicare services were going to end, but the social worker had left for the day and was not available for interview until 4/9/2018. The Administrator reported it was her expectation the correct forms were used for residents when their Medicare services ended. The Social Worker (SW) was interviewed on 4/9/2018 at 9:20 AM via phone call. The SW reported she was responsible for submitting the CMS 10123 NOMNC letter to residents when they were discharged from skilled services. She further reported she was not aware a CMS-10055 SNFABN was to be submitted to the resident and signed if the resident was staying in the facility.	F 582	Root Cause Analysis Based on the root cause analysis by the administrative staff and facility Executive Director it was determined that there was a lack of clear understanding of the regulatory requirement to provide a skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services for residents who planned to remain in the facility for long term care. Immediate Action Advanced Beneficiary Notices (SNF ABN) for resident #81 and resident #198 were issued on 4/27/2018. Identification of Others On 4/24/18 a 100% audit of the last 30 days of discharges was conducted by the Social Service Director to determine others who may have been affected by the alleged deficient Practice. Systemic Changes On 4/24/18 education was provided the Executive Director to the Social Service Director regarding the regulatory requirements for issuing an ABN. This education included that residents who remain in the facility after Medicare A services ended require an ABN be given. Beginning 4/24/2018 the Social Service Director will maintain a log of resident who are discharged from Medicare part A services and plan to remain in the facility for long term care. On this log will be the resident□s name, date Medicare Part A discharge and the date the ABN was provided. The log will be kept in a binder along with a copy of the ABN that has been provided to long term care residents.	

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F 582	Continued From page 6 She concluded by reporting that she would submit both the CMS-10123 NOMNC and CMS-10055 SNFABN in the future for residents discharged from skilled services. 2. Resident #198 was admitted to the facility on 11/4/2017. A review of the medical record for Resident #198 revealed a CMS 10123 NOMNC letter had been signed by Resident #198 on 1/9/2018. Therapy services were scheduled to end on 1/12/2018 for Resident #198. A review of the chart revealed a CMS-10055 SNFABN had not been provided to the Resident #198. The Administrator was interviewed on 4/7/2018 at 4:43 PM. She reported the social worker was responsible for getting the forms signed by the resident when their Medicare services were going to end, but the social worker had left for the day and was not available for interview until 4/9/2018. The Administrator reported it was her expectation the correct forms were used for residents when their Medicare services ended. The SW was interviewed on 4/9/2018 at 9:20 AM via phone call. The SW reported she was responsible for submitting the CMS 10123 NOMNC letter to residents when they were discharged from skilled services. She further reported she was not aware a CMS-10055 SNFABN was to be submitted to the resident and signed if the resident was staying in the facility. She concluded by reporting that she would submit both the CMS-10123 NOMNC and CMS-10055 SNFABN in the future for residents discharged from skilled services.	F 582	Monitoring Beginning 4/24/18 the Executive Director (ED) of the facility will review the Medicare Part A discharge binder weekly and validate that the ABN has been provided to those long term residents who□s Medicare Part A services have ended. The ED will sign the Medicare Part A discharge log weekly for 4 weeks and then monthly for 3 months. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		5/1/18

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F 585	Continued From page 8	F 585		

completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 9 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to record a grievance and failed to provide a written grievance summary for 1 of 4 residents reviewed for grievances (Resident #48). Findings include: Resident #48 was most recently readmitted on 6/1/17 and was originally admitted on 11/18/16 with admission diagnoses which included: Diabetes, Chronic Obstructive Pulmonary Disease (COPD), kidney failure, heart failure, and generalized weakness. Review of Resident #48's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 2/2/18. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and did not display any abnormal behavior.	F 585	F585 Grievances Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director, it was determined that the facility did not follow policy and procedure for executing a grievance. Immediate Action On 4/7/18 a grievance was filled out for resident #48. Identification of others On 4/9/18 Residents were educated on what a grievance is, how to file a grievance and what the process is during Resident Council meeting. Systemic Changes Effective 4/27/18, 100% of staff was in-serviced on the grievance process. This education was provided by Executive Director/ Assistant Director of Nursing. Grievances will be addressed in daily stand up meeting Monday through Friday to ensure department heads are aware of	

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F 585	Continued From page 10 An interview was conducted with Resident #48 on 4/3/18 at 3:33 PM. Resident #48 stated last month she had a carton of cigarettes come up as missing. The resident further stated she told a facility staff person and she had not received a response. An interview was conducted with Nurse #4 on 4/5/18 at 11:30 AM. The nurse stated Resident #48 had informed her of the allegation the resident was missing cigarettes. The nurse further stated she had informed the Social Worker and the Supervisor about the allegation. The nurse stated she may have completed a grievance form, but she did not remember. An interview conducted with the Social Worker (SW) on 4/5/18 at 11:51 AM revealed she had been out sick for the month of March. The SW stated she had been in charge of the grievances prior to her being out sick for the month of March. The SW stated the Administrator had taken over the grievances once she went out sick for the month of March and the Administrator continued to be in charge of the grievances. The SW stated she did not recall a grievance from Resident #48 regarding an allegation of missing cigarettes. The SW stated she was unable to refer to the grievance log to verify if an allegation had or had not been logged for Resident #48 regarding missing cigarettes due to the Administrator having had taken charge of the grievances. During an interview conducted with the Administrator on 4/5/18 at 11:59 AM she stated it had not been reported to her Resident #48 had alleged she had missing items nor had she received a grievance in regards to Resident #48 alleging she had missing items.	F 585	grievances filed. Any staff not educated will not be allowed to work until educated. This education will also be added to the new hire process. Monitoring Effective 4/27/18, the Executive Director will discuss grievances in daily stand up meeting Monday through Friday. The grievance log will be signed every week by the administrative team that is responsible for investigating and following through with grievances. Grievances will be monitored by the Executive Director. This monitoring will be conducted daily x4 weeks, then weeklyx4, then monthly thereafter. Findings will be reported in the monthly Quality Assurance Performance Improvement (QAPI) committee for recommendations and modifications until a pattern of compliance is achieved.	

