STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE HEALTH AND REHABILITATION	104 COLLEGE DRIVE FLAT ROCK, NC 28731

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		6/22/18

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

Electronically Signed | 06/25/2018

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

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to maintain residents' wheelchair in good repair for 2 of 8 sampled residents reviewed (Residents #18 and #58). The finding included: 1.a. Resident #18 was admitted to the facility on 04/06/16. Her diagnoses included heart failure, chronic pain in both legs, difficulty walking and stage 3 of chronic kidney disease. Resident #18's quarterly Minimum Data Set (MDS) dated 03/16/18 indicated her cognition was intact and she had adequate hearing/vision with clear speech. The MDS specified Resident #18 had impairment on one side of her lower extremities and was using wheelchair and walker as mobility device. She required limited assistance with 1 person physical assist for most of her activities of daily living (ADLs) In an observation conducted on 06/04/18 at 4:22 PM, the right arm rest of Resident #18's wheelchair had 2 torn and ripped lines approximately 1 inch long. Resident #18's skins in contact with the right arm rest were intact without any redness. The right arm rest for Resident #18's wheelchair remained in the same condition on the following observations: 06/05/18 at 2:43 PM, 06/06/18 at 12:41 PM, and 06/07/18 at 2:46 PM. During an interview conducted on 06/04/18 at 4:22 PM Resident #18 stated she could not recall	F 584	F584 Safe, Clean, Comfortable, Homelike Environment During Annual Survey dated June 4 – June 7, 2018 it was discovered that 2 Residents wheelchair armrests were in need of repair. Arm rests were either torn or split. After being notified of repair maintenance immediately repaired wheelchair armrests. There was not a formal process in place to monitor wheelchair repairs. Staff were to use maintenance work order log but were not consistently using this tool to notify maintenance of equipment issues. All wheelchair armrests are being inspected and replaced with new nylon padded armrests if torn or in need of repair. This will be completed by June 20, 2018. All staff will be inserviced on the Maintenance work order process and the importance of equipment being in proper working condition for Resident Safety by the Administrator. This will be completed by June 22, 2018. There was not a formal process in place to monitor wheelchair repairs. Staff were to use maintenance work order log but were not consistently using this tool to notify maintenance of equipment issues.	

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F 584	Continued From page 2	F 584		

how long the right arm rest of her wheelchair had been torn and ripped. It bothered her as the broken arm rest could sometimes irritated her skin. She would like the facility to fix or replace the right arm rest of her wheelchair as soon as possible. She stated she did not tell any nursing or maintenance staff about the broken right arm rest of her wheelchair.

b. Resident #58 was admitted to the facility on 02/02/17. Her diagnoses included heart failure, end-stage renal disease, anxiety, and depression.

Resident #58's Annual Minimum Data Set (MDS) dated 01/30/18 indicated her cognition was severely impaired. She had adequate hearing/vision with clear speech. The MDS specified Resident #58 was using wheelchair and walker as mobility device. She required extensive assistance with 1 person physical assist for most of her activities of daily living (ADLs)

In an observation conducted on 06/05/18 at 2:00 PM, both arm rests of Resident #58's wheelchair were observed with areas of torn, frayed, and ripped approximately 1 square on both sides. Resident #58's skins in contact with both arm rests were intact without any redness. The arm rests for Resident #58's wheelchair remained in the same condition on the following observations: 06/06/18 at 1:04 PM, and 06/07/18 at 3:47 PM.

During an interview conducted on 06/05/18 at 2:00 PM Resident #58 stated the arm rests of her wheelchair had been torn, frayed, and ripped for at least 1 month. She did not tell any nursing or maintenance staff about her wheelchair that was in disrepair. It bothered her as the broken arm rests could sometimes irritated her skin. She

Plan for Correction:
All wheelchair armrests are being inspected and replaced with new nylon padded armrests if torn or in need of repair. This will be completed by June 20, 2018.

Wheelchair Inspections will be completed by the 25th of each month by the Maintenance Director and or Environmental Director. Documentation will consist of wheelchair being in good condition or noting any areas that need to be repaired or replaced. Next Inspection will be due by July 25, 2018, and this will be on going monthly.

All staff will be inserviced on the Maintenance work order process and the importance of equipment being in proper working condition for Resident Safety by the Administrator. This will be completed by June 22, 2018.

Monitoring:
Wheelchairs will be inspected during morning room rounds and documented on Room Round Sheet by department managers assigned to specific halls. Any wheelchairs in need of repair will be noted in Maintenance Work Order Log Book.

Maintenance Director and or Environmental Director will review work orders (3) times per day for any outstanding work orders. Administrator will spot check daily work orders and Morning Room Round Sheets for

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F 584	Continued From page 3 would like someone to fix the arm rests of her wheelchair as soon as possible. During an interview conducted on 06/07/18 at 2:19 PM, Nurse #4 stated under normal circumstances, nurse aides (NAs) had more direct interactions with the residents compared to the nurses. She checked residents' health care devices including wheelchairs each time when she was administering medication or providing care. She was not aware of any wheelchair in disrepair in her hall as she had not heard of any complaints from the residents or NAs. Otherwise, she would have submitted a work order to the maintenance department to fix their wheelchair. During an interview conducted on 06/07/18 at 2:49 PM, NA #1 stated whenever he transferred or provided care for the residents, he would take a quick glance at the resident's wheelchair to ensure it was in good repair. NA #1 added he failed to identify the wheelchairs that were in disrepair as the residents covered the arm rest most of the time when they were using it. Otherwise, he would have reported the needed repair to maintenance department via maintenance order requests book in a timely manner. Interview with the Maintenance Director on 06/07/18 at 3:07 PM revealed he was the only staff in maintenance department. He stated his workload was heavy and challenging but manageable. He denied any scheduled inspections for wheelchair on regular basis was in place and acknowledged both wheelchairs for Resident #18 and # 58 were in disrepair. He was unaware of these repair needs as he relied heavily on work orders filed by the nursing or	F 584	Compliance. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: Wheelchairs will be inspected during morning room rounds and documented on Room Round Sheet by department managers assigned to specific halls. Any wheelchairs in need of repair will be noted in Maintenance Work Order Log Book. Maintenance Director and or Environmental Director will review work orders (3) times per day for any outstanding work orders. Administrator will spot check daily work orders and Morning Room Round Sheets for Compliance. This will be incorporated into our QAPI monthly meetings for 3 months. Maintenance Director, Environmental Director and Administrator will be responsible for implementing POC.	

