STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/5/18

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

Electronically Signed | 06/29/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and family member interviews, the facility failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living (ADLs). The findings included: 1. Resident #60 was admitted to the facility on 2/22/17 with diagnoses, in part, of Alzheimer's. A review of the quarterly Minimum Data Set (MDS) assessment dated 4/10/18 revealed the resident had severely impaired cognition and required extensive assistance of two people for bed mobility, toileting and hygiene and was always incontinent of bladder. A review of the care plan dated 4/20/18 revealed a problem of incontinence with an intervention of "I need assistance with incontinent care." An observation on 6/4/18 at approximately 4:15PM revealed the resident lying in bed. A urine odor was noted and the resident had a large, circular brownish area noted to the pad underneath him. An observation on 6/5/18 at 8:34 AM revealed the resident lying in bed. A strong urine odor was present in the hallway and, upon entering the resident's room, a large, circular brownish area noted to the pad underneath him.	F 550	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 RESIDENT RIGHTS/EXERCISE OF RIGHTS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living. C N A could not provide incontinence care herself because resident became combative and needed assistance. Resident #60: Incontinence care was provided per plan of care and also provided prior to being assisted with meals. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/28/2018, the Director of Nursing,	

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F 550	Continued From page 2 An observation on 6/5/18 at 8:45 AM revealed Nurse Aide (NA) #1 in Resident #60's room feeding him breakfast. Incontinent care had not been provided and the urine odor remained. Continuous observation was conducted on 6/5/18 between 8:45 AM to 10:30 AM. There were no incontinent care provided during that time. At approximately 10:30 AM on 6/5/18, Hospice NA #1 entered the room. An observation at that time revealed the Hospice NA pull the top sheet off the resident and state "he's soaked". The resident's top sheet, brief, pad and bottom sheet were wet with urine. The resident's t-shirt was wet up his back and had a brownish colored stain where the wetness ended. A strong urine odor was observed. An observation of resident's skin did not indicate any redness or open areas. An interview with NA #1 on 6/5/18 at approximately 11:30 AM revealed she knew the resident was incontinent when she was feeding him, but couldn't do it herself because the resident became combative so she told NA #2, who was assigned to Resident #60. An interview with NA #2 on 6/5/18 at approximately 11:45 AM revealed he checks the residents for incontinence every 2 hours. He stated he did not know the resident was incontinent during breakfast and did not answer when asked if NA #1 had told him the resident was incontinent during breakfast. He stated he changed the resident at 6:00 AM and 9:00 AM that morning. When it was revealed the resident was eating breakfast at 9:00 AM, he stated that he changed him at 6:00 AM.	F 550	Quality Assurance Nurse Consultant and Unit Manager began in-servicing the nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) that the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. The facility must ensure to provide care to maintain a resident's dignity by providing incontinence care before feeding a resident As of 7/5/2018 no nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 7/5/2018, this training is incorporated into the new	

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F 550	Continued From page 3 An interview with the Corporate Nurse Consultant on 6/6/18 at 2:01 PM revealed incontinent care is provided per the care plan. If the care plan indicated the resident was incontinent, she would expect the staff to check the resident frequently to see if incontinent care was needed. She further revealed she would not expect staff to continue feeding a resident if they were aware the resident needed to be changed. An interview with the residents' wife on 6/7/18 at 12:30 PM revealed she frequently finds him wet up his back when she visits. She stated Resident #60 would be very upset if he knew he was left wet because he was always such a neat person.	F 550	employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Unit Manager will observe 5 residents each week to include the weekend during meals to ensure that they have had incontinence care provided before being assisted with feeding by using a quality assurance survey tool This will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 577	Right to Survey Results/Advocate Agency Info	F 577		7/5/18

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F 577 SS=C	Continued From page 4 CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results. Findings included: During a tour of the facility on 6/3/18 at 7:00 AM an observation was made that survey results were located in a notebook binder on a table near	F 577	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	

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F 577	Continued From page 5 the reception desk in the front lobby. An observation on 6/3/18 at 10:00 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An observation on 6/4/18 at 2:00 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. On 6/5/18 at 3:30 PM the Resident Council interview was completed. During the meeting, the Resident Council members stated they had no knowledge of the location of the survey results notebook. An interview with the Resident Council President during the meeting revealed she didn't know what the survey results were, where they were located and had not seen any signage that directed residents to their location. An observation on 6/5/18 at 4:14 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An interview was completed with the Administrator on 6/7/18 at 2:48 PM. She stated she thought a notice was posted in the facility and there were numerous bulletin boards located throughout the facility but some had been removed during building renovations. She said she expected a notice be posted that directed residents and families to the location of the survey results and planned to have the notice posted in the facility.	F 577	deficiencies cited have been or will be corrected by the date or dates indicated. F577 RIGHT TO SURVEY RESULTS/ADVOCATE AGENCY INFO. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to post the notice of location and availability of the facility's survey results. Facility had renovations in the past year with survey result postings removed and placed in a different location. Post renovation the posting of the survey results location and availability were not placed appropriately. On 6/7/2018 Notice was posted in the facility regarding the availability and location of recent survey results in areas that are prominent and accessible to the public, resident and families. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/7/2018 the Administrator ensured that Notice (s) was posted in the facility regarding the availability and location of recent survey results in areas that are prominent and accessible to the public, residents and families. Resident Council President and Members were verbally notified about the posting. On 6/8/2018 the Quality Assurance Nurse Consultant in serviced the Administrator that the resident has the right to: Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in	

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F 577	Continued From page 6	F 577	effect with respect to the facility and Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. The facility must; Post in a place readily accessible to residents/ and family members and legal representative of residents, the results of the most recent survey of the facility. Have reports with respect to any surveys, certifications and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. The facility must Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility shall not make available identifying information about complainants or residents Resident Council Meeting was scheduled for 6/25/2018. On 6/25/2018 during the Resident Council meeting, the Resident Council President and Resident Council Members revealed that they knew what the survey results were, where they were located and that notice was posted in the facility that directed them to the location of the survey book. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard	

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F 577	Continued From page 7	F 577	orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator, during weekly facility rounds, will ensure that a notice is posted in the facility regarding the availability and location of recent survey results in areas that are prominent and accessible to the public, residents and families. This will be done using a survey tool. This will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		7/5/18

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F 636	Continued From page 8 §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with	F 636		

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F 636	Continued From page 9 licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews the facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services (Resident #80). Findings include: Resident #80 was admitted to the facility on 4/20/18 with diagnoses that included anemia, hypertension (high blood pressure), End Stage Renal Disease (ESRD), diabetes mellitus, and hyperlipidemia (high cholesterol). The admission Minimum Data Set (MDS) dated 4/27/18 specified the resident had intact cognition, no behaviors or rejection of care. Resident #80 ' s Care Area Analysis from 4/27/18	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F636 COMPREHENSIVE ASSESSMENTS & TIMING. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	

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F 636	Continued From page 10 stated the resident received hemodialysis three times a week. A Physician ' s order was placed for dialysis on Monday, Wednesday and Friday at the dialysis facility. Review of Section O of the admission MDS dated for 4/27/18 did not specify that resident #80 was receiving dialysis services. During an interview with the MDS Coordinator on 6/8/18 at 10:35 AM she stated that not indicating the resident received dialysis services on her admission MDS from 4/27/18 was an error and that she must have overlooked it while completing the assessment. During an interview with the Administrator and the Quality Assurance Regional Nurse Consultant on 6/8/18 at 1:25 PM they stated that it was their expectation for the MDS to be completed accurately.	F 636	cited; The facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services. (Resident #80). MDS Coordinator omitted to code dialysis on the comprehensive assessment dated 4/27/18. Resident #80: Resident Minimum Data Set Assessment (Admission Comprehensive Assessment) with Assessment Reference Date (ARD) of 4/27/2018 was modified with a Corrective Attestation Date of 6/8/2018. The assessment was submitted to the state QIES system on 6/11/2018 and was accepted on 6/11/2018. Submission ID 14914790 The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/25/2018 through 6/27/2018 the Director of Nursing, Quality Assurance Nurse Consultant and Mini Data Set (MDS) Coordinators reviewed the most current Mini Data Set (MDS) for the last 6 months to ensure that Section O0100J Dialysis was coded appropriately. On 6/26/2017 the Quality Assurance Nurse Consultant in serviced the Director of Nursing, Dietary Manager, and Mini Data Set (MDS) Coordinator’s on the importance of accurately coding the Mini Data Set assessments for Dialysis. Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record	

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F 636	Continued From page 11	F 636	Treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item.IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IVmedications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis. As of 7/3/2018 no employee who is involved with coding Section O0100J, Dialysis (that is Director of Nursing, Mini Data Set (MDS) Coordinators) will be allowed to work until the training has been completed. Effective 7/3/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review 5 resident electronic medical records Mini Data Set (MDS) assessment	

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F 636	Continued From page 12	F 636	this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section O0100J, Dialysis was coded appropriately. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		7/5/18