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F 585	Continued From page 11 Review of the facility grievances since 10/1/17 revealed no recorded grievances in regards to Resident #48 alleging she was missing any items. During an interview conducted with the Administrator on 4/7/18 at 4:18 PM she stated it was her expectation when a staff member was informed about an allegation of a missing item or items, a grievance form would be completed and it would be forwarded to the administrator. The Administrator further stated in addition to the grievance form being completed for the allegation of a missing item, a report would be forwarded to the Health Care Registry, Adult Protective Services (APS) would be notified, the allegation would be reported to the police, and the ombudsman would be notified.	F 585		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	F 660		5/1/18

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updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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F 660	Continued From page 13 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement an effective discharge plan for 2 of 2 residents reviewed for discharge planning (Resident #41 and #98). Findings included: 1. Resident #41 was admitted to the facility on 7/28/2017 with diagnoses to include malignant neoplasm of the upper lobe, chronic obstructive lung disease and dementia. The admission Minimum Data Set (MDS) assessment assessed him to be cognitively intact. Care area assessments (CAA) from the admission MDS dated 8/4/2017 did not trigger for discharge to the community. Section Q of the admission MDS dated 8/4/2017 was reviewed and question Q0400 "discharge plan" was answered 1-yes. Question Q0600 "Has	F 660	F 660 Discharge Planning Process Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility did not follow policy and procedures for providing and updating discharge plans of care in conjunction with the MDS section Q. Immediate Actions On 4/25/18, the MDS section Q was modified for residents #41 and #98. The discharge plan of care was modified for resident #41. Identification of Others Effective 4/27/18 an audit of the last 30 days of section Q of the MDS and discharge care plans was conducted by the Social Services Director to determine others who may have been affected by the deficient practice. No other residents	

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F 660	Continued From page 14 a referral been made to the local contact agency?" was answered 0-no. A care plan dated 8/11/2017 was reviewed and the problem statement was documented as "(Resident #41) wants to return to the community, possibly be moved closer to (family member)" with interventions to include "schedule a family meeting to discuss (Resident #41 ' s) discharge needs; assist (Resident #41) with obtaining community resources for discharge." The resident care planning conference dated 8/23/2017 was reviewed. The section "social services" was reviewed and revealed a handwritten note "Possible move to (family member). Continue with care plan." A nursing note dated 8/29/2017 was reviewed and the note documented Resident #41 ' s family member ' s desire to move Resident #41 closer to him. A handwritten note dated 10/5/2017 by the Social Worker (SW) documented communication with a healthcare provider from Ohio and the SW indicated the provider would need to call the Cabarrus County Department of Social Services. The care plan had a handwritten note dated 11/23/2017 "(Resident #41) will be LTC (long-term care) at present." The resident care planning conference dated 12/16/2017 was reviewed and section "social services" documented "Plans are still to move to (be near family member). Continue with care plan."	F 660	were identified. Systemic Changes On 4/24/18 education was provided by the Executive Director to the Social Service Director regarding the regulatory requirements for Section Q of the MDS and discharge care planning. The Social Services Director was educated on initiating a discharge plan of care as well as continued updates to said plan as needed. Monitoring Beginning 4/24/18 the Executive Director will review audit of new admissions for discharge care plans and Section Q on the MDS accuracy weekly x 4 weeks, then monthly for 3 months. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and modifications until pattern of compliance is achieved.	

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Section Q of the quarterly MDS dated 12/22/2017 was reviewed and question Q0400 "discharge plan" was answered 1-yes. Question Q0600 "Has a referral been made to the local contact agency?" was answered 0-no.

The most recent quarterly MDS assessment dated 1/25/2018 assessed the resident to be severely cognitively impaired. The resident required extensive one-person assistance with bed mobility, transfers, dressing, toileting and total assistance with personal hygiene and bathing. Resident #41 was unable to balance without staff assistance.

An interview was conducted with the SW on 4/7/2018 at 9:52 AM. The SW reported that Resident #41 ' s family member wanted him to move closer to him, but had not communicated on a regular basis with SW. The SW reported she had spoken to him, but had not documented the conversations and was unable to recall the specifics of the conversations.

The SW was interviewed on 4/7/2018 at 11:56 AM. She reported that she was not certain why the handwritten note was not transcribed into the electronic documentation system.

The Administrator was interviewed on 4/7/2018 at 2:42 PM. She reported the nurse who discontinued the care plan in November 2017 was no longer employed with the facility, and the nurse who documented the nursing note in August 2017 was no longer employed with the facility. The Administrator reported it was her expectation that care plans were initiated, updated and reviewed as needed to provide care for the residents.

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2. Resident #98 was admitted to the facility on 10/3/2017. Diagnoses for Resident #98 included neuropathy, difficulty walking and muscle weakness.

The interim/admission care plan dated 10/3/2017 identified the care area "discharge planning" with the goal to "achieve discharge as planned" and interventions to interview resident, make post discharge arrangements and referrals as needed.

The admission Minimum Data Set (MDS) dated 10/10/2017 assessed the resident to be cognitively intact and she required extensive one-person assistance with bed mobility, locomotion, dressing, toileting, hygiene and bathing and two-person assistance for transfers.

The care areas assessment from the admission MDS dated 10/10/2017 did not trigger discharge planning care area.

A review of the care plans for Resident #98 revealed no care plan in place for discharge planning.

Section Q of the admission MDS dated 10/10/2017 was reviewed and question Q0400 "discharge plan" was answered 1-yes. Question Q0600 "Has a referral been made to the local contact agency?" was answered 0-no.

A review of the medical record revealed a note by social services dated 11/28/2017 that documented a friend of Resident #98 stated she was unable to care for Resident #98 if she was discharged home. The note further documented a conversation with the occupational therapist (OT)

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F 660	Continued From page 17 providing care for Resident #98. The SW documented the OT had recommended assisted living care for Resident #98 due to difficulties with walking and toileting. The note documented SW intent to have further discussions with Resident #98 regarding discharge from the facility. A social service note dated 12/29/2017 was reviewed and revealed the SW had a conversation with Resident #98 in which the resident stated she was going to return home. The SW documented a conversation with a friend of Resident #98 that disclosed the friend would not be able to care for Resident #98 if she was discharged home. The SW contacted Adult Protection Services (APS) and communicated the intention of Resident #98 to return home against medical advice (AMA) and APS instructed SW to communicate if Resident #98 left the facility. A nursing note dated 1/2/2018 was reviewed and the note documented Resident #98 ' s discharge from the facility AMA. An interview was conducted with the SW on 4/7/2018 at 2:09 PM. The SW reported she had not started a care plan for discharge for Resident #98 because she had not been in the habit of initiating the discharge care plan. SW further reported Resident #98 had concerns regarding finances and did not want to apply for Medicaid. The Administrator was interviewed on 4/7/2018 at 2:42 PM. The Administrator reported it was her expectation that care plans were initiated, updated and reviewed as needed to provide care for the residents.	F 660		
F 677	ADL Care Provided for Dependent Residents	F 677		5/1/18

