STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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
E 000	Initial Comments An unannounced recertification survey was conducted 01/22/19 to 01/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 15I511.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID#15I511.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		2/22/19

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

Electronically Signed | 02/18/2019

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to resolve discrepancies regarding code status for 2 of 3 sampled residents whose code status were reviewed (Resident #44 and #25). The findings included: 1. A record review revealed Resident #44 was readmitted to the facility on 12/09/18, after multiple hospitalizations from 09/2018 to 10/2018, with an original admission date of 06/28/18 with the following diagnoses: diabetes mellitus, peripheral vascular disease (PVD), hypertension, and chronic kidney disease. A review of the medical record indicated Resident #44 had a pacemaker placed during the hospitalizations and was treated for a urinary tract infection (UTI). The medical record further indicated that Resident #44 obtained a Palliative care consult during hospitalizations due to complaints of female pain and pressure and was	F 578	The Plan of Correction is not to be construed as an admission of any wrong doing of liability. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves the rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceedings. The facility offers its response, credible allegations of compliance and plan of correction as part	

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F 578	Continued From page 2 followed by Care Partners palliative care services. A review of Resident #44's paper medical record indicated there was an undated Medical Order for Scope of Treatment (MOST) Form which stated she was a "Do Not Resuscitate" (DNR) and the Medical Directive Upon Admission form, dated 6/28/18 and signed by the resident, further indicated she was a "Full Code." A physician's order, dated 10/19/18, which was reviewed in the paper medical record indicated Resident #44 was a "Full Code" and review of the Electronic Health Record revealed she was a "Full Code." A review of the paper medical record further revealed there was no DNR Golden Rod sheet to match the MOST form. A review of Resident #44's significant change minimum data set (MDS), dated 01/01/19, indicated her cognition was intact. A review of the Advance Directives care plan, dated 12/17/18, indicated Resident #44 had a DNR code status. An interview was conducted with the Social Worker (SW) on 01/24/19 at 11:12 AM. During the interview, the following information was reviewed with the SW: Resident # 44's undated MOST form, Medical Directive Upon Admission Form, Full Code status and no DNR Golden Rod sheet to match the MOST form. The SW indicated that the palliative care nurse came to the facility after the resident readmitted from the hospital in December 2018 and initiated the MOST form. She further indicated that she believed the DNR status was started when the resident was readmitted to the facility but was unsure of the DNR order change and she had to	F 578	of its ongoing efforts to provide quality care to residents. F578 Request/Refuse/Discontinue Treatment 1a. Resident #44□s attending physician confirmed the wishes regarding code status on 1/24/19. Both the paper and electronic chart were reviewed and updated to reflect the wishes regarding code status by Unit Coordinator on 1/24/19: Medical orders for scope of treatment (MOST) form was completed on 1/24/2019 and placed in the paper chart, Do not resituate (DNR) Order written in paper chart on 1/24/2019, DNR Electronic Order entered on 1/24/2019, Golden Rod form placed in the paper chart on 2/14/2019. Care plan reviewed and reflects current code status on 2/5/2019. 1b. Resident #25□s attending physician confirmed the wishes regarding code status on 2/5/19. Both the paper and electronic chart were reviewed and updated to reflect the wishes regarding code status by Unit Coordinator on 2/5/19: DNR Order written in paper chart on 2/5/2019, DNR Electronic Order entered on 2/5/2019. Care plan reviewed and reflects current code status on 2/5/19. 2. Advance directive validation audit of current residents was completed by nursing admin staff to include Director of Nursing (DON) and/or unit Coordinator	

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F 578	Continued From page 3 speak to the Director of Nursing (DON) regarding the specifics of the DNR order. An interview was conducted with the DON on 01/24/19 at 11:28 AM. During the interview, the following information was reviewed with the DON: Resident # 44's undated MOST form, Medical Directive Upon Admission Form, Full Code status and no DNR Golden Rod sheet to match the MOST form. She stated that the staff should have asked the resident what her wishes were regarding her code status and the staff should have notified the physician to determine the validity her code status in the event of an emergency. The DON indicated that poor communication between the palliative care services and the nursing staff led to the facility not having an order for DNR code status for Resident #44. She further indicated that her expectation was that a physician order for the code status change should have been written, verified with a physician and signed by a physician and the medical record updated to reflect the correct code status. An interview was conducted with the Administrator on 01/24/19 at 4:25 PM. The Administrator indicated that an order for the code status change should have been obtained and updated in the paper medical record and the electronic health record. 2. Resident #25 was admitted to the facility on 04/18/18 with multiple diagnoses that included malignant neoplasm of cervix, chronic obstructive pulmonary disease (difficulty breathing) and atrial fibrillation (irregular heartbeat). Review of the significant change MDS (Minimum	F 578	and Staff Development Coordinator (SDC) on 1/26/2019. On 2/7/2019, Regional Nurse Consultant provided training on the new process to Nursing Home Administrator, Social Worker, Minimum Data Set Nurse and Nursing Admin staff to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC)and any remaining IDT members. On 2/13/19 Staff Development Coordinator (SDC) re-educated current licensed nursing staff on the advance directive process. Current licensed nursing staff will be re-educated prior to working next scheduled shift and this education has been added to the new hire orientation. New admission/readmissions: the Social worker or a licensed nurse will review the advance directive with the family and resident. The completed advance directive will be given to the social services director and the Director of Nursing. The social services director will place the advance directive paperwork in the doctor□s box for signature. The Director of Nursing will communicate to the physician the request on the advance directive and an order will be obtained and placed in the medical record. The social services director or Minimum data set (MDS) nurse will update the care plans to reflect current advance directives decisions. The interdisciplinary team (IDT) will discuss and verify the status of the advance directive during each resident and family meeting.	

