DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	C 12/07/2018

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

(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=D	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 resident interviews, staff interviews,	F 565	1. Center failed to follow up on	1/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/31/2018

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

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and record review, the facility failed to resolve concerns expressed by residents during resident council meetings. During a resident group meeting 7 of 8 residents who participated expressed ongoing issues with medications being administered late, cold foods being served in resident rooms, not being informed of doctors' appointments in a timely manner, and staff using cell phones during resident care, which had been discussed during resident council meetings.

Findings included:

1 a. Minutes from the 10/3/18 resident council meeting documented, "Morning medications still come very late, residents feel they have to get up early and wait in line at the nurse's cart to get medications, meal trays being cold when arriving to residents' rooms, and residents would like to be informed of doctor's appointment before the morning of the appointment.

Minutes from the 9/6/18 resident council meeting documented, "Cold coffee, cold breakfast and all meals cold, cell phone use in dining room, staff needs to be more alert in the dining room and with surroundings".

Minutes from the 8/2/18 resident council meeting documented, "resident getting medication late."

Minutes from the 7/5/18 resident council meeting documented, "late medications, and not receiving sleeping medications until 11:30 PM, late meal trays, and cold meals.

These concerns were not resolved and continued to be ongoing.

F 565

grievances reported to Grievance Officer during the 07/05/18, 8/2/18, 9/6/18, and 10/3/18 Resident Council Meetings. Grievances reported during the above meetings were logged and taken through the grievance process.
2. 100% audit related to grievances was completed on current residents to ensure grievances are known and being addressed through the facility grievance process.
3. Facility staff were in-serviced on Grievance Policy and Procedure which was completed by Director of Nursing/Designee. Audit of residents/family-members will be completed weekly for four weeks, then monthly for two months.
4. Grievance Log and audits will be reviewed by the QA Committee at the Monthly QA Committee Meeting with follow-up when needed. The next Monthly QA Committee Meeting will be held on 1/16/19.
5. The Administrator is responsible for implementing and acceptance plan of correction.

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b. On 12/5/18 eight residents participated in a group meeting, a review of their minimum data set (MDS) assessment revealed that all eight were documented as having intact cognition. During the meeting 7 of 8 residents stated there were core issues shared during group meetings which did not seem to get resolved. They reported that medications continued to be given late, and meal trays delivered to the resident rooms were cold, that the trays sat on the food cart in the hallway to long before being delivered to the residents' rooms. There were concerns shared of being notified of doctors' appointments during breakfast, to hurry up and eat due to a scheduled appointment that the resident was unaware of. The residents stated that although these concerns had been discussed multiple times in group meetings, it kept reoccurring. They reported that on multiple occasions staff would use their cell phones during resident care.

An interview was conducted on 12/5/18 @ 2:05 PM with the Social Worker/Activities Director. She stated she is aware of the concerns addressed. She stated when concerns are shared in resident council meetings, she emails the concerns to all department heads for review, her goal is they would email her of any resolutions by the next resident council meeting. During the following resident council meeting they review minutes from the last meeting including interventions, if concerns were not addressed they would be included in that month's meeting minutes. Her expectation is that the concerns are addressed by the next meeting.

c. A review of the grievance logs dated 6/18/18 a grievance was filed by one of the group members

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F 565	Continued From page 3 regarding late medications. On 9/6/18 a grievance was filed regarding medication administration. On 12/1/18 a grievance was filed regarding cold foods. A review of the In-service Training Record revealed in-services were conducted on 12/4/18 regarding late medications, appointment times, and cell phone use, which per in-service record documented this was regarding concerns from September and October 2018. An interview was conducted on 12/7/18 @ 1:05 PM with the facility Administrator. He stated that he does expect that resident council meeting concerns are addressed and followed through with. He stated he will be working to improve the resolution process when concerns are expressed in those meetings. He stated he will be working with the department heads on resolving those concerns for the residents, and to be able to share the outcome or resolution with the residents as quickly as possible or at least by the next meeting.	F 565		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 602	1. On 5/23/18, resident # 219 debit card	1/4/19