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F 584	Continued From page 4 therapy staff via maintenance order requests log that located at each nurse station. The maintenance director stated he reviewed the maintenance order requests log at least once daily. In an interview with the Administrator (AD) and Director of Nursing (DON) on 06/07/18 at 4:36 PM, both stated they expected the maintenance director to inspect all the wheelchair on monthly basis. They also expected all the nursing and therapy staff to check on wheelchairs when they provided care for the residents and reported repair needs through the work order system in a timely manner. It was the AD and DON's expectation for the Maintenance department to ensure all the wheelchairs to be maintained in good repair at all times.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 (Resident #112) closed records reviewed for hospitalization. The findings included: Resident #112 was admitted to the facility on 3/10/18 with diagnoses including osteoporosis, unsteadiness on her feet, and lack of coordination.	F 641	F641 Accuracy of Assessments During Annual Survey dated June 4 – June 7, 2018 it was discovered that a Residents discharge location was incorrectly coded on their MDS Assessment. MDS Coordinator immediately corrected the assessment changing the discharge from hospitalization to home. MDS Director and or MDS Coordinator did not verify with Social Services the	6/22/18

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F 641	Continued From page 5 The admission MDS dated 3/17/18 revealed Resident #112 was cognitively intact and required extensive assistance for bed mobility, transfer, dressing, and eating. The discharge MDS dated 3/30/18 indicated Resident #112 was coded under Section A-Identification Information as being discharged to an acute hospital. A Physician order dated 3/29/18 stated to discharge Resident #112 home when she was ready. A nurse's note dated 3/30/18 at 1:58 pm stated Resident #112 was discharged home with her daughter. An interview with MDS nurse #5 was conducted on 6/7/18 at 1:12 pm regarding the accuracy of Resident #112's discharge MDS. The MDS indicated Resident #112 was discharged to an acute hospital. MDS nurse #5 stated the MDS should have been coded to reflect Resident #112 was discharged home and was inaccurately coded. MDS nurse #5 stated the discharge MDS would require a correction to reflect Resident #112 was discharged home. On 6/7/18 at 2:30 pm an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the discharge MDS would have been coded accurately to reflect Resident #112 was discharged home. The DON also stated she would expect a correction to the discharge MDS to reflect Resident #112 was discharged home. On 6/7/18 an interview was conducted with the Administrator. The Administrator stated it was his	F 641	discharge location of the resident prior to completing their assessment for transmission. MDS Director and MDS Coordinator will be inserviced on maintaining accuracy of discharge locations for residents on the MDS Assessments by the DON. This was completed by June 22, 2018 An audit was conducted on all discharged residents starting from January 1, 2018 to Present verifying there discharge location with the MDS. Any discrepancies were immediately corrected. This was completed by June 11, 2018. Plan for Correction: MDS Coordinator will be documenting daily as needed all discharged residents and their locations on a Discharge Location Audit Sheet. Discharge locations will be verified weekly by the DON or ADON to ensure compliance. This will be on going for 3 months. MDS Director and MDS Coordinator will be inserviced on maintaining accuracy of discharge locations for residents on the MDS Assessments by the DON. This was completed by June 22, 2018. Monitoring: MDS Coordinator will be documenting daily as needed all discharged residents and their locations on a Discharge Location Audit Sheet. Discharge locations will be verified weekly by the DON and or ADON to ensure compliance. This will be on going for 3 months.	

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F 641	Continued From page 6 expectation that the discharge MDS would have been coded accurately to reflect Resident #112 was discharged home. The Administrator also stated he would expect a correction to the discharge MDS to reflect Resident #112 was discharged home.	F 641	Administrator will spot check weekly discharge locations of residents with the MDS Assessments to insure compliance. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: MDS Coordinator will be responsible for documenting initial discharge location of resident in the MDS Assessment and on the Discharge Location Audit Sheet. The DON and or ADON will be responsible for verifying weekly the discharge locations for all discharged residents for 3 months. MDS Coordinator, DON, ADON and Administrator will be responsible for implementing POC.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with the staff, Physician Assistant (PA), and Medical Director, the facility failed to follow physician orders for 1 of 2 residents (Resident #11) reviewed for splint application and failed to follow physician orders for oxygen settings for 2 of 3 residents reviewed (Residents #70 and #3) who were receiving oxygen therapy. The findings included:	F 658	F658 Services Provided Meet Professional Standards During Annual Survey dated June 4 – June 7, 2018 it was discovered that 3 resident's physicians' orders were not followed as ordered. Resident #11 had a follow up physicians' appointment and upon returning to facility resident did not have any paperwork	6/22/18

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F 658	Continued From page 7 1. Resident #11 was admitted to the facility 3/6/18 with diagnoses including injury of C5 and C6 (vertebrae in the neck at the cervical portion of the spinal column) and lack of coordination. An admission Physician order dated 3/6/18 stated Resident #11 was to wear a hard cervical collar at all times. An admission Minimum Data Set (MDS) dated 3/13/18 revealed Resident #11 had a diagnosis of injury of C5 and C6 and was cognitively intact. The MDS also revealed Resident #11 required extensive assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. A review of the working care plan (a quick reference guide for the nurse aides to know how to provide care for each resident) dated 3/6/18 stated Resident #11 was to wear the hard cervical collar at all times. An observation of Resident #11 on 6/5/18 at 2:47 pm revealed she was in her wheelchair in her room watching TV and no neck collar was in place. An observation of Resident #11 on 6/5/18 at 4:06 pm revealed she remained up in her wheelchair in her room watching TV and no neck collar was in place. In an interview with nurse #2 on 6/5/18 at 4:09 pm she stated Resident #11 did not have the hard cervical collar in place. Nurse #2 also stated there was a Physician order to wear the hard cervical collar at all times but she thought physical therapy might have changed that order.	F 658	documenting progress notes or physician orders from office visit. The Unit Manager failed to follow up on missing paperwork from the physician office visit to ensure that no new orders were to be obtained. Resident returned with new adaptive equipment without a physician order or documentation on CNA Care Guide or Resident Plan of Care. Resident #70 the nurse failed to notify the physician when resident's respiratory status changed and required an increase in supplemental oxygen with failure to obtain order to titrate oxygen. The nurse failed to administer oxygen as ordered. Resident #3 the nurse failed to clarify the physician order for oxygen to be delivered via trach collar versus nasal cannula. The nurse failed to verify the oxygen was set at the appropriate rate per minute. Resident #11 was found not to be wearing her hard cervical collar while up watching TV in her wheelchair. Care Plan stated for her to have hard cervical collar on at all times. During investigation DON found a physician's progress note from Neurosurgeon on April 4, 2018 indicating that it is was okay to discontinue the hard cervical collar and switch to soft cervical collar to be worn with gait training. Staff immediately clarified order with physician and updated CNA Care Guide and Resident Plan of Care noting that resident could switch to soft cervical collar to be worn with gait training and discontinue the use of the hard cervical collar.	