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F 578	Continued From page 4 Data Set) dated 12/06/18 revealed Resident #25 had moderate impairment in cognition. Review of the social services progress notes revealed an entry dated 01/03/19 that read in part, "Resident is under hospice care and is a DNR (Do Not attempt Resuscitation)." Review of Resident #25's medical chart on 01/23/19, 01/24/19 and 01/25/19 revealed a hard copy of a MOST (Medical Orders for Scope of Treatment) form dated 12/21/18 with DNR marked. There was no hard copy of a physician's order indicating code status. Review of Resident #25's electronic medical record on 01/23/19, 01/24/19 and 01/25/19 revealed no indication of code status under her resident profile. Review of the electronic physician orders revealed no order indicating code status. During an interview on 01/24/19 at 3:34 PM, Nurse #3 stated she checked both the medical chart and electronic medical record when determining a resident's code status. Nurse #3 confirmed Resident #25's electronic profile did not indicate her code status. Nurse #3 explained a physician's order should be obtained any time a resident's code status changed and their medical chart and electronic medical record updated to reflect the correct code status. During an interview on 01/25/19 at 9:40 AM, the Director of Nursing stated it was her expectation a written physician's order indicating code status was filed in the resident's medical chart and their electronic medical record updated to reflect the correct code status.	F 578	3. The Director of nursing or the staff development/unit coordinator nurse will review 5 new/readmissions weekly for 4 weeks (starting 2/4/19) and monthly for 2 months to validate that the advance directive and the orders are in place and it reflects the correct information. New admissions and re-admissions will be reviewed daily (Monday to Friday) for one week (1/28/19 - 2/1/19) by the Director of Nursing, Staff development nurse or Unit Coordinator to validate the completion of the advance directive and communication of the advance directive to the Interdisciplinary team. 4. Effective February 21, 2019 the Social Services Director or the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	

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F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640		2/22/19

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F 640	Continued From page 6 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit a discharge MDS (Minimum Data Set) assessment within the required time frame for 1 of 1 resident reviewed for Resident Assessments (Resident #1). Findings included: Resident #1 was admitted to the facility on 08/24/18. Review of Resident #1's most recent MDS was an admission assessment dated 08/31/18. There were no other MDS assessments completed or transmitted after the date of 08/31/18. Review of Resident #1's medical record revealed a nurse note dated 09/25/18 that read in part, Resident #1 discharged home. During an interview on 01/24/19 at 3:20 PM, the MDS Coordinator confirmed Resident #1 discharged home on 09/25/18. The MDS Coordinator stated it was an oversight on her part and a discharge assessment should have been completed on 09/25/18. She added she would	F 640	F640 Encoding/Transmitting Resident Assessment 1. Resident #1, Discharge Assessment submitted on 1/24/2019 and accepted on 1/30/2019 by Minimum Data Set Nurse (MDS Nurse). 2. Casper□s Missing Assessment Report pulled and reviewed by Minimum Data Set Nurse (MDS Nurse) on 1/29/2019 and Point Click Care□s Admit/Discharge To/From Report to reflect discharges for the 30-days prior on 1/29/2019. Any deficient items were corrected by the Minimum Data Set Nurse (MDS Nurse). 3. Education provide to Minimum Data Set Nurse (MDS Nurse) by Regional Minimum Data Set Consultant on 2/7/2019, regarding timely completion and submission of Discharge Assessments. Minimum Data Set Nurse (MDS Nurse) will provide weekly submission report to Nursing Home Administrator along with Point Click Care□s Admit/Discharge	

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F 640	Continued From page 7 complete and transmit the assessment. During an interview on 01/24/19 at 4:19 PM, the Administrator stated he expected for MDS assessments to be completed and transmitted within the required time frame. During an interview on 01/24/19 at 4:35 PM, the Director of Nursing stated she expected for MDS assessments to be accurately coded, completed and transmitted within the required time frame.	F 640	To/From Report to validate discharge assessment submission is timely as scheduled. Nursing Home Administrator will pull Casper□s Missing Assessment Report monthly for 3 months to ensure discharge assessments are completed timely. 4. Effective February 21, 2019, the MDS Coordinator and Nursing Home Administrator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the MDS (Minimum Data Set) assessments in the areas of Hospice (Resident #25), Level II Preadmission Screening and Resident Review (Resident #23),	F 641	F641 Accuracy of Assessments 1. Minimum Data Set Nurse (MDS Nurse) modified the assessment for resident #25 to reflect the correct coding	2/22/19