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F 602	Continued From page 4 facility failed to prevent misappropriation of property when an employee stole a resident's bank debit card and used the card to make unauthorized withdrawals of money from the resident's bank account for 1 of 1 sampled residents (Resident #219) reviewed for misappropriation of property. Findings include: Resident #219 was admitted to the facility on 04/11/18 and discharged home on 06/05/18. Resident #219 had diagnoses of osteoarthritis, hemiplegia, and hypothyroidism. Review of the admission Minimum Data Set (MDS) dated 04/18/18 revealed Resident #219 was cognitively intact. Resident #219 needed the assistance of two people for bed mobility and transfers. Review of the facility Initial Allegation Report dated 05/26/18 revealed there was an allegation made that Nursing Assistant (NA) #3 had stolen and used Resident #219's bank debit card to make unauthorized charges. Review of a police Incident/Investigation Report dated 05/26/18 revealed an officer had been called out to the facility and a report regarding the allegations had been done. The officer who had taken the report was not available for an interview. Review of the facility Investigation Report dated 06/01/18 revealed that the accused staff member (NA #3) had returned the bank debit card to Resident #219 and reimbursed $575.00 in unauthorized charges. The facility found there to be a reasonable suspicion of a crime and the allegation was substantiated. NA #3 admitted to	F 602	was stolen from resident and used. Facility failed to prevent misappropriation of property. The incident was reported to the State, investigated by facility. Employee was reported to law enforcement and terminated from employment. The employee returned the resident's funds to her on 5/28/18. 2. 100% audit of residents with a BIMS score of 12 or higher and responsible parties for residents with a BIM score below 12 were interviewed regarding misappropriation of property. 3. Facility staff were in-serviced by Director of Nursing/Designee on Residents Rights Policy and Procedure regarding misappropriation of property by 12/28/18. 4. Since any misappropriation of funds allegation is a grievance, the Grievance Log will be reviewed by the QA Committee at the Monthly QA Committee Meeting with follow-up when needed. The next Monthly QA Committee Meeting will be held on 1/16/19. 5. The Administrator is responsible for implementing and acceptance plan of correction.	

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F 602	Continued From page 5 using Resident #219's bank debit card to make unauthorized purchases and was terminated. In a telephone interview on 12/05/18 at 10:30 AM NA #3 stated that at the time of the incident she had a lot going on in her life. She admitted that she had taken the bank debit card and used it to make unauthorized purchases. She indicated she wrote a letter of apology to Resident #219 and paid back the money. In a telephone interview on 12/05/18 at 10:56 AM the former Director of Nursing (DON) stated Resident #219 had reported the missing bank debit card to a staff member and the staff member, whose name she could not remember, reported the incident to her. She indicated an investigation was conducted and the accused NA admitted she had stolen Resident #219's bank debit card and used it to make unauthorized purchases. The former DON stated NA #3's employment had been terminated. In an interview on 12/05/18 at 4:50 PM the interim DON stated it was her expectation that staff not steal from the residents.	F 602		
F 623 SS=E	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	F 623		1/4/19

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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;
(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;

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(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 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

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F 623	Continued From page 8 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 record review and staff interviews, the facility failed to provide a copy of written notification of the reason for discharge to the hospital to the Ombudsman for 4 of 4 sampled residents reviewed (Resident #267, Resident #40, Resident 32, and Resident # 68 for hospitalizations. Findings included: 1. Resident #267 was admitted to the facility on 05/01/18, discharged to the hospital on 11/08/18 and readmitted on 11/28/18 after hospitalization. Cumulative diagnoses included a fib, stroke, high blood pressure, insomnia, anorexia, benign prostate hypertrophy (BPH), depression, hypokalemia, hypernatremia, infection to central line - Methicillin Resistant Staphylococcus Aureus (MRSA) and urogenital implants. . The Minimum Data Set (MDS) dated 11/02/18 significant change assessment revealed the resident was moderately cognitively impaired. 2. Resident #40 was admitted to the facility on 04/11/17, discharged to the hospital on 10/19/18 and readmitted on 10/22/18 after hospitalization. Cumulative diagnoses included Alzheimer ' s with early onset, dementia with behaviors, chronic kidney disease, a fib, chronic obstructive pulmonary disease (COPD), dependent on	F 623	1. Facility failed to provide a copy of written notification of the reason for discharge to the hospital to the Ombudsman for 4 of 4 sampled residents, #267, #40, #32 and #68. Administrator emailed list of residents discharged to a hospital during the year of 2018 to the Regional Ombudsman on 12/07/18. 2. Facility implemented a search and made an exhaustive list of residents discharged to a hospital during the year 2018. That list was emailed to the Regional Ombudsman on 12/07/18. 3. All Interdisciplinary Management Team members were in-serviced regarding this process on12/07/18. DON initiated and will maintain Monthly Log of Residents Discharged to a Hospital, and will send that log to the Regional Ombudsman monthly. 4. Monthly Log of Residents Discharged to a Hospital has been added to the list of logs reviewed at the Monthly QA Committee Meeting. QA Committee will monitor monthly and follow up as needed. 5. The Administrator is responsible for implementing and acceptance plan of correction.	

