STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL NURSING & REHABILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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 3/11/19 through 3/14/19. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID # S18N11	E 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 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	F 578		4/5/19

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

Electronically Signed | 04/05/2019

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F 578	Continued From page 1 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 staff interviews, interview with a physician assistant and record review, the facility failed to accurately document code status in both the electronic medical record and paper chart for 1 of 27 residents (Resident #15) reviewed for advance directives. Findings included: Resident #15 was admitted to the facility on 11/15/18 with diagnoses that included, in part, atrial fibrillation and cerebral infarction. A review of the comprehensive Minimum Data Set (MDS) assessment dated 11/22/18 revealed Resident #15 had severe cognitive impairment. A review of the monthly physician orders for March 2019 in the electronic medical record revealed an advance directive that included full code status (initiate cardio-pulmonary resuscitation should respirations and heartbeat stop). A review of the paper chart revealed a physician telephone order dated 11/15/18, "Code status-full code."	F 578	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F578 Request/Refuse/Discontinue Treatment Formulate Advanced Directives ROOT CAUSE The alleged noncompliance resulted from the facility failing to accurately document code status in both the electronic medical record and paper chart for resident # 15. IMMEDIATE ACTION On 3/14/2019 resident # 15□s code status was verified as DNR via MOST form and Physicians order and was corrected in the electronic medical record. IDENTIFICATION OF OTHERS Effective 4/02/2019 -□ 4/05/2019 the	

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F 578	Continued From page 2 A review of the paper chart revealed a Medical Orders for Scope of Treatment (MOST) form that was checked "Do Not Attempt Resuscitation." The effective date on the form was 11/15/18 and the form was signed by the Provider on 11/16/18. On 3/14/19 at 8:36 AM an interview was completed with Nurse #3. She said when a resident was admitted to the facility a MOST form was completed with the resident or resident representative. She stated once the MOST form was completed it was signed by the Provider and then placed on the front of the resident's chart. On 3/14/19 at 9:30 AM an interview was completed with the Unit Manager who completed the admission orders when Resident #15 was admitted to the facility. She stated when a resident was admitted the nurse typically had a conversation with the resident or resident representative and clarified the resident's preferred code status. A MOST form was then completed and placed on the chart. The Unit Manager reported when she completed the admission orders for Resident #15 the hospital paperwork indicated the resident was a full code so that was what she placed on the hand written order prior to Resident #15's admission to the facility. The Unit Manager said once Resident #15 arrived either the resident or the resident representative indicated the code status was DNR which was then reflected on the MOST form and signed by the Provider. The Unit Manager stated the updated code status information should have been transcribed into the electronic medical record and reflected on the monthly physician order sheet and was unsure why it was not appropriately transcribed.	F 578	Director of Nursing and Unit Coordinators completed an audit of 100% of residents currently in the facility. All residents with advanced directives to include Most forms and/or physicians order were reviewed and verified against the electronic medical record and any issues identified were corrected. SYSTEMIC CHANGES Effective 4/05/2019, all residents with no DNR code status upon arrival to the facility will have a code status of FULL written on a physician□s order form and entered into the electronic medical record. The Admissions Coordinators will review and complete a MOST form and Code Status Agreement with all new residents/family during the admitting process to confirm or determine a change in code status. The Most form and Code Status Agreement will be reviewed by nursing and the medical provider in daily clinical stand up meeting Monday □ Friday. The unit coordinators will verify the code status is entered correctly in the electronic medical record. MONITORING PROCESS Effective 04/05/2019, The Director of Nursing and or unit coordinator will monitor compliance by reviewing all new admissions MOST forms and Code Status Agreement and orders in the electronic health record in the daily clinical stand up meeting Monday □ Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any identified issues will be corrected promptly. Effective 04/05/2019, the Director of	

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F 578	Continued From page 3 On 3/14/19 at 8:59 AM an interview was completed with the Physician's Assistant (PA). She stated a signed MOST form was considered a physician's order. She said she did not know why there was a handwritten order for full code or why the monthly physician order sheet reflected Resident #15 was a full code status. On 3/14/19 at 9:38 AM an interview was completed with the Director of Nursing (DON). He said staff were educated to look at the front of the paper chart for the code status. He stated if there was no MOST form on the chart the staff looked in the physician orders for the code status. He further stated he expected code status information be consistent in both the paper chart and electronic medical record.	F 578	Nursing Services will report the findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/05/2019 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/5/19

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F 584	Continued From page 4 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff, resident and family interviews the facility failed to (1) maintain the walls in residents' rooms to prevent areas of exposed plaster for 4 of 13 rooms (rooms 310, 311, 706 and 711), (2) failed to repair peeling wall paper boarders in 7 of the 13 rooms (rooms 708, 709, 710, 711, 716, 717 and 718), (3) repair loose and leaking faucets in the residents bathrooms for 3 of 13 rooms (rooms 708, 710 and 711), (4) repair or replace broken items for 5 of 13 resident rooms (rooms 310, 703, 706, 717 and 718) and (5) keep carpets clean and free of stains in the common areas on 6 of 7 hallways (200, 300, 400, 500, 600 and 700 hallways).	F 584	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F584 Safe/Clean/Comfortable/Homelike Environment	

