STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 565	Preparation and/or execution of this plan,	10/11/18

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

Electronically Signed | 10/11/2018

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F 565	Continued From page 1 and resident interview, the facility failed to resolve grievances related to food that were reported in the resident council for 5 of 5 interviewable residents who attended the resident council meeting (Residents # 22, 17, 13, 21 & 9). Findings included: The resident council minutes from March - August 2018 were reviewed. On 3/19/18, the minutes revealed that food was over cooked and the menus on the tickets were not being served. On 5/29/18, the minutes revealed same vegetables over and over. On 6/25/18, the minutes revealed same food over and over, no condiments, spoiled milk and cold food. On 8/27/18, the minutes revealed too many meals with noodles and broccoli and cold food. On 9/27/18 at 2:00 PM, a resident council meeting was conducted. Five interviewable residents revealed that the food was still a concern. The food served was not seasoned, repetitious, cold and menus not being followed. Resident #21, the president of the resident council, indicated that the food continued to be a problem, the same vegetable over and over again, the menu not being followed, ran out of milk, cream and butter and rice and potato served all the time. Resident # 13 stated that the food didn't taste good, no seasoning. Resident # 9 stated that the food was cold, she had dried grits in the morning. Resident # 17 stated that the food "sucks". She	F 565	does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F636483.20 (b) (1) (2) (i) (iii) F565 – 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Between March, 2018 through August, 2018, on 4 separate occasions, resident council participants had voiced concerns regarding dietary. These concerns included menus not being followed, food being overcooked, same food over and over, kitchen running out of condiments, milk, and too many meals with noodles and broccoli. Through root cause analysis, it was determined that the facility's Dietary Manager was not following through with corrections from grievances, nor performing her duties as the Dietary Manager. On 9/10/2018, the Regional Dietary Manager had placed the facility's Dietary Manager on an action plan to fix the food concerns but on 9/14/2018, the facility's Dietary Manager quit so the action plan was never implemented. As of 10/1/2018, the Regional Dietary Manager hired a new Dietary Manager and will provide education during the orientation of new Dietary Manager. Additionally, on 10/1/2018, the Regional Dietary Manager conducted a quality review of menu cycles utilized for facility meal planning and made adjustments to meals based upon	

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F 565	Continued From page 2 indicated that the kitchen ran out of food all the time and food dislikes were served over and over. Resident # 22 stated that the food was not good, not seasoned. She also added that the kitchen ran out of food and same food served over and over. On 9/26/18 at 10:30 AM, the acting Dietary Manager was interviewed. She stated that the facility's Dietary Manager (DM) had quit 2 weeks ago. She stated that the facility's Administrator had called her due to the food concerns from the resident council. She came to the facility and on September 10, 2018, she had given the facility's DM an action plan to fix the food concerns but on September 14, 2018, the DM had quit, so the action plan was not implemented. The acting DM indicated that the action plan included changing the menus, creating a food committee consisting of the DM and the residents and to meet monthly and to increase the PAR level (increasing the amount of food supplies ordered). The acting DM further stated that the food concerns were due to the previous DM not doing her responsibilities as DM. The acting DM also indicated that the cooks were not printing the recipes and the production worksheets, so she had in-serviced all the cooks to print and to follow the recipes and production worksheets every meal/day. On 9/26/18 at 10:45 AM, the Cook was interviewed. She stated that she had been a cook at the facility for 2-3 years now. She indicated that their DM had quit about 2 weeks ago. The Cook verified that they ran out of food supplies like milk, juice, bread, cream and food/vegetable on the menu. When she asked the previous DM what to cook, the DM would tell	F 565	the findings. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 10/10/2018 to discuss the root cause analysis and plan of correction. To maintain compliance, starting 10/3/2018, the Executive Director, along with the Dietary Manager will meet weekly with resident council (including residents #22, #17, #13, #21 and #9) to discuss dietary. Any concerns will be addressed immediately. This will be completed weekly for 4 weeks, then monthly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Executive Director is responsible for	

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F 565	Continued From page 3 her to cook whatever was available. The Cook stated that she was not aware that residents had food concerns because the previous DM would not communicate with them.	F 565	implementing and executing this plan. Date of compliance: October 11, 2018	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		10/11/18