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F 641	Continued From page 8 Diagnoses (Resident #42 and #53), and Activities of Daily Living (Resident #52) for 5 of 22 residents reviewed for MDS accuracy. Findings included: 1. Resident #25 was admitted to the facility on 04/18/18 with multiple diagnoses that included malignant neoplasm of cervix, chronic obstructive pulmonary disease (trouble breathing) and atrial fibrillation (irregular heartbeat). Review of the staff progress notes for Resident #25 revealed an entry dated 12/05/18 that read in part, Resident #25 returned from appointment with referral order for hospice services. Review of Resident #25's medical chart revealed hospice documentation that indicated she was admitted to Hospice services on 12/06/18. Review of the significant change MDS dated 12/06/18 indicated Resident #25 had a life expectancy of less than 6 months. Further review of the MDS revealed under Section O, O0100K Resident #25 was not coded as receiving Hospice care. A review of the cognition Care Area Assessment (CAA) associated with the MDS dated 12/06/18 read in part, "hospice services in place for end of life care related to diagnosis of cervical cancer." During an interview on 01/24/19 at 3:20 PM, the MDS Coordinator confirmed Resident #25 was admitted to hospice services on 12/06/18 and added "that was why I completed the significant change MDS assessment." The MDS Coordinator stated she missed coding Section O, O0100K to indicate Resident #25 was receiving	F 641	on January 28th, 2019 (#23) and January 25th, 2019 (#52) February 10th, 2019 and (#42 and #53) February 15th, 2019. 2. Sections A, G, I and O of the most recent Minimum Data Set, for current residents, for census date February 15th, 2019; will be audited for accuracy by the Director of Nursing and or Staff Development nurse. Opportunities corrected by the MDS Coordinator. 3. Minimum Data Set Nurse (MDS Nurse) will be re-educated by the Regional Minimum Data Set Consultant by February 7th 2019, regarding the importance of accurately coding the Minimum Data Set (MDS), specifically, Level II PASRR, ADLs, Diagnoses and Hospice. Regional MDS Consultant or Director of nursing will audit section A, G, I and O by comparing the current documentation in the medical record regarding Level II PASRR, ADL documentation, active diagnoses and if the resident is receiving hospice services for 3 Minimum Data Sets per week for 4 weeks then monthly for 2 months to ensure accuracy. 4. Effective February 21, 2019, the Regional MDS Consultant or Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and	

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F 641	Continued From page 9 hospice services and would submit a modification. During an interview on 01/24/19 at 4:35 PM, the Director of Nursing stated she expected for MDS assessments to be accurately coded. 2. Resident #23 admitted to the facility on 08/28/18 with multiple diagnoses that included bipolar disorder. Review of Resident #23's electronic medical record revealed she had a Level II PASRR listed under her resident profile. Review of the admission Minimum Data Set (MDS) dated 09/04/18 revealed Resident #23 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review was used for formulating a determination of need, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. During an interview on 01/25/19 at 3:20 PM, the MDS Coordinator stated she was unaware Resident #23 had a Level II PASRR and added the Admissions Director (AD) usually informed her when a resident was admitted with a Level II PASRR. She reviewed Resident #23's electronic medical record, confirmed she had a Level II PASRR and stated the admission MDS dated 09/04/18 was incorrectly coded. She stated she would submit a correction for the admission MDS to reflect Resident #23 was a Level II PASRR. During an interview on 01/24/19 at 4:35 PM, the	F 641	performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	

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F 641	Continued From page 10	F 641		

Director of Nursing stated she expected for MDS assessments to be accurately coded.

During an interview on 01/25/19 at 10:05 AM, the AD stated she reviewed new admission paperwork and kept track of residents admitted with a Level II PASRR so that she could submit screening review requests prior to the PASRR expiration date. The AD confirmed Resident #23 had a Level II PASRR upon her admission on 08/28/18. She stated the MDS Coordinator was included in an email sent on 08/28/18 at 11:09 AM informing various facility staff of Resident #23's admission and pertinent billing information which included her Level II PASRR number. She added the MDS Coordinator was also included in a second email sent on 09/03/18 indicating Resident #23's electronic medical record was updated to reflect her new limited-stay Level II PASRR.

3. Resident #42 was admitted to the facility on 12/07/18 with diagnoses including: depression, diabetes, and Alzheimer's disease.

A review of the Admission Minimum Data Set (MDS) assessment dated 12/14/18 indicated that Resident #42 was cognitively intact. The MDS further revealed Resident #42 received an anticoagulant, antianxiety, and antipsychotic during the assessment period with no diagnoses coded for these medications.

An interview with the MDS Coordinator on 01/25/19 at 8:30 AM revealed she missed coding these correctly and admitted they were coding errors. She further stated she should have caught it and she will correct. She stated did not know why she had missed this information.

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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 641	Continued From page 11	F 641		

During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON stated she had been signing the MDS without a thorough review and stated in the future she would be thoroughly reviewing the MDS assessments before they were submitted.

During an interview on 01/25/19 with the Administrator he stated it was his expectation that the MDS be accurately coded.

4. Resident #53 was admitted to the facility on 08/03/18 with diagnoses including: hypertension, cervical vertebra fracture, non-Alzheimer's dementia, and edema.

A review of the quarterly MDS assessment dated 12/29/19 indicated that Resident #53 had severely impaired cognition.

A review of the medical record revealed Resident #53 was receiving Norco and Oxycodone for pain, Xanax for anxiety, and Risperidone for agitation. There were no diagnoses coded for these medications on the MDS.

An interview with the MDS Coordinator revealed on 01/25/19 at 8:30 AM she missed coding these correctly and admitted they were coding errors. She further stated she should have caught it and she will correct. She stated she did not know why she had missed this information.

During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON had been signing the MDS without a

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F 641	Continued From page 12	F 641		

thorough review and stated in the future she would be thoroughly reviewing the MDS assessments before they were submitted.

During an interview on 01/25/19 with the Administrator he stated it was his expectation that the MDS be accurately coded.

5. Resident #52 was readmitted to the facility on 12/27/18 (original admission date was 08/04/05) with diagnoses including: Alzheimer's disease, non-Alzheimer's dementia, Parkinson's disease.

A review of the significant change MDS assessment dated 01/03/19 indicated that Resident #52 was cognitively intact. The MDS further revealed Resident #52 was coded as eating with supervision.