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F 584	Continued From page 5 Findings included: 1a. An observation of room #310 occurred on 3-11-19 at 2:59pm. The wall behind the bed was noted to have paint chipped off exposing the plaster. Room #310 was observed again on 3-14-19 at 3:00pm revealing the wall behind the resident's bed had paint chipped off exposing the plaster. 1b. An observation of room #311 occurred on 3-12-19 at 9:03am. The wall behind the bed was noted to have gouges in the paint exposing the plaster. Room #311 was observed again on 3-14-19 at 3:01pm revealing the wall behind the resident's bed had gouges in the paint exposing the plaster. 1c. An observation of room #706 occurred on 3-11-19 at 11:55am. The wall behind the resident's bed was noted to have deep gouges in the wall that was exposing the plaster and there was plaster on the floor. Room #706 was observed again on 3-14-19 at 3:02pm revealing the wall behind the resident's bed had deep gouges in the wall that was exposing the plaster. 1d. An observation of room #711 on 3-11-19 at 1:27pm revealed the wallpaper border was peeling off the wall and the wall behind the resident's bed had deep gouges exposing the plaster. Room #711 was observed again on 3-14-19 at 3:06pm revealing the wallpaper border was peeling off the wall and the wall behind the resident's bed had deep gouges exposing the plaster.	F 584	ROOT CAUSE The alleged noncompliance resulted from the facility failing to, 1. Maintain the wall in residents room to prevent areas of exposed plaster (in rooms 310, 311, 706 and 711) 2. Repair peeling wall paper boarders (in rooms 708, 709, 710, 711, 716, 717 and 718) 3. Repair loose and leaking faucets (in rooms 708, 710 and 711) 4. Repair or replace broken items (in rooms 310, 703, 706, 717 and 718) and 5. Keep carpets clean and free of stains in common areas on hallways (200, 300, 400, 500, 600 and 700 Hallways). IMMEDIATE ACTION Effective 04/05/2019 the Director of Maintenance/designee repaired or replaced, exposed plaster (in rooms 310, 311, 706 and 711), peeling wall paper boarders (in rooms 708, 709, 710, 711, 716, 717 and 718), loose and leaking faucets (in rooms 708, 710 and 711), and broken items (in rooms 310, 703, 706, 717 and 718) and a flooring contractor was retained and will proceed with estimated work of replacing carpet with LVT flooring throughout the facilities carpeted areas beginning the week of 4/29/2018. Effective 04/05/2019 the Corporate Plant Operations Consultant re-educated the Director of Maintenance and Maintenance personnel regarding the weekly environmental rounds utilizing the Enviro-round checklist and submission of the checklist to the Plant Operations Consultant.	

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F 584	Continued From page 6 The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was aware of the issue with the wall behind the beds being damaged and the facility needed to purchase "bed guards" to help prevent the damage to the walls. He also stated he was unsure if the facility was going to make such a purchase but that he made weekly environmental rounds to note such issues and that it may take up to a week to correct any issues. The maintenance manager also discussed having a work order binder in each nursing station that was checked "multiple times a day" and if the issue could be fixed quickly than he would fix it, otherwise, he scheduled a time with staff and the resident to have the issue fixed. During an interview with the Administrator and Director of Nursing on 3-14-19 at 5:19pm, the Director of Nursing stated he expected the facility to be in substantial compliance. 2a. An observation of room #708 occurred on 3-11-19 at 11:59am. The border wallpaper was noted to be peeling away from the wall in several different areas. Room #708 was observed again on 3-14-19 at 3:03pm revealing the border wallpaper was peeling away from the wall. 2b. An observation of room #709 occurred on 3-11-19 at 4:00pm. The border wallpaper was noted to be peeling away from the wall in several different areas. Room #709 was observed again on 3-14-19 at 3:04pm revealing the border wallpaper was peeling away from the wall. 2c. An observation of room #710 occurred on	F 584	IDENTIFICATION OF OTHERS Effective 04/02/2019 - 04/05/2019, Director of Maintenance completed an environmental audit of all resident rooms and common areas throughout the facility utilizing an Enviro-round checklist. Identified areas of concern needing repairing or replacing will be schedule for service by the Director of Maintenance and be completed within 7 days where as possible. Any repair or replacement exceeding 7 days for completion requires Facilities Administrator s approval. SYSTEMIC CHANGES Effective 04/05/2019 the Director of Maintenance will utilize and Enviro-round checklist on weekly basis. The Enviro-round checklist will be used by maintenance personnel to complete the identified areas needing repairs or replacement of broken items in 5-10 resident rooms per week. Enviro-round checklist will be scanned to Corporate Plant Operations Consultant and facility Executive Director weekly upon completion of rounds. Identified areas or items needing repair or replacement will be completed within 7 days where as possible. Any repair or replacement exceeding 7 days for completion requires Facilities Administrator s approval. MONITORING PROCESS Effective 04/05/2019 The Director of Maintenance will monitor compliance by reviewing the Enviro-round checklist for completion daily Monday - Friday for 2 weeks, then weekly for 4 weeks, then	