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F 656	Continued From page 13 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to implement the comprehensive care plans for 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents and for 1 of 6 sampled residents reviewed for limited range of motion/contractures (Resident #87). The facility also failed to develop a comprehensive care plan for 1 of 6 sampled residents reviewed with a splinting device for contractures (Resident #114)	F 656	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged	

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F 656	Continued From page 14 and failed to follow the care plan to provide application of a brace for contracture management for 1 of 27 residents' care plans reviewed (Resident #69). Findings included: 1. Resident #69 was admitted to the facility on 5/1/11 with diagnoses that included, in part, hemiplegia and contracture, unspecified joint. A review of the annual Minimum Data Set (MDS) assessment dated 8/7/17 revealed Resident #69 had severely impaired decision making skills and had impairment on both sides of her upper extremity. A review of the care plan updated 5/2/18 revealed a problem of, "right upper extremity contracture." A care plan intervention included, "Apply splint to right hand daily and remove at night." A review of a physician order dated 2/21/18 revealed, "Nursing to put brace on right hand in the morning and off at evening. Diagnosis: contracture right hand." A review of the Medication Administration Record (MAR) for June 2018 revealed the brace was to be applied to Resident #69's right hand at 8:00 AM and removed at 9:00 PM. On 6/3/18 at 10:16 AM an observation of Resident #69 in her room revealed her right hand to be closed and the hand brace was not in place. The resident was unable to verbally answer questions but shook her head "no" when asked if she could open her hand. Further observation revealed a hand brace was on top of Resident	F 656	deficiencies cited have been or will be corrected by the date or dates indicated. F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to implement the comprehensive care plans for 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents and for 1 of 6 sampled residents reviewed for limited range of motion/contractures (Resident #87). The facility also failed to develop a comprehensive care plan for 1 of 6 sampled residents reviewed with a splinting device for contractures (Resident #114) and failed to follow the care plan to provide application of a brace for contracture management for 1 of 27 resident□s care plans reviewed (Resident #69). Resident #34 and #87 care plan was not implemented by staff. Resident #87, #114, and #69 care plan was not implemented by staff due to lack of knowledge. Resident #34: Care plan meeting with interdisciplinary team (Social worker, Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide, Administrator, Therapy,) and Resident representative held. Reviewed current interventions per care plan, resident has not had a fall, but is at risk for falls. Fall mat discontinued as not an appropriate intervention for resident. All other interventions are active and appropriate.	

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F 656	Continued From page 15 #69's dresser. On 6/4/18 at 10:45 AM an observation was made of Resident #69 in the day room. The brace was not on her right hand. On 6/4/18 at 3:14 PM an observation was made of Resident #69 in her room. The brace was not on her right hand. On 6/5/18 at 3:52 PM an interview was completed with Resident #69's Family Member. He stated Resident #69 had the right hand contracture before she was admitted to the facility. The Family Member reported that when he visited on 6/4/18 and 6/5/18 the resident's brace was not on her right hand and so he applied the brace both days. He said he typically visited Resident #69 five days per week and often, when he visited, the brace was not on the resident's hand. On 6/6/18 at 11:11 AM an observation was made of Resident #69 in the day room. The brace was not on her right hand. On 6/6/18 at 11:20 AM an interview was completed with Nurse #1. She stated the nurse aides (NAs) applied the braces/splints for contracture management. She said Resident #69's right hand had a contracture and that sometimes the NAs needed the nurse's help when they applied the brace. Nurse #1 said she thought the NAs forgot to put the brace on Resident #69's right hand for the last couple of days and said the resident's Family Member had mentioned to her in the past that when he visited Resident #69 her hand brace was not on. On 6/6/18 at 11:25 AM an interview was	F 656	Resident #87: Care plan meeting with interdisciplinary team (Social worker, Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide, Administrator, Therapy,) and Resident representative held. Reviewed current interventions per care plan, resident has not had a fall, but is at risk for falls. Fall mat discontinued as not an appropriate intervention for resident. All other interventions are active and appropriate. Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per physician orders. Resident #114: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per physician orders. Resident #69: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per physician orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/18/2018 through 6/27/2018 the Director of Nursing, Quality Assurance Nurse Consultant, Therapy Director, Unit Manager and Minimum Data Set Coordinators reviewed all current residents with care plan interventions that required the use of a fall mat. They also reviewed all current residents with splinting / brace devices for contractures management to ensure that a comprehensive care plan was developed, and plan of care was followed by nursing department (Registered nurses RN,	

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F 656	Continued From page 16 completed with NA #3. She stated she had never seen Resident #69 with a hand brace and didn't know she was supposed to apply the hand brace every day. On 6/6/18 at 2:22 PM an interview was completed with the Administrator. She stated she expected that staff follow the care plan and that the brace be applied daily to Resident #69's right hand. 2a. Resident #34 was admitted to the facility on 5/1/11 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dementia with behavioral disturbance, and a history of falling. Review of the quarterly Minimum Data Set (MDS) dated 3/20/18 indicated Resident #34 was severely, cognitively impaired; required extensive assistance of two staff for bed mobility and transfers; had impaired range of motion on one side of her body; and had no falls since the comprehensive assessment. The Care Plan dated 4/5/18 revealed Resident #34 was susceptible to falling which may cause physical harm related to hemiplegia secondary to her cerebrovascular accident; and the resident was non-weight bearing of bilateral extremities. Interventions included: remind the resident of the risks of throwing her legs over the side of the bed; a blue fall mat to the right side of the; and ensure the bed was in the lowest position at all times. Observations on 6/03/18 at 9:05 a.m., 6/6/18 at 1:18 p.m., and 6/7/18 at 1:15 p.m., revealed Resident #34 was in her bed which was raised at regular height (approximately 3-feet from floor).	F 656	Licensed Practical Nurses LPN and Nurse Aides) for splints/braces used for contracture management. On 6/26/2017 through 7/5/2018 the Quality Assurance Nurse Consultant and Unit Manager in serviced the Nurses (RN and LPN) and Nurse Aides (Full time, Part time, and PRN) that the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. Splints/ Braces: Physician orders will be placed in the electronic health record for the resident under the Administration Record. A comprehensive care plan will be developed and implemented for residents who use Splints/Braces and who use fall mats. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 656	Continued From page 17 The gray fall mat was folded and positioned upright against the wall on the right side of the bed. There was no fall mat on the floor positioned next to either side of the bed. During an interview on 6/7/18 at 3:32 p.m., MDS Nurse #1 stated Resident #34 had right side hemiparesis. She revealed the resident was non-ambulatory, but was able to move her body and would sometimes throw her leg over the side of the scoop mattress. She stated that the resident had no recent falls. 2b. Resident #87 was admitted to the facility on 12/10/14 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia with behavioral disturbance, and Alzheimer's disease. Review of the annual Minimum Data Set dated 5/1/18 indicated Resident #87 was moderately, cognitively intact, required extensive assistance of two staff for bed mobility, was totally dependent of two staff for transfers, had impaired range of motion of upper and lower extremities on one side, and had no falls. The Care Plan revealed Resident #87 was at increased susceptibility to falling that may cause physical harm related to unsteady balance secondary to cerebrovascular disease with left hemiplegia, and was non-weight bearing of her left lower extremity. Interventions included: a cushioned fall mat at bedside; and, bed in low position. Observations on 6/3/18 at 8:06 a.m. and on	F 656	requirements; The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents with orders for splints/braces to ensure that it is implemented as ordered and that is it care planned. The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents with care plan interventions to have a fall mat beside their bed while in bed to ensure that the plan of care is being implemented. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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6/5/18 at 10:53 a.m., Resident #87 was in bed in the low position near the door, but the fall mat was not next to the bed. The fall mat was on the floor on the far side of the room, beneath the window.

During an interview on 6/6/18 at 1:36 p.m., NA#5 (nursing assistant) stated Resident #87 was non-ambulatory, but would often wiggle down in the bed. NA#5 revealed when the resident was in the bed, the fall mat was to be placed on the floor on the right side of the bed.

3. Resident #87 was admitted to the facility on 12/10/14 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia with behavioral disturbance, and Alzheimer's disease.

Review of the annual Minimum Data Set (MDS) dated 5/1/18 indicated Resident #87 was moderately, cognitively intact, required extensive assistance of two staff for bed mobility, was totally dependent of two staff for transfers, had impaired range of motion of upper and lower extremities on one side; and had no falls.

The Care Plan revealed Resident #87 received restorative nursing for splinting/brace application. Interventions included: assist with application of splint according to the schedule; and assist with removal of the brace according to the schedule.

The Care Plan also revealed Resident #87 had impaired physical mobility related to left sided hemiplegia, loss of balance, and coordination due to a history of cerebrovascular accident.

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Interventions included: hand splint on in morning and off at bedtime.

Observations of Resident #87 on 6/5/18 at 10:55 a.m., 6/6/18 at 1:28 p.m., and 6/7/18 at 9:44 a.m., revealed the resident without a splinting device on her contracted left hand. There was no splinting device visible in the resident's room.