An interview with the MDS Coordinator on 01/24/19 at 5:30 PM revealed she had misunderstood the coding instructions for eating with supervision. She stated she had been coding every resident in the facility as needing supervision. She further stated this is being corrected with each resident quarterly assessment. The MDS Coordinator stated this error had been discovered very recently and they were in the process of correcting it.

During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON had been signing the MDS without a thorough review and stated in the future she would be thoroughly reviewing the MDS assessments before they were submitted.

During an interview on 01/25/19 with the

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F 641	Continued From page 13 Administrator he stated it was his expectation that the MDS be accurately coded.	F 641		
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 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	F 656		2/22/19

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F 656	Continued From page 14 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 review and staff interviews, the facility failed to develop a care plan to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #23) identified as PASRR Level II and failed to implement care plan interventions by not utilizing an air mattress as stated in the care plan for 1 of 22 residents (Resident #44) reviewed for comprehensive care plans. Findings included: 1. Resident #23 admitted to the facility on 08/28/18 with multiple diagnoses that included bipolar disorder. Review of the admission Minimum Data Set (MDS) dated 09/04/18 revealed Resident #23 received antidepressant medication daily during the 7-day assessment period. Review of Resident #23's care plans, last revised on 12/11/18, revealed there was a care plan for psychotropic medication use but no care plan was developed for PASRR Level II. Review of Resident #23's electronic medical record on 01/23/19 at 1:53 PM revealed she had a Level II PASRR listed under her resident profile.	F 656	F656 Develop/Implement Comprehensive Care Plan 1a. Resident #23: PASRR II Care Plan initiated on 1/25/2019 by Minimum Data Set Nurse (MDS Nurse) and validated by Director of Nursing. 1b. Resident #44: Air Mattress applied to bed on 1/24/2019 by Central Supply Coordinator and validated by Nursing Home Administrator. Director of Nursing confirmed care plan intervention was in place as outlined by the Care Plan. 2a. 100% audit of Care Plans for Residents with pressure ulcers was completed by nursing admin staff to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) to ensure interventions in place on 2/8/19. Any opportunities were corrected by nursing admin staff to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) 2b. 100% audit of Any Resident with Level II PASRR Care plan was audited to ensure that MDS and Care plan	

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F 656	Continued From page 15 During an interview on 01/25/19 at 3:20 PM, the MDS Coordinator reviewed Resident #23's electronic medical record and confirmed she had a Level II PASRR. She added the Admissions Director (AD) usually informed her when a resident was admitted with a Level II PASRR. The MDS Coordinator stated she was unaware Resident #23 had a Level II PASRR when she had completed the admission MDS dated 09/04/18 and therefore, a care plan was not developed. During an interview on 01/25/19 at 9:40 AM, the Director of Nursing stated it was her expectation Resident #23's care plans would be comprehensive and include a Level II PASRR. During an interview on 01/25/19 at 10:05 AM, the AD stated she reviewed new admission paperwork and kept track of residents admitted with a Level II PASRR so that she could submit screening review requests prior to the PASRR expiration date. The AD confirmed Resident #23 had a Level II PASRR upon her admission on 08/28/18. She stated the MDS Coordinator was included in an email sent on 08/28/18 at 11:09 AM informing various facility staff of Resident #23's admission and pertinent billing information which included her Level II PASRR number. She added the MDS Coordinator was also included in a second email sent on 09/03/18 indicating Resident #23's electronic medical record was updated to reflect her new limited-stay Level II PASRR. 2. A record review revealed Resident #44 was readmitted to the facility on 12/09/18 with the	F 656	appropriately coded. Audit was conducted by nursing admin staff to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) and any opportunities corrected. 3. Minimum Data Set Nurse (MDS Nurse) and Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) re-educated by the Regional Minimum Data Set Consultant on 2/7/2019, regarding accuracy of Care Plan interventions. During weekly Risk Meeting, all new interventions for prevention of skin breakdown will be reviewed weekly by IDT. DON will randomly Audit 3 charts weekly for prevention of skin breakdown and PASRR II care plans and intervention implementation weekly for 4 weeks then monthly for 2 months. 4. Effective February 21, 2019, the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for	

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F 656	Continued From page 16 following diagnoses: diabetes mellitus, peripheral vascular disease (PVD), three stage 2 pressures on her right and left buttock and sacrum, hypertension, and chronic kidney disease. A review of Resident #44's significant change minimum data set (MDS), dated 01/01/19, indicated her cognition was intact, she required limited assistance with 1-person physical assistance for bed mobility, extensive assistance with 2 plus person physical assistance for transfers, and had three new Stage 2 pressure ulcers and was coded as not refusing care. A review of the pressure ulcer care plan, initiated on 01/02/19 indicated the resident had a pressure relieving mattress and the revision of the care plan, dated 01/16/19, further indicated that an air mattress was added due to her wounds. A review of the pressure ulcer care area assessment (CAA), dated 01/17/19, revealed Resident #44 developed three, stage 2 pressure ulcers on her right and left buttock and sacrum. The CAA further revealed she was refusing all doctor visits and procedures and she wanted comfort care only and was offered hospice services, but she refused hospice. The CAA indicated she required extensive assistance with her transfers and bathing and refused to allow staff to turn and position her and refused to reposition herself in bed even with verbal cues. A review of the MDS Nurse's Risk Meeting Note, dated 01/17/2019, indicated Resident #44 had an air mattress applied and she was non-compliant with turning. A review of a Dietary Note, dated 01/17/2019,	F 656	implementation of the plan. Correction date: Feb 22, 2019	

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F 656	Continued From page 17	F 656		

indicated Resident #44 was at risk for skin breakdown related to refusal of care as evidenced by skin break down and overall general decline.