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F 623	Continued From page 4 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 5 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify the Regional Ombudsman of residents' hospital transfers for 4 (Resident #25, Resident #27, Resident #24 and Resident #17) of 4 residents reviewed for hospitalizations. The findings included: 1. Resident # 25 was admitted on 10/8/16 with cumulative diagnoses of Congestive Heart Failure and Atrial Fibrillation. Resident #25 was transferred to the hospital on 6/10/18 and readmitted to the facility on 6/14/18. She was transferred to the hospital on 7/11/18 and readmitted to the facility on 7/14/18.	F 623	F623 – 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge The facility failed to notify the Regional Ombudsman for 4 residents reviewed for hospitalizations. Through root cause analysis, it was determined that the facility's Social Services Director was not following the requirement of notifying the Regional Ombudsman because she was unaware of the requirement. On 9/26/2018, the Director of Nursing notified the Regional Ombudsman of resident #17, #24, #25 and #27's discharges to the hospital. On 9/28/2018, the Executive Director	

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F 623	Continued From page 6 In an Interview on 9/26/18 at 9:20 AM, the Social Services Director (SSD) stated she started the role of SSD the end of June 2018. She stated she was not aware the Regional Ombudsman had to be notified of resident transfers to the hospital. In an interview on 9/26/18 at 12:00 PM, the Admissions Coordinator stated she was the SSD prior to moving to the Admission Coordinator role. She stated she was not aware of the need to notify the Regional Ombudsman of resident hospital transfers. In an interview on 9/26/18 at 1:52 PM, the SSD stated she sent the Regional Ombudsman a list of residents' hospital transfers for the last 90 days. A message was left for the Regional Ombudsman to return call on 9/26/18 at 12:07 PM. In an interview on 9/27/18 at 10:40 AM, the Director of Nursing (DON) stated that at her previous facility, a list of the resident hospital transfers was faxed to the Regional Ombudsman monthly. She stated it was her expectation that the Regional Ombudsman's be notified of residents' hospital transfers. 2. Resident #27 was admitted on 1/20/18 with cumulative diagnoses of Congestive Heart Failure and Chronic Pulmonary Obstruction Disease. Resident #27 was transferred to the hospital on 9/8/18 and returned to the facility on 9/15/18. In an Interview on 9/26/18 at 9:20 AM, the Social	F 623	educated the Social Services Director in regards to the requirement of notifying the Regional Ombudsman on transfer / discharge. The Executive Director directed the Social Services Director to contact the local Ombudsman to determine how often she wanted to be notified of transfer / discharge. It was decided that it be weekly. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 10/10/2018 to discuss the root cause analysis and plan of correction. To maintain compliance, starting 10/1/2018, the Social Services Director began faxing a weekly list of all transfer / discharge to the Regional Ombudsman. This will be completed weekly for 4 weeks, then weekly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. A copy of the faxed listing of all transfer / discharge sent to the Regional Ombudsman will be kept by the Social Services Director. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as	

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F 623	Continued From page 7 Services Director (SSD) stated she started the role of SSD the end of June 2018. She stated she was not aware the Regional Ombudsman had to be notified of resident transfers to the hospital. In an interview on 9/26/18 at 12:00 PM, the Admissions Coordinator stated she was the SSD prior to moving to the Admission Coordinator role. She stated she was not aware of the need to notify the Regional Ombudsman of resident hospital transfers. In an interview on 9/26/18 at 1:52 PM, the SSD stated she sent the Regional Ombudsman a list of residents' hospital transfers for the last 90 days. A message was left for the Regional Ombudsman to return call on 9/26/18 at 12:07 PM. In an interview on 9/27/18 at 10:40 AM, the Director of Nursing (DON) stated that at her previous facility, a list of the resident hospital transfers was faxed to the Regional Ombudsman monthly. She stated it was her expectation that the Regional Ombudsman's be notified of residents' hospital transfers. 3. Resident #24 was originally admitted to the facility on 1/9/15. He was discharged to the hospital on 7/9/18, 8/18/18 and 9/14/18. Review of the medical records revealed no documentation that the ombudsman was notified in writing when Resident #24 was transferred/discharged to the hospital. On 9/26/18 at 12:00 PM, the Admission	F 623	necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Social Services Director is responsible for implementing and executing this plan. Date of compliance: October 11, 2018	

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Coordinator was interviewed. She stated that she was not aware that the Ombudsman had to be notified when a resident was discharged/transferred to the hospital.

On 9/26/18 at 9:20 AM, interview with the Social Services Director (SSD) was conducted. The SSD stated that she was not aware that the Ombudsman had to be notified when a resident was discharged/transferred to the hospital.