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F 584	Continued From page 7 3-11-19 at 1:00pm. The border wallpaper was noted to be peeling away from the wall in several different areas. Room #710 was observed again on 3-14-19 at 3:05pm revealing the border wallpaper was peeling away from the wall. 2d. An observation of room #711 on 3-11-19 at 1:27pm revealed the wallpaper border was peeling off the wall. Room #711 was observed again on 3-14-19 at 3:06pm revealing the wallpaper border was peeling off the wall. 2e. An observation of room #716 on 3-11-19 at 1:52pm revealed the wallpaper border was peeling off the wall in several places. Room #716 was observed again on 3-14-19 at 3:07pm revealing the wallpaper border was peeling off the wall in several places. 2f. An observation of room #717 occurred on 3-11-19 at 1:58pm. The room was noted to have wallpaper border that was peeling away from the wall and paint peeling off the wall next to the bed. Room #717 was observed again on 3-14-19 at 3:08pm and was noted to have wallpaper border that was peeling away from the wall and paint peeling off the wall next to the bed. The maintenance manager was interviewed on 3-14-19 at 3:10pm. The maintenance manager stated he was not aware of the paint peeling off the wall next to the resident's bed but that he would have it corrected. 2g. An observation of room #718 occurred on 3-11-19 at 2:31pm. The room was noted to have	F 584	monthly for 3 months or until a pattern of compliance is maintained. Effective 04/05/2019, the Director of Maintenance will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/05/2019 the Administrator and Director of Maintenance will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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wallpaper border that was peeling away from the wall.

Room #718 was observed again on 3-14-19 at 3:09pm and was noted to have wallpaper border that was peeling away from the wall.

The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was aware of the issue with the wallpaper border but did not have any plans in place to correct the issue.

During an interview with the Administrator and Director of Nursing on 3-14-19 at 5:19pm, the Director of Nursing stated he expected the facility to be in substantial compliance.

3a. An observation of room #708 occurred on 3-11-19 at 11:59am. The sink in the resident's bathroom was noted to have a faucet that was loose from the sink and dripping.

Room #708 was observed again on 3-14-19 at 3:03pm revealing the bathroom sink faucet was loose and dripping

3b. An observation of room #710 occurred on 3-11-19 at 1:00pm. The faucet in the resident bathroom sink was able to be moved and was dripping.

Room #710 was observed again on 3-14-19 at 3:05pm revealing the faucet in the resident bathroom sink was able to be moved and was dripping.

3c. An observation of room #711 on 3-11-19 at 1:27pm revealed the faucet in the resident's bathroom sink was loose and dripping.

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Room #711 was observed again on 3-14-19 at 3:06pm revealing the faucet in the resident's bathroom sink was loose and dripping.

The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was unaware the faucet in the bathroom was loose and dripping but he would have the issue corrected.

During an interview with the Administrator and Director of Nursing on 3-14-19 at 5:19pm, the Director of Nursing stated he expected the facility to be in substantial compliance.

4a. An observation of room #310 occurred on 3-11-19 at 2:59pm. The resident's nightstand was noted to be missing the middle drawer.

Room #310 was observed again on 3-14-19 at 3:00pm revealing the resident's nightstand was noted to be missing the middle drawer.

4b. An observation of room #703 occurred on 3-12-19 at 8:46am. The residents room air/heating unit was noted to have 3 broken slats.

Room #703 was observed again on 3-14-19 at 3:10pm revealing the rooms air/heating unit had 3 broken slats.

The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was unaware the air/heating unit in the resident's room had broken slats but that he would have the issue corrected.

4c. An observation of room #706 occurred on 3-11-19 at 11:55am. The resident's dresser was noted to have a section at the bottom where the

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veneer had come off revealing the particle board.

Room #706 was observed again on 3-14-19 at 3:02pm revealing the resident's dresser was noted to have a section at the bottom where the veneer had come off revealing the particle board.

The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was aware of the issue with the resident's dressers and that he planned on coving the areas with wall trim painted the same color as the dresser, but the plan had not been implemented and did not know when the plan would be implemented.

4d. An observation of room #717 occurred on 3-11-19 at 1:58pm. The resident's nightstand was noted to have the bottom right piece separating from the rest of the nightstand making it unstable.

Room #717 was observed again on 3-14-19 at 3:08pm and was noted the resident's nightstand had the bottom right piece separating from the rest of the nightstand making it unstable.

4e. An observation of room #718 occurred on 3-11-19 at 2:31pm. The resident's bathroom door was noted not to be able to shut due to the door separating from the door hinge.

Room #718 was observed again on 3-14-19 at 3:09pm and the resident's bathroom door was noted not to be able to shut due to the door separating from the door hinge.

The maintenance manager was interviewed on 3-14-19 at 3:10pm, he stated he was unaware of the issue with the resident's bathroom door but that he would have the issue corrected. He stated

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he was also unaware of the night stands in the residents rooms being damaged but that he would have the issue corrected.

During an interview with the Administrator and Director of Nursing on 3-14-19 at 5:19pm, the Director of Nursing stated he expected the facility to be in substantial compliance.