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oxygen (O2), anemia, legally blind and vitamin D deficiency.

The MDS quarterly assessment dated 10/27/18 revealed the resident was cognitively aware.

3. Resident #32 was admitted on 02/29/16, discharged to the hospital on 11/14/18 and readmitted on 11/19/18 after hospitalization. Cumulative diagnoses included congestive heart failure, diabetes, fracture of left ulna and closed fracture to lower end of left radius, and history of falls.

The MDS quarterly assessment dated 10/18/18 revealed the resident was severely cognitively impaired.

An interview was conducted with the Ombudsman on 12/04/18 at 9:45 AM. The Ombudsman reported she has not received notification of residents being discharged to the hospital since July, 2018.

An interview was conducted with the Administrator on 12/07/18 at 2:18 PM. The Administrator stated that a list of residents discharged to the hospital with the rationale for sending them to the emergency room was supposed to be sent to the ombudsman at the end of every month. He reported the former Director of Nursing (DON) had started this process, but when she left in August 2018, the acting DON who took her place had not been educated that this was one of her responsibilities. He commented that due to this break in communication the ombudsman probably had not received the information she needed in the last four months.

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4. Resident #68 was admitted to the facility on 09/27/18, and discharged to the hospital on 09/29/18 without return to the facility. The resident's documented diagnoses included multiple fractures and dementia without behavioral disturbances.

A 09/29/18 11:17 AM Health Status Note documented, "Resident (#68) has been lethargic with bouts of what seems to be syncope. Refusing to eat or drink. Will not take medications, temperature has been checked with a result of 102.1. Exhibiting tremors and slurred speech. Can not follow commands. POA (power of attorney) has arrived to facility at time of this inspection and has requested to send resident to ER (emergency room) for evaluation. On call (physician) has been contacted with verbal ok to send resident to ER."

An interview was conducted with the Ombudsman on 12/04/18 at 9:45 AM. The Ombudsman reported she had not received notification of residents being discharged to the hospital from this facility since July 2018.

An interview was conducted with the Administrator on 12/07/18 at 2:18 PM. The Administrator stated that a list of residents discharged to the hospital with the rationale for sending them to the emergency room was supposed to be sent to the Ombudsman at the end of every month. He reported the former Director of Nursing (DON) had started this process, but when she left in August 2018, the acting DON who took her place had not been educated that this was one of her responsibilities. He commented that due to this break in

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F 623	Continued From page 11 communication the Ombudsman probably had not received the information she needed in the last four months.	F 623		
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 observation, record review and staff interviews the facility failed to prevent the worsening of a pressure ulcer for 1 of 2 Residents (Resident #7) whose pressure ulcers were reviewed. Findings include: Resident #7 was re-admitted to the facility on 08/17/18 and had diagnoses of quadriplegia, diabetes, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated 08/24/18 revealed Resident #7 was cognitively intact. Resident #7 needed the extensive assistance of two people for bed mobility and was totally dependent on two people for transfers. Resident #7 had two stage four	F 686	1. Facility failed to prevent the worsening of a pressure ulcer for resident #7 8/24/2018 indicated by MDS. Wound was reassessed and the following interventions were implemented by 12/5/18 : added nutritional supplement Prostat AWC; began use of low-air-loss mattress; added to care plan change of positioning q 2 hours. 2. 100% audit on resident #7 and all residents with a pressure area were evaluated for worsening wounds and none found on 12/10/2018. 3. All nursing staff in-serviced on wound prevention, wound processes and documentation completion on 12/28/2018.	1/4/19