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F 658	Continued From page 8 A telephone interview with the Medical Director on 6/5/18 at 5:00 pm revealed he expected Resident #11 to wear the hard cervical collar at all times as written in the Physician orders. An interview with the Director of Nursing (DON) on 6/5/18 at 5:13 pm revealed Resident #11 had a Physician order to wear a hard cervical collar at all times. The DON stated Resident #11 saw a Neurosurgeon on 4/4/18. The Neurosurgeon wrote on the facility progress note that it was ok to discontinue the hard cervical collar and switch to a soft cervical collar to be worn with gait training on 4/4/18 but did not write a Physician order. The DON stated since the Neurosurgeon wrote on a progress note and not a Physician order sheet it was not considered a Physician order. The DON further stated the working care plan for nurse aides was updated using Physician orders and the working care plan was not updated because there was no updated Physician order to change the cervical collar from hard cervical collar to be worn at all times to a soft cervical collar to be worn with gait training. An interview with the Administrator on 6/5/18 at 6:03 pm revealed he expects Physician orders to be followed. The Administrator also stated if a Physician wrote on progress notes instead of writing on a Physician order sheet he expected nursing to get a clarification Physician order. 2. Resident #70 was admitted to the facility on 04/26/18 with diagnoses including heart failure and cardiomyopathy (enlarged heart).	F 658	RN Unit Managers, RN Weekend Supervisor, MDS Director and Nurses, Unit Clerk, Administrator and DON will be inserviced by Regional Clinical Coordinator. All outside physician appointments will be reviewed daily in the Clinical Operations Meeting. RN Unit Managers will follow up daily to ensure consult/recommendations are received and processed from each appointment and ensure physician orders are written as indicated per physician progress notes. MDS will be notified immediately of any new physician orders in order for Comprehensive Care Plan and CNA Care Guide to be updated. This will be completed by June 5, 2018. Resident #70 was found with Oxygen at 4 LPM when order stated 3 LPM. Staff immediately notified Physician Assistant to assess the residents' respiratory status and supplemental oxygen needs. New orders were written stating oxygen at 3.5 LPM may titrate 1 – 5 LPM to maintain oxygen saturation at greater than 90% and notify physician if unable to maintain oxygen saturation at greater than 90%. CNA Care Guide and Comprehensive Care Plan were updated on June 7, 2018. Resident #3 was found with Oxygen at 3 LPM via trach collar when physician order stated 2 LPM via nasal cannula. Staff immediately notified physician to clarify oxygen orders. New orders were written stating to administer continuous oxygen at 2 LPM via trach collar to maintain oxygen	

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F 658	Continued From page 9 A record review of the admission Minimum Data Set (MDS) assessment dated 05/03/18 revealed Resident #70 was cognitively intact and received oxygen therapy. A physician's order dated 05/23/18 revealed Resident #70 was to receive continuous oxygen 3 liters per minute (LPM) via nasal cannula. A review of the current care plan with admission date of 05/23/18 revealed Resident #70 was to receive continuous oxygen at 3 LPM via nasal cannula. Observations of Resident #70's oxygen setting were as follows: · 06/04/18 at 11:28 AM Resident #70 was receiving oxygen at 4 LPM via nasal cannula. · 06/05/18 at 10:13 AM Resident #70 was receiving oxygen at 3 ½ LPM via nasal cannula. · 06/05/18 at 2:31 PM Resident #70 was receiving oxygen at 3 ½ LPM via nasal cannula. · 06/05/18 at 8:20 AM Resident #70 was receiving oxygen at 3 ½ LPM via nasal cannula. On 06/06/18 at 8:43 AM an interview was conducted with Nurse #1 who verified the physician's order indicated Resident #70 was to receive continuous oxygen at 3 LPM per nasal cannula. Nurse #1 confirmed that Resident #70 was receiving oxygen at 3 ½ LPM via nasal cannula. Nurse #1 stated there was no physician's order to increase the oxygen setting for Resident #70 above 3 LPM via nasal cannula	F 658	saturations at greater than 90%. May titrate oxygen at 1 – 5 LPM via trach collar to maintain oxygen saturations at greater than 90%. Staff to check O2 stats per shift and to notify physician if respiratory condition or status changes. CNA Care Guide and Comprehensive Care Plan were updated on June 6, 2018. All licensed nurses will be inserviced by the DON on Oxygen Orders to include the oxygen delivery rate, route of delivery and oxygen saturation to be maintained. Titration orders are to include the numbers of LPM and oxygen saturations to be maintained. If respiratory status / condition changes physician provider is to be notified immediately. This will be completed by June 8, 2018. Audit was completed on June 7, 2018 for all residents receiving oxygen therapy to ensure that oxygen was being administered at the rate and route prescribed by physician. Plan for Correction: Daily review of all outside physician appointments will be done by RN Unit Managers, DON and or ADON to ensure that any new order changes that are reflected in the physician progress notes are transcribed to a physicians' order and then transcribed to the MAR, TAR and CNA Care Guide. MDS will be notified immediately of any new physician orders in order for Comprehensive Care Plan and CNA Care Guide to be updated.	

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F 658	Continued From page 10 and an order should have been obtained to increase the oxygen setting above 3 LPM. Nurse #1 stated Resident #70 had a respiratory episode on 06/04/18 and the oxygen setting was adjusted above 3 LPM and a physician's order was not obtained to increase the oxygen setting. Nurse #1 stated the physician's order that indicated Resident #70 was to receive 3 LPM via nasal cannula was not followed and a new order was not obtained to increase the oxygen setting. On 06/06/18 at 9:12 AM an interview was conducted with the Physician's Assistant (PA) who stated her expectation was that staff would have followed the physician's order that indicated Resident #70 was to receive continuous oxygen at 3 LPM via nasal cannula. The PA stated her expectation was that staff would have obtained a physician's order prior to placing Resident #70's oxygen setting above 3 LPM via nasal cannula. On 06/06/18 at 9:27 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that staff would have followed the physician's order that indicated Resident #70 was to receive oxygen at 3 LPM via nasal cannula. The DON stated her expectation was that staff would have obtained a physician's order prior to placing Resident #70's oxygen setting above 3 LPM and would not have adjusted the oxygen setting without a physician's order. On 06/06/18 at 10:01 AM an interview was conducted with the Administrator who stated his expectation was that staff would have followed the physician's order for Resident #70's oxygen	F 658	All licensed nurses will be inserviced by the DON on the need for Oxygen Orders to include the oxygen delivery rate, route of delivery and oxygen saturation to be maintained. Titration orders are to include the numbers of LPM and oxygen saturations to be maintained. If respiratory status / condition changes physician provider is to be notified immediately. RN Unit Managers, DON and or ADON will review daily oxygen orders at Clinical Operations Meeting and verify that all oxygen orders are being followed according to physician orders. RN Unit Managers, DON, ADON and or Administrator will spot check daily for 1 month to observe the residents oxygen settings and then weekly thereafter for 2 months to ensure compliance. Monitoring: Daily review of all outside physician appointments will be done by RN Unit Managers, DON and or ADON to ensure that any new order changes that are reflected in the physician progress notes are transcribed to a physicians' order and then transcribed to the MAR, TAR and CNA Care Guide. MDS will be notified immediately of any new physician orders in order for Comprehensive Care Plan and CNA Care Guide to be updated. All licensed nurses will be inserviced by the DON on the need for Oxygen Orders to include the oxygen delivery rate, route of delivery and oxygen saturation to be	