5. On 3/11/19 at 12:44 PM, an observation was made of multiple stains on the carpet on the 600 hallway.

On 3/12/19 an observation from 10:35AM to 10:45AM revealed multiple large white stains on the carpet in the sitting area of the 200, 300 and 400 halls, a large bright orange stain on the carpet on the 600 hallway, and multiple other stained areas on the carpet in the living area of 500, 600 and 700 halls. Large dark areas were observed on the carpet on the 600 hallway. Some stains were noted to be surrounded by large white areas. On the 600 hall all carpeted areas of the entry thresholds to resident rooms observed with large darkened areas.

On 3/13/19 at 11:00 AM, a resident council meeting was conducted as part of the survey. Resident #66 stated the staff go around with a broom and a dust pan and collect debris from the carpet. Resident #66 stated the staff also spray the carpet stains with a substance that does not remove the stains.

On 3/14/19 at 10:30 AM the large stains were still visible on the carpet in the sitting area of the 200, 300 and 400 halls, a large bright orange stain on the carpet on the 600 hallway was still visible and multiple other stained areas on the carpet in the

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F 584	Continued From page 12	F 584		

living area of 500, 600 and 700 halls. Large dark areas were still visible on the carpet on the 600 hallway. The entry thresholds to resident rooms on the 600 hallway continued to have large darkened areas.

On 3/14/19 at 2:00 PM, and interview was conducted with a family member of a resident who resided on the 700 hallway. He stated the carpet needed to be removed because it was dirty and stained.

On 3/14/19 at 2:31 PM, an interview was conducted with Resident #81 who resided on the 700 hallway. She stated the carpet in the hallway is very dirty and it smells bad.

On 3/14/19 at 2:48 PM, an interview was conducted with Housekeeper #1. She stated she had been working at the facility for four months and the carpet had always been stained and dirty.

On 3/14/19 at 2:55 PM an interview with a family member who resided on the 600 hallway revealed the carpet needed to be removed because it was dirty and stained.

On 3/14/19 at 2:55 PM an interview with a family member of a resident who resided on the 600 hallway revealed the carpet needed to be removed because it was dirty and stained.

On 3/14/19 at 3:43 PM, an interview with the Housekeeping Director was conducted. She stated she had been working at the facility for a year. She revealed the carpet was old and stained and as much as it is cleaned, some stains will not come out. She stated the carpet is vacuumed daily and there is a schedule for

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F 584	Continued From page 13 shampooing and extracting the carpet that is done three times a week on second shift. She revealed an inservice was conducted in October of 2018 on shampooing and extracting the carpets that all housekeeping staff attended. She stated she makes spot checks to the facility at night to ensure the carpet is being shampooed. On 3/14/19 at 4:30 PM, an interview was conducted with the Administrator. She revealed she knew the carpet was old and needed to be replaced and she was working on it. She stated the owner of the building came to tour in August of 2018. She brought contractors with her and estimates for replacing the carpet were done. She was given estimates of 2 options she could choose. She stated she sent a Facility Expense Report to the corporate office and stated they have several layers they have to go through in order to get things approved and she hasn ' t received the final approval yet.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		4/5/19

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F 637	Continued From page 14 by: Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 15 resident (Resident #72) reviewed for MDS assessment. Findings included: Resident #72 was admitted to the facility on 1-2-19 with multiple diagnoses that included aspiration pneumonia, heart failure, dysphagia and pressure ulcer of the sacrum. Resident #72's care plan dated 1-9-19 revealed goals and interventions for aspiration, skin breakdown and pressure ulcers and having his needs met daily. The 30-day MDS dated 2-3-19 revealed Resident #72 was cognitively impaired and needed extensive assistance with 2 people for bed mobility, transfers, dressing, toileting and personal hygiene. A review of the physician orders dated 2-26-19 revealed Resident #72 was placed on Hospice services on 2-26-19. The care plan for Resident #72 was updated on 2-26-19 to add a goal and intervention for Hospice services. Resident #72's medical record did not have a significant change MDS assessment indicating the resident was placed on Hospice services. An interview with the Hospice nurse occurred on 3-14-19 at 11:46am. The nurse stated Resident	F 637	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F637 Comprehensive Assessment After Significant Change ROOT CAUSE The alleged noncompliance resulted from MDS Nurse #1 failing to complete a significant change in status Minimum Data Set (MDS) on Resident # 72, on 02/26/2019 when the resident was admitted to hospice services. IMMEDIATE ACTION On 03/15/2019 the MDS Nurse #1 completed a significant change in status Minimum Data Set (MDS) on Resident # 72. On 04/05/2019 the MDS Coordinators were re-educated regarding the completion of a significant change in status Minimum Data Set (MDS) when a resident is admitted to hospice. IDENTIFICATION OF OTHERS On 04/02/2019 - 04/05/2019 MDS nurse completed an audit of 100% of all resident currently in the facility that were admitted to hospice to verify a significant change in status MDS was completed. All resident identified as admitted to hospice had a	