An interview was conducted with Resident #44 on 01/22/19 at 03:04 PM. She indicated that she never had an air mattress placed on her bed. She further indicated that her wounds were almost healed. She stated that she could reposition herself if needed but did not indicate that she refused repositioning. During the interview, an observation was made of Resident #44's bed and revealed there was no air mattress on her bed, but the bed did provide pressure relief.

An interview was conducted with the Staff Development Coordinator on 01/24/19 at 11:44 AM. She indicated that Resident #44 did not have an air mattress. She further indicated that Resident #44 could turn herself.

An interview was conducted with the MDS Coordinator on 01/24/19 at 5:12 PM. The MDS Coordinator indicated the air mattress should not have been added to the pressure ulcer care plan until it arrived at the facility. She further indicated that she jumped the gun and went down to see the resident in her room on 01/17/19 and did not check to see if the air mattress was on her bed. She stated that she charted a risk meeting note in error, which was dated 01/17/19. She further stated that she charted the note in error because the air mattress was not on the resident's bed.

An interview was conducted with the Administrator on 01/24/19 at 4:25 PM. The Administrator indicated that Resident #44's care plan should have addressed that the air mattress

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F 656	Continued From page 18 was applied only when it arrived at the facility and was implemented upon arrival. An interview was conducted with the Director of Nursing (DON) on 01/24/19 at 4:45 PM. The DON indicated that Resident #44's air mattress should not have been documented on the care plan until the air mattress was in the facility. The DON also indicated that Resident #44's air mattress would be delivered on the next day from a closer vendor.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, staff interviews, and physician interview the facility failed to obtain oxygen orders for 1 of 1 residents reviewed with oxygen (Resident #52). Findings included: Resident #52 was readmitted to the facility on 12/27/18 (original admission date was 08/04/05) with diagnoses including: hypertension, Alzheimer's disease, cerebrovascular accident, and non-Alzheimer's dementia.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. Resident #52 physician notified, and oxygen order updated by unit coordinator on 1/25/2019. 2. 100% Audit of all residents receiving oxygen was completed by Unit Coordinator on 1/25/2019, no other residents found to be affected at this time. 3. Education provided to licensed staff	2/22/19

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F 695	Continued From page 19 A review of the significant change Minimum Data Set (MDS) assessment dated 01/03/19 indicated that Resident #52 was cognitively intact and required the use of oxygen. Review of the physician orders revealed no order for oxygen use. Observations made on 01/22/19 at 9:22 AM and 01/23/19 at 10:00 AM revealed Resident #52 to be receiving oxygen via nasal cannula at 4 liters per minute. An interview conducted on 01/24/19 at 5:27 PM with Resident #52 revealed he receives oxygen when he wants it at 4 liters per minute. An interview conducted on 01/25/19 at 12:23 PM with Nurse #4 revealed Resident #52 wears oxygen when he wants it. Nurse #4 could not locate a physician order for oxygen. An interview conducted on 01/25/19 at 1:25 PM with the Director of Nursing (DON) revealed it was her expectation for all residents receiving oxygen to have a physician order for the administration of oxygen. An interview conducted on 01/25/19 at 1:48 PM with the physician revealed it was his expectation that the staff notify him or on call staff for order for oxygen use. An interview conducted on 01/25/19 at 3:17 PM with the administrator revealed it was his expectation the staff obtain physician orders for resident oxygen.	F 695	regarding Oxygen use and orders by Staff Development Coordinator (SDC) 2/13/2019. Current licensed nursing staff will be re-educated prior to working next scheduled shift and this education has been added to the new hire orientation. Central Supply Coordinator will provide list of residents, weekly whom oxygen supplies are distributed. Nursing admin team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will review list weekly for orders. Nursing admin to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will randomly audit 3 residents weekly to ensure accuracy of Oxygen orders weekly for 4 weeks then monthly for 2 months. 4. Effective February 21, 2019, the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	

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F 761	Continued From page 20	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard 1 of 2 multi-dose tuberculin vaccine vial that was opened and undated and available for use in 1 of 1 medication refrigerators and failed to discard 1 of 1 Novolog insulin vial that was expired for 31 days and failed to discard 1 of 1 Levemir insulin vial that was expired for 22 days and was available for use on 1 or 2 medications carts.	F 761	F761 Label/Store Drugs & Biologicals 1. Expired medications immediately removed from medication cart and medication refrigerator on 1/23/2019 by Director of Nursing (DON). Medications replaced with newly delivered Medications on-hand.	2/22/19