On 9/27/18 at 10:35 AM, interview with the Director of Nursing (DON) was conducted. The DON stated that she expected the SSD to notify the Ombudsman when a resident was discharged/transferred to the hospital.

4. Resident #17 was originally admitted to the facility on 3/5/18. She was discharged to the hospital on 7/3/18.

Review of the medical records revealed no documentation that the ombudsman was notified in writing when Resident #17 was transferred/discharged to the hospital.

On 9/26/18 at 12:00 PM, the Admission Coordinator was interviewed. She stated that she was not aware that the Ombudsman had to be notified when a resident was discharged/transferred to the hospital.

On 9/26/18 at 9:20 AM, interview with the Social Services Director (SSD) was conducted. The SSD stated that she was not aware that the Ombudsman had to be notified when a resident was discharged/transferred to the hospital.

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F 623	Continued From page 9 On 9/27/18 at 10:35 AM, interview with the Director of Nursing (DON) was conducted. The DON stated that she expected the SSD to notify the Ombudsman when a resident was discharged/transferred to the hospital.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to accurately code the admission Minimum Data Set (MDS) in hearing (Resident #50) and in diagnoses for Resident #16 and Resident #23). This was for 3 of 15 residents reviewed for MDS accuracy. The findings included: 1. Resident # 50 was admitted on 8/31/18 with cumulative diagnoses of Diabetes and Atrial Fibrillation. Resident #50's admission MDS dated 9/7/18 indicated moderate cognitive impairment with no exhibited behaviors. Section B of the MDS was coded as Resident #50's hearing was adequate. There was no care plan for impaired communication related to hearing. In an interview and observation on 9/24/18 at 4:35 PM, Resident #50 was in her room sitting up in her wheelchair. While interviewing Resident #50, she turned her head to the right stating she could not hear anything. Resident #50 confirmed being very hard of hearing. She stated she did not	F 641	F641 – 483.20(g) Accuracy of Assessments Facility failed to accurately code the admission Minimum Data Set (MDS) in hearing (resident #50) and in diagnoses for (Resident # 16 and Resident #23). This was for 3 of 15 residents reviewed for MDS accuracy. After an internal root cause analysis the Minimum Set Data Nurse (MDS) failed to code residents assessment to accurately reflect current status. Resident #23 MDS was modified on 9/27/18 to accurately reflect resident current status by the MDS nurse. Resident #16 MDS was modified on 9/27/18 to accurately reflect resident current status by the MDS nurse. . Resident #50 MDS was modified on 9/27/18 to accurately reflect resident current status by the MDS nurse. On 9/27/18 to 10/10/18 the MDS nurse and Regional MDS performed Quality Monitoring of the last 90 days worth of MDS's for accurate coding. Follow up for accurate coding was based on findings.	10/11/18

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F 641	Continued From page 10 own a pair of hearing aids nor did she wish to pursue the possibly of obtaining hearing aids. Resident #50 stated if surveyor would speak loudly into her left ear, she would be better able to understand the questions. In an interview on 9/26/18 at 8:50 AM, Nurse #1 stated Resident #50 was very hard of hearing and that was the reason she spoke so loudly. In an interview on 9/26/18 at 11:45 AM, Nursing Assistant (NA) #1 stated Resident #50 was very hard of healing. She stated staff had to lean in and talk loudly into her left ear. In an interview on 9/26/18 at 3:40 PM, the Activity Director (AD) stated she was aware the Resident #50 was hard of hearing. The AD stated Resident #50 often asked staff to repeat themselves. She stated Resident #50 did not attend group activities often but did attend Bingo on one occasion. The AD stated Resident #50 did not participate in Bingo the day she attended. She stated she did not inquire as to why Resident #50 did not participate in Bingo. The AD stated for residents who are hearing impaired, she put those residents in the front of the room and allowed those residents to visualize the Bingo numbers. The AD stated Resident #50 was not moved up to the front of the room on the one occasion she attended Bingo. In an interview on 9/26/18 at 3:45 PM, the Director of Nursing (DON) confirmed Resident #50 was hard of hearing. In an interview on 9/26/18 at 3:50 PM, the MDS Nurse stated she always talked loudly so she did not notice that Resident #50 was hard of hearing	F 641	This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 10/10/2018 to discuss the root cause analysis and plan of correction. On September 27 2018, The Regional MDSC provided re education to the MDS nurse on accurate coding of the MDS to reflect resident current The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of 5 residents comprehensive and/ or quarterly MDS for accurate coding of hearing and diagnosis's two times a week for four weeks then one time a week for eight weeks then monthly thereafter and as needed for one year. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Director of Nursing is responsible for implementing and executing this plan.	