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F 637	Continued From page 15 #72 was placed back on Hospice on 2-26-19 for aspiration pneumonia. During an interview with the MDS nurse on 3-14-19 at 12:15pm, she stated she had done a significant change MDS on 1-9-19 to indicate the resident had been discharged from Hospice and placed on a gastric tube but did not do a significant change on 2-26-19 when the resident was placed back on Hospice "because it was not a significant change. He should never have come off Hospice." The Administrator and Director of Nursing were interviewed on 3-14-19 at 5:19pm. The Director of Nursing stated he expected the facility to be in substantial compliance in MDS assessments.	F 637	significant change in status Minimum Data Set (MDS) completed. No other residents were identified during the audit. SYSTEMIC CHANGES Effective 04/05/2019 The Director of Nursing Services/Designee and MDS coordinators will review all new residents admitted to hospice in the daily clinical stand up meeting Monday - Friday. The Director of Nursing Services/Designee and MDS coordinators will verify the significant change in status Minimum Data Set (MDS) is completed. MONITORING PROCESS Effective 04/05/2019 The Director of Nursing Services/Designee and MDS coordinators will review all new residents admitted to hospice daily in the clinical stand up meeting and will verify the significant change in status Minimum Data Set (MDS) was completed, Monday-Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Findings of this review will be documented and maintained in a clinical binder. Any identified issues will be corrected promptly. Effective 04/05/2019 the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY	

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F 637	Continued From page 16	F 637	Effective 4/05/2019 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
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 staff interviews and record review the facility failed to accurately code the use of an antibiotic medication on the Minimum Data Set (MDS) assessment and failed to accurately code the use of skin creams on the MDS assessment for 2 of 27 residents (Residents #95 and 64) reviewed for MDS accuracy. Findings included: 1. Resident #95 was admitted to the facility on 8/20/18 with diagnoses that included, in part, urinary tract infection. A review of a physician's order dated 12/18/18 revealed Trimethoprim (an antibiotic), 100 milligrams, in the evening for urinary tract infection. A review of the medication administration record (MAR) for February 2019 revealed Resident #95 received Trimethoprim daily. A review of the quarterly MDS assessment dated	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F641 Accuracy of Assessments ROOT CAUSE The alleged noncompliance resulted from MDS nurse #1 failed to accurately code the use of an antibiotic medication on resident # 95 on the minimum data set (MDS) dated 2/15/2019 and MDS nurse #2 failed to accurately code the use of skin creams on resident #64 on the minimum data set (MDS) dated 1/25/2019.	4/5/19

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F 641	Continued From page 17 2/15/19 revealed the use of antibiotics was not checked. On 3/14/19 at 1:28 PM an interview was completed with MDS Nurse #1. She said she had not coded the use of antibiotics on the quarterly MDS. She stated it should have been coded and she inadvertently missed coding that Resident #95 received an antibiotic. On 3/14/19 at 3:42 PM an interview with the Administrator revealed it was her expectation that MDS assessments be accurately coded. 2. Resident #64 was admitted to the facility on 9-22-17 with multiple diagnoses that included atrial fibrillation, cognitive communication deficit and dementia. A review of the physician orders dated 12-23-18 revealed Resident #64 was to receive Cetaphil Cream to both feet daily. A review of the physician's orders dated 1-4-19 revealed Resident #64 was to receive Hydrocerin cream to both lower extremities. A review of the treatment administration record from 1-15-19 to 3-13-19 revealed Resident #64 had received his Cetaphil cream and his Hydrocerin cream as ordered daily. The quarterly Minimum Data Set (MDS) dated 1-25-19 revealed Resident #64 was mildly cognitively impaired and needed limited assistance with one person for bed mobility, transfers, dressing, eating, toileting and personal hygiene. The MDS did not have his skin treatments coded.	F 641	IMMEDIATE ACTION On 3/14/2019 MDS Nurse #1 completed a modification of the minimum data set (MDS) dated 2/15/2019 for resident #95 to include use of an antibiotic medication. On 4/2/2019 MDS Nurse # 2 completed a modification of the minimum data set (MDS) dated 1/25/2019 for resident #64 to include the use of skin creams. On 04/05/2019 the MDS coordinators were re-educated regarding the accurate coding of the MDS by the Director of Nursing Services. IDENTIFICATION OF OTHERS Effective 04/02/2019 □- 04/05/2019 the MDS Coordinators completed an audit of 100% of residents currently in the facility, that received antibiotic therapy within the past 90 days and reviewed the MDS for accurate coding. Other residents that were identified as having an inaccurately coded assessment were modified and re-submitted by MDS coordinators. Effective 04/02/2019 □- 04/05/2019 the MDS Coordinators completed an audit of 100% of residents currently in the facility that had orders for skin creams within the past 90 days and reviewed their MDS for accurate coding. Other residents that were identified as having an inaccurately coded assessment were modified and re-submitted by MDS coordinators. SYSTEMIC CHANGES Effective 4/05/2019 The Director of Nursing Services and MDS coordinators will review all new physician orders in the daily clinical stand up meeting, Monday -□ Friday. The MDS coordinators will print out and review all new physician orders	