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F 761	Continued From page 21 Findings included: 1. a. A review of the manufacturer's recommendation for multi-dose tuberculin vaccine indicated that once opened the product was to be discarded after 30 days. A review of the facility policy entitled Storage of Medications (revised 04/2007) indicated the facility shall not use outdated or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed. On 01/23/19 at 10:11 AM 1 of 2 multi-dose vial of tuberculin purified protein derivative with lot #321478 and a manufacturer's expiration date of 06/2020 was observed opened and undated in the medication refrigerator. Nurse #1 verified the tuberculin vaccine was opened and undated and remained in the medication refrigerator ready for resident use. Nurse #1 stated the facility policy was to date the tuberculin vial when opened. Nurse #1 stated because the tuberculin vaccine had not been dated when opened then it could not be determined when the tuberculin vaccine would expire. Nurse #1 immediately removed the undated tuberculin vaccine vial from the medication refrigerator. On 01/23/19 at 10:21 AM an interview was conducted with the Director of Nursing (DON) who verified that the tuberculin vaccine multi-dose vial was opened and ready for resident use in the medication refrigerator. The DON stated the tuberculin vaccine should have been dated when opened as per facility policy. The DON stated the tuberculin vaccine per	F 761	2. Other 2 medication carts and 2 treatment carts were reviewed by the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC), and no other expired items identified on 1/23/2019. 3. Education provided to licensed nurses by Staff Development Coordinator (SDC) regarding medication storage on 2/12/2019. Current licensed nursing staff will be re-educated prior to working next scheduled shift and this education has been added to the new hire orientation. the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will randomly audit 2 carts per week to ensure there are no expired medications present. Weekly audits will be conducted for 4 weeks then monthly for 2 months. 4. Effective February 21, 2019, the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for	

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F 761	Continued From page 22 manufacturer ' s instructions was good for 30 days once opened. The DON stated because the tuberculin vaccine was not dated when opened it could not be determined when the vaccine would expire. The DON stated she did not have a system in place to check for out dated medication in the medication refrigerator. On 01/23/19 at 10:54 AM an interview was conducted with the Administrator who stated his expectation was that the tuberculin vaccine located in the medication refrigerator would have been dated when opened per manufacturer's recommendation and facility policy. The Administrator stated because the tuberculin vaccine was not dated when opened it could not be determined when the vaccine would expire. b. A review of the manufacturer's recommendation for Novolog insulin vial indicated that once opened the product was to be discarded after 28 days. A review of the facility policy entitled Storage of Medications (revised 04/2007) indicated the facility shall not use outdated or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed. On 01/23/19 at 11:00 AM 1 of 1 Novolog insulin vial was observed opened and dated 11/26/18 and remained on 1 of 2 medication carts ready for resident use. Nurse #2 verified the Novolog insulin was opened and dated 11/26/18 and remained on the West Wing medication cart ready for resident use. Nurse #2 stated Novolog insulin was good for 28 days once opened and was expired and should have been discarded.	F 761	implementation of the plan. Correction date: Feb 22, 2019	

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F 761	Continued From page 23	F 761		

Nurse #2 stated she had not checked the West Wing medication cart for expired medications when she took control of the cart at the beginning of her shift. Nurse #2 stated she had not administered Novolog insulin using the expired vial.

On 01/23/19 at 11:21 AM an interview was conducted with the Director of Nursing (DON) who verified the Novolog insulin vial was opened and dated 11/26/18 and was ready for resident use on the West Wing Medication cart. The DON stated the Novolog insulin vial per manufacturer's instructions was good for 28 days once opened and was expired. The DON stated her expectation was that staff would have removed the expired Novolog insulin vial from the West Wing medication cart.

On 01/23/19 at 11:30 AM an interview was conducted with the Administrator who stated his expectation was that staff would have discarded the expired Novolog insulin vial that was dated 11/26/18. The Administrator stated Novolog insulin was good for 28 days once opened.

c. A review of the manufacturer's recommendation for Levemir insulin vial indicated that once opened the product was to be discarded after 42 days.

A review of the facility policy entitled Storage of Medications (revised 04/2007) indicated the facility shall not use outdated or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed.

On 01/23/19 at 11:00 AM 1 of 1 Levemir insulin

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F 761	Continued From page 24 vial was observed opened and dated 11/20/18 and remained on 1 of 2 medication carts ready for resident use. Nurse #2 verified the Levemir insulin was opened and dated 11/20/18 and remained on the West Wing medication cart ready for resident use. Nurse #2 stated Levemir insulin was good for 42 days once opened and was expired and should have been discarded. Nurse #2 stated she had not checked the West Wing medication cart for expired medications when she took control of the cart at the beginning of her shift. Nurse #2 stated she had not administered Levemir insulin using the expired vial. On 01/23/19 at 11:21 AM an interview was conducted with the Director of Nursing (DON) who verified the Levemir insulin vial was opened and dated 11/20/18 and was ready for resident use on the West Wing Medication cart. The DON stated the Levemir insulin vial per manufacturer's instructions was good for 42 days once opened and was expired. The DON stated her expectation was that staff would have removed the expired Levemir insulin vial from the West Wing medication cart. On 01/23/19 at 11:30 AM an interview was conducted with the Administrator who stated his expectation was that staff would have discarded the expired Levemir insulin vial that was dated 11/20/18. The Administrator stated Levemir insulin was good for 42 days once opened.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/22/19

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F 812	Continued From page 25 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to cover two dessert trays that contained vanilla pudding cups and cups of orange slices and failed to discard a bag of green peppers that were moldy and had an expiration date of 12/30/18 that were stored in 2 of 2 reach-in refrigerators observed in the kitchen. The findings included: 1. Observations of the kitchen, on 01/22/19 from 8:55 AM to 9:15 AM, revealed uncovered and spoiled foods were stored in the kitchen's two reach in refrigerators. Observation of food stored in reach-in refrigerator #1 revealed two dessert trays, prepared for lunch on 01/22/19, had 8 dessert cups of 1/2 slices of oranges without a covering and the remainder of the dessert cups contained vanilla pudding without a covering. Observation of the food stored in reach-in	F 812	F812 Food Procurement Store/Prepare/Serve 1a. Moldy Peppers and outdated carrots were immediately discarded on 1/22/2019. Consultant Registered Dietician (RD) conducted in-service with all kitchen staff 1/22/2019 regarding food storage. 1b. Desserts were covered prior to distribution on 1/22/2019. 2. Kitchen rounds completed by Consultant Registered Dietician (RD)/Dietary staff on 1/22/2019, no other items identified as deficient. 3. Education given to all dietary staff regarding food storage by Consultant	