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	345442	A. BUILDING _____ B. WING _____	C 09/27/2018

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F 641	Continued From page 11	F 641	Completion date 10/11/18	

when she conducted her admission MDS interview. The MDS Nurse stated the MDS assessment should be accurate to care plan communication problems.

In an interview on 9/27/18 at 10:40 AM, the DON stated it was her expectation that the MDS be coded correctly to accurately reflect Resident #50's hearing and communication needs.

2. Resident # 16 was admitted to the facility on 1/5/18 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 7/12/18 indicated that Resident #16 had severe cognitive impairment. The assessment was not coded to indicate that Resident #16 had a diagnosis of Hyperlipidemia.

Resident #16's medications included Atorvastatin (used to treat hyperlipidemia) 20 milligrams (mgs) 1 tablet by mouth daily.

On 9/27/18 at 10:01 AM, the MDS Nurse was interviewed. She verified that Resident #16 was on Atorvastatin and had a diagnosis of Hyperlipidemia. She acknowledged that she missed to code the Hyperlipidemia under the diagnoses.

On 9/27/18 at 10:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessment accurately.

3.

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F 641	Continued From page 12 Resident #23 ' s quarterly Minimum Data Set (MDS) dated 7/20/18 revealed the resident had a moderately impaired cognition with no behavior. The resident required extensive assistance of one staff for all activities of daily living. The active diagnoses included non-Alzheimer's dementia, depression, and psychotic disorder unspecified. Resident #23 ' s care plan dated 3/13/18 revealed goals and interventions included for dementia and behavior including resisted care. The resident ' s psychiatry note dated 9/10/18 review revealed the resident was treated for dementia with behavioral disturbance which included Alzheimer ' s dementia. The resident ' s physician progress note dated 9/13/18 review revealed the diagnoses Alzheimer's dementia. On 9/27/18 at 10:04 am an interview was conducted with the MDS Nurse who stated that she miss-coded Resident #23's diagnoses of Alzheimer's dementia for the quarterly MDS dated 7/20/18. On 9/27/18 at 11:30 am an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurately coded.	F 641		
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	F 688		10/11/18

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F 688	Continued From page 13 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 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to apply the left hand splint as ordered by the physician for 1 of 2 sampled residents reviewed for limitation in range of motion (Resident #22). Findings included: Resident #22 was originally admitted to the facility on 12/24/15 with multiple diagnoses including hemiplegia and hemiparesis following unspecified cardiovascular disease affecting left non dominant side. The quarterly Minimum Data Set (MDS) assessment dated 7/20/18 indicated that Resident #22's cognition was intact and she had impairment and limitation in range of motion on one side of her upper extremity. Resident #22's care plan dated 8/19/18 was reviewed. One of the problems was self-care deficit related to hemiplegia and the goal was for the resident to receive appropriate staff support with activities of daily living through the review date. The approaches included brace and splint as ordered.	F 688	F688 – 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility The facility failed to apply the left hand splint as ordered by the physician for 1 of 2 sampled residents reviewed for limitation in range of motion (Resident #22) After an internal root cause analysis the nurse/restorative aide failed to apply resident #22 left hand splint as ordered. Resident #22 left hand splint was applied as ordered on 9/27/18 when the deficient practice was identified. On 9/27/18 the Director of Nursing and or/Nursing Supervisors performed Quality Monitoring for all residents who had a physicians order for splints. All residents with a physician order for splints were referred to the Rehabilitation Department for re-evaluation. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on	