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F 658	Continued From page 11 setting. The Administrator stated his expectation was that staff would have obtained a physician's order if Resident #70 required a change in oxygen setting. 3. Resident #3 was admitted to the facility on 08/12/14 with diagnoses that included malignant neoplasm (abnormal growth of tissue) of head, face and neck, atrial fibrillation (fast, irregular heart beat) and tracheotomy (surgical incision into the windpipe to allow a tube insertion for the passage of air). Review of the quarterly Minimum Data Set (MDS) dated 05/16/18 revealed Resident #3 had moderate impairment in cognition and received oxygen therapy. Review of Resident #6's electronic medical record revealed a physician's order dated 12/04/17 which read in part, continuous oxygen at 2 Liters per Minute (LPM) via nasal cannula. Review of Resident #6's care plans, with a recent review date of 05/30/18, revealed a plan in place for oxygen use. Interventions included for staff to administer oxygen as ordered at 2 LPM via nasal cannula. Observations of Resident #6 on 06/06/18 at 9:30 AM and 12:25 PM revealed she was receiving continuous oxygen at 3 LPM via trach. An observation of Resident #6 was conducted on 06/06/18 at 12:40 PM with the Director of Nursing (DON) who confirmed she was receiving	F 658	maintained. Titration orders are to include the numbers of LPM and oxygen saturations to be maintained. If respiratory status / condition changes physician provider is to be notified immediately. RN Unit Managers, DON and or ADON will review daily oxygen orders at Clinical Operations Meeting and verify that all oxygen orders are being followed according to physician orders. RN Unit Managers, DON, ADON and or Administrator will spot check daily for 1 month to observe the residents oxygen settings and then weekly thereafter for 2 months to ensure compliance. Administrator will spot check weekly any new order changes from outside physician appointments to ensure compliance for 3 months. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: RN Unit Managers, DON and or ADON will review all new physician order changes daily at Clinical Operations meeting and ensure they are transcribed to the MAR, TAR and CNA Care Guide. MDS will be notified immediately of any new physician orders in order for Comprehensive Care Plan and CNA Care Guide to be updated. Administrator, DON and or ADON will be responsible for implementing POC This will be incorporated into our QAPI monthly meetings for 3 months.	

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F 658	Continued From page 12 continuous oxygen at 3 LPM via trach. An interview was conducted on 06/06/18 at 12:40 PM with the DON. The DON confirmed Resident #6 had an order for oxygen to be administered at 2 LPM and added the order should indicate via trach and not via nasal cannula. The DON stated it was her expectation for staff to administer oxygen as ordered by the physician and if oxygen settings needed to be changed, the physician should be notified.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure equipment was in working order for 1 of 3 residents reviewed for mechanical lift transfers (Resident #26). The findings included: Review of the facility's mechanical lift policy last revised in July 2017 specified all necessary equipment (slings, hooks, chains, straps, and supports) was on hand and in good condition. The policy further specified that prior to lifting the resident all hooks, clips, or fasteners were	F 689	F689 Free of Accident Hazards/Supervision/Devices During Annual Survey dated June 4 – June 7, 2018 it was discovered that a resident was being transferred improperly using the Sit to Stand lift. The abdominal portion of the mechanical lift sling was observed to be unfastened around the resident's waist, as part of the buckle was missing and could not be fastened. CNA's completed the transfer without correcting the sling.	6/22/18

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F 689	Continued From page 13 examined. Resident #26 was admitted to the facility 04/23/13 with diagnoses including diabetes, muscle weakness, and mobility abnormality. An annual Minimum Data Set (MDS) 04/02/18 revealed Resident #26 required extensive assistance for bed mobility, transfers, and dressing. A Care Area Assessment (CAA) dated 04/02/18 for activities of daily living (ADL) revealed Resident #26 required assistance with dressing and transfers. A working care plan (a quick reference guide for nurse aides listing each resident's care needs) for Resident #26 updated 06/18/17 revealed she required a sit to stand mechanical lift for transfers. A care plan for Resident #26 last updated 04/23/18 for ADL deficit revealed she required a sit to stand mechanical lift for transfers. A sit to stand mechanical lift transfer lift was observed for Resident #26 on 06/06/18 at 10:40 AM. Nurse Aides (NAs) #4 and #5 placed the mechanical lift sling around Resident #26, attached the sling to the mechanical lift, and raised her to a standing position. As Resident #26 was in the standing position the abdominal portion of the mechanical lift sling was observed to be unfastened around Resident #26's waist. Upon further observation of the mechanical lift sling part of the buckle was missing and could not be fastened. NA #4 and NA #5 completed the transfer of Resident #26 to the chair with the mechanical sit to stand lift.	F 689	CNA Staff failed to follow facility policy and procedure for mechanical lift operation and safe resident transfers. Facility was immediately notified of broken sling was removed from service and an audit was conducted on all mechanical lift slings for both Hoyer and Sit to Stand lifts to check for missing parts or damaged slings. Slings that were found to be noncompliant were immediately pulled from service and discarded. This was completed on June 6, 2018. All staff were inserviced on the proper maintenance of Hoyer Lift and Sit to Stand Lift slings by the Regional Clinical Coordinator. They were instructed to inspect mechanical lift slings prior to each use, and remove immediately from service if damaged or have any missing parts prior to transferring resident and to notify Maintenance immediately via work order log. This was completed on June 8, 2018. An additional inservice was conducted on safe lifting and movement of residents via mechanical lift, by Regional Clinical Coordinator. This was completed on June 8, 2018. All Mechanical Lift Slings are being inspected, removed and discarded if torn or in need of repair. This will be completed by June 6, 2018. Mechanical Lift Sling Inspections will be completed by the 25th of each month by the Maintenance Director and or	

