STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

(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 on 4/15/19 through 4/18/19. The facility was found in compliance with the requirement CFR 483.73,Emergency Preparedness. Event ID #H7KB11.	E 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		5/16/19

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

Electronically Signed | 05/13/2019

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and family member and staff interviews, the facility failed to notify the Responsible Party of a new wound and treatment for 1 of 4 residents reviewed for wounds (Resident #30) and failed to notify a family member and physician of a resident fall for 1 of 1 residents reviewed for accidents (Resident #11). Findings included: 1. Resident #30 admitted to the facility on 9/1/17 with diagnoses of Alzheimer's Dementia and Parkinson's Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/19, revealed Resident #30 was moderately cognitively impaired and required extensive to total care with all activities of daily living. The assessment further revealed Resident #30 did not have a pressure ulcer during the	F 580	Resident Affected: Nurse Management immediately corrected observed deficient practice for Resident #30 and Resident #11. Resident #30 Responsible Party and Medical Provider were notified of change (pressure ulcer) on 5/3/19 and pressure ulcer has been resolved. Resident #11 Responsible Party and Medical Provider were notified of change (fall) on 3/3/19. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Nurse Management conducted a 100% audit on all incidents/accident reports, which list resident wounds and falls, for the last 30 days to ensure Responsible Party and Medical Provider were notified	

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F 580	Continued From page 2 assessment period. A review of Resident #30's Physician's Orders revealed an order for a Hydrocolloidal Dressing to Sacrum every 5 days and as needed for decubitus ordered on 3/9/19. The Treatment Record for March 2019 revealed Resident #30 had a wound dressing treatment of "Hydrocolloidal Dressing to sacrum every 5 day and as needed for decubitus". The Treatment Record revealed the treatment started on 3/9/19. A review of the Treatment Record for April 2019 revealed Resident #30 continued to have a treatment for "Hydrocolloidal Dressing to sacrum every 5 day and as needed for decubitus" and the treatment continued. A Care Plan dated 3/27/19 stated Resident #30 had a potential for skin breakdown due to deconditioning, incontinence, and decreased mobility. A review of the Care Plan revealed no care plan for the current sacral wound. During an interview with Resident #30's Family Member on 4/15/19 at 12:22 pm, she stated she had visited the facility on 4/14/19 and found a dressing lying on Resident #30's bed and asked the Nurse if Resident #30 had a wound. She stated the nurse told her Resident #30 had a pressure ulcer to her sacrum. The Family Member stated the wound had not been reported to her and she was Resident #30's Responsible Party and Health Care Power of Attorney. An interview on 4/16/19 at 2:09 pm with Nurse Aide #1 revealed Resident #30 had a small open area on her sacrum.	F 580	on 5/8/19. No concerns were noted following completion of audit. Systemic Changes: The Staff Development Coordinator will educate licensed nursing staff on required notification of Condition Change of a Resident, including reporting falls to responsible party and medical provider. Staff Development Coordinator initiated in service on 5/1/19 to Licensed nursing staff on proper notification of Condition Change of a Resident, including reporting wounds to responsible party and medical provider. All new licensed nursing staff will be educated during orientation on Condition Change of a Resident Policy. Nurse Management will audit all incident/accidents reports 5 times per week for 3 months to ensure proper notification of falls and wounds to family and medical provider. Licensed nursing staff in-services will be completed prior to returning to work after May 16, 2019 Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 580	Continued From page 3	F 580		

During an interview on 4/18/19 at 1:40 pm with the Wound Care Nurse, she indicated she was notified of Resident #30's pressure ulcer on 3/8/19 and had not notified the Responsible Party. She stated she thought it was the responsibility of Nurse #1 to notify the Responsible Party since she had found the new pressure ulcer.

An interview with Nurse #1 on 4/18/19 at 3:01 pm revealed she did not notify the Responsible Party of the pressure ulcer she found on Resident #30's sacrum when she found the area on 3/8/19. She stated she did notify the Wound Care Nurse of the wound and obtained an order for treatment from the Physician. Nurse #1 stated she thought the Wound Care Nurse would notify the Responsible Party of Resident #30's wound.

On 4/18/19 at 3:00 pm the Director of Nursing stated she expected the Nurse that found a wound to immediately notify the Wound Care Nurse, the Physician, the Director of Nursing, and the Responsible Party when a wound was discovered on a resident.

During an interview with the Administrator on 4/18/19 at 6:00 pm he indicated he expected the Nurse to notify the Responsible Party of any changes in a resident's condition.

2. Resident #11 was admitted to the facility on 8/18/2018 and readmitted 3/8/2019 with diagnoses to include fractured femur, difficulty walking, muscle weakness and adult failure to thrive. The most recent significant change

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F 580	Continued From page 4	F 580		

Minimum Data Set (MDS) assessment dated 3/24/2019 assessed Resident #11 to be severely cognitively impaired and she required limited 1-person assistance with transfers and she was non-ambulatory.

A nursing note written by Nurse #5 was reviewed and the nurse documented she had called the family member (FM) of Resident #11 on 3/3/2019 at 9:50 AM to inform the FM of "incident that happened last Thursday (2/28/2019)."