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F 688	Continued From page 14 On 7/20/18, there was a physician's order to discontinue skilled occupational therapy (OT) services and for nursing/restorative to apply the left hand splint for 6 hours interval. The September 2018 physician's orders included left hand splint - off for hygiene and at night. On 9/24/18 at 10:55 AM, 9/25/18 at 3:15 PM and 9/26/18 at 11:10 AM, Resident #22 was observed. Her left hand was on a fist position and there was no splint noted. On 9/25/18 at 3:16 PM, Resident #22 was interviewed. She stated that she didn't know who was responsible for the splint but it has not been applied for over a month now. On 9/26/18 at 11:15 AM, Nurse Aide (NA) #2, assigned to Resident #22, was interviewed. She stated that she had not seen a splint on Resident #22's left hand for a while now. She stated that the resident used to have a splint when the therapy was working with her, when discharged from therapy, restorative was responsible for the splint application. NA #2 added that currently the facility did not have a restorative aide. On 9/26/18 at 12:05 PM, Nurse #2, assigned to Resident #22, was interviewed. She stated that NA #1 was responsible for the splint application because currently the facility did not have restorative aides. On 9/26/18 at 12:15 PM, NA #1 was interviewed. She stated that her responsibilities were central supply, scheduling, transportation and as NA on the floor. She also stated that she was	F 688	10/10/2018 to discuss the root cause analysis and plan of correction. On 9/28/18 the Director of Nursing and or/Nursing Supervisors provided re education for 100 % of all CNA's and Licensed Nurses on the proper use and application of splints as well as confirming use prior to documenting. The Director of Nursing and or/ Nursing Supervisor to perform Quality Improvement Monitoring of all residents with splints for application compliance two times a week for four weeks then one time a week for eight weeks then monthly thereafter and as needed for one year. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Director of Nursing is responsible for implementing and executing this plan. Completion date 10/11/18	

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F 688	Continued From page 15 responsible for the splint application and she applied the splints when she had time, not every day and not on the weekends. NA #1 stated that nobody was applying the splints on the weekends. On 9/27/18 at 10:35 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the splints to be applied as ordered.	F 688		
F 804 SS=E	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 record review, observation and staff and resident interview, the facility failed to ensure food was palatable and was served at an appetizing temperature for 5 of 5 interviewable residents who complained about the food (Residents # 22, #17, #9, #13 & #21). Findings included: 1. Resident #21 was admitted to the facility on 3/16/16. Her quarterly Minimum Data Set (MDS) assessment dated 7/18/18 indicated that her cognition was intact. On 9/25/18 at 11:50 AM, Resident #21 was	F 804	F804 – 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp The facility failed to ensure food was palatable and served at an appetizing temperature. Other concerns included menus not being followed, food being overcooked, same food over and over, kitchen running out of condiments, milk. Through root cause analysis, it was determined that the facility's Dietary Manager was not following through with corrections from grievances, nor performing her duties as the Dietary Manager.	10/11/18

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F 804	Continued From page 16 interviewed. She stated that she was the president of the resident council. She indicated that the food continued to be a problem, the same vegetable over and over again, the menu not being followed, ran out of milk, cream and butter and rice and potato served all the time. Resident #21 indicated that the food concerns had been discussed in the resident council meetings and there was no improvement noted. 2. Resident # 13 was admitted to the facility on 12/18/14. Her quarterly MDS assessment dated 7/11/18 indicated that her cognition was intact. On 9/26/18 at 3:47 PM, Resident #13 was interviewed. She stated that the food didn't taste good, no seasoning. She indicated that she had told the staff so many times but they didn't pay any attention. She also stated that the food concerns had been discussed in the resident council meetings. 3. Resident # 9 was admitted to the facility on 7/5/18. Her admission MDS assessment dated 7/12/18 indicated that she had moderate cognitive impairment. On 9/27/18 at 9:05 AM, Resident #9 was interviewed. She stated that the food was cold, she had dried grits in the morning. 4. Resident # 17 was admitted to the facility on 3/5/18. Her quarterly MDS assessment dated 7/15/18 indicated that her cognition was intact. On 9/26/18 at 10:55 AM, Resident #17 was interviewed. She stated that the food "sucks". She indicated that the food concerns had been brought up in the resident council meetings	F 804	On 9/10/2018, the Regional Dietary Manager had placed the facility's Dietary Manager on an action plan to fix the food concerns but on 9/14/2018, the facility's Dietary Manager quit so the action plan was never implemented. As of 10/1/2018, the Regional Dietary Manager hired a new Dietary Manager. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 10/10/2018 to discuss the root cause analysis and plan of correction. To maintain compliance, starting 10/1/2018, the Dietary Manager or Dietary Aides will take food temps at all meals and document those temps. Test trays will be temped across all meals/shifts and all days/weekends, 3 times per week for 4 weeks, then monthly thereafter. Additionally, starting 10/3/2018, the Executive Director, along with the Dietary Manager will meet weekly with resident council (including residents #22, #17, #13, #21 and #9) to discuss dietary. Any concerns will be addressed immediately. This will be completed weekly for 4 weeks, then monthly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and	