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F 689	Continued From page 14 An interview with NA #4 and NA#5 on 06/06/18 at 10:50 AM revealed the transfer for Resident #26 was the first time either NA had used the sit to stand mechanical lift on 06/06/18. Na #4 and NA #5 stated the last time either of them used the sit to stand mechanical lift was on 06/05/18 and both parts of the abdominal buckle on the sling were in place and able to be used correctly at that time. NA # 4 stated part of the buckle may have come off when the laundry washed the mechanical lift sling. Na #4 and NA #5 stated usually both parts of the abdominal buckle for the mechanical lift sling were present and in working order. Na #4 and Na #5 stated the lift should not have been used with a broken buckle. An interview with the Director of Nursing (DON) on 06/06/18 at 10:55 AM revealed her expectation was for staff to examine all equipment prior to use and discard or take out of use any equipment not correctly working. The DON stated the NAs should have examined the mechanical lift sling prior to use, discarded the sling with the broken buckle, and obtained a new sling in working order prior to transferring Resident #26. An interview with the Administrator on 06/06/18 at 11:12 AM revealed he expected staff to use equipment only when in working order. If equipment was not in working order it should be discarded or taken out of use.	F 689	Environmental Director. Documentation will consist of Mechanical Lift Slings being in good condition or noting any areas that need to be repaired or replaced. Next Inspection will be due by July 25, 2018, and this will be on going monthly. Plan of Correction: All staff will inspect mechanical lift slings prior to each use, and remove immediately from service if damaged or have any missing parts prior to transferring resident and to notify Maintenance immediately via work order log. Mechanical Lift Sling Inspections will be completed by the 25th of each month by the Maintenance Director and or Environmental Director. Documentation will consist of Mechanical Lift Slings being in good condition or noting any areas that need to be repaired or replaced. Next Inspection will be due by July 25, 2018, and this will be on going monthly. Monitoring: Mechanical Lift Slings will be inspected prior to each use, and removed immediately from service if damaged or have any missing parts prior to transferring resident and to notify Maintenance immediately via work order log. Unit Managers, DON and or ADON will spot check daily Mechanical Lift Slings for proper safety compliance for 1 month,	

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F 689	Continued From page 15	F 689	then weekly thereafter for 2 months. Maintenance Director and or Environmental Director will review work orders (3) times per day for any outstanding work orders. Administrator will spot check daily work orders. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: Mechanical Lift Slings will be inspected prior to each use, and removed immediately from service if damaged or have any missing parts prior to transferring resident and to notify Maintenance immediately via work order log. Unit Managers, DON and or ADON will spot check daily Mechanical Lift Slings for proper safety compliance for 1 month, then weekly thereafter for 2 months. Maintenance Director and or Environmental Director will review work orders (3) times per day for any repairs needed. Administrator will spot check daily work orders. This will be incorporated into our QAPI monthly meetings for 3 months. Maintenance Director, Environmental Director, DON, ADON and or Administrator will be implementing POC. This will be incorporated into our QAPI monthly meetings for 3 months.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/22/18

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F 758	Continued From page 16	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their

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F 758	Continued From page 17 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, consultant pharmacist and Physician Assistant (PA) interviews, the facility failed to ensure physician's orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 5 sampled residents (Residents #44) reviewed for unnecessary medications. Resident #44 was admitted to the facility on 10/21/16 with diagnoses that included vascular dementia with behavioral disturbance, depression, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 04/17/18 indicated Resident #44's cognition was severely impaired. She had history of rejection of care on 1 to 3 days during the MDS review period. Resident #44 received antipsychotic and antidepressant medications on 7 of 7 days and antianxiety medication on 1 of 7 days. A physician's order dated 04/19/18 indicated Ativan (antianxiety medication) 1 milligram (mg) per 1 cubic centimeter (CC) cream applied 1 CC topically once every 6 hours as needed (PRN) for agitation was ordered for Resident #44. There was no stop date for this PRN Ativan order. A review of the current physician's order for	F 758	F758 Free from Unnecessary Psychotropic Medications/PRN Use During Annual Survey dated June 4 – June 7, 2018 it was discovered that a resident had an order for Ativan 1mg per 1cc Cream PRN Psychotropic Medication with no 14 Day stop date. The Physician Assistant wrote an order to continue Ativan Cream PRN without evaluating residents need for continued medication per pharmacy recommendation. Physician Assistant did not document the rationale for continued use and duration on the order. The facility nurse failed to ensure that the proper guidelines were followed for PRN Psychotropic Medication. Facility investigated and immediately contacted physician to have order clarified and rewritten if necessary. PA rewrote order for Ativan 1mg per 1cc Cream PRN for 14 days. This was completed on June 7, 2018. Facility conducted an audit of all residents with PRN Psychotropic Medication orders to ensure that each order had a 14 Day	

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F 758	Continued From page 18 Resident #44 on 06/06/18 revealed this physician order had not been updated with a stop date. A review of Resident #44's medication administration record (MAR) revealed the resident had received Ativan cream PRN topically 6 times in April 2018, 10 times in May 2018, and 1 time in June 2018. After reviewing the Ativan cream PRN order without a stop date written on 04/19/18, the Consultant Pharmacist had suggested the physician to consider discontinuing and at a minimum to chart the rationale for continual needs of Ativan cream PRN in the "Consultant Pharmacist Communication to Physician" dated 05/09/18. The Consultant Pharmacist also recommended the physician to order a future date for reevaluation and placed it in MAR. The PA responded by stating "No change" and it was signed and dated on 05/17/18. In an interview conducted on 06/06/18 at 10:40 AM, the Consultant Pharmacist indicated he was aware of the new regulations regarding PRN psychotropic medications. He stated PRN psychotropic medication was limited to 14 days and if the prescriber wanted to extend the order past 14 days a rationale and time limited duration was to be documented in the medical record. Resident #44 was noted with an order dated 04/19/18 for Ativan cream 1 mg/CC applied topically once every 6 hours PRN agitation with no stop date and it was not in compliance with the new Centers of Medicare & Medicaid Services (CMS) psychotropic regulations. He sent recommendations to physician on 05/09/18 to consider to reevaluate the continued needs for Ativan cream PRN and to discontinue the	F 758	stop date. Any orders found out of compliance were immediately addressed with physician to clarify. This was completed June 21, 2018. All licensed nurses will be inserviced by the DON on the regulation regarding PRN psychotropic medications limited to 14 days. If the physician wants to extend the order past 14 days a rational and time limited duration must be documented in the medical record by the physician. This was completed June 8, 2018. Plan of Correction: All licensed nurses will be inserviced by the DON on the regulation regarding PRN psychotropic medications limited to 14 days and if the physician wants to extend the order past 14 days a rational and time limited duration must be documented in the medical record by the physician. This was completed June 8, 2018. RN Unit Managers, DON and or ADON will review daily physician orders at Clinical Operations Meeting and verify that all PRN Psychotropic Medication orders are being followed according to physician orders, to include a 14 Day stop date. RN Unit Managers, DON, ADON and or Administrator will spot check daily for 1 month to ensure that PRN Psychotropic Medications have a 14 Day stop date, and then weekly thereafter for 2 months to ensure compliance. Monitoring:	