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F 677 SS=D	Continued From page 18 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide nail care to 1 of 3 residents reviewed for Activities of Daily Living (ADLs) (Resident #16). The findings included: Resident #16 was admitted to the facility on 12/6/12 with diagnoses which included: Alzheimer's disease, generalized weakness, and dysphagia (difficulty swallowing). Review of Resident #16's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/8/18 revealed the resident's cognition was severely impaired. The resident required extensive or total staff assistance for all activities of daily living. Review of Resident #16's care plan which was most recently reviewed on 1/11/18 revealed the resident was care planned as having required extensive assistance for all ADLs due to the resident would not initiate or follow through on her own related to dementia. The goals listed for the resident were for the resident to be able to participate in part of ADLs as able and the resident would have her personal care needs met by staff daily through the next review. The approaches/interventions listed included one	F 677	F 677 ADL Care Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility did not follow policy and procedure for providing ADL care for a dependent resident Immediate Actions On 4/7/2018 resident #16 finger nails were cleaned and trimmed. Identification of others All residents are at risk for the deficient practice therefore an on 4/25/18 a 100% audit was conducted on the condition of the resident finger nails. Any residents identified with needing nails cleaned or trimmed their nails were cleaned and trimmed. Systemic Changes Effective 4/27/2018 the Director of Nursing / Assistant Director of Nursing will review 5 resident s finger nails to verify condition of finger nails in daily clinical meeting 5 days per week (Monday □ Friday) Findings will be documented on the daily clinical rounds report form and filed in a binder in the Director of Nursing office. If any finger nails identified in needing care, the administrative nurses will follow up with the assigned staff to ensure care is provided.	

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F 677	Continued From page 19 person to assist the resident with bathing and one person to provide extensive assistance with bathing, dressing, and grooming. An observation conducted on 4/3/18 at 12:19 PM revealed Resident #16's fingernails extended beyond her fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail. An observation conducted on 4/5/18 at 11:13 AM revealed Resident #16's fingernails extended beyond her fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail. An interview was completed with Nursing Assistant (NA) #6 while conducting an observation of Resident #16 was conducted on 4/5/18 at 11:15 AM. Resident #16's fingernails remained extended beyond her fingertips on all ten fingers and the dark debris remained under the free edge of the nail on each of the resident's ten fingernails. The NA stated Resident #16 was on her assignment and she had provided morning care for the resident which had included washing the resident's face, upper body, and administering a total bed bath. The NA also stated she had assisted the resident with breakfast. The NA stated the resident received her showers on Wednesday and Saturday, it was Thursday so the resident's shower day had been scheduled for the day before. An observation conducted on 4/6/18 at 11:31 AM revealed Resident #16's fingernails extended beyond her fingertips on all five fingers on each	F 677	Effective 4/27/2018 100% of nursing staff was in-serviced on providing nail care for a depended resident during showers, bathing ADL care and as needed. The education was provided by the Director of nursing/ Assistant Director of Nursing, any staff not educated will not be allowed to work until education is completed. This education will be added to the new hire process for new nursing staff. Monitoring Effective 4/27/2018 the Director of Health Services/Assistant Director of Health Services, and or Unit Manager will review clinical report sheet daily during clinical meeting (Monday □ Friday) to identify any residents needing nail care. This monitoring process will be continued by the charges on Saturday and Sunday. This monitoring will be conducted daily x4 weeks, then weekly x4weeks, then monthly thereafter. Findings will be reported in the monthly Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	

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F 677	Continued From page 20 hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail. An interview was completed with Nursing Assistant (NA) #7 while conducting an observation of Resident #16 was conducted on 4/6/18 at 11:43 AM. Resident #16's fingernails remained extended beyond her fingertips on all ten fingers and the dark debris remained under the free edge of the nail on each of the resident's ten fingernails. The NA stated Resident #16 was on her assignment. The NA stated the resident's fingernails did appear to have dark matter under the nails on 10 of 10 fingers and the resident's nails needed to be cleaned and trimmed. An observation conducted on 4/7/18 at 11:48 AM revealed Resident #16's fingernails extended beyond her fingertips on all five fingers on each hand. All five fingernails on each hand were observed with dark debris under the free edge of each nail. An interview with the Director Of Nursing (DON) while conducting an observation of Resident #16 was conducted on 4/7/18 at 12:16 PM. Resident #16's fingernails were observed to have remained extended beyond her fingertips on all ten fingers and the dark debris remained under the free edge of the nail on each of the resident's ten fingernails. The DON stated it was her expectation for the residents' fingernails to be kept shorter and clean.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		5/1/18

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F 692	Continued From page 21 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to put into place interventions for a resident as having been identified as having had significant weight loss for 1 of 4 residents reviewed for nutrition (Resident #16). The findings included: Resident #16 was admitted to the facility on 12/6/12 with diagnoses which included: Alzheimer's disease, generalized weakness, and dysphagia (difficulty swallowing). Review of Resident #16's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of	F 692	F 692 Nutrition/Hydration Status Root Cause Analysis Based on the root cause analysis by the facility Administrative staff and the facility executive director the facility did not follow policy and procedure by failing to put interventions in place for a resident having been identified with significant weight loss. Immediate Action On April 11, 2018 the Dietitian was notified and the resident was placed on Med Pass 2.0, 120ml by mouth four times per day. Identification of Others All residents are at risk for the deficient practice therefore a 100 percent audit was completed by the Dietary manager on residents on monthly and weekly weights	

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F 692	Continued From page 22 1/8/18 revealed the resident's cognition was severely impaired. The resident required extensive or total staff assistance for all activities of daily living, including extensive assistance of one person for eating. The resident was coded as having been 65 inches tall and weighed 119 pounds. The resident was coded as having been on a therapeutic diet. Review of Resident #16's care plan which was most recently reviewed on 1/11/18 revealed the resident was care planned as having had a risk for altered nutritional status due to the resident received a therapeutic diet. The care plan also documented the resident received small portions per her request as well as not wanting to gain weight. In addition the need section documented the resident had numerous food preferences and the resident refused breakfast at times. The goal listed was the resident would tolerate diet as ordered, consume 75-100% most meals and have no significant weight changes through the next review period. The approaches listed included: Registered Dietitian to follow up with the resident as needed, encourage resident to consume 75-100% of most meals, provide small portion meal per resident request, and provide a heartier 10 AM snack. Review of Resident #16's recorded weights in her Electronic Medical Record (EMR) revealed the following weights: 5/2/17-133.8 pounds, 6/2/17-133.8 pounds, 7/16/17-132.0 pounds, 8/10/17-122.4 pounds, 8/15/17-123.2 pounds, 8/24/17-122.4 pounds, 9/14/17-118.0 pounds, 9/20/17-118.9 pounds, 10/8/17-120.8 pounds, 10/20/17-118.9 pounds, 11/9/17-118.9 pounds, 12/4/17-118.0 pounds, 12/27/17-118.9 pounds, 1/2/18-118.6 pounds, 2/1/18-118.2 pounds,	F 692	to identify any residents with significant weight loss. If any resident were identified with significant weight loss an intervention was put in place and placed on the list for the dietitian to see on her next visit. Systemic Changes Effective April 27, 2018 The Dietary Manager will review weekly and monthly weights to identify any residents with significant weight loss. The dietary manager will place those residents identified on the weekly standards of care list to be reviewed by the IDT during the weekly standards of care meeting to discuss interventions to put in place. The residents will be placed on the Dietitian□s list to review during her next visit; nurse management will notified the Physician/ Nurse Practitioner to inform of weight loss and approve interventions suggested. Effective 4/27/2018 the Dietary Manager was in-serviced by the executive director to report any residents identified with significant loss to the Dietitian , executive director, and Nurse management weekly/monthly to ensure interventions are put in place to prevent future weight loss or to maintain weight. Each resident identified must be placed on the weekly standards of care meeting list and the Dietitian list for review. Effective April 27, 2018 100% of nursing staff was in-serviced to report a decline in residents□ intake or the ability to feed self or any weight changes to nursing administration as soon as identified. Licensed staff to place on 24 hour report sheet. Nursing administration will review 24 hour report sheet daily during clinical	