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F 812	Continued From page 26 refrigerator #2 revealed a one 5-pound bag of molded green peppers with a yellow slimy substance in the bag with an expired date of 12/30/18. An interview was conducted with the Dietary Manager (DM) on 01/22/19 at 9:15 AM. The DM indicated that the refrigerators, freezer, and dry storage were checked daily for expiration dates and signs of spoilage. She further indicated that her expectation was the molded green peppers should have been thrown away because of the expiration date of 12/30/19 and the dessert cups were left to chill, but they should have been covered. An interview was conducted with the Administrator on 01/24/19 at 4:25 PM. The Administrator indicated that his expectation was that food stored in the kitchen should have been checked daily for expiration dates and signs of spoilage and there should not have been any outdated food found in kitchen storage areas.	F 812	Registered Dietician (RD) on 1/22/2019. Education given to all dietary staff regarding proper covering of food items upon delivery to floor by Dietary Manager and/or Consultant Registered Dietician (RD) on 1/22/2019. Dietary Manager will audit kitchen weekly for expired items. Dietary Manager will randomly audit meal service delivery carts one time per week to ensure all items are covered when served, weekly for 4 weeks then monthly for 2 months. 4. Effective February 21, 2019, the Dietary Manager will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		2/22/19

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F 867	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to two recited deficiencies that were originally cited following the 04/19/18 annual recertification survey. The recited deficiencies were in the areas of encoding/transmitting resident assessments and label/store drugs and biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. a. 483.20 Encoding/Transmitting Resident Assessment: Based on record review and staff interviews, the facility failed to complete and transmit a discharge MDS (Minimum Data Set) assessment within the required time frame for 1 of 1 resident (Resident #1) reviewed for Resident Assessments. During the annual recertification survey of 04/19/18 the facility was cited for failure to complete and transmit discharge MDS assessments for two residents. b. 483.45 Label/Store Drugs and Biologicals: Based on observations, record review, and staff interviews, the facility failed to discard 1 of 2 multi-dose tuberculin vaccine vial that was opened and undated and available for use in 1 of	F 867	F867 QAPI/QAA Improvement Activities F640 Encoding/Transmitting Resident Assessment 1. Resident #1, Discharge Assessment submitted on 1/24/2019 and accepted on 1/30/2019 by Minimum Data Set Nurse (MDS Nurse). 2. Casper□s Missing Assessment Report pulled and reviewed by Minimum Data Set Nurse (MDS Nurse) on 1/29/2019 and Point Click Care□s Admit/Discharge To/From Report to reflect discharges for the 30-days prior on 1/29/2019. Any deficient items were corrected by the Minimum Data Set Nurse (MDS Nurse). 3. Education provide to Minimum Data Set Nurse (MDS Nurse) by Regional Minimum Data Set Consultant on 2/7/2019, regarding timely completion and submission of Discharge Assessments. Minimum Data Set Nurse (MDS Nurse) will provide weekly submission report to Nursing Home Administrator along with Point Click Care□s Admit/Discharge To/From Report to validate discharge assessment submission is timely as scheduled. Nursing Home Administrator will pull Casper□s Missing Assessment Report monthly for 3 months to ensure discharge assessments are completed timely.	

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F 867	Continued From page 28 1 medication refrigerators and failed to discard 1 of 1 Novolog insulin vial that was expired for 31 days and failed to discard 1 of 1 Levemir insulin vial that was expired for 22 days and available for use on 1 of 2 medication carts. During the annual recertification survey of 04/19/18 the facility was cited for failure to discard 2 opened Novolog insulin FlexPens that were not dated when opened. During an interview on 01/25/19 at 4:40 PM the Administrator stated systems were put into place to correct the deficiencies cited following the recertification survey of 04/19/18 and felt the breakdown was a result of the multiple transitions in Administrative staff and the facility's change in corporate ownership. He stated going forward he was committed to putting processes into place to address the repeated areas of concern and the QA committee would review and monitor the systems to ensure the facility maintained ongoing compliance.	F 867	4. Effective February 21, 2019, the MDS Coordinator and Nursing Home Administrator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. F761 Label/Store Drugs & Biologicals 1. Expired medications immediately removed from medication cart and medication refrigerator on 1/23/2019 by Director of Nursing (DON). Medications replaced with newly delivered Medications on-hand. 2. Other 2 medication carts and 2 treatment carts were reviewed by the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC), and no other expired items identified on 1/23/2019. 3. Education provided to licensed nurses by Staff Development Coordinator (SDC) regarding medication storage on 2/12/2019. Current licensed nursing staff will be re-educated prior to working next scheduled shift and this education has been added to the new hire orientation. The Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development	

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F 867	Continued From page 29	F 867	Coordinator (SDC) will randomly audit 2 carts per week to ensure there are no expired medications present. Weekly audits will be conducted for 4 weeks then monthly for 2 months. 4. Effective February (date of QA meeting), the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		2/22/19