During an interview on 6/06/18 at 1:36 p.m., NA#5 (nursing assistant) revealed that she would apply the hand splint to Resident #87's contracted left hand at the beginning of her shift for four hours, but most of the time the resident would remove it and discard it in the bed.

During an interview on 6/7/18 at 10:15 a.m., the Administrator stated that the nursing assistants should have reported to the nurse that Resident #87 frequently removed the hand splint then the nurse should notify MDS nurse so the resident's Care Plan could be updated/revised.

4. Resident #114 was admitted to the facility on 11/1/16 with diagnoses which included: diabetes mellitus with neuropathy, and a history of transient ischemic attack and cerebral infarction with residual deficits.

Review of the Occupational Therapy Discharge Summary dated 12/16/16 revealed Resident #114 was to receive restorative nursing for the application of a right, resting hand splint.

The annual Minimum Data Set dated 5/15/18 indicated Resident #114 was cognitively intact; required extensive assistance of two staff with bed mobility and transfers; had impaired range of

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motion of her upper and lower extremities on one side; and had no falls.

The review of the Care Plan dated 5/30/18 revealed Resident #114 had a self-care deficit related to the inability to perform ADLs (activities of daily living) satisfactorily, secondary to old cerebrovascular accident with residual right side weakness and contraction to fingers on her right hand. Interventions included: one staff assistance to re-position and turn in bed; and, the use of quarter side rails for safety when staff provided care.

There was no Care Plan with Interventions for range of motion services or the splinting device on Resident #114's right hand contracture.

During an observation and interview on 6/4/18 at 11:05 a.m., Resident #114 was sitting up in bed. The fingers of the resident's right hand were bent toward the palm of the hand. A stained, blue hand splint was observed hanging from the nightstand located to the right of the resident's head of the bed. Resident #114 revealed the hand splint was not applied to her hand every day and only when her family applied it.

During an observation on 6/6/18 at 1:16 p.m., Resident #114 was sitting up in bed feeding herself lunch. The blue hand splint was in a chair with a stack of other items.

On 6/7/18 at 2:00 p.m., Resident#114 was observed sitting upright in bed with a blue hand splint on her right hand.

During an interview on 6/8/18 at 9:13 a.m., MDS Nurse#2 revealed that during her observation

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F 656	Continued From page 21 assessment of Resident#114 during care, she did notice the resident's right hand contracture, but did not observe a splinting device in the room and the nursing assistant (could not recall which nursing assistant) did not indicate the resident had a splint. At this point of the interview MDS Nurse#2 excused herself from the room to make an observation of the resident in her room. Upon returning to the interview, MDS Nurse#2 revealed she observed a hand splint on Resident#114's nightstand and the resident informed her that she (the resident) did not want the splint applied. MDS Nurse#2 stated that if she had been made aware the resident had a splint, it would have been on the care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		7/5/18

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F 657	Continued From page 22 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living (ADLs). The findings included: Resident #81 was admitted to the facility on 8/16/17 with diagnoses, in part, of left ankle fracture. A review of the admission Minimum Data Set (MDS) assessment dated 8/23/17 revealed the presence of a fracture. A review of the quarterly MDS dated 2/11/18 did not indicate the presence of a fracture. A review of the care plan dated 4/27/18 revealed a problem of "risk for impaired skin integrity related to limited bed mobility secondary to pain from left ankle fracture and presence of cast." An observation on 6/3/18 at 10:37 AM revealed resident sitting up in her wheelchair with no observation of a cast to her left ankle. An interview with MDS nurse #1 on 6/7/18 at 1:44 PM revealed she updates the care plan regularly	F 657	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 CARE PLAN TIMING AND REVISION. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to update a resident's care plan to reflect cast removal for 1 of 7(Resident #81) residents reviewed for activities of daily living. (ADLs). Minimum Data Set Nurse did not resolve the care plan once cast was removed. Resident #81: Care plan was updated to reflect cast removal on 6/7/2018. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

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F 657	Continued From page 23 with information she receives during the daily clinical meeting. All of the care plans are updated quarterly. MDS nurse #1 revealed she should have removed the cast from Resident #81's care plan but she missed it. An interview with the Administrator on 6/7/18 at 3:15 PM revealed her expectation was that the care plan be updated according to the regulation.	F 657	On 6/18/2018 through 6/27/2018 the Quality Assurance Nurse Consultant and Minimum Data Set Coordinators reviewed all current residents with care plan interventions with the presence of cast. No current resident in the facility has a cast and no intervention reflects presence of cast. On 6/26/2017 through 7/5/2018 the Quality Assurance Nurse Consultant in serviced the Minimum Data Set Coordinator that the facility must develop and implement a comprehensive person-centered care plan for each resident and it has to be developed within 7days after completion of the comprehensive assessment by the interdisciplinary team which includes but not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, to the extent practicable, the participation of the resident , a dietary member, to the extent practicable , the participation of the resident and the resident's representative (s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of resident's care plan. When a cast is removed, the care plan must be updated to reflect cast removal. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has	

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F 657	Continued From page 24	F 657	been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents to ensure that a comprehensive care plan is developed within 7days after completion of the comprehensive assessment and it is revised timely. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator.	
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-	F 658		7/5/18

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F 658	Continued From page 25 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to follow physician orders to obtain daily weights and report changes to the physician for 1 of 1 residents (Resident #117) with change of condition with shortness of breath and chest discomfort. Findings include: Resident #117 was admitted to the facility on 5/14/18 with diagnoses that included chronic atrial fibrillation, hypertension (high blood pressure), multiple pressure ulcers, and chronic systolic congestive heart failure. The admission Minimum Data Set (MDS) dated 5/21/18 specified the resident had intact cognition, no behaviors or rejection of care. Resident #117 required two person extensive assistance for bed mobility, transfers, toilet use, and bathing, and required one person extensive assistance with locomotion on/off unit, dressing, eating, and personal hygiene. The resident was always continent of bowel movements, had an indwelling urinary catheter, and was administered a diuretic 7 of 7 days during that assessment period. Review of the resident's care plan dated for 5/16/18 revealed Resident #117 had Congestive Heart Failure (CHF), with goals to be free of peripheral edema (swelling) and for his body weight to remain within normal limits through the review date. Interventions to be in place were to check breath sounds and monitor/document for	F 658	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F658 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to follow physician orders to obtain daily weights and report changes to the physician for 1 of 1 residents (Resident #117) with change of condition with shortness of breath and chest discomfort. Nurse did not document daily weight obtained by nurse aide in the electronic health record. Resident #117: Daily Weight was obtained, Medical Doctor was notified, new orders implemented per physician orders, Care plan revised. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/18/2018 through 6/27/2018 the Quality Assurance Nurse Consultant and Unit Manager reviewed all current	

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F 658	Continued From page 26 labored breathing, encourage adequate nutrition, and to monitor/document/report to physician as needed of any signs and symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. Review of physician order's revealed an order placed on 6/4/2018 for daily weights to be obtained every evening shift. Weights were documented as: 5/14/2018 9:31 PM - 236.8 pounds (Lbs) 5/14/2018 10:51 PM - 236.8 Lbs 5/16/2018 4:41 AM - 237.2 Lbs 5/21/2018 6:26 AM - 235.9 Lbs 5/24/2018 6:37 AM - 236.3 Lbs 5/24/2018 2:23 PM - 234.0 Lbs (No weights were obtained from 5/25/18 through 6/2/18) 6/3/2018 5:47 PM - 226.8 Lbs (No weights were obtained from 6/4/18 through 6/6/18) 6/7/2018 11:45 PM - 236.7 Lbs During an interview and observation on 6/3/18 at 8:39 AM the resident was is his bed, alert and oriented, and was eating ice chips. He stated that he had just been cleared to start eating my speech therapy but was still receiving a continuous feeding through his PEG tube. The resident did not exhibit any signs or symptoms of CHF, his breathing was unlabored, no obvious edema, and stated he had no chest pain.	F 658	residents with daily weights to ensure that daily weights were obtained as per physician orders and that physician was notified for any change of condition. . On 6/26/2017 through 7/5/2018 the Quality Assurance Nurse Consultant in serviced the all nurses (Registered Nurse, License Practical Nurses) and Medication Aide that the facility must ensure that the services provided or arranged by the facility as outlined by the comprehensive care plan meet professional standards of quality. Daily weights have to be obtained daily per physician orders, physician orders have to be followed and to immediately notify physician of any change of condition. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Unit Manager will review weekly, including the weekend, 5 residents with daily weights ordered to ensure that daily weights are obtained per physician orders and that physician has been notified for	

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F 658	Continued From page 27 During an observation on 6/07/18 9:41 AM resident #117 was in bed and presented with shortness of breath and was holding his chest. The resident stated he was having chest discomfort, was overall very uncomfortable and couldn't catch his breath. The resident's face was flushed and periorbital edema (swelling around eyes) was noted. When asked if they had obtained his daily weight that morning, he stated they had not weighed him yet, and also stated that it was not done daily, only on occasion, and that he had not refused at any time. During an interview with Nurse #50 on 6/07/18 09:48 AM when asked about weights and stated that she noticed this morning that a weight had not been obtained. When shown the weight log she stated that weights were not done daily according to the records and stated that they were not ordered to be done on her shift, so she hadn't realized they weren't being done. This surveyor informed Nurse #50 of the symptoms observed (shortness of breath, holding chest, and the resident had stated he felt uncomfortable and couldn't catch his breath). She stated that they were aware and that a weight would be obtained as soon as possible. During an interview with the Quality Assurance Regional Nurse Consultant on 6/7/18 at 11:24 PM she stated that it was her expectation for staff to follow physician orders and that it was important to obtain daily weights for CHF residents. During an interview with the dietician on 6/7/18 at 1:38 PM she stated that she had not realized that daily weights were not being obtained. She stated that it was important to obtain daily weights	F 658	any change of condition. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator.	