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UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 692	Continued From page 23 3/15/18-108.0 pounds (a significant weight loss of 8.6% in one month), 3/21/18-107.0 pounds, 3/30/18-106.0 pounds, and 4/2/18 106.0 pounds. Review of Resident #16's physicians' orders revealed an order dated 8/18/17 to give 120 milliliters (ml) of nutritional supplement orally three times for weight loss. The resident was on a regular consistency diet, with no added salt, and the resident was ordered to receive small portions at meal per the resident's family's request. Review of Resident #16's Registered Dietitian (RD) notes revealed the most recent note was dated 12/27/17. The note documented the resident was seen due to supplement use and to continue the resident's current diet of no added salt, small portions, and nutritional supplement three times a day. Review of Resident #16's dietary notes revealed the most recent note was dated 1/4/18 which documented, the resident's weight was discussed during the weekly weight meeting and the resident's weight was found to have been stable. The note documented to continue with dietary recommendations and monthly weights. Review of Resident #16's Departmental Notes revealed the following: 3/23/18 at 2:58 PM, the nurse attempted to call the Responsible Party (RP) of Resident #16 to inform her of the resident's 11 pound weight loss in three months. The nurse left a message for the RP to call the nurse. Review of Resident #16's Departmental Notes revealed the following: 3/23/18 at 3:38 PM, the	F 692	rounds. This education was provided by the Director of Nursing/ Assistant Director of Nursing, any staff not educated will not be allowed to work until educated. This education will also be added to the new hire process. Monitoring Effective April 28, 2018 the Director of Nursing/ Assistant Director of Nursing / Unit Manager will review the 24 hour report to identify any residents with poor intake, decrease in the ability to feed self and weight changes during daily clinical meeting 5 days per week (Monday □ Friday). This Monitoring will be continued by the Charge nurses on Saturdays and Sundays. The Dietary manager will monitor weekly /monthly weights to identify residents with significant weight loss and verify an intervention is put in place. This monitoring will be conducted daily x4 weeks, then weekly x4 weeks, then monthly thereafter. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	

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RP returned call and made aware of Resident #16's weight loss. The RP was documented as having voiced no concerns.

An interview was conducted with NA #6 on 4/5/18 at 11:15 AM. The NA stated she had assisted resident #16 with breakfast and the resident had at about 50% of her breakfast. The NA stated she was aware the resident received a nutritional supplement.

An observation or Resident #16 eating lunch was conducted on 4/5/18 at 1:04 PM. The resident was being assisted with lunch by NA #6. The resident was observed to eat less than 25% of her lunch.

An interview was conducted with NA #6 on 4/5/18 at 1:19 PM. The NA stated Resident #16 had not been eating well. The NA stated she would inform the nurse the resident had at less than 25% of her meal.

An interview was conducted with NA#7 on 4/6/18 at 11:49 AM. The NA stated Resident #16's ability to feed herself had declined. The NA stated she used to be able to feed herself about 3 months ago and in the resident's current condition staff members had to assist the resident with feeding.

A phone interview was conducted with the Registered Dietitian (RD) on 4/7/18 at 2:33 PM. The RD stated she was not familiar with Resident #16 and was not aware the resident had experienced a 10.2 pound or 8.6% weight loss from February 1, 2018 to March 15, 2018 and had continued to have weight loss from 3/15/18 through 3/30/18 of another 2 pounds. The RD

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stated she was unable to comment on the reason as to why the resident was on small portions due to not having familiar with Resident #16. The RD stated she was going to be at the facility on 4/11/18 and she would observe the resident eating, place the resident on weekly weights, review her meal intake percentages, and review her nutritional supplement percentages. The RD stated after she had reviewed the resident, her intake, and weight loss she would determine what intervention to put into place to address the resident's weight loss. The RD stated she was at the facility on 4/3/18 and had not reviewed the resident's weight loss nor had she been asked to review the resident for weight loss.

An interview was conducted with the Director Of Nursing (DON) on 4/7/18 2:58 PM. The DON stated she was aware of Resident #16's weight loss. The DON stated Resident #16 was switched to weekly weights when the weight loss was identified. The resident's weight loss was discussed in the Inter Departmental Team (IDT) meeting. The DON stated the IDT discussed the small portion size request by the family but no staff members had followed up with the family regarding their request for small portion size. The DON stated the small portion size had remained on the resident's diet orders. The DON stated dietary was responsible for the list of residents for the RD to review when she comes to the facility. The DON stated she did not know why the RD did not see the resident when she was at the facility on 4/3/18.

An interview was conducted with the DON on 4/7/18 at 3:54 PM. The DON stated it was her expectation when a resident experienced a significant weight loss an intervention which

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F 692	Continued From page 26 would actively encourage weight gain would be put into place. An interview was conducted with the Administrator on 4/7/18 at 4:31 PM. The Administrator stated it was her expectation for the RD to see a resident and explore further interventions when a resident has been identified as having had significant weight loss to increase or maintain the resident's weight.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to consistently assess pain in addition to the Resident Assessment Instrument in 2 of 3 residents, Resident # 15 and #89, reviewed for pain control. Findings included: 1. Review of medical record revealed Resident #15 was admitted to the facility on 8/18/16 with diagnoses of Neuropathic Pain, weakness, and frequent falls. He had a physician's orders for Fentanyl Patch 24 micrograms per hour (mcg/hr) one patch and Fentanyl Patch 12 mcg/hr one patch every three days for pain. He also had a physician's order for Tramadol 50 milligrams (mg) every 6 hours for pain.	F 697	F697 Pain Management Root Cause Analysis Based on root cause analysis by the facility administrative staff and the executive director the facility did not follow policy and procedure to asses each resident for pain each shift. Immediate Action On April 9, 2018 pain assessment was placed on the MAR for resident # 15 and resident # 89. Identification of Others All residents are at risk for the deficient practice therefore on April 9, 2018 a 100% audit was conducted to verify that each resident had pain assessment every shift on the medication administration record.	5/1/18