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F 686	Continued From page 12 pressure ulcers and two unstageable pressure ulcers. Review of the MDS Discharge Assessment Return Anticipated dated 11/07/18 revealed Resident #7 was discharged to the hospital. Review of the 11/12/18 MDS Entry Tracking Record revealed Resident #7 was readmitted back to the facility. Review of the Weekly Pressure Ulcer Review dated 11/12/18 revealed a 6 cm (centimeter) by 6 cm by 5.5 cm pressure ulcer to Resident #7's left buttock. The stage was listed as NA (not applicable). There were no signs or symptoms of infection. Review of the physician communication book revealed no communications written to the physicians regarding Resident #7 from 11/14/18 to 11/28/18. Review of the weekly skin check dated 11/18/18 and performed by Nurse #7 revealed there were no new skin concerns. Review of the Skilled Nursing Notes dated 11/18/18-11/20/18 revealed no mention of any changes to Resident #7's wounds. The facility was unable to produce the weekly documentation that Resident #7's wounds were measured and assessed on 11/19/18. Review of the 11/21/18 Physician Note revealed Resident #7's pressure wound looked worse that day. The wound had increased moisture, was deeper, and the skin appeared macerated. The	F 686	4. Wound Care Nurse to evaluate wounds daily for 4 weeks then weekly with appropriate documentation and monitor for worsening wounds. Nurse will review all new admissions and readmits skin assessments and place treatments as needed. This process is implemented in monthly QAPI process. 5. The Administrator is responsible for implementing and acceptance plan of correction.	

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F 686	Continued From page 13 physician ordered an antibiotic for the pressure wound. Review of the physician orders dated 11/21/18 revealed an order for avelox (an antibiotic) 400 mg (milligrams) by mouth daily times five days for a diagnosis of a wound infection for Resident #7. Review of Resident #7's Care Plan updated 11/24/18 revealed wound treatments were to be done as ordered and monitored for effectiveness. Wounds were to be assessed, recorded, and monitored weekly for wound healing. The length, width, and depth of wounds was to be measured. In an observation on 12/04/18 at 2:38 PM Resident #7 was sitting up in a motorized wheelchair in his room. In an observation on 12/05/18 at 4:25 PM Resident #7 was lying in bed on his right side. Nurse #1 provided treatments for the pressure wounds. In an interview on 12/05/18 at 4:50 PM the interim Director of Nursing (DON) indicated that at the time the 11/19/18 wound assessment should have been completed there was a Support Nurse (Nurse #5) filling in. She indicated it would have been the responsibility of Nurse #5 to assess and measure resident's wounds weekly. The interim DON checked the computer documentation of Resident #7's wounds and confirmed the assessment and measurements for the 11/19/18 weekly review were not in the computer. She indicated that someone should notify the physician right away if wounds got worse in any way.	F 686		

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F 686	Continued From page 14	F 686		

In a telephone interview on 12/06/18 at 10:14 AM Nurse #5 indicated that although he was the Support Nurse on the day in question he was not told he was responsible for wounds and did not assess or measure any wounds during his time as a Support Nurse.

In an interview on 12/06/18 at 12:05 PM Nurse #6 indicated the physician had come in and assessed Resident #7's wounds and started the resident on antibiotics for a wound infection. He indicated the wound had an increase in odor but could not remember if there was an increase in the amount of drainage. He stated it was the responsibility of the Support Nurse to visually assess the wounds and perform the weekly assessments.

In an interview on 12/06/18 at 1:45 PM the Treatment Aide (TA) stated the physician had informed her the week prior to 11/19/18 that she wanted to see Resident #7's wounds. She indicated when the physician came in on 11/21/18 an antibiotic had been ordered for a wound infection.

In an observation on 12/06/18 at 5:30 PM Resident #7 was sitting up in a motorized wheelchair in his room.

In an interview on 12/07/18 at 8:42 AM the Interim DON stated she expected wounds to be assessed weekly by a licensed nurse. She indicated the purpose of weekly wound assessments was to find any problems early and to prevent any worsening of the wounds.