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F 658	Continued From page 28 for residents with CHF, especially with continuous tube feedings. During an interview with Nurse #50 on 6/07/18 at 2:23 PM she stated she was aware of the "10 pound weight gain" but had not called to notify the provider at that time. When this surveyor asked if she felt it was important to notify providers of a 10 pound weight gain with someone who has CHF she stated she did not feel it was necessary because it was the first one obtained since they had restarted daily weights, but that she was planning on calling the provider for the resident's increased congestion and cough. Review of a Nurse's Note from 6/7/2018 2:42 PM stated that the Nurse Practitioner (NP) was called and notified about weight gain and congestion. New orders were placed for chest x-ray and one time order for Lasix 20mg tablet by mouth. NP and MD were to follow up in the morning. During an interview with 6/7/18 at 4:18 PM the facility's MD stated that he would expect staff to report a 10 pound weight gain immediately as well as the shortness of breath, cough, and any other signs or symptoms of a CHF exacerbation. Depending on the condition of the resident, it could possibly require an admission to the hospital for further evaluation.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents 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	F 677		7/5/18

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F 677	Continued From page 29 by: Based on observations, record review, staff and family member interviews, the facility failed to provide incontinent care for 1 of 7 residents (Resident #60) requiring assistance with Activities of Daily Living (ADLs). The findings included: 1. Resident #60 was admitted to the facility on 2/22/17 with diagnoses, in part, of Alzheimer's. A review of the quarterly Minimum Data Set (MDS) assessment dated 4/10/18 revealed the resident had severely impaired cognition and required extensive assistance of two people for bed mobility, toileting and hygiene and was always incontinent of bladder. A review of the care plan dated 4/20/18 revealed a problem of incontinence with an intervention of needing assistance with incontinent care. An observation on 6/4/18 at approximately 4:15 revealed the resident lying in bed. A urine odor was present and the resident had a large, circular brownish area noted to the pad underneath him. An observation on 6/5/18 at 8:34 AM revealed the resident lying in bed. A strong urine odor was present in the hallway and, upon entering the resident's room, a large, circular brownish area noted to the pad underneath him. An observation on 6/5/18 at 8:45 AM revealed Nurse Aide (NA) #1 in Resident #60's room feeding him breakfast. Incontinent care had not been provided and the urine odor remained.	F 677	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to failed to provide incontinent care for 1 of 7 residents (Resident #60) requiring assistance with Activities of Daily Living (ADLs). Nurse aide did not provide incontinent care as resident was combative and was waiting for assistance. Resident #60: Incontinence care was provided per plan of care. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/25/2018, the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) that a resident who is unable to carryout activities of daily living receives the necessary services to maintain good	

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F 677	Continued From page 30 Continuous observation was conducted on 6/5/18 between 8:45 AM to 10:30 AM. There were no staff observed entering the resident's room. At approximately 10:30 AM on 6/5/18, Hospice NA #1 entered the room. An observation at that time revealed the Hospice NA pull the top sheet off the resident and state "he's soaked". The resident's top sheet, brief, pad and bottom sheet were wet with urine. The resident's t-shirt was wet up his back and had a brownish colored stain where the wetness ended. A strong urine odor was present. An observation of resident's skin did not indicate any redness or open areas. An interview with NA #1 on 6/5/18 at approximately 11:30 AM revealed she knew the resident was incontinent when she was feeding him, but couldn't do it herself because the resident became combative so she told NA #2, who was assigned to Resident #60. An interview with NA #2 on 6/5/18 at approximately 11:45 AM revealed he checks the residents for incontinence every 2 hours. He stated he did not know the resident was incontinent during breakfast and did not answer when asked if NA #1 had told him the resident was incontinent during breakfast. He stated he changed the resident at 6:00 AM and 9:00 AM that morning. When it was revealed the resident was eating breakfast at 9:00 AM, he stated that he changed him at 6:00 AM. An interview with the Corporate Nurse Consultant on 6/6/18 at 2:01 PM revealed incontinent care is provided per the care plan. If the care plan indicated the resident was incontinent and needed assistance with incontinent care, she	F 677	nutrition, grooming, and personal and oral hygiene; The facility must ensure to provide incontinence care per plan of care. As of 7/5/2018 no nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Unit Manager will observe 5 residents each week to include the weekend who are unable to carry out Activities of Daily Living to ensure that they had incontinence care provided per plan of care by using a quality assurance (QA) survey tool This will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse,	

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F 677	Continued From page 31 would expect the staff to check the resident frequently to see if incontinent care was needed. She further revealed she would not expect staff to continue feeding a resident if they were aware the resident needed to be changed.	F 677	Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete weekly pressure ulcer assessments that included measurement of the wound for 1 of 3 residents (Resident #67) reviewed for pressure ulcers. Findings included: Resident #67 was admitted to the facility on 6/13/17 with diagnoses that included, in part,	F 686	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	7/5/18

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F 686	Continued From page 32 peripheral vascular disease, end stage renal disease and non-Alzheimer's dementia. A review of the annual Minimum Data Set (MDS) assessment dated 4/16/18 revealed Resident #67 had severely impaired cognition. She had an unstageable/deep tissue injury pressure ulcer and received pressure ulcer care. A review of the care plan updated 5/25/18 revealed a problem of, "Currently has suspected deep tissue injury (SDTI) to left heel related to immobility." Care plan interventions included: "Administer treatments as ordered and monitor for effectiveness. Keep pillows beneath calves to lift heels off of bed. Observe/document/report to physician changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size, stage." A review of physician (MD) order dated 3/23/18 revealed, "Skin prep to left heel daily every day shift for wound care." A review of the weekly pressure ulcer review dated 3/28/18 revealed an onset date of 3/22/18. The wound was not community acquired and was unstageable. The wound was not measured. A review of the weekly pressure ulcer review dated 4/2/18 revealed the wound was not measured. A review of the weekly pressure ulcer review dated 4/9/18 revealed the assessment had not been completed and was "in progress." A review of the MD progress note dated 4/25/18 revealed a wound to the back of the left heel that	F 686	deficiencies cited have been or will be corrected by the date or dates indicated. F686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to complete weekly pressure ulcer assessments that included measurement of the wound for 1 of 3 residents. (Resident #67) reviewed for pressure ulcers. Resident #67: Weekly pressure ulcers assessment that included measurement of the wound was completed weekly. Wound documentation was completed by the physician and the treatment nurse was in training. Treatment nurse had not completed facility required wound documentation. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/27/2018-6/29/2018 weekly pressure ulcers assessments were completed by Wound Nurse for all residents who have pressure ulcers. On 6/25/2018, the Director of Nursing and Unit Manager began in-servicing the nurses (Registered nurses and License Practical Nurse: Full time, Part time and PRN) that the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates	

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F 686	Continued From page 33 measured 1.5 centimeters (cm) by 1 cm. Diagnosis included, "SDTI of unknown depth of heel. Continue to apply skin prep to the back of the heel daily." A review of the weekly pressure ulcer review dated 5/23/18 revealed a measurement of 1.5cm by 1.0 cm. A review of the medical record revealed no pressure ulcer reviews or measurements were completed for the weeks of 4/16/18, 4/30/18, 5/7/18, 5/14/18, or 5/28/18. On 6/6/18 at 8:51 AM an interview was completed with Nurse Aide (NA) #4. He stated while the new treatment nurse was in orientation he helped provide wound treatments. He said Resident #67 had the wound on her left heel "for a while" and that the Medical Director staged the wound each week. On 6/6/18 at 1:49 PM an interview was completed with the Nurse Consultant. She said wound treatments were done as ordered and a weekly assessment was completed to measure the wound and identify the location and type of tissue. She stated the Medical Director completed his own measurements of the wound and that unless there was a change in the wound the Medical Director wouldn't write a new pressure ulcer note. On 6/6/18 at 2:15 PM an interview was completed with the Administrator. She stated the previous treatment nurse left in April and the Director of Nursing and Nurse Supervisor had rounded with the Medical Director when he assessed wounds. The Administrator did not answer as to why the weekly pressure ulcer reports and measurements	F 686	that they were unavoidable. The facility must ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The facility must complete weekly pressure ulcers assessments that include measurements of the wounds weekly for residents who have pressure ulcers. Weekly pressure ulcer assessments will be completed weekly by the wound nurse and or Unit Manager. As of 7/5/2018 no nursing staff (Registered nurses and License Practical Nurse: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Unit Manager will review 5 residents each week, who have pressure ulcers to ensure that a weekly pressure ulcer assessment that included measurement of the wound has been completed by using a quality	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(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 686	Continued From page 34 were not completed. On 6/6/18 at 3:55 PM an interview was completed with the Medical Director. He stated Resident #67's wound to her left heel started at the facility, had improved and "We healed her out today." He said the facility had three different treatment nurses in the past year and because of the turnover they had lost continuity in completing wound documentation but stated he expected wound reviews and measurements be completed weekly.	F 686	assurance (QA) survey tool This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		7/5/18