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F 697	Continued From page 27 Review of the most recent Annual Minimum Data Set (MDS) Assessment for Resident #15 dated 8/25/17 revealed he was cognitively intact and was independent with bed mobility, transfers, and toileting. The assessment stated he rated his pain at 6 on a scale of 1-10 and he was occasionally in pain. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment for Resident #15 dated 1/8/18 revealed he was cognitively intact and was independent with bed mobility, transfers, and toileting. The assessment stated he rated his pain at 4 on scale of 1-10 and he was occasionally in pain. Review of Resident #14's Care Plan dated 1/12/18 revealed care plan of "Experiencing the presence of pain in right lower extremity related to recent fractures" and "a goal of decreased pain to 4 or less." Review of the Nurse's Notes from 2/7/18 to 4/1/18 revealed one note on 4/1/18 that addressed pain for Resident #15. The 4/1/18 Nurses Note stated, "resident complains of pain at times and scheduled meds given with some effectiveness." During an interview on 4/3/18 at 11:22 am Resident #15 stated he was in pain and had asked to be referred to a pain clinic. He stated he had a patch for pain and a pain pill, Tramadol, for breakthrough pain. An interview on 4/6/18 at 4:30 pm with the Assistant Director of Nursing revealed pain assessments were not done on the residents, but	F 697	For reach resident identified the pain assessment each shift was placed on the medication administration record. Systemic Changes Effective 4/27/2018 the Director of Nursing/ Assistant Director of Nursing/ Unit Manager will review new admissions and 5 residents to verify that pain assessment every shift is placed on the Medication administration record and that documentation is complete during daily clinical meetings 5 days per week (Monday □ Friday). Findings will be documented on the clinical rounds forms and filed in a clinical meeting binder Effective 4/27/2018 100% of licensed nursing staff was in-serviced on placing pain assessment Q shift on the medication administration record on all new admissions and to document every shift on new and current residents. This education was provided by the Director of Nursing/ Assistant Director of Nursing. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process for all new licensed nurses. Monitoring The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday- Friday) that all new admissions and current residents have pain assessment every shift on the medication administration record and that documentation is complete. This monitoring process will continue by the Charge Nurses on Saturday and Sunday. This monitoring will be conducted daily x4	

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F 697	Continued From page 28 the nurses chart in the notes regarding the resident's pain. An interview on 4/7/18 at 1:44 pm with Nurse #1 revealed that the nurses do not have anywhere to rate pain unless the resident receives a PRN (as needed pain medication). She stated she documents in her Nurses Note when the resident had a bad pain day. On 4/7/18 at 2:00 pm an interview with the Director of Nursing revealed the nurses should document in the nurse's notes when they see any signs of distress or comfort. She stated the pain scale is used for prn pain meds only (as needed pain medication) when the resident asks for pain medication or has nonverbal signs of pain. She stated they do not routinely ask the residents to rate their pain unless they ask for as needed pain medication. 2. Resident #89 was admitted 12/13/16 with diagnoses of history of falls, femur fracture, Diabetes, right above the knee amputation, Major Depressive Disorder, Peripheral Vascular Disease, and difficulty swallowing. Review of the physician's orders revealed Resident #89 had physician's orders for Gabapentin 300 mg by mouth each night at bedtime for pain (ordered 3/25/18) and Acetaminophen 325 mg 2 tablets every 6 hours as needed for pain (ordered 3/25/18). A review of the most recent comprehensive Minimum Data Set (MDS) Admission Assessment dated 2/20/18 revealed Resident #89 was cognitively intact; he required limited assistance with moving about in bed and transferring to and from bed; and he stated his pain was occasional	F 697	weeks, then weekly x4 weeks and then monthly thereafter. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modification until a pattern of compliance is achieved.	

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and rated it at 8 at worst on scale of 1-10 over the 5 days prior to the assessment date.

Review of Resident #89's Care Plan for 2/23/18 revealed he was care planned for, "Complaints of pain due to recent right hip fracture" and "the goal was resident would have a decreased pain goal of 3 or less throughout his daily activities."

Review of the physician's orders revealed Resident #89 had physician's orders for Gabapentin 300 milligrams (mg) by mouth each night at bedtime for pain (ordered 3/25/18) and Acetaminophen 325 milligrams (mg) 2 tablets every 6 hours as needed for pain (ordered 3/25/18).

Review of Nurse's Notes from 3/25/18 to 4/5/18 revealed Resident #89 had "no complaints of pain or discomfort" documented in 9 days of the 12 days reviewed. There was no documentation of pain assessment on 4/3/18, 3/29/18, or 3/28/18.

Review of Resident #89's Medication Administration Record for April 2018 revealed there was no documentation of pain being rated or as needed pain medications given.

Interview on 4/5/18 at 4:34 pm with Resident #89 revealed his hips hurt him all the time and he spoke with the nurse about his pain but they don't do anything about it.

On 4/5/18 at 4:39 pm an interview with Nurse Aide #5 revealed Resident #89 usually doesn't ask for pain medication but she states she can tell when he is in pain.

On 4/7/18 at 1:36 pm an interview with Nurse #4

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F 697	Continued From page 30 revealed she didn't know if there was a place that she could document that she assessed pain each shift. She stated there was no place on their electronic documentation that asks for a pain scale. She stated she hoped Resident #89 would tell us that he was hurting but he is very quiet. On 4/7/18 at 2:00 pm an interview with the Director of Nursing revealed the nurses should document in the nurse's notes when they see any signs of distress or discomfort that the resident is having pain. She also stated the pain scale is used for as needed pain medications when the resident asks for pain or has nonverbal signs of pain. She stated the facility does not routinely ask the residents to rate their pain unless they ask for pain medication. On 4/7/18 at 3:18 pm an interview with the Administrator revealed her expectation was that all residents' pain should be assessed every shift and with any as needed pain medication. On 4/7/18 at 3:23 pm an interview with the Director of Nursing revealed her expectation was the residents' pain should be assessed every shift, with any indication a resident is in pain, and with any as needed pain medications. She stated the assessment should not be limited to as needed pain medications.	F 697		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician	F 710		5/1/18