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F 641	Continued From page 18 Resident #64's care plan dated 1-25-19 revealed a goal that the resident would participate in activities of daily living. The interventions for that goal were as followed; explain procedures, allow resident time to respond, encourage involvement and administer medications as ordered. The MDS nurse was interviewed on 3-13-19 at 9:10am. The MDS nurse stated she had "missed" coding Resident #64's skin care "just a coding error on my part." During an interview with the Administrator and Director of Nursing on 3-14-19 at 5:19pm, the Director of Nursing stated he expected the facility to be in substantial compliance with the MDS assessments.	F 641	prior to the completion of the MDS to ensure accuracy. The Director of Nursing/ designee and MDS Nurse will verify the accuracy of the assessment prior to submission of the MDS. Any identified issues will be corrected promptly. MONITORING PROCESS Effective 4/05/2019 The Director of Nursing and MDS coordinators will review the accuracy of MDS assessment prior to submission of the MDS, daily in the clinical stand up meeting Monday - Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. The monitoring tool for this process will be maintained in a binder in the MDS office and will be reviewed at clinical stand up meeting Monday - Friday. Any identified issues will be corrected promptly. Effective 4/05/2019, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/05/2019 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge summary for 1 of 1 (Resident #131) residents reviewed for a planned discharge home. Findings included:	F 661	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth	4/5/19

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F 661	Continued From page 20 Resident #131 was admitted to the facility on 12/14/18. A review of the comprehensive Minimum Data Set assessment dated 12/21/18 revealed Resident #131 had an active discharge plan in place to return to the community. Resident #131 was discharged home on 1/8/19. A record review revealed a post-discharge plan of care dated 1/2/19. A record review revealed no discharge summary for Resident #131 was completed prior to or after discharge. The resident did have a post discharge plan of care for discharge. On 3/13/19 at 4:16 PM, an interview was conducted with Social Worker (SW) #1. She stated they did the post discharge plan of care forms for discharge, but the facility had not been completing the discharge summary with a recapitulation of the residents stay. On 3/13/19 at 4:19 PM, an interview was conducted with SW #2. She stated she handled the long term residents and had not been completing a discharge summary for residents with planned discharges. On 3/14/19 at 8:45 AM, an interview with the Administrator was conducted. She stated the staff was unaware they needed to be completing a discharge summary.	F 661	on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F661 Discharge Summary ROOT CAUSE The alleged noncompliance resulted from Social worker #1 failing to complete a discharge summary with a recapitulation of the residents stay on resident # 131 for a planned discharge on 01/08/2019. IMMEDIATE ACTION On 04/04/2019 Social worker #1 completed a discharge summary with a recapitulation of the resident□s stay on resident # 131 and a copy was mail to the resident. On 03/7/2019 the facility self-identified that social services were completing a discharge summary that did not include a recapitulation of the residents stay for those residents with a planned discharge. The discharge summary with a recapitulation of the resident□s stay was initiated on 03/07/2019. IDENTIFICATION OF OTHERS On 04/05/2019 The Director of Nursing Services and Social workers audit 100% all residents with a planned discharged from the facility. All residents since 03/07/2019 had a completed discharge summary with a recapitulation of the residents stay. SYSTEMIC CHANGES Effective 04/05/2019 The Social workers will complete a discharge summary with a recapitulation of the residents stay on all	

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F 661	Continued From page 21	F 661	planned discharges. Planned discharges and the discharge summary with a recapitulation of the residents stay will be initiated by social workers prior to daily clinical standup Monday - Friday. The Director of Nursing/designee and Social workers will ensure the initiation discharge summary with a recapitulation of the residents stay in the daily clinical stand up meeting Monday - Friday. MONITORING PROCESS Effective 04/05/2019 the Director of Nursing/designee and Social workers will monitor compliance by reviewing all planned discharges ensure the initiation and completion of the discharge summary with a recapitulation of the residents stay in the daily clinical stand up meeting Monday - Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. The monitoring will be maintained in a binder in the social service and will be brought to the clinical standup meeting. Any identified issues will be corrected promptly. Effective 04/05/2019 the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/05/2019 the Administrator and Director of Nursing Services will be	

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F 661	Continued From page 22	F 661	ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 692 SS=G	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 record review, family interview, physician interview, staff interview and observation the facility failed to provide tube feeding at a rate consistent with the rate on the discharge summary and clarify the admission tube feeding orders which resulted in unplanned, severe weight loss for 1 of 1 resident (Resident	F 692	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth	4/5/19

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F 692	Continued From page 23 #72) reviewed for nutrition. Findings included: Resident #72 was re-admitted to the facility on 1-2-19 with multiple diagnoses that included aspiration pneumonia, heart failure, dysphagia, pressure ulcer of the sacrum and severe protein-calorie malnutrition. The discharge summary paperwork from the hospital dated 1-2-19 revealed Resident #72 was to continue Osmolite 1.5 (brand of nutrients given through a feeding tube) at 55ML (milliliters) per hour continuous for 24 hours. This rate provided 1980 kilocalories. The hospital discharge medication list dated 1-2-19 revealed Resident #72 was to receive Osmolite 1.5 "place 1,000ML into feeding tube continuous." There was no rate of administration for the tube feeding on the medication list. A review of the facility admission notes dated 1-2-19 revealed the admitting nurse set the rate for Resident #72's tube feedings at 42ML per hour continuous for 24 hours. There was no further documentation noted that the admitting nurse clarified the rate for Resident #72's feeding. The physician's orders were reviewed for 1-2-19 and revealed no order for Resident #72's tube feedings. The Director of Nursing was interviewed on 3-13-19 at 3:30pm. The Director of Nursing stated the admitting nurse calculated the per hour rate by using the 1,000 ML order from the hospital discharge medication list and dividing it by 24	F 692	on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F 692 Nutrition/Hydration Status Maintenance ROOT CAUSE The alleged noncompliance resulted from the facilities failure to provide a tube feeding rate that resulted in unplanned weight loss for resident # 72. IMMEDIATE ACTION Resident # 72 no longer resides in the facility. No additional interventions identified. IDENTIFICATION OF OTHERS Effective 04/04/2019 the Registered Dietician completed a 100 % audit of all residents with tube feedings. No issues related to the tube feeding rate or weight loss were identified. SYSTEMIC CHANGES Effective 04/05/2019 the Nurse manager/Admitting nurse will review both the discharge summary and medication list for all newly admitted residents with a tube feeding and will document order verification with the medical provider, on the discharge summary and or nursing note. Effective 04/05/2019 the Assistant dietary manager and or Nurse manager/admitting nurse will review all new residents with a tube feeding on admission and confirm tube feeding rate with the registered dietician. Effective 04/05/2019 The Director of	