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F 688	Continued From page 35 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide application of a splint/brace for contracture management for 3 of 6 sampled residents (Residents #87, #114, and #69) reviewed for limited range of motion. Findings included: 1. Resident #87 was admitted to the facility on 12/10/14 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia with behavioral disturbance, and Alzheimer's disease. Review of the annual Minimum Data Set (MDS) dated 5/1/18 indicated Resident #87 was moderately, cognitively intact, required extensive assistance of two staff for bed mobility, was totally dependent of two staff for transfers, had impaired range of motion of upper and lower extremities on one side; and had no falls. The Care Plan revealed Resident #87 received restorative nursing for splinting/brace application. Interventions included: assist with application of splint according to the schedule; and assist with removal of the brace according to the schedule. The Care Plan also revealed Resident #87 had impaired physical mobility related to left sided hemiplegia, loss of balance, and coordination due to a history of cerebrovascular accident.	F 688	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F688 INCREASE PREVENT DECREASE IN ROM MOBILITY. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to provide application of a splint/brace for contracture management for 3 of 6 sampled residents (Resident #87, #114, #69) reviewed for limited range of motion. Resident #87: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per physician orders. Resident #114: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per physician orders. Resident #69: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per	

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F 688	Continued From page 36 Interventions included: hand splint on in morning and off at bedtime. Review of the Documentation Survey Reports of completed tasks by the facility's nursing assistants included: PROM (passive range of motion) to left hand for 15 minutes daily. Apply splint during day, leave on for 4-6 hours. Observe skin around splint daily. Check for redness, increased swelling and sore. Clean in between fingers before donning and after splint removal. The May 2018 and June 2018 survey reports indicated Resident#87 did not receive PROM services and her hand splint was not applied for 14 days in May 2018 and on June 3, 2018. Observations of Resident #87 on 6/5/18 at 10:55 a.m., 6/6/18 at 1:28 p.m., and 6/7/18 at 9:44 a.m., revealed the resident without a splinting device on her contracted left hand. There was no splinting device visible in the resident's room. During an interview on 6/06/18 at 1:36 p.m., NA#5 (nursing assistant) revealed that she would apply the hand splint to Resident #87's contracted left hand at the beginning of the 7:00 a.m. shift for four hours, but most of the time the resident would remove it and discard it in the bed. The NA stated she ensured palm of the resident's contracted hand was washed during her showers which were on Mondays and Thursdays. During this interview, NA#5 was observed removing the splinting device (a black hand roll with finger separators) from a drawer in the resident's room. As she applied the splint to the resident's left hand, NA#5 commented the resident's hand had small dirt particles and had an odor. During a closer observation of Resident #87's	F 688	physician orders. Care plan was not implemented by staff for resident #87, #114, #69 due to lack of knowledge. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/18/2018 through 6/27/2018 the Director of Nursing, Quality Assurance Nurse Consultant, Therapy Director, Unit Manager and Minimum Data Set Coordinators reviewed all current residents with splinting / brace devices for contractures management to ensure that they were applied per physician orders by nursing department (Registered nurses RN, Licensed Practical Nurses LPN and Nurse Aides). On 6/26/2017 through 7/5/2018 the Quality Assurance Nurse Consultant and Unit Manager in serviced the Nurses (RN and LPN) and Nurse Aides (Full time, Part time, and PRN) that The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident□s clinical condition demonstrates that a reduction in range of motion is unavoidable and A resident with limited range of motion receives appropriate treatment and services to increase range of motion and /or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with maximum practicable independence unless a reduction in	

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F 688	Continued From page 37 contracted hand with the splint on, there was an unpleasant odor emitting from the hand. During an interview on 6/7/18 at 10:15 a.m., the Administrator stated the facility's restorative nursing was incorporated with the daily care provided to residents. She indicated the nursing assistants should have reported to the nurse that Resident #87 frequently removed the hand splint then the nurse should notify MDS nurse so the resident's Care Plan could be updated/revised. 2. Resident #114 was admitted to the facility on 11/1/16 with diagnoses which included: diabetes mellitus with neuropathy, and a history of transient ischemic attack and cerebral infarction with residual deficits. Review of the Occupational Therapy (OT) Discharge Summary dated 12/16/16 revealed Resident #114 was to receive restorative nursing for the application of a right, resting hand splint. The annual Minimum Data Set dated 5/15/18 indicated Resident #114 was cognitively intact; required extensive assistance of two staff with bed mobility and transfers; had impaired range of motion of her upper and lower extremities on one side; and had no falls. The review of the Care Plan dated 5/30/18 revealed Resident #114 had a self-care deficit related to the inability to perform ADLs (activities of daily living) satisfactorily, secondary to old cerebrovascular accident with residual right side weakness and contraction to fingers on her right hand. Interventions included: one staff assistance to re-position and turn in bed; and, the use of	F 688	mobility is demonstrably unavoidable. Splints/Braces have to be applied per physician orders. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents weekly including the weekend, with orders for splints/braces to ensure that it is implemented /applied as ordered This will be done on a weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator.	

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F 688	Continued From page 38 quarter side rails for safety when staff provided care. During an observation and interview on 6/4/18 at 11:05 a.m., Resident #114 was sitting up in bed. The fingers of the resident's right hand were bent toward the palm of the hand. A stained, blue hand splint was observed hanging from the nightstand located to the right of the resident's head of the bed. Resident #114 revealed the hand splint was not applied to her hand every day and only when her family applied it. During an observation on 6/6/18 at 1:16 p.m., Resident #114 was sitting up in bed feeding herself lunch. The blue hand splint was in a chair with a stack of other items. On 6/6/18 at 3:30 p.m., after reviewing of the nursing assistants' tasks records and the medication administration records of Resident #114, the facility's Nurse Consultant confirmed there was no available documentation indicating the resting hand splint was applied by facility staff as recommended by OT. On 6/7/18 at 2:00 p.m., Resident#114 was observed sitting upright in bed with a blue hand splint on her right hand. During an interview on 6/8/18 at 9:13 a.m., MDS Nurse#2 revealed that during her observation assessment of Resident#114 during care, she did notice the resident's right hand contracture, but did not observe a splinting device in the room and the nursing assistant (could not recall which nursing assistant) did not indicate the resident had a splint.	F 688	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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F 688	Continued From page 39	F 688		

3. Resident #69 was admitted to the facility on 5/1/11 with diagnoses that included, in part, hemiplegia and contracture, unspecified joint.

A review of the annual Minimum Data Set (MDS) assessment dated 8/7/17 revealed Resident #69 had severely impaired decision making skills and had impairment on both sides of her upper extremity.

A review of the care plan updated 5/2/18 revealed a problem of, "right upper extremity contracture." A care plan intervention included, "Apply splint to right hand daily and remove at night."

A review of a physician order dated 2/21/18 revealed, "Nursing to put brace on right hand in the morning and off at evening. Diagnosis: contracture right hand."

A review of the Medication Administration Record (MAR) for June 2018 revealed the brace was to be applied to Resident #69's right hand at 8:00 AM and removed at 9:00 PM.

On 6/3/18 at 10:16 AM an observation of Resident #69 in her room revealed her right hand to be closed and the hand brace was not in place. The resident was unable to verbally answer questions but shook her head "no" when asked if she could open her hand. Further observation revealed a hand brace was on top of Resident #69's dresser.

On 6/4/18 at 10:45 AM an observation was made of Resident #69 in the day room. The brace was not on her right hand.

On 6/4/18 at 3:14 PM an observation was made

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F 688	Continued From page 40	F 688		

of Resident #69 in her room. The brace was not on her right hand.

On 6/5/18 at 3:52 PM an interview was completed with Resident #69's Family Member. He stated Resident #69 had the right hand contracture before she was admitted to the facility. The Family Member reported that when he visited on 6/4/18 and 6/5/18 the resident's brace was not on her right hand and so he applied the brace both days. He said he typically visited Resident #69 five days per week and often, when he visited, the brace was not on the resident's hand.