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F 710	Continued From page 31 assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a physician evaluate a resident as having been identified as having had significant weight loss for 1 of 4 residents reviewed for nutrition (Resident #16). The findings included: Resident #16 was admitted to the facility on 12/6/12 with diagnoses which included: Alzheimer's disease, generalized weakness, and dysphagia (difficulty swallowing). Review of Resident #16's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/8/18 revealed the resident's cognition was severely impaired. The resident required extensive or total staff assistance for all activities of daily living, including extensive assistance of one person for eating. The resident was coded as having been 65 inches tall and weighed 119 pounds. The resident was coded as having been on a therapeutic diet.	F 710	F710 Resident□s Care Supervised by a Physician Root Cause Analysis Based on root cause analysis by the facility administrative staff and the Executive Director it was determined the facility failed to follow policy and procedure for notification of physician of a resident having significant weight loss. Immediate Action On 4/7/18 Telephone order was obtained for Fortified shake at all meals on 4/11/18 a telephone order was obtained for Med Pass 2.0 120mls four times per day. On 4/20/18 Physician assessed resident #16 for significant weight loss. Identification of Others All residents are at risk for deficient practice therefore 100% audit was completed by the Dietary Manager on resident monthly and weekly weights to identify any residents with significant weight loss. If any residents were identified with significant weight loss, a	

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F 710	Continued From page 32 Review of Resident #16's care plan which was most recently reviewed on 1/11/18 revealed the resident was care planned as having had a risk for altered nutritional status due to the resident received a therapeutic diet. The care plan also documented the resident received small portions per her request as well as not wanting to gain weight. In addition the need section documented the resident had numerous food preferences and the resident refused breakfast at times. The goal listed was the resident would tolerate diet as ordered, consume 75-100% most meals and have no significant weight changes through the next review period. The approaches listed included: Registered Dietitian to follow up with the resident as needed, encourage resident to consume 75-100% of most meals, provide small portion meal per resident request, and provide a heartier 10 AM snack. Review of Resident #16's recorded weights in her Electronic Medical Record (EMR) revealed the following weights: 5/2/17-133.8 pounds, 6/2/17-133.8 pounds, 7/16/17-132.0 pounds, 8/10/17-122.4 pounds, 8/15/17-123.2 pounds, 8/24/17-122.4 pounds, 9/14/17-118.0 pounds, 9/20/17-118.9 pounds, 10/8/17-120.8 pounds, 10/20/17-118.9 pounds, 11/9/17-118.9 pounds, 12/4/17-118.0 pounds, 12/27/17-118.9 pounds, 1/2/18-118.6 pounds, 2/1/18-118.2 pounds, 3/15/18-108.0 pounds (a significant weight loss of 8.6% in one month), 3/21/18-107.0 pounds, 3/30/18-106.0 pounds, and 4/2/18 106.0 pounds. Review of Resident #16's physicians' orders revealed an order dated 8/18/17 to give 120 milliliters (ml) of nutritional supplement orally three times for weight loss. The resident was on	F 710	requisition for the Physician /NP to see them on their next visit would be initiated. The nurse would also document the request for the Physician/NP to see the residents identified. Systemic Changes Effective April 27, 2018 The Dietary Manager was educated by the Executive Director to review weekly and monthly weights to identify any residents with significant weight loss. The dietary manager will place those residents identified on the weekly standards of care list to be reviewed by the IDT during the weekly standards of care meeting to discuss interventions to put in place and the nurse management will notify the Physician/ Nurse Practitioner to inform of significant weight loss. Effective April 27, 2018 100% of nursing staff was in-serviced to report a decline in resident□s intake or the ability to feed self or any weight changes to nursing administration as soon as identified. Licensed staff is to place on 24 hour report sheet. Nursing administration is to review the 24 hour report sheet daily, Monday through Friday, during daily clinical rounds. This education was provided by the Director of Nursing/ Assistant Director of Nursing. Any staff not educated will not be allowed to work until education is completed. This education will also be added to the new hire process. Monitoring Effective April 28, 2018 the Director of Nursing/ Assistant Director of Nursing / Unit Manager will review the 24 hour	

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F 710	Continued From page 33 a regular consistency diet, with no added salt, and the resident was ordered to receive small portions at meal per the resident's family's request. Review of Resident #16's Registered Dietitian (RD) notes revealed the most recent note was dated 12/27/17. The note documented the resident was seen due to supplement use and to continue the resident's current diet of no added salt, small portions, and nutritional supplement three times a day. Review of Resident #16's dietary notes revealed the most recent note was dated 1/4/18 which documented, the resident's weight was discussed during the weekly weight meeting and the resident's weight was found to have been stable. The note documented to continue with dietary recommendations and monthly weights. Review of Resident #16's physician progress notes revealed the physician's last documented visit was 3/9/18. There was no mention of the resident's nutritional status or weight loss in the progress note. Review of Resident #16's Departmental Notes revealed the following: 3/23/18 at 2:58 PM, the nurse attempted to call the Responsible Party (RP) of Resident #16 to inform her of the resident's 11 pound weight loss in three months. The nurse left a message for the RP to call the nurse. Review of Resident #16's Departmental Notes revealed the following: 3/23/18 at 3:38 PM, the RP returned call and made aware of Resident #16's weight loss. The RP was documented as	F 710	report to identify any residents with poor intake, decrease in the ability to feed self and weight changes during daily clinical meeting 5 days per week (Monday Friday). Findings will be documented on the daily clinical rounds form and filed in a binder in the Director of Nursing office. This monitoring will continue Saturday and Sunday by the Charge Nurse. The Dietary manager will monitor weekly /monthly weights to identify residents with significant weight loss and verify the Physician/NP are notified and documentation completed. This monitoring will be conducted daily x4 weeks, then weekly x4 weeks, then monthly thereafter. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	

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F 710	Continued From page 34	F 710		

having voiced no concerns.

An interview was conducted with NA #6 on 4/5/18 at 11:15 AM. The NA stated she had assisted resident #16 with breakfast and the resident had at about 50% of her breakfast. The NA stated she was aware the resident received a nutritional supplement.

An observation or Resident #16 eating lunch was conducted on 4/5/18 at 1:04 PM. The resident was being assisted with lunch by NA #6. The resident was observed to eat less than 25% of her lunch.

An interview was conducted with NA #6 on 4/5/18 at 1:19 PM. The NA stated Resident #16 had not been eating well. The NA stated she would inform the nurse the resident had at less than 25% of her meal.

An interview was conducted with NA#7 on 4/6/18 at 11:49 AM. The NA stated Resident #16's ability to feed herself had declined. The NA stated she used to be able to feed herself about 3 months ago and in the resident's current condition staff members had to assist the resident with feeding.