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F 758	Continued From page 19 medication or at least to chart the rationale for continued needs and to order a future date for reevaluations. His recommendations were responded by a PA stating "No change" to the order. In an interview conducted on 06/06/18 at 11:00 AM, the PA indicated she was aware of the new CMS regulations regarding PRN psychotropic medications. She believed the PRN Ativan cream was necessary to treat Resident #44's intermittent episodes of extreme agitation. The PA acknowledged she was the one who signed the Consultant Pharmacist's recommendations on 05/17/18 and had ordered "No change" to the PRN Ativan cream order. She stated when she signed the recommendations, she was not aware of the order had no stop date as she did not check the order. An interview was conducted with the Administrator and Director of Nursing (DON) on 06/07/18 at 4:36 PM. They both indicated they expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. They expected the prescriber to review all PRN orders for psychotropic medications before signing off the Consultant Pharmacist's recommendations and to follow the new CMS psychotropic medication regulations.	F 758	RN Unit Managers, DON and or ADON will review daily physician orders at Clinical Operations Meeting and verify that all PRN Psychotropic Medication orders are being followed according to physician orders, to include a 14 Day stop date. RN Unit Managers, DON, ADON and or Administrator will spot check daily for 1 month to ensure that PRN Psychotropic Medications have a 14 Day stop date, and then weekly thereafter for 2 months to ensure compliance. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: RN Unit Managers, DON, ADON and or Administrator will spot check daily for 1 month to ensure that PRN Psychotropic Medications have a 14 Day stop date, and then weekly thereafter for 2 months to ensure compliance. Administrator, DON and or ADON will be responsible for implementing POC. This will be incorporated into our QAPI monthly meetings for 3 months.	
F 810 SS=E	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming	F 810		6/22/18

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F 810	Continued From page 20 meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to provide modified utensils and cups for 5 of 6 residents (Resident #50, Resident #47, Resident #98, Resident #73, and Resident #53) reviewed for adaptive equipment. The findings included: 1. A quarterly Minimum Data Set (MDS) dated 4/18/18 for Resident #50 revealed she had diagnoses including diabetes and hypertension (high blood pressure). Resident #50 was cognitively intact and required extensive assistance with eating. The quarterly MDS coded Resident #50 as having a swallowing disorder and receiving a therapeutic diet. The care area assessment (CAA) for nutrition dated 7/27/17 revealed Resident #50 required a weighted spoon. A working care plan (a quick care reference guide for the nurse aides caring for each resident) dated 10/27/15 indicated Resident #50 was to receive adaptive feeding equipment as needed. A care plan for Resident #50 for the potential for dehydration last updated 5/2/18 indicated she should receive adaptive equipment as needed or recommended. On 6/4/18 at 12:35 PM Resident #50 was observed in the main dining room feeding herself with regular utensils. An observation of Resident#50's tray card at the same date and	F 810	F810: Assistive Eating Devices During Annual Survey dated June 4 – June 7, 2018 it was discovered that (4) four residents had an order for adaptive eating utensils, and (1) one resident had an order for a sippy cup which were not supplied to the residents during meal time. Dietary Staff were not reviewing tray tickets prior to preparing resident meal trays to ensure the proper adaptive equipment was in place, and dietary department did not have enough proper adaptive equipment at the time to provide adaptive equipment for each resident. Staff serving residents were not reviewing tray tickets prior to serving resident meal trays to ensure the proper adaptive equipment was in place. Facility immediately investigated and obtained appropriate adaptive devices and supplied residents with their utensils and cups. Dietary Manager and DON conducted an audit of all residents with Dietary Communication Orders for adaptive utensils, plates and cups and compared to tray ticket audit for same and any errors found were immediately corrected. This was completed on June 8, 2018. All Dietary staff were inserviced on Adaptive Equipment by the Dietary	

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F 810	Continued From page 21 time stated she was to receive weighted utensils. In an interview with the Dietary Manager (DM) on 6/4/18 at 12:35 PM she stated Resident #50 should have received weighted utensils and she was not sure why the resident did not receive them. The DM stated all residents with orders for adaptive equipment should receive adaptive equipment. 2. A quarterly MDS for Resident #47 dated 4/16/18 revealed he had diagnoses including diabetes, anemia, and hypertension. Resident #47 was coded as being cognitively intact and required extensive assistance with eating. Resident #47 was also coded as having a swallowing disorder and receiving a therapeutic diet. A working care plan for Resident #47 dated 5/14/18 stated he was to receive adaptive feeding equipment as needed or recommended. On 6/4/18 at 12:45 PM Resident #47 was observed in the main dining room feeding himself with regular utensils. An observation of Resident #47's tray card at the same date and time stated he was to receive foam handled utensils. In an interview with nurse #3 on 6/4/18 at 12:45 PM she stated Resident #47 should have foam handle utensils and she was not sure why the resident did not have them. In an interview with the DM on 6/4/18 at 12:47 PM she stated Resident #47 should have had foam handled utensils but the kitchen had run out of foam and it was being reordered. The DM further stated she was not sure how long the foam for	F 810	Manager on providing Adaptive Equipment to Resident with meal tray according to Tray Ticket Order. Adaptive Equipment will be highlighted on Tray Ticket alerting Dietary Staff of special equipment. Dietary Staff will then initial Adaptive Equipment List to verify that adaptive equipment has been supplied to the resident on each meal tray. This will be completed by June 20, 2018. Plan of Correction: All Dietary staff were inserviced on Adaptive Equipment by the Dietary Manager on providing Adaptive Equipment to Resident with meal tray according to Tray Ticket Order. Adaptive Equipment will be highlighted on Tray Ticket alerting Dietary Staff of special equipment. Dietary Staff will then initial Adaptive Equipment List to verify that adaptive equipment has been supplied to the resident on each meal tray. This will be completed by June 20, 2018. Newly admitted Resident diet orders will be verified by Dietary Manager and or Assistant Dietary Manager with physician orders to determine if adaptive equipment is necessary. Tray Tickets will be compared to physician orders by Dietary Manager and or Assistant Dietary Manager on the 1st of each month to ensure that all residents are receiving adaptive equipment as ordered. RN Unit Managers, DON and or ADON will review daily physician orders at	