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F 692	Continued From page 24 hours. He also stated "we don't look at the summary. We typically only look at the medication orders." The Director of Nursing also stated the admitting nurse would use the hospital discharge orders and not re-write the order for the facility physician unless she was clarifying an order. A review of Resident #72's weights upon discharge from the hospital and re-admission to the facility on 1-2-19 revealed a weight of 174 pounds. The nurse's notes were reviewed from 1-2-19 to 1-9-19 and revealed Resident#72 continued to receive Osmolite 1.5 at 42ML per hour continuous for 24 hours. This tube feeding prescription provided 1512 kilocalories per day. An interview with dietitian #3 occurred on 3-14-19 at 10:00am. The dietitian stated she did not see Resident #72 when he was admitted on 1-2-19 and did not assess the resident's nutritional needs. She also stated Resident #72 was not seen by dietary until dietitian #1 saw him on 1-9-19. The 14-day Minimum Data Set (MDS) dated 1-16-19 revealed Resident #72 was severely cognitively impaired and needed extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for dressing and total assistance with 2 people for toileting and personal hygiene. The MDS also revealed the resident was 6 feet 6 inches tall and weighed 189 pounds. He was coded for a feeding tube and not on a physician-prescribed weight loss regimen.	F 692	Nursing Services/designee will review all new residents with tube feeding orders and will validate, order verification of the both the registered dietician and medical provider daily Monday □- Friday in the clinical standup meeting. Effective 04/05/2019 The Director of Nursing/designee and Assistant dietary manager will review the weights of all residents receiving a tube feeding weekly in standard of care meeting. MONITORING PROCESS Effective 04/05/2019 The Director of Nursing / Nurse managers will review both the discharge summary and medication list for all newly admitted residents with a tube feeding and validate order verification with both the registered dietician and the medical provider, daily in the clinical standup meeting, Monday -□ Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 04/05/2019 the Director of Nursing / Nurse managers and Assistant dietary manger will review the weights of all residents with a tube feeding in the weekly standards of care meeting, weekly for 12 weeks, or until a pattern of compliance is maintained. Any negative findings identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 04/05/2019, the Director of Nursing Services will report the finding to the Quality Assurance and Performance	

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F 692	Continued From page 25 The care plan for Resident #72 dated 1-9-19 revealed a goal stating he would have adequate intake with no weight loss. The interventions for that goal were dietician to evaluate and feeding tube. A review of dietitian #1's note dated 1-9-19 revealed documentation of Resident #72 receiving Osmolite 1.5 at 42ML per hour continuous over 24 hours and other discharge documentation from the hospital stating Resident #72 was to receive Osmolite 1.5 at 55ML per hour continuous over 24 hours. The documentation also revealed the dietician #1 recommended Resident #72 receive Osmolite 1.5 at 70ML per hour for 20 hours due to a weight loss greater than 25% in 30 days. This tube feeding recommendation provided 2100 kilocalories per day. During an interview with dietitian #1 on 3-14-19 at 10:33am, the dietitian stated the procedure when a resident was admitted to the facility on tube feedings the dietitian #3 or the Director of Nurses would call her within 24 hours with the resident's weight, height, pertinent information about the resident and the current order. The dietitian #1 stated she had received a call about Resident #72 and was informed of the resident's height, weight and the order for his tube feedings. The dietitian stated she calculated Resident #72's tube feeding to be 42ML per hour giving him 1500 calories a day and that was an adequate number of calories to sustain his weight and appropriate since the resident was new to tube feedings. She also denied the need to see the resident earlier because "I rely on staff to let me know if the rate is insufficient, if the resident is losing weight or if something is wrong with the feeding." Dietitian #1	F 692	Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 04/05/2019 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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stated Resident #72 could have been losing weight due to his recent illness but "that is why I increased the rate, to see if it would help with his weight loss."

The physician's orders from 1-9-19 revealed an order for Resident #72 to receive Osmolite 1.5 at 70ML per hour for 20 hours.