A phone interview was conducted with the Registered Dietitian (RD) on 4/7/18 at 2:33 PM. The RD stated she was not familiar with Resident #16 and was not aware the resident had experienced a 10.2 pound or 8.6% weight loss from February 1, 2018 to March 15, 2018 and had continued to have weight loss from 3/15/18 through 3/30/18 of another 2 pounds. The RD stated she was unable to comment on the reason as to why the resident was on small portions due

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to not having familiar with Resident #16. The RD stated she was going to be at the facility on 4/11/18 and she would observe the resident eating, place the resident on weekly weights, review her meal intake percentages, and review her nutritional supplement percentages. The RD stated after she had reviewed the resident, her intake, and weight loss she would determine what intervention to put into place to address the resident's weight loss. The RD stated she was at the facility on 4/3/18 and had not reviewed the resident's weight loss nor had she been asked to review the resident for weight loss.

An interview was conducted with the Director Of Nursing (DON) on 4/7/18 2:58 PM. The DON stated she was aware of Resident #16's weight loss. The DON stated Resident #16 was switched to weekly weights when the weight loss was identified. The resident's weight loss was discussed in the Inter Departmental Team (IDT) meeting. The DON stated the IDT discussed the small portion size request by the family but no staff members had followed up with the family regarding their request for small portion size. The DON stated the small portion size had remained on the resident's diet orders. The DON stated dietary was responsible for the list of residents for the RD to review when she comes to the facility. The DON stated she did not know why the RD did not see the resident when she was at the facility on 4/3/18.

An interview was conducted with the DON on 4/7/18 at 3:54 PM. The DON stated Resident #16 was last seen by her physician on 3/9/18. The DON stated the resident had not been seen by a physician since her significant weight loss had been identified. The DON stated the

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F 710	Continued From page 36 resident's significant weight loss was discovered on 3/15/18. The DON stated the physician had been in the facility since the resident's weight loss had been discovered. The DON further stated it was her expectation when a resident experienced a significant weight loss an intervention which would actively encourage weight gain would be put into place. An interview was conducted with the Administrator on 4/7/18 at 4:31 PM. The Administrator stated it was her expectation for the resident's physician to see a resident and explore further interventions when a resident has been identified as having had significant weight loss to increase or maintain the resident's weight.	F 710		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 7.14% (2 errors out of 28 opportunities) (Resident #88). Findings included: 1. Resident #88 ' s physician orders were reviewed and he was prescribed Vitamin D3 5000 units by mouth daily dated 2/5/2018. The electronic medication administration record	F 759	F759 Free of Medication Error Rate of 5% or More Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the Executive Director it was determined the facility failed to follow policy and procedure for medication administration. Immediate On April 6, 2018 an order was obtained from the physician may give 5 tabs from house stock medication D3 1000 units	5/1/18

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F 759	Continued From page 37 (eMAR) was reviewed and Vitamin D3 5000 units was documented as administered on 4/6/2018. A medication administration was observed on 4/6/2018 at 8:43 AM with Medication Technician (MT) #1. The Vitamin D3 was not administered to Resident #88. MT #1 was interviewed on 4/6/2018 at 9:32 AM. She searched the stocked medications for Vitamin D3 in the strength 5000 units, but found only Vitamin D3 1000 u. She then searched for the medication card for the resident with Vitamin D3, but was unable to locate the medication. She reported that she thought she had administered the vitamin, but she must have been mistaken. The Director of Nursing (DON) was interviewed on 4/6/2018 at 9:39 AM. She reported it was her expectations that medications were administered according to orders and professional standards. The Administrator was interviewed on 4/7/2018 at 2:42 PM. She reported it was her expectation that medications were administered correctly. 2. Resident #88 ' s physician orders were reviewed and he was prescribed Flonase 50 micrograms 2 sprays each nostril daily dated 4/5/2018. A medication administration was observed on 4/6/2018 at 8:43 AM with MT #1. Flonase was administered to Resident #88, 1 spray each nostril. MT #1 was interviewed on 4/6/2018 at 9:32 AM. She reported that she thought she had administered two sprays of Flonase in each	F 759	until medication is received from pharmacy for resident #75. On April 6, 2018 the medication aide was re-educated on administrating medications as ordered. Identification of Others All residents are at risk for the deficient practice therefore on April 23, 2018 the Medication Aides and licensed nurses were re-educated on administering medications as ordered. Systemic Changes Effective April 27, 2018 100% of licensed nurses and medication aides were in-serviced on the five rights of medication administration, make sure medications are available and do not document medications as given when medication is not available. Nurse is to notify physician if a medication is not available to obtain an order to hold the medication until available from Pharmacy. All medications must be administered as ordered. This education was provided by the Assistant Director of Nursing. Any staff not educated will not be allowed to work until educated. Any staff not educated will not be allowed to work until educated. This education will also be added to the new hire process. . Monitoring Effective April 27, 2018 medication administration will be observed by the Director of Nursing/ Assistant Director of Nursing/ Unit Manager and / Pharmacy. Observation will consist of ensuring medications are being administered as ordered. This monitoring will be conducted 3x per week for 4 weeks , then	

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F 759	Continued From page 38 nostril. The DON was interviewed on 4/6/2018 at 9:39 AM. She reported it was her expectations that medications were administered according to orders and professional standards. The Administrator was interviewed on 4/7/2018 at 2:42 PM. She reported it was her expectation that medications were administered correctly.	F 759	weekly x4 weeks, then monthly thereafter. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and modifications until a pattern of compliance is achieved.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		5/1/18

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to display correct signage for enteric precautions for 1 of 1 residents reviewed for contact precautions (Resident #197) and failed to use gloves when administering nasal spray medication or perform hand hygiene after administering nasal spray for 1 of 1 residents observed for medication administration (Resident #88). Findings included: 1. The facility ' s Infection Prevention and Control Program policy, dated 10/19/2017 was reviewed. The policy read, in part: Three categories of transmission are contact, droplet and airborne; transmission-based precautions will be utilized in addition to standard precautions when the route of transmission is not completely interrupted by using standard precautions alone. The Center for Disease Control and Prevention specifies that the Clostridium difficile (c. dif) infection is caused by spores that are not killed by hand sanitizer and hand washing with soap and water is required. A sign for contact precautions was observed on the door of Resident #197 on 4/3/2018 at 9:22 AM. The sign did not specify the type of precautions to be used with Resident #197. Instructions on the contact isolation sign stated to "perform hand hygiene before entering the room and after exiting". The Infection Preventionist nurse for the facility provided the Contact precautions: special enteric	F 880	F 880 Infection Control Root Cause Analysis Based on root cause analysis by the facility administrative staff and the facility executive director it was determined that the facility failed to follow policy and procedure for infection control. Immediate On April 6, 2018 the correct signage for enteric precautions was placed on the door for resident # 197. The Med aide administering medications to resident # 88 was in-serviced on wearing gloves while performing invasive procedures during a medication pass and proper hand washing with observation doing medication pass . The education was provided by the Assistant Director of Health Services/Infection Control Nurse. Identification of Others All residents are at risk for the potential risk so therefore no other residents were identified with a diagnosis of c-diff requiring enteric precautions. All nursing staff will be re-educated on placing the correct signage for transmission precautions and proper handwashing technique. Systemic Changes Effective April 27, 2018 the Director of Nursing/ Assistant Director of Nursing/Unit Manager will review 24 hour report to see if any resident was admitted with or has a new diagnosis of c-diff requiring enteric precautions or any other diagnosis requiring transmission precaution and verify the correct signage is posted on the	