On 6/6/18 at 11:11 AM an observation was made of Resident #69 in the day room. The brace was not on her right hand.

On 6/6/18 at 11:20 AM an interview was completed with Nurse #1. She stated the nurse aides (NAs) applied the braces/splints for contracture management. She said Resident #69's right hand had a contracture and that sometimes the NAs needed the nurse's help when they applied the brace. Nurse #1 said she thought the NAs forgot to put the brace on Resident #69's right hand for the last couple of days and said the resident's Family Member had mentioned to her in the past that when he visited Resident #69 her hand brace was not on.

On 6/6/18 at 11:25 AM an interview was completed with NA #3. She stated she had never seen Resident #69 with a hand brace and didn't know she was supposed to apply the hand brace every day.

On 6/6/18 at 2:22 PM an interview was completed with the Administrator. She stated she expected

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F 688	Continued From page 41 that staff follow the physician order and that the brace be applied daily to Resident #69's right hand.	F 688		
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 position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents. Findings included: 1. Resident #34 was admitted to the facility on 5/1/11 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dementia with behavioral disturbance, and a history of falling. Review of the quarterly Minimum Data Set (MDS) dated 3/20/18 indicated Resident #34 was severely, cognitively impaired; required extensive assistance of two staff for bed mobility and transfers; had impaired range of motion on one side of her body; and had no falls since the comprehensive assessment.	F 689	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and	7/5/18

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F 689	Continued From page 42 The Care Plan dated 4/5/18 revealed Resident #34 was susceptible to falling which may cause physical harm related to hemiplegia secondary to her cerebrovascular accident; and the resident was non-weight bearing of bilateral extremities. Interventions included: remind the resident of the risks of throwing her legs over the side of the bed; a blue fall mat to the right side of the; and ensure the bed was in the lowest position at all times. Observations on 6/03/18 at 9:05 a.m., 6/6/18 at 1:18 p.m., and 6/7/18 at 1:15 p.m., revealed Resident #34 in her bed which was raised at regular height (approximately 3-feet from floor). The gray fall mat was folded and positioned upright against the wall on the right side of the bed. There was no fall mat on the floor positioned next to either side of the bed during each of the observations. During an interview on 6/7/18 at 3:32 p.m., MDS Nurse #1 stated Resident #34 had right side hemiparesis. She revealed the resident was non-ambulatory, but was able to move her body and would sometimes throw her leg over the side of the scoop mattress. She stated that the resident had no recent falls. 2. Resident #87 was admitted to the facility on 12/10/14 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia with behavioral disturbance, and Alzheimer's disease. Review of the annual Minimum Data Set dated 5/1/18 indicated Resident #87 was moderately,	F 689	#87) reviewed for accidents. Resident #34: Care plan meeting with interdisciplinary team (Social Worker, Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide, Administrator, Therapy,) and Resident representative held. Reviewed current interventions per care plan, resident has not had a fall, but is at risk for falls. Fall mat discontinued as not an appropriate intervention for resident. All other interventions are active and appropriate. Resident #87: Care plan meeting with interdisciplinary team (Social Worker, Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide, Administrator, Therapy,) and Resident representative held. Reviewed current interventions per care plan, resident has not had a fall, but is at risk for falls. Fall mat discontinued as not an appropriate intervention for resident. All other interventions are active and appropriate. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/18/2018 through 6/27/2018 the Director of Nursing, Quality Assurance Nurse Consultant, Therapy Director, Unit Manager and Minimum Data Set Coordinators reviewed all current residents with care plan interventions that required the use of a fall mat. Care plan meeting with interdisciplinary team (Social Worker, Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide, Administrator, Therapy,) and Resident representative held on 6/27/2018-6/29/2018. Reviewed current	

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F 689	Continued From page 43 cognitively intact, required extensive assistance of two staff for bed mobility, was totally dependent on two staff for transfers, had impaired range of motion of upper and lower extremities on one side, and had no falls. The Care Plan revealed Resident #87 was at increased susceptibility to falling that may cause physical harm related to unsteady balance secondary to cerebrovascular disease with left hemiplegia, and was non-weight bearing of her left lower extremity. Interventions included: a cushioned fall mat at bedside; and, bed in low position. On 6/3/18 at 8:06 a.m. and on 6/5/18 at 10:53 a.m., Resident #87 was observed in a low bed near the door, but the fall mat was not next to the bed. The fall mat was on the floor on the far side of the room, beneath the window during both observations. During an interview on 6/6/18 at 1:36 p.m., NA#5 (nursing assistant) stated Resident #87 was non-ambulatory, but would often wiggle down in the bed. NA#5 revealed when the resident was in the bed, the fall mat was to be placed on the floor on the right side of the bed.	F 689	interventions per care plan to ensure fall mat was an appropriate intervention for each resident. Care plans revised and current interventions are active and appropriate. On 6/26/2017 through 7/5/2018 the Quality Assurance Nurse Consultant and Unit Manager in serviced the Nurses (RN and LPN) and Nurse Aides (Full time, Part time, and PRN) that the facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. Fall mats will be implemented per plan of care. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Minimum Data Set Coordinators will observe 5 resident with care plan interventions to have a fall mat beside their bed while in bed to ensure that the plan of care is being implemented. This will be done on weekly basis to include the	

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F 689	Continued From page 44	F 689	weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interviews the facility failed to maintain appropriate temperatures and ensure palatability of food items transported with dialysis residents to the dialysis facility for 3 of 3 dialysis residents reviewed.	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	7/5/18

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(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 804	Continued From page 45 Findings include: 1)Resident #80 was admitted to the facility on 4/20/18 with diagnoses that included anemia, hypertension (high blood pressure), End Stage Renal Disease (ESRD), diabetes mellitus, and hyperlipidemia (high cholesterol). The admission Minimum Data Set (MDS) dated 4/27/18 specified the resident had intact cognition, no behaviors or rejection of care, and the resident was independent for eating meals. Resident #80's Care Area Analysis from 4/27/18 stated the resident received hemodialysis three times a week, and was ordered a liberalized renal diet for management of ESRD. A Physician's order was placed for dialysis on Monday, Wednesday and Friday at the dialysis facility. During an observation and interview with resident #80 on 6/4/18 9:15 AM, a large plastic resealable bag was observed in the resident's bag hanging on the back of her wheelchair containing a plastic wrapped sandwich, a container of apple sauce, two packs of saltine crackers, and a small can of ginger ale. When asked about the meal in her bag, the resident stated that this was the meal given to take with her to eat for lunch at the dialysis facility, and that it is brought to her on the breakfast tray at approximately 8:00 AM in the plastic bag each day she went for dialysis. She stated that the sandwich was usually some kind of sandwich meat or peanut butter and jelly. She stated that she did not usually eat her meal because it didn't taste good, was room temperature by the time she would eat it for lunch at the dialysis facility, and was never enough to fill her up.	F 804	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP The plan for correcting the specific deficiency. The plan should address processes that lead to the deficiency cited. The facility failed to maintain appropriate temperatures and ensure palatability of food items transported with dialysis residents to the dialysis facility. Resident #80. Food items transported to the dialysis center for resident #80 were placed in zip lock bags. The Corporate Dietitian with the Contract Food Management Company purchased insulated cooler bags on Wednesday, June 6, 2018, which were put into use on Friday, June 8, 2018. Dietary staff will place appropriate dialysis meal in cooler bag with freezer (ice) pack and deliver to resident with breakfast tray. Dietary Management will monitor compliance with this policy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; An in-service on Preparing Dialysis Bags was conducted for all Dietary staff on June 6, 2018 by the Corporate Dietitian with the Contract Food Management	

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F 804	Continued From page 46 During an interview with the Dietician and assistant dietary manager on 6/07/18 at 1:38 PM, when asked about how meals are prepared prior to transport to the dialysis facility for the three dialysis residents residing in the facility, she stated that a sandwich is wrapped in plastic separately, a soda, fruit, and crackers were placed in a large resealable plastic bag and delivered to the resident's on their breakfast trays. The sandwich was usually some kind of meat such as ham or turkey, or peanut butter and jelly. She stated that the facility had been asked to provide the resident's with insulated bags but that it had not been done. During an interview with Transport on 6/07/18 1:58 PM, she stated that there was no cooler on the bus, and that the residents kept their food bags with them during and after transport to the dialysis facility. She also stated that it took about 10-15 minutes to drive to the dialysis facility and that the van had air conditioning. During an interview with the Administrator and Quality Assurance Regional Nurse Consultant on 6/8/2018 at 1:25 PM, the Administrator stated that she had been made aware of the issue and that coolers were bought to transport the food items for the three resident receiving dialysis. She stated that it was her expectation that staff follow facility policy to ensure appropriate temperatures and palatability of food for all residents. 2)Resident #101 was admitted to the facility on 5/8/18 with diagnoses that included atrial fibrillation, coronary artery disease, heart failure, hypertension (high blood pressure), End Stage Renal Disease (ESRD), diabetes mellitus,	F 804	Company. Topics covered included appropriate items to be placed in dialysis bag, review of updated list of residents on dialysis and their respective diet order and procedure for packing meal in insulated cooler bag with freezer (ice) pack. An audit tool was put into place to monitor compliance with this policy on 6/29/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Dining & Nutrition Services or designee will monitor packing of dialysis bags to ensure that appropriate meal is in cooler bag(s) with freezer (ice) pack on dialysis days and delivered to resident(s) with breakfast tray using the Dietary Quality Assurance Audit Tool. This will be done 5 days per week, including weekend days, for two months and then weekly for one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Committee. The weekly Quality Assurance Meeting is attended by The Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager and the Director of Dining & Nutrition Services. The title of the person responsible for implementing the plan of correction.	