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F 883	Continued From page 30	F 883		

annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

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F 883	Continued From page 31 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess the residents for eligibility and ensure residents were offered the influenza and pneumococcal vaccinations upon admittance into the facility for 3 of 5 residents reviewed for immunizations (Resident #42, #35 and #53). Findings included: The facility's policies on influenza and pneumococcal immunizations which were revised August 2016 were reviewed. The pneumococcal immunization policy indicated all residents will be offered pneumococcal vaccines. This policy indicated residents will be offered the vaccine within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The influenza immunization policy indicated all resident who have no medical contraindications to the vaccine will be offered the influenza vaccine annually between October 1st and March 31st each year. 1. Resident #42 was admitted to the facility on 12/07/18 with diagnoses including: depression, Alzheimer's dementia, and diabetes. Review of immunization record for Resident #42 revealed no pneumococcal or influenza immunizations had been documented as administered or received. An interview with Nurse #3 (Infection Control	F 883	F883 Infection Prevention & Control 1. Residents #53, #42, #35: Families contact via phone by the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) on 2/2/2019 and preference/consent obtained. 2. 100% audit conducted by nursing admin on consents/refusal and administration on 2/2/2019 by the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC). Any opportunities were corrected. 3. Flu/Pneumovax consent will be added to the new admission packet checklist. Licensed nurses educated by the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) on the consents and new process upon admission on 2/2/19. Current licensed nursing staff will be re-educated prior to working next scheduled shift and this education has been added to the new hire orientation. The Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development	

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F 883	Continued From page 32 Nurse) on 01/25/19 at 9:10 AM revealed the resident had not had the influenza vaccine. She further revealed she did not know if Resident #42 had received the pneumococcal vaccine or not. Nurse #3 stated it should have been done, but she had not done it. The Infection Control Nurse stated she was responsible for obtaining consent, administering the vaccines and maintaining surveillance data on all pneumococcal and influenza vaccines. Nurse #3 explained the facility policy for the pneumococcal vaccine was each resident would be assessed within 5 working days of the resident's admission and for the influenza vaccine, residents will be offered the influenza vaccine between October 1st and March 31st of each year. In addition, residents admitted between October 1st and March 31st will be offered the vaccine within 5 working days of admission. An interview was conducted with the Director of Nursing (DON) on 01/25/19 at 9:51 AM regarding the lack of pneumococcal and influenza vaccines. Her expectation was that Nurse #3 would have provided the vaccines and documentation. She further stated she was aware there was a problem with the pneumococcal and influenza administration and documentation system due to multiple staff changes and she had provided an audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved. An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the facility policy.	F 883	Coordinator (SDC) will review all new admits daily (Monday-Friday) for 1 week (2/4/19 - 2/8/19) for consent forms and follow-up. Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will randomly audit 3 charts per week for flu/pneumovax consent/refusal/administration weekly for 4 weeks (starting 2/11/19) then monthly for 2 months. 4. Effective February 21, 2019, the Nursing Admin Team to include Director of Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (SDC) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: Feb 22, 2019	

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2. Resident #53 was admitted to the facility on 08/03/18 with diagnoses including: hypertension, cervical vertebra fracture, non-Alzheimer's dementia, and edema.

Review of immunization record for Resident #53 revealed no pneumococcal or influenza immunizations had been documented.

An interview with Nurse #3 (Infection Control Nurse) on 01/25/19 at 9:10 AM revealed the resident had not had the influenza vaccine. She further revealed she did not know if Resident #53 had received the pneumococcal vaccine or not. The Infection Control Nurse stated it should have been done, but she had not done it. Nurse #3 stated she was responsible for obtaining consent, administering the vaccines and maintaining surveillance data on all pneumococcal and influenza vaccines. Nurse #3 explained the facility policy for the pneumococcal vaccine was each resident would be assessed within 5 working days of the resident's admission and for the influenza vaccine, residents will be offered the influenza vaccine between October 1st and March 31st of each year. In addition, residents admitted between October 1st and March 31st will be offered the vaccine within 5 working days of admission.

An interview was conducted with the Director of Nursing (DON) on 01/25/19 at 9:51 AM regarding the lack of pneumococcal and influenza vaccines. Her expectation was that Nurse #3 would have provided the vaccines and documentation. She further stated she was aware there was a problem with the pneumococcal and influenza administration and documentation system due to multiple staff changes and she had provided an

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F 883	Continued From page 34	F 883		

audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved.

An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the facility policy.

3. Resident #35 was admitted to the facility on 06/21/18 with diagnoses including: aftercare following joint replacement surgery.

Review of immunization record for Resident #35 revealed the influenza vaccine was administered on 10/19/18. Further record review revealed no documentation of the pneumococcal vaccine.

An interview with Nurse #3 (Infection Control Nurse) on 01/25/19 at 9:10 AM revealed the resident had not had the influenza vaccine. She further revealed she did not know if Resident #35 had received the pneumococcal vaccine or not. Nurse #3 stated it should have been done, but she had not done it. The Infection Control Nurse stated she was responsible for obtaining consent, administering the vaccines and maintaining surveillance data on all pneumococcal and influenza vaccines. Nurse #3 explained the facility policy for the pneumococcal vaccine was each resident would be assessed within 5 working days of the resident's admission and for the influenza vaccine, residents will be offered the influenza vaccine between October 1st and March 31st of each year. In addition, residents admitted between October 1st and March 31st will be offered the vaccine within 5 working days of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 35 admission. An interview was conducted with the Director of Nursing (DON) on 01/25/19 at 9:51 AM regarding the lack of pneumococcal and influenza vaccines. Her expectation was that Nurse #3 would have provided the vaccines and documentation. She further stated she was aware there was a problem with the pneumococcal and influenza administration and documentation system due to multiple staff changes and she had provided an audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved. An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the facility policy.	F 883		