In an interview on 12/07/18 at 10:05 AM Nurse #7 stated she discovered an odor to Resident #7's

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F 686	Continued From page 15 wound on 11/18/18. She indicated she thought she wrote something in the physician communication book regarding the wound. She indicated she told Nurse #5 on the morning of 11/19/18 about the odor and that the wound needed to be assessed.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide nutritional supplements ordered by the physician for 1 of 4 sampled residents (Resident #29) reviewed for nutritional status. Findings included:	F 692	1. Facility failed to provide nutritional supplements ordered by the physician for resident #29. On 12/6/18 tray cards and orders of those with nutritional supplements were reviewed and corrected to include supplements.	1/4/19

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F 692	Continued From page 16 Record review revealed Resident #29 was admitted to the facility on 01/06/17. The resident's documented diagnoses included severe protein-calorie malnutrition, cerebrovascular accident with dysphagia, hypertension, and atherosclerotic heart disease. The resident's Weight Summary documented she weighed 94.6 pounds on 01/09/18. On 01/26/18 Resident #29's care plan identified "I have a potential nutritional problem r/t (related to) mechanically altered diet and low BMI (body mass index)" as a problem. Interventions to this problem included "Provide and serve supplements as ordered." The resident's Weight Summary documented she weighed 96.2 pounds on 04/08/18. A 05/11/18 Registered Dietitian (RD) Note documented on 05/03/18 Resident #29 weighed 97.8 pounds, and a gradual weight gain might be beneficial. She reported the resident was on a puree diet with nectar thick liquids, and ate less than 50% of most meals. A 05/14/18 physician order started Resident #29 on Ensure pudding two times a day and Magic Cup two times a day with lunch and supper. The resident's Weight Summary documented she weighed 99.4 pounds on 06/05/18. A 07/11/18 Dietary Manager (DM) Note documented Resident #29 was fed by staff, and the facility provided the resident with nutritional supplements to increase the amount of calories and protein consumed.	F 692	2. 100% residents with supplements were audited and monitored to be sure they were given as ordered by physician on 12/31/18. 3. All interdisciplinary staff in-serviced by Director of Nursing/Designee regarding supplements for nutritional purposes by 12/28/2018. 4. All supplements monitored on residents meal tray daily for 4 weeks then weekly by Director of Nursing/Designee. Process implemented into the QAPI monthly process. 5. The Administrator is responsible for implementing and acceptance plan of correction.	

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The resident's Weight Summary documented she weighed 96.8 pounds on 08/12/18 and 97.2 pounds on 10/11/18.

The resident's 10/11/18 quarterly minimum data set (MDS) documented her cognition was severely impaired, she exhibited no behaviors including resistance to care, she required supervision with the set-up of meals, she was 63 inches tall and weighed 96 pounds, her weight was stable, and she was on a mechanically altered diet.

The resident's Weight Summary documented she weighed 95.8 pounds on 11/20/18.

On 12/05/18 at 8:57 AM Resident #29 was being fed in bed by staff. She had Ensure pudding on her breakfast tray. Her tray slip documented she was supposed to receive Ensure pudding with this meal.

On 12/05/18 at 1:05 PM Resident#29 was being fed in bed by staff. There were no supplements on her meal tray. Her tray slip documented she was supposed to receive a Magic Cup with this meal.

On 12/05/18 at 6:40 PM Resident #29 was being fed in bed by staff. There was a Magic cup on her supper tray. However, her tray slip documented she was supposed to receive both a Magic Cup and Ensure pudding with this meal.

For the entire day on 12/05/18 Resident #29 only received one Ensure pudding and one Magic Cup on her meal trays. Physician orders and the tray slips documented the resident was supposed to

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F 692	Continued From page 18 receive two Magic Cups and two Ensure puddings daily with her meals. On 12/05/18 at 6:52 PM the DM reported the dietary employee on the end of the tray line was supposed to check the tray slips for accuracy to make sure that the diet prescription was correct, dislikes were honored, and supplements were on the meal trays. On 12/05/18 at 6:55 PM nursing assistant (NA) #1 stated the dietary department was supposed to put the supplements on the meal trays, but the NAs were supposed to check the meal trays to make sure the supplements were present. She commented if supplements were listed on the tray slips but did not appear on the meal trays, the NAs called the kitchen, and dietary employees brought the supplements to them. On 12/07/18 at 9:04 AM the acting director of nursing (DON) stated nutritional supplements to be served with meals were placed on the trays by the dietary department, the NAs were supposed to check on the provision of these supplements as they delivered and set up the meal trays, and nurses were supposed to visualize this provision or be informed of the provision by the NAs before signing off that the supplements were received by residents on the medication administration record (MAR). She reported if the physician ordered nutritional supplements for residents then she expected the facility to provide them.	F 692		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when	F 773		1/4/19