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F 880	Continued From page 41 signage for review. Noted on the sign was instructions stated to "perform hand hygiene before entering room and wash hands with soap and water before leaving room". Resident #197 was admitted to the facility on 3/30/2018 with diagnoses to include chronic obstructive pulmonary disease, enterocolitis due to Clostridium difficile (c. dif) and muscle weakness. The physician orders were reviewed and an order for contact isolation for c. dif was dated 3/30/2018. A baseline care plan dated 3/30/2018 noted isolation for c. dif. A nursing note dated 3/31/2018 documented the c. dif infection and contact precautions in place. Nurse #4 was interviewed on 4/3/2018 at 9:22 AM. She reported the resident was under contact precautions for c. dif. She was unable to list the different types of precautions and was unable to state hand washing with soap and water was required when a resident had a diagnosis of c. dif. An interview was conducted with Nurse #1 on 4/5/2018 at 2:14 PM. The nurse reported when a resident was admitted, the orders were reviewed and if admission orders specified contact precautions, the admitting nurse would gather the equipment and place a precautions sign on the door to the resident ' s room. She was unable to list the different types of precautions and was unable to state hand washing with soap and water was required when a resident had a diagnosis of c. dif.	F 880	resident□s door. This monitoring will be completed 5 days per week during Clinical meeting (Monday □ Friday). Findings of this meeting will be documented on the clinical meeting form and filed in a clinical meeting binder. The Assistant Director of Health Services / Unit Manager will observe 10 nursing staff members per week during medication administration and while providing care for a resident for proper handwashing technique and wearing gloves during invasive procedures during medication administration. Effective April 27, 2018 100% nursing staff was in-serviced on ensuring the proper signage is posted for transmission precautions, proper handwashing with soap and water after providing care to a resident with a diagnosis of c-diff, must wear gloves during an invasive procedure during medication administration and must wash hands before and after administration. This education was provided by the Director of Nursing/ Assistant Director of Nursing. Any staff members not educated will not be allowed to work until education is completed. This education will also be added to the new hire process for all nursing staff. Monitoring Effective April 27, 2018 the Director of Nursing/ Assistant Director of Nursing/ Unit manager will review clinical report sheet daily during clinical meeting 5 days per Week (Monday □ Friday) to identify residents requiring transmission precautions and ensure the correct signage is posted. The Director of	

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F 880	Continued From page 42 Nurse #2 was interviewed on 4/5/2018 at 2:25 PM. She was unable to list the different types of precautions and was unable to state hand washing with soap and water was required when a resident had a diagnosis of c. dif. Nurse #3 was interviewed on 4/5/2018 4:06 PM. She was unable to list the different types of precautions and was unable to state hand washing with soap and water was required when a resident had a diagnosis of c. dif. An interview was conducted with nursing assistant (NA) #2 on 4/7/2018 at 10:32 AM. NA #2 reported she did not know the difference between contact precautions, but she read the sign and followed the directions on the sign. NA #3 was interviewed at the same time, and she reported she read the sign to know what to do for the resident. Nurse #5 was interviewed on 4/7/2018 at 12:33 PM. She could state different types of precautions and the difference between contact precautions and enteric precautions. She reported that hands must be washed with soap and water prior to exiting the resident ' s room. The infection control nurse was interviewed on 4/6/2018 at 3:08 PM. She reported she was the antibiotic steward for the facility and was responsible for tracking infections in the facility. She reported she was not aware Resident #197 had a contact precaution sign in place and not a special enteric contact precautions sign. The Director of Nursing (DON) was interviewed	F 880	Nursing/Assistant Director of Nursing/ Unit manager will observe handwashing technique during medication administration, while providing care for a resident for proper technique and wearing gloves during invasive procedures during medication administration. This monitoring process will be continued by the Charge Nurse on Saturday and Sunday. This monitoring will be conducted daily x4 weeks, then weekly x4, then monthly thereafter. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until a pattern of compliance is achieved.	

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on 4/7/2018 at 12:49 PM. She reported it was her expectation that the correct contact precaution signs were displayed and that all staff have a good understanding of the different types of precautions.

The Administrator was interviewed on 4/7/2018 at 2:42 PM. She reported it was her expectation that the correct signage was used for each different type of contact precautions.

2. A review of staff handwashing check off dated 1/18/2018 and signed by Medication technician (MT) #1 indicated MT #1 had completed hand washing to meet requirements.

A handwashing validation dated 1/24/2018 and signed by MT #1 indicated she was competent with handwashing and hand hygiene with alcohol-based hand sanitizer.

Resident #88 was admitted to the facility on 2/5/2018 with diagnoses to include hypoxemia (low oxygen), cerebral palsy and difficulty walking. The admission Minimum Data Set (MDS) dated 2/12/2018 assessed the resident to be severely cognitively impaired.

Resident #88 ' s physician orders were reviewed and he was prescribed Flonase 50 micrograms 2 sprays each nostril daily dated 4/5/2018.

A medication administration was observed on 4/6/2018 at 8:43 AM. MT #1 prepared Flonase to administer to Resident #88. She was not wearing gloves and opened the nasal spray and inserted the tip into Resident #88 ' s nose and attempted to administer the medication, but found the spray

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mechanism locked. She removed the spray and unlocked the mechanism, then reinserted the nasal spray tip into Resident #88 ' s nose. The MT then attempted to administer the nasal spray, but found the medication needed to be primed to spray. She removed the nasal spray tip from Resident #88 ' s nose and primed the nasal spray, then reinserted the nasal spray and administered the medication to Resident #88, one spray in each nostril. MT #1 completed her medication administration and returned to the cart. She did not perform hand hygiene. MT #1 proceeded to use her computer to start the next medication administration. MT #1 opened the drawer to the medications without performing hand hygiene.

MT#1 was interviewed on 4/6/2018 at 9:12 AM. She reported she usually kept hand sanitizer on the medication cart, but had forgotten it this morning. She reported she was not certain why she did not wear gloves for the medication administration or why she did not perform hand hygiene.

The DON was interviewed on 4/7/2018 at 12:49 PM. She reported it was her expectation the staff used gloves during administration of medications that required gloves and that hand hygiene was performed before and after all medication administration.

The Administrator was interviewed on 4/7/2018 at 2:42 PM. She reported it was her expectation proper hand washing or sanitizing was performed.