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F 804	Continued From page 17 several times and has not improved at all. The kitchen ran out of food all the time and food dislikes were served over and over. 5. Resident # 22 was admitted to the facility on 1/15/15. Her quarterly MDS assessment dated 7/20/18 indicated that her cognition was intact. On 9/25/18 at 3:15 PM, Resident #22 was interviewed. She stated that the food was not good, not seasoned. She also added that the kitchen ran out of food and same food served over and over. The resident council minutes from March - August 2018 were reviewed. On 3/19/18, the minutes revealed that food was over cooked and the menus on the tickets were not being served. On 5/29/18, the minutes revealed same vegetables over and over. On 6/25/18, the minutes revealed same food over and over, no condiments, spoiled milk and cold food. On 8/27/18, the minutes revealed too many meals with noodles and broccoli and cold food. On 9/27/18 at 2:00 PM, a resident council meeting was conducted. Five interviewable residents revealed that the food was still a concern. The food served was not seasoned, repetitious, cold and menus not being followed. On 9/26/18 at 10:30 AM, the acting Dietary Manager was interviewed. She stated that the facility's Dietary Manager (DM) had quit 2 weeks ago. She stated that the facility's Administrator had called her due to the food concerns from the resident council. She came to the facility and on September 10, 2018, she had given the facility's DM an action plan to fix the food concerns but on	F 804	/or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Dietary Manager is responsible for implementing and executing this plan. Date of compliance: October 11, 2018	

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F 804	Continued From page 18 September 14, 2018, the DM had quit, so the action plan was not implemented. The acting DM indicated that the action plan included changing the menus, creating a food committee consisting of the DM and the residents and to meet monthly and to increase the PAR level (increasing the amount of food supplies ordered). The acting DM further stated that the food concerns were due to the previous DM not doing her responsibilities as DM. The acting DM also indicated that the cooks were not printing the recipes and the production worksheets, so she had in-serviced all the cooks to print and follow the recipes and production worksheets every meal/day. On 9/26/18 at 10:45 AM, the Cook was interviewed. She stated that she had been a cook at the facility for 2-3 years now. She indicated that their DM had quit about 2 weeks ago. The Cook verified that they ran out of food supplies like milk, juice, bread, cream and food/vegetable on the menu. When she asked the previous DM what to cook, the DM would tell her to cook whatever was available. The Cook stated that she was not aware that residents had food concerns because the previous DM would not communicate with them. On 9/27/18 at 12:23 PM, a test tray (regular diet) was observed. The temperature of the scalloped potato was 134 degrees Fahrenheit (F). On 9/27/18 at 10:35 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the dietary department to respond and to resolve the food concerns brought up in the resident council.	F 804		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/11/18

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F 812 SS=E	Continued From page 19 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 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 observation and staff interview, the facility failed to discard date-expired refrigerated food and liquid thickener. Findings included: On 9/26/18 at 12:00 pm during kitchen observation of the reach-in refrigerator two bottles of liquid thickener was date expired 9/11/18 and 9/22/18, tomato ketchup label date expired 8/27/18, multiple single-serve mayonnaise cups label date expired 9/21/18, and chicken gravy in storage container label date expired 9/24/18. The Dietary Manager was present for the observation. On 9/26/18 at 12:15 pm an interview was	F 812	F812 – 483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary The facility failed to ensure expired food was discarded in a timely manner. Through root cause analysis, it was determined that the facility's Dietary Manager trainee and dietary aides were not discarding expired food timely. As of 10/1/2018, the Regional Dietary Manager hired a new Dietary Manager. The new Dietary Manager will continue to have training until he is proficient as a Certified Dietary Manager. As of	

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F 812	Continued From page 20 conducted with the Dietary Manager who stated the observed expired food and liquid thickener should have been discarded when expired. The DON stated she asked the Dietary Manager trainee to discard the refrigerated expireables yesterday and it appeared he needed re-education. The Dietary Manager stated she expected staff to discard expired food and drinks. On 9/27/18 at 11:30 am an interview was conducted with the Director of Nursing who stated she expected staff to discard expired food and drink.	F 812	9/28/2018, an inservice with all dietary staff on checking for expired items was completed. Additionally, the Regional Dietary Manager conducted a quality review of current stored food items to ensure not expired and no further expired stored food was found. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 10/10/2018 to discuss the root cause analysis and plan of correction. To maintain compliance, starting 10/1/2018, the Dietary Manager or Dietary Aides will do a daily label and dating utilizing a log to ensure no food items are expired. Any concerns will be addressed immediately. This will be completed daily and ongoing as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical	

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F 812	Continued From page 21	F 812	Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Dietary Manager is responsible for implementing and executing this plan. Date of compliance: October 11, 2018	