The facility's Physician Assistant (PA) was interviewed on 3-13-19 at 2:45pm. The PA stated she did not remember the amount of tube feeding Resident #72 was receiving when he was admitted to the facility on 1-2-19 but did state "If the resident was not receiving enough feeding he would certainly lose weight."

Resident #72's weight for 1-17-19 was reviewed and revealed a weight of 167 pounds.

The weights for Resident #72 were reviewed for 2-8-19 and 2-9-19 and revealed a weight of 159 pounds.

Resident #72's weight for 2-15-19 was reviewed and revealed a weight of 152 pounds.

A review of Resident #72's physician orders revealed the resident remained on Osmolite 1.5 at 70ML per hour for 20 hours (2100 kilocalories) from 1-9-19 until re-evaluated on 2-15-19 by dietitian #2.

A review of dietitian #2's documentation dated 2-15-19 revealed Resident #72 was still underweight and had a weight loss greater than 4.11 % in 39 days. Dietitian #2 recommended for Resident #72's tube feedings to be increased to Osmolite 1.5 at 80ML per hour continuous for 24

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hours which would increase Resident #72's kilocalorie intake to 2880.

A review of the physician's orders dated 2-15-19 revealed an order for Resident #72 to receive Osmolite 1.5 at 80ML per hour continues for 24 hours.

The weights for Resident #72 was reviewed for 2-25-19 and revealed a weight of 167 pounds.

During a family interview on 3-11-19 at 1:29pm, the family member stated she could see Resident #72 becoming weaker as he could no longer help to turn himself and the resident was losing weight. She also stated she mentioned her concerns to the facility physician but "nothing was changed for about a month." The family member also stated the resident "would say he was hungry every day until about a month ago when the doctor increased the amount of his tube feedings."

During an interview with dietitian #2 on 3-12-19 at 2:50pm, she stated she did not rely on a resident's weight to determine the nutritive value the resident may need but reviewed "trends" in the resident's health and weight and then determined what type of diet or amount of tube feeding was needed. She also stated she recommended to increase the tube feeding to Osmolite 1.5 at 80ML per hour continuous for 24 hours because she recognized Resident #72's weights showed a steady decline.

Resident #72 was observed through out the survey from 3-11-19 to 3-14-19. The resident's tube feeding was noted to be Osmolite 1.5 running at 80ML per hour continuous. Resident

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F 692	Continued From page 28 #72 was noted to be in the bed during the survey, unable to reposition himself but was able to sporadically inform staff of his needs. The Administrator and Director of Nursing was interviewed on 3-14-19 at 5:19pm. The Director of Nursing stated he did not have any expectations because the facility "carried out the physicians orders and followed the RD recommendations."	F 692		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the area surrounding the dumpster area free from trash and debris. This was evident in 2 of 2 observations of the dumpster area. Findings included: During an observation of the dumpster area on 3-11-19 at 9:10am with the Dietary Manager revealed trash and debris, which included; paper, paper bags, plastic gloves, cups, cardboard and broken furniture. The trash and debris were also noted to have blown from the dumpster area to the bushes which was approximately 25 feet from the dumpsters. The Dietary Manager was interviewed on 3-11-19 at 9:10am. The manager stated the task of cleaning the dumpster area was shared between dietary and environmental services. She stated she would inform environmental services of the	F 814	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F814 Dispose Garbage and Refuse Properly ROOT CAUSE The alleged noncompliance resulted from the facilities Dietary Managers failure to maintain the area surrounding the dumpster free from trash and debris on 03/13/2019. IMMEDIATE ACTION	4/5/19

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F 814	Continued From page 29 condition of the dumpsters and have them clean the area. Another observation of the dumpster area was made on 3-12-19 at 9:00am with the Dietary Manager. The trash and debris that had blown up under the bushes had been cleaned, however, the area surrounding the dumpsters continued to have paper, cardboard and broken furniture. An interview with the Dietary Manager occurred on 3-12-19 at 9:05am. The manager stated she was told by environmental services that the dumpster area had been cleaned and that she would "get my staff out here to clean this up." The Administrator and Director of Nursing was interviewed on 3-14-19 at 5:19pm. The Director of Nursing stated he expected the facility to be in substantial compliance.	F 814	0n 3/14/2019 the Dietary Manager cleaned the area around the dumpster to ensure it was free from trash and debris per facility protocols. Effective 04/05/2019 The Dietary Manager was re-educated regarding the facilities process for maintaining the area around the dumpster by the facilities Administrator. IDENTIFICATION OF OTHERS Effective 04/05/2019 the Dietary Manager audited the area around the dumpster to ensure the surrounding area was free from trash and debris. No other issues were identified. SYSTEMIC CHANGES Effective 04/05/2019 The Dietary Manager will in-service 100% of all dietary staff on the facilities process and procedures for maintain the area around the dumpster free from trash and debris. Dietary Manager/designee will monitor the area around the dumpster to ensure it is free from trash and debris daily Monday - Friday. MONITORING PROCESS Effective 04/05/2019 the Dietary Manager/designee will monitor compliance of maintaining the area around the dumpster to ensure it is free from trash and debris daily, Monday - Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative findings identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 04/05/2019, the Dietary Manager will report the findings to the Quality	

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F 814	Continued From page 30	F 814	Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 04/05/2019 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	