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F 773	Continued From page 19 ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain an urinalysis and culture and sensitivity (UA and C & S) as ordered by the physician for 1 of 2 sampled residents (Resident #19) reviewed for urinary tract infections (UTIs). Findings included: Record review revealed Resident #19 was admitted to the facility on 10/01/18. The resident's documented diagnoses included overactive bladder, hypertension, and anxiety. The resident's 10/11/18 admission minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required limited assistance by a staff member for toileting, and she was occasionally incontinent of bowel and bladder. On 10/15/18 "I have occasional bladder incontinence with increased risk for skin breakdown and infections" was identified as a problem in Resident #19's care plan. Interventions to this problem included "Observe for/document for s/sx (signs and symptoms) of UTI: pain, burning, blood tinged urine,	F 773	1. Facility failed to obtain a urinalysis and culture and sensitivity as ordered by the physician for resident #19. Urinalysis and culture sensitivity were re-ordered on 12/10/18 for resident #19 with negative results for UTI on returned 12/15/18. 2. 100% residents and resident #19 were audited with labs ordered to be drawn with 100% compliance on 12/6/18. 3. All nursing staff in-serviced by Director of Nursing/Designee regarding new lab process of obtaining lab order(s) place in point click care to be checked off and placed in lab book and nurse signs lab book once obtained by 12/7/18. 4. Lab book will be audited daily for 4 weeks then weekly, by Director of Nursing/Designee. This will be implemented into the monthly QAPI process. 5. The Administrator is responsible for implementing and acceptance plan of correction.	

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cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Report to nurse if noted."

In a 11/06/18 progress note nurse practitioner (NP) #1 documented Resident #19 complained to her about experiencing dysuria (pain, discomfort, and/or burning upon urination) and abdominal pain. In her plan the NP requested that the facility collect an urine sample so that an UA and C & S might be obtained.

A 11/06/18 physician order documented that an UA and C & S was to be obtained for Resident #19.

Review of the facility's lab book revealed it was documented that an urine specimen was to be collected for Resident #19 on 11/07/18.

Review of Resident #19's electronic and paper medical records revealed there were no lab results generated from a urine specimen which was collected on 11/07/18. In addition, there was no documentation that urine could not be collected from the resident.

On 12/06/18 at 11:12 AM Nurse #1 (a support nurse) stated the nurse who took the order for an UA and C & S was supposed to place it in the lab book, and most of the time the night shift nurses drew the labs. She also reported night shift chart checks were supposed to detect the lack of lab results, the physician was to be contacted about labs that were not collected, and the physician made a decision about how to proceed.

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On 12/06/18 at 2:48 PM physician assistant (PA) #1 stated if a physician order was written to obtain an UA and C & S for a resident, unless the resident refused to cooperate, she expected the facility to follow through and collect an urine sample which was sent to the lab for analysis. However, she stated she had not been made aware that Resident #19 was continuing to experience discomfort and signs and symptoms of an UTI over the last month.

On 12/06/18 at 3:26 PM a clinical nurse consultant stated the lab did not have any record of receiving an urine sample for Resident #19 on or around 11/07/18. Therefore, she explained an UA and C & S had not been obtained for the resident as ordered by the physician on 11/06/18.

On 12/07/18 at 9:04 AM the acting director of nursing (DON) stated the nurses who took lab orders were responsible for placing them on the lab calendar. She reported if the orders were received early in the day the nurses who worked from 7:00 AM - 7:00 PM or a support nurse drew the labs, and if the orders were received late in the day the nurses who worked from 7:00 PM - 7:00 AM or a support nurse drew the labs. She commented lab results came through a facility printer, and the support nurses were responsible for making sure all lab results were received. If lab results were missing, she explained the support nurses called the physicians who ordered the labs. According to the acting DON, progress notes were supposed to be written if staff were unable to collect the labs, if the physician had to be contacted about missing labs, or there were resident refusals to have the labs drawn. Since there were no such progress notes for Resident

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F 773	Continued From page 22 #19, the acting DON stated she assumed staff forgot to collect an urine specimen or the specimen was never delivered to the lab.	F 773		