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F 804	Continued From page 47	F 804		

hyperlipidemia (high cholesterol), and chronic obstructive pulmonary disease. The most recent Minimum Data Set (MDS) dated for 6/6/18 specified the resident had intact cognition, no behaviors or rejection of care, and required supervision for eating meals. The MDS also indicated that the resident received dialysis treatment and a physician order was placed for dialysis treatment three days a week.

During an interview with resident #101 on 6/07/18 2:09 PM he stated that his food came to him on his breakfast tray in a plastic bag. It was usually a turkey sandwich, crackers, applesauce, and a ginger ale. He stated that he didn't eat his meals because he can't eat the same thing every other day, they weren't appetizing, that he can't drink hot soda, and that he went for dialysis treatments three days a week.

During an interview with the Dietician and assistant dietary manager on 6/07/18 at 1:38 PM, when asked about how meals are prepared prior to transport to the dialysis facility for the three dialysis residents residing in the facility, she stated that a sandwich is wrapped in plastic separately, a soda, fruit, and crackers were placed in a large resealable plastic bag and delivered to the resident's on their breakfast trays. The sandwich was usually some kind of meat such as ham or turkey, or peanut butter and jelly. She stated that the facility had been asked to provide the resident's with insulated bags but that it had not been done.

During an interview with Transport on 6/07/18 1:58 PM, she stated that there was no cooler on the bus, and that the residents kept their food bags with them during and after transport to the

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

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F 804	Continued From page 48	F 804		

dialysis facility. She also stated that it took about 10-15 minutes to drive to the dialysis facility and that the van had air conditioning. She also stated that she noticed that resident #101 never ate his meals sent with him to dialysis, and the bag would still have the food in it during transport back to the facility.

During an interview with the Administrator and Quality Assurance Regional Nurse Consultant on 6/8/2018 at 1:25 PM, the Administrator stated that she had been made aware of the issue and that coolers were bought to transport the food items for the three resident receiving dialysis. She stated that it was her expectation that staff follow facility policy to ensure appropriate temperatures and palatability of food for all residents.

3)Resident #71 was admitted to the facility on 5/8/18 with diagnoses that included anemia, heart failure, hypertension (high blood pressure), End Stage Renal Disease (ESRD), diabetes mellitus, and hyperlipidemia (high cholesterol). The most recent Minimum Data Set (MDS) dated for 6/6/18 specified the resident had intact cognition, no behaviors or rejection of care, and was independent for eating meals. The MDS also indicated that the resident received dialysis treatment and a physician order was placed for dialysis treatment three days a week.

Several attempts were made to interview resident # 71, but no interview was obtained.

During an interview with the Dietician and assistant dietary manager on 6/07/18 at 1:38 PM, when asked about how meals are prepared prior to transport to the dialysis facility for the three dialysis residents residing in the facility, she

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F 804	Continued From page 49 stated that a sandwich is wrapped in plastic separately, a soda, fruit, and crackers were placed in a large resealable plastic bag and delivered to the resident's on their breakfast trays. The sandwich was usually some kind of meat such as ham or turkey, or peanut butter and jelly. She stated that the facility had been asked to provide the resident's with insulated bags but that it had not been done. During an interview with Transport on 6/07/18 1:58 PM, she stated that there was no cooler on the bus, and that the residents kept their food bags with them during and after transport to the dialysis facility. She also stated that it took about 10-15 minutes to drive to the dialysis facility and that the van had air conditioning. During an interview with the Administrator and Quality Assurance Regional Nurse Consultant on 6/8/2018 at 1:25 PM, the Administrator stated that she had been made aware of the issue and that coolers were bought to transport the food items for the three resident receiving dialysis. She stated that it was her expectation that staff follow facility policy to ensure appropriate temperatures and palatability of food for all residents.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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	F 812		7/5/18

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F 812	Continued From page 50 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 dietary staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. Findings included: 1. During the initial tour of the kitchen on 6/3/18 at 6:36 a.m., a mop in a bucket full of brown colored water was observed next to the "meat" sink. In the sink labeled "meat sink only", there was a small red bucket of water containing two stained cloths. There was a broom leaning against a storage rack of clean dishware in the dishwashing room. There was a white, sheet of linen noted on the floor aligned against the bottom of the closed kitchen door (which opened to the dining room). Throughout these observations, the dietary cook was preparing food for the breakfast meal.	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 FOOD PROCUREMENT, STORE/PREPARE/SSERVE-SANITARY The plan for correcting the specific deficiency. The plan should address the processes that lead to deficiency cited. The facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. Staff	

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F 812	Continued From page 51 During an interview on 6/3/18 at 6:40 a.m., the dietary cook revealed she was the only dietary staff currently on duty until 6:45 a.m. She stated that the mop in the bucket of dirty water was left in the kitchen by the dietary staff who worked the previous night. She also stated she did not know why or who placed the sheet of linen on the floor against the bottom of the kitchen door; but she noticed it upon her arrival to work that morning. 2. During observations of the refrigeration units in the kitchen on 6/3/18 at 6:45 a.m., there was a tray of unlabeled and not dated 6 ounce glasses of red colored juices in the reach-in refrigerator. The walk-in refrigerator#2 contained resealed but not dated and not labeled raw meats (1-bag of raw chicken and 1-half roll of raw ground beef). There was 1-case of frozen breadsticks on the floor and multiple cases of frozen food items stacked haphazardly on a platform in the center back of the walk-in freezer.	F 812	did not label and date resealed food, and did not remove food items off the floor. Staff did not remove soiled cloths and cleaning equipment after completion. These observations were made during the initial kitchen tour on June 3, 2018 and were discussed with the Cook on duty that morning. The Director of Dining & Nutrition Services with the Contract Food Management Company was informed of the findings by the Cook and all areas were corrected immediately and inspected by the Director of Dining & Nutrition Services on her initial walk through on Monday, June 4, 2018. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; An in-service on Sanitation and Proper Food Storage was conducted for all Dietary staff on June 6, 2018 by the Corporate Dietitian with the Contract Food Management Company. Topics covered included discussion of the findings during the Surveyor's initial tour of the kitchen, proper storage of items in all food storage areas, proper labeling and dating of open items in food storage areas, proper storage of mops and other cleaning tools, department closing procedures and appropriate use of designated food preparation sinks. An audit tool was put into place to monitor compliance with this policy on 6/29/18. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 812	Continued From page 52	F 812	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Dining & Nutrition Services or designee will monitor sanitary practices of the kitchen to include proper storage of cleaning tools; proper use of designated food preparation sinks; proper labeling, dating and storage of food in all food storage areas; and adherence to department closing procedures using the Dietary Quality Assurance Audit Tool. This will be done 5 days per week, including weekend days, for two months and then weekly for one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Committee. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager and the Director of Dining & Nutrition Services. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance	F 865		7/5/18

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F 865	Continued From page 53 improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Assessment Committee failed to maintain implemented procedures and monitor the interventions put in place following the recertification survey of 5/25/17. Deficiencies in the areas of residents rights/exercise of rights, comprehensive assessments and timing, care plan timing and revision, free of accident hazards/supervision/devices, and food procurement store/prepare/serve - sanitary was recited on the recent recertification/complaint survey of 6/8/18. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Assessment program. The findings included: These tags are cross referenced to:	F 865	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F865 QAPI PRGM/PLAN, DISCLOSURE /GOOD FAITH ATTMPT The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility's Quality Assessment and	