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F 810	Continued From page 22 utensils had been unavailable. 3. An annual MDS dated 5/8/18 for Resident #98 revealed she had diagnoses including heart failure, hypertension, and respiratory failure. Resident #98 was coded as being cognitively impaired and required extensive assistance with eating. Resident #98 was also coded as having a swallowing disorder and receiving a mechanically altered diet. A working care plan for Resident #98 dated 5/7/18 stated she must have cups with lids and was to receive adaptive feeding equipment as needed or recommended. A care plan for Resident #98 last updated 5/29/18 for potential for weight loss stated resident was to receive adaptive feeding equipment as needed or recommended. On 6/4/18 at 12:50 PM Resident #98 was observed in the main dining room being assisted with her lunch tray. Resident #98 had 2 cups of liquid on her tray with no lids in place. An observation of Resident #98's tray card at the same date and time stated she was to receive all drinks in a "sippy" cup. In an interview with the DM on 6/4/18 at 12:52 PM she stated the facility considers any cup with a lid a "sippy" cup. The DM also stated that Resident #98 did not receive a lid for either cup on her lunch tray. The DM further stated nurses or nurse aides (NAs) were responsible for providing liquids to residents when they ate in the dining room. The DM stated nursing should have placed lids on both of Resident #98's cups.	F 810	Clinical Operations Meeting and verify that Diet Orders are being communicated to the Dietary Staff via Dietary Communication Form. Dietary Manager, Assistant Dietary Manager and or Administrator will spot check daily for 1 month to ensure that Resident Meal Trays have appropriate adaptive equipment as ordered and then weekly thereafter for 2 months to ensure compliance. Monitoring: Newly admitted Resident diet orders will be verified by Dietary Manager and or Assistant Dietary Manager with physician orders to determine if adaptive equipment is necessary. Tray Tickets will be compared to physician orders by Dietary Manager and or Assistant Dietary Manager on the 1st of each month to ensure that all residents are receiving adaptive equipment as ordered. RN Unit Managers, DON and or ADON will review daily physician orders at Clinical Operations Meeting and verify that Diet Orders are being communicated to the Dietary Staff via Dietary Communication Form. Dietary Manager, Assistant Dietary Manager and or Administrator will spot check daily for 1 month to ensure that Resident Meal Trays have appropriate adaptive equipment as ordered and then weekly thereafter for 2 months to ensure compliance. This will be incorporated into our QAPI	

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F 810	Continued From page 23 An interview with NA #2 on 6/4/18 at 12:57 PM revealed nurses and NAs are responsible for setting up and delivering resident beverages when residents eat in the dining room. NA #2 stated that a "sippy" cup was a cup with a lid in this facility. 4. An annual MDS dated 5/1/18 for Resident #73 revealed she had diagnoses including coronary artery disease, malnutrition, and adult failure to thrive. Resident #73 was coded as being cognitively impaired and requiring extensive assistance with eating. Resident #73 was also coded as having a swallowing disorder and receiving a mechanically altered diet. A working care plan dated 9/19/16 for Resident #73 stated she required adaptive equipment as needed or recommended. A care plan for Resident #73 last updated 5/22/18 for potential weight loss stated resident was to receive adaptive equipment as needed or recommended. On 6/4/18 at 1:01 PM Resident #73 was observed in the main dining room being assisted with set up of her lunch tray. Resident #73 had regular utensils on her tray. An observation of Resident #73's tray card at the same date and time stated she was to receive foam handled utensils. In an interview with NA #2 on 6/4/18 at 1:01 PM she stated Resident #73 should have had foam handled utensils, the kitchen should have sent them, and it was an oversight that she did not get them.	F 810	monthly meetings for 3 months. Responsibility: RN Unit Managers, DON and or ADON will review daily physician orders at Clinical Operations Meeting and verify that Diet Orders are being communicated to the Dietary Staff via Dietary Communication Form. Dietary Manager, Assistant Dietary Manager and or Administrator will spot check daily for 1 month to ensure that Resident Meal Trays have appropriate adaptive equipment as ordered and then weekly thereafter for 2 months to ensure compliance. Dietary Manager, Assistant Dietary Manager and Administrator will be implementing POC. This will be incorporated into our QAPI monthly meetings for 3 months.	

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F 810	Continued From page 24 5. A quarterly MDS for Resident #53 dated 4/19/18 revealed she had diagnoses including heart failure, hypertension, and multiple sclerosis. Resident #53 was coded as being cognitively intact and requiring extensive assistance with eating. Resident #53 was also coded as having a swallowing disorder and receiving a mechanically altered diet. A working care plan dated 5/7/18 stated Resident #53 stated she required adaptive feeding equipment as needed or recommended. A care plan for Resident #53 last updated 5/3/18 for being at risk for aspiration stated Resident #53 was to receive adaptive equipment as needed or recommended. On 6/6/18 at 8:19 AM Resident #53 was observed in the main dining room eating her breakfast tray. Resident #53 had regular utensils on her tray. An observation of Resident 53's tray card at the same date and time stated she was to receive foam handled utensils. In an interview with NA #3 on 6/6/18 at 8:19 AM she stated resident #53 should have received foam handled utensils and she went to the kitchen to get the correct utensils. An interview on 6/6/18 at 4:46 PM with the Administrator revealed he expected residents to receive adaptive equipment as ordered or recommended.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		6/22/18

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F 812	Continued From page 25 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food for 1 of 1 walk in coolers and label and date potentially hazardous food after opening for 1 of 1 kitchen storage rooms. The findings included: 1. Initial observation of walk in cooler on 6/4/18 at 9:35 am revealed a bag of pre-packaged coleslaw available for use with an expiration date of 5/21/18. 2. Initial observation of the kitchen storage room on 6/4/18 at 9:42 am revealed the following foods were unlabeled and undated: 1 bag of enriched spaghetti	F 812	F812: Food Procurement, Store/Prepare/Serve-Sanitary During Annual Survey dated June 4 – June 7, 2018 it was discovered that (3) three bulk food items were found to be unlabeled and dated in addition to (1) one bag of prepackaged coleslaw which had expired. Dietary Staff did not complete their daily assigned tasks of labeling and dating any open food products that they used for the day and checking for expired foods prior to completion of their shift. Dietary Staff immediately labeled and dated the bulk food items and discarded the prepackaged coleslaw.	