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F 865	Continued From page 54 F-550. Based on observations, record review, staff and family member interviews, the facility failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living (ADLs). During the recertification survey of 5/25/17 the facility was cited at F-241 for failure to promote resident dignity by placing a wander-guard ankle bracelet on one of one alert and oriented residents (Resident #35). F-636. Based on record review and facility staff interviews the facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services (Resident #80). During the recertification survey of 5/25/17 the facility was cited at F-272 for failure to comprehensively assess the dental needs for 1 of 3 sampled residents (Resident #77) reviewed for dental status and services. F-657. Based on observations, record review and staff interviews, the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living (ADLs). During the recertification survey of 5/25/17 the facility was cited at F-280 for failure to update a care plan for falls for one of two sampled residents with falls. F-689. Based on observations, record reviews,	F 865	Assurance Committee failed to maintain implemented procedures and monitor interventions put in place following the recertification survey of 5/25/2017. The deficiency was in the areas of resident's rights/exercise of rights, comprehensive assessments and timing, care plan timing and revision, free of accident hazards/supervision/devices, and food procurement store/prepare/serve- sanitary was recited on the recent recertification /complaint survey of 6/8/2018. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Assessment program. F550-Nurse aide did not provide incontinence care as resident was combative and was waiting for assistance. F636- Minimum Data Set Nurse omitted to code dialysis on the comprehensive assessment dated 4/27/18. F657- Minimum Data Set Nurse did not resolve the care plan upon removal of the cast. F689- Care was not implemented by staff. F812- Staff did not label and date resealed food, and did not remove food items off the floor. Staff did not remove soiled cloths and cleaning equipment after completion. This tag is cross referenced to: F550 The facility failed to failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living (ADLs). During the recertification survey of 5/25/17 the facility was cited at F-241 for failure to	

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F 865	Continued From page 55 and staff interviews, the facility failed to position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents. During the recertification survey of 5/25/17 the facility was cited at F-323 for failure to secure the wheelchair to the floor of the facility van according to manufacturer's instructions before transporting one of one resident reviewed for van transportation, Resident #54. During transport the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting her head on the van floor. Resident #54 complained of right shoulder pain after the incident. F-812. Based on observations and dietary staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. During the recertification survey of 5/25/17 the facility was cited at F-323 for failure to label food items and properly clean 1 of 3 residents' nourishment refrigerators. Nourishment Refrigerator #3. An Interview was conducted with the facility's Administrator and Quality Assurance (QA) Nurse Consultant on 6/8/18 1:25 PM. They stated that department heads met every week for a Quality of Life meeting and that the QA meetings were held monthly to discuss problem areas and concerns and the Administrator, DON, ADON,	F 865	promote resident dignity by placing a wander-guard ankle bracelet on one of one alert and oriented residents (Resident #35) F636 The facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services. (Resident #80). During the recertification survey of 5/25/2017 the facility was cited at F-272 for failure to comprehensively assess the dental needs for 1 of 3 sampled residents (Resident #77) for dental status and services F-657 the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living. (ADLs). During the recertification survey of 5/25/2017 the facility was cited at F-280 for failure to update a care plan for falls for one of two sampled residents with falls. F689 the facility failed to position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents. During the recertification survey of 5/25/2017 the facility was cited at F-323 for failure to secure the wheelchair to the floor of the facility van according to manufacturer's instructions before transporting one of one resident reviewed for van transportation, Resident #54. During transport the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting	

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F 865	Continued From page 56 Social Worker, the medical director attended, as well as all of the other department heads.. Quality of care was monitored by survey process, audits, daily focus rounds, and focus areas of infection control, nutrition, pressure ulcers, etc. were reviewed. When asked what expectations the facility's administration had for preventing reoccurring problems, they stated the expectation was that changes would be made throughout the facility to ensure the issues were resolved.	F 865	her head on the van floor. Resident #54 complained of right shoulder pain after the incident. F812 Based on observation and dietary staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. During the recertification survey on 5/27/2017 the facility was cited at F-323 for failure to label food items and properly clean 1 of 3 residents' nourishment refrigerators. Nourishment Refrigerator #3. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; This tag is cross reference to F550 The facility failed to failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living. F636 the facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services. (Resident #80). F-657 the facility failed to update a resident's care plan to reflect cast removal for 1 of 7(Resident #81) residents reviewed for activities of daily living. F689 the facility failed to position fall mats on the floor, next to the beds of 2 of 4	

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F 865	Continued From page 57	F 865		

sampled residents (Residents #34 and #87) reviewed for accidents.
F812 Based on observation and dietary staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation.

On 6/25/2018, The Quality Assurance Nurse in serviced the Administrator in reference to the Quality Assessment and Assurance. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:(i) The director of nursing services;(ii) The Medical Director or his/her designee;(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The quality assessment and assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the

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F 865	Continued From page 58	F 865	requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; This tag is cross reference to F550 The facility failed to failed to provide care to maintain a residents dignity by not providing incontinent care before feeding a resident (Resident #60) for 1 of 7 residents (Resident #60) reviewed for Activities of Daily Living (ADLs). F636 the facility failed to comprehensively assess a resident receiving dialysis for 1 of 3 residents reviewed for dialysis services. (Resident #80). F-657 the facility failed to update a resident's care plan to reflect cast removal for 1 of 7(Resident #81) residents reviewed for activities of daily living. (ADLs). F689 the facility failed to position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and	

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F 865	Continued From page 59	F 865	#87) reviewed for accidents. F812 Based on observation and dietary staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food items off of the floor; and by failing to ensure the kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation To ensure compliance, Administrator or Director of Nursing will monitor this issue using a quality assurance survey tool. Facility will monitor compliance of Quality Assurance for F550, F636, F657, F689, and F812. This will be done on weekly basis for 4 weeks then monthly for 3 months by Administrator and reviewed monthly by the Quality Assurance Nurse Consultant to ensure compliance. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager, Wound Nurse. The title of the person responsible for implementing the acceptable plan of	

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F 865	Continued From page 60	F 865	correction; Administrator and /or Director of Nursing.	
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, 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;	F 880		7/5/18

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F 880	Continued From page 61 (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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to follow ordered isolation precautions for 1 of 1 residents (Resident #55) on isolation precautions. Findings included:	F 880	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	

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F 880	Continued From page 62 A review of the facility's policy dated July 1, 2002 (revision date of May 2014) and titled "Contact Precautions" revealed "in addition to standard precautions use of contact precautions, or the equivalent, for specified residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident-care activities that require touching the resident dry skin) or indirect contact (touching) with environment surfaces or resident-care items in the residents' environment". Resident #55 was admitted to the facility 3/16/18 with diagnoses that included, in part, heart failure, hypertension, hyperlipidemia, diabetes mellitus, and chronic obstructive pulmonary disease. Review of active physician orders and assessments revealed the resident was being treated for Clostridium difficile (bacterial infection causing severe diarrhea) as of 6/4/18. An observation on 6/4/18 at 1:32 PM nurse assistant (NA) #6 was observed feeding resident #55's roommate without a gown or gloves on, a contact precautions sign was posted on the door, and personal protective equipment (PPE) and trashcan with lid was located outside the room door. During an observation on 6/4/18 NA #7 entered room at 1:35 PM without donning a gown or gloves, picked up resident #55's food tray, and walked out of the room. When asked what was the facility policy for resident's with contact precautions she stated that she was supposed to put on a gown, gloves, and wash her hands with	F 880	Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION PREVENTION & CONTROL. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to follow ordered isolation precautions for 1 of 1 residents (Resident #55) on isolation precautions. Staff did not understand isolation precautions regarding cohorting of residents when one is on contact isolation and the other is not. Resident #55. Isolation precautions discontinued per physician orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/25/2018 to 7/4/2018, The Quality Assurance Nurse Consultant and Regional Staff development Nurse in serviced all staff (full time, part time and PRN) to inform them that the facility 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 disease and infection. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum , the	

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F 880	Continued From page 63 soap and water after leaving the resident's room. During an observation on 6/4/18 at 1:38PM Housekeeping #1 entered resident #55's room without wearing a gown and was wearing gloves. When asked about the facility policy he stated he was supposed to wear what was required per the sign on the door but just hadn't seen it. During an interview with NA #6 on 6/4/18 at 1:55 PM, she stated that it was the facility's policy that if she was working directly with the resident on isolation precautions she was required to wear gloves and a gown, but since she was working with her roommate, it wasn't required. During an interview with the Quality Assurance Regional Nurse Consultant on 6/07/18 11:24 AM she stated that the expectation is that staff follow the policy of contact precautions, that they should have been wearing gowns and gloves while in the isolation room, and that staff were educated about the policy annually and as needed.	F 880	following elements; A system for preventing identifying , reporting , investigating and controlling infections and communicable disease for all residents, staff , volunteers , visitors and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to And following accepted national standards; written standards, policies, and procedures for the program , which must include, but are not limited to: A system of surveillance designed to identify possible communicable disease or infections before they can spread to other persons in the facility; when and to whom possible incidents of communicable disease or infections should be reported, standard and transmission-based precautions to be followed to prevent spread of infections; when and how isolation should be used for a resident; including but not limited to: The type and duration of the isolation, depending upon the infectious agent or organism involved, and A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease and the hand hygiene procedures to be followed by staff involved in direct resident contact. A system for recording incidents identified under the facilities IPCP and the corrective actions taken by the facility. Personnel must handle, store, process and transport linens so as to prevent the	

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F 880	Continued From page 64	F 880	spread of infection. As of 7/5/2018 no employee will be allowed to work until the training has been completed. Effective 7/5/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Nurse Manager will observe 5 employees weekly to ensure that they demonstrate and follow ordered isolation precautions. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for	

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F 880	Continued From page 65	F 880	implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	