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F 812	Continued From page 26 1 bin of sugar 1 bin of flour An interview with the Dietary Manager (DM) on 6/4/18 at 9:45 am revealed that all food should be discarded or used before the expiration date. The DM further stated all food in the kitchen storage room should be labeled and dated at the time it was opened. An interview with the Administrator on 6/6/18 at 4:46 pm revealed it was his expectation food in the walk in cooler or kitchen storage room be labeled and dated at the time it was opened.	F 812	Dietary Manager inspected all remaining food items in dry storage and walk-in refrigerator for unlabeled, undated and expired foods. Any items found out of compliance were immediately corrected. This was completed on June 4, 2018. All Dietary staff were inserviced by the Dietary Manager on labeling and dating all food products upon delivery and when food items are prepared for service. An audit sheet is posted in dry storage and walk-in refrigerator noting that all food is to be checked (2) two times per day for labeling, dating and expiration dates. In addition dietary staff were inserviced by Dietary Manager on inspecting expiration dates of perishable foods and discarding when food products are out of date. This will be completed by June 20, 2018. Plan of Correction: All Dietary staff will be labeling and dating all food products upon delivery and when food items are prepared for service. An audit sheet is posted in dry storage and walk-in refrigerator noting that all food is to be checked (2) two times per day for labeling, dating and expiration dates. In addition dietary staff will be inspecting expiration dates of perishable foods and discarding when food products are out of date. Dietary Manager, Assistant Dietary Manager and or Administrator will spot check daily for 1 month to ensure that all food items are labeled, dated and inspected for expiration dates and then	

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F 812	Continued From page 27	F 812	weekly thereafter for 2 months to ensure compliance. Monitoring: All Dietary staff will be labeling and dating all food products upon delivery and when food items are prepared for service. An audit sheet is posted in dry storage and walk-in refrigerator noting that all food is to be checked (2) two times per day for labeling, dating and expiration dates. In addition dietary staff will be inspecting expiration dates of perishable foods and discarding when food products are out of date. Dietary Manager, Assistant Dietary Manager and or Administrator will spot check daily for 1 month to ensure that all food items are labeled, dated and inspected for expiration dates and then weekly thereafter for 2 months to ensure compliance. This will be incorporated into our QAPI monthly meetings for 3 months. Responsibility: Dietary Manager, Assistant Dietary Manager and Administrator will be implementing POC. This will be incorporated into our QAPI monthly meetings for 3 months.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		6/22/18

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F 867	Continued From page 28 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to three recited deficiencies that were originally cited following the 07/20/17 annual recertification survey, recited following the 11/19/2017 complaint investigation and recited again on the current recertification and complaint investigation survey. The recited deficiencies were in the areas of safe/clean/comfortable/homelike environment, free of accident hazards/supervision/devices, and food procurement, store/prepare/serve - sanitary. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. a. 483.10 Safe/Clean/Comfortable/Homelike Environment: Based on observations, staff and resident interviews, the facility failed to maintain residents' wheelchairs in good repair for 2 of 8 sampled residents reviewed (Residents #18 and #58).	F 867	F867: QAPI/QAA Improvement Activities During Annual Survey dated June 4 – June 7, 2018 it was discovered that facility failed to ensure compliance with 3 previously cited deficiencies in the areas of F584 Safe/Clean/Comfortable/Homelike Environment, F689 Free of Accident Hazards/Supervision/Devices and F812: Food Procurement, Store/Prepare/Serve-Sanitary. F584: Facility will inspect and replace wheelchair armrest with new nylon padded armrests if torn or in need of repair. This will be completed by June 20, 2018. F689: Facility was immediately notified of broken sling and it was removed from service and an audit was conducted on all mechanical lift slings for both Hoyer and Sit to Stand lifts to check for missing parts or damaged slings. Slings that were found to be noncompliant were immediately pulled from service and discarded. This was completed on June 6, 2018. F812: Dietary Staff immediately labeled and dated the bulk food items and discarded the prepackaged coleslaw. Dietary Manager inspected all remaining	

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F 867	Continued From page 29 During the annual recertification survey of 07/20/17 the facility was cited for failure to label and store personal care items in a resident's shared bathroom. b. 483.25 Free of Accident Hazards/Supervision/Devices: Based on observations, record review, and staff interviews the facility failed to ensure equipment was in working order for 1 of 3 residents reviewed for mechanical lift transfers (Resident #26). During the complaint investigation of 11/19/17 the facility was cited for failure to provide a safe environment and maintain safe use of side rails on a resident's bed who got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel. c. 483.60 Food Procurement, Store/Prepare/Serve - Sanitary: Based on observations and interviews the facility failed to remove expired food for 1 of 1 walk in coolers and failed to label and date potentially hazardous food after opening for 1 of 1 kitchen storage rooms. During the annual recertification survey of 07/20/17 the facility was cited for failure to maintain freezer temperatures at 0 degrees Fahrenheit, failure to ensure all dishes stored ready for use were completely dry with no water on the surfaces, and failed to ensure fly activity measures were effective to prevent fly activity	F 867	food items in dry storage and walk-in refrigerator for unlabeled, undated and expired foods. Any items found out of compliance were immediately corrected. This was completed on June 4, 2018. Facility will be conducting their monthly QAPI meeting on June 22, 2018 with interdisciplinary team, maintenance, environmental services, medical director and pharmacist in attendance to review and discuss plan to maintain compliance for survey deficiencies. Plan of Correction: Facility will meet monthly with interdisciplinary team, maintenance, environmental services, medical director and pharmacist to review systems and plans of correction to monitor interventions that the committee has put in place for facility compliance. Interdisciplinary team, maintenance and environmental services will meet weekly to review systems and plans of correction to monitor interventions that the committee has put in place for facility compliance for 1 month, then biweekly thereafter. Monitoring: Facility will meet monthly with interdisciplinary team, maintenance, environmental services, medical director and pharmacist to review systems and plans of correction to monitor interventions that the committee has put in place for facility compliance.	

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F 867	Continued From page 30 over the kitchen meal service line. During an interview on 06/07/18 at 5:00 PM the Administrator stated after the recertification survey of 07/20/17 the Quality Assessment and Assurance (QAA) committee met to review the areas of concern and systems were put into place to correct the deficiencies cited. He explained the monitoring of the systems put into place were overshadowed by the areas of concern identified during the complaint investigation of 11/19/17 and for the first part of this year, their focus has been identifying, correcting and monitoring the safety of side rail use for the residents. The Administrator added the repeated areas of concern would be reviewed by the QAA committee to discuss and develop a plan of action.	F 867	Interdisciplinary team, maintenance and environmental services will meet weekly to review systems and plans of correction to monitor interventions that the committee has put in place for facility compliance for 1 month, then biweekly thereafter. Responsibility: Administrator, DON, ADON, Maintenance Director, Environmental Services and remaining Interdisciplinary Team will be implementing POC.	