A nursing note written by the 2nd shift (3:00 PM -11:00 PM) supervisor (Nurse #3) dated 3/3/2019 at 6:11 PM was noted to be a late entry for 2/28/2019 at 6:00 PM. The note documented Resident #11 had experienced an unwitnessed fall in her room and she was assessed to have no injury and assisted back into her wheelchair by staff. The note went on to document the nurse (Nurse #4) had been notified of the incident.

Resident #11 ' s FM was interviewed via phone call on 4/17/2019 at 3:22 PM. The FM reported she had not been notified Resident #11 had fallen on 2/28/2019 and she did not find out Resident #11 had a fall until 3/3/2019.

An interview was conducted with the nurse practitioner (NP) #1 on 4/17/2019 at 3:30 PM and he reported he was the first point of contact for the physician after 6:00 PM on weeknights and he had not received report from the facility regarding Resident #11 ' s fall on 2/28/2019.

NP #2 was interviewed via phone call on 4/18/2019 at 11:30 AM and she reported she took calls at night and on the weekends for the facility physician and she was not notified of Resident

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F 580	Continued From page 5 #11 ' s fall on 2/28/2019. An interview was conducted with Nurse #3 on 4/18/2019 at 3:21 PM. Nurse #3 reported she was the 2nd shift supervisor and was working 2/28/2019 when Resident #11 fell. Nurse #3 went on to explain she had assisted Resident #11 back into her wheelchair and had reported to Nurse #4 details of the fall and Nurse #4 had responded "okay" to her. Nurse #3 explained when Nurse #4 told her "okay", she expected Nurse #4 to contact the physician and the family to report the fall. Nurse #3 then shared she was not aware the physician or the family were not notified until 3/3/2019. Nurse #4 was interviewed on 4/18/2019 at 3:42 PM and she reported the evening of 2/28/2019 was very busy, but when she was told Resident #11 had fallen, she went to assess her and check for injuries. Nurse #4 then reported she forgot to call the physician and the family and did not remember the incident until 3/3/2019 when she was reminded by the nursing supervisor. Attempts to interview Nurse #5 by telephone were unsuccessful. The Director of Nursing was interviewed on 4/18/2019 at 4:52 PM and she reported it was her expectation the physician and the family were notified of falls or incidents immediately. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported it was his expectation that physicians and family members were notified of any accidents immediately.	F 580		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		5/16/19

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F 584 SS=C	Continued From page 6 CFR(s): 483.10(i)(1)-(7)	F 584		

§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 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

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F 584	Continued From page 7 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and functional environment as evidenced by failure to maintain intact sheetrock for three of seven rooms (Rooms 106, 117, and 178) and bathroom sinks failed to drain for two of seven rooms (Rooms 107 and 117), reviewed for environment. Findings included: 1. An observation conducted on 4/15/19 at 10:15 AM of the sink in the bathroom of room 107 revealed the sink quickly filled with water to the point of the overflow and drained very slowly. An observation was conducted of room 117 on 4/15/19 at 2:56 PM. An observation in the bathroom of room 117 revealed the sink rapidly filled with water to the point of the overflow and took 67 seconds to drain to the point of the sink drain. Observations were conducted during a round on 4/17/19, which started at 4:49 PM. An observation in room 107 revealed when the sink rapidly filled with water to the point of the overflow. After 5 minutes the water had only drained approximately 2-3 inches below the overflow and was still approximately half full of water. An observation in the bathroom of room 117 revealed the sink rapidly filled with water to the point of the overflow and took 2 minutes and 24 seconds to drain to the point of the sink drain.	F 584	Resident Affected: The Maintenance Director immediately corrected and replaced sheetrock in resident rooms 106, 117, and 178 on 4/18/19. The Maintenance Director immediately corrected and repaired water drainage effectiveness of bathroom sinks in resident rooms 107 and 117 on 4/18/19. Residents with Potential to be Affected: All residents have the potential for being affected. Maintenance Director conducted 100% audit to ensure that all resident rooms did not contain broken sheet rock. Maintenance Director conducted 100% audit to ensure that all bathroom sinks were properly draining water. Systemic Changes: The Executive Director educated the Maintenance Director on the requirements for a safe, clean, comfortable, homelike environment, including the observed deficient practices of broken sheet rock and improper water drainage in bathroom sinks. The Executive Director will educate all staff on the procedure for writing and creating work orders on observed environmental concerns requiring correction for the Maintenance Department. All education will be	

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F 584	Continued From page 8 Observations were conducted during a round on 4/18/19, which started at 8:52 AM. An observation in room 107 revealed when the sink rapidly filled with water to the point of the overflow. After 2 minutes the water had only drained approximately 1-2 inches below the overflow and the sink was still over half full of water. An observation in the bathroom of room 117 revealed the sink rapidly filled with water to the point of the overflow and took 2 minutes and 31 seconds to drain to the point of the sink drain. During an interview conducted on 4/18/19 at 9:11 AM with the Housekeeper she stated the sink in room 107 had not drained well for a while. She further stated it had overflowed and flooded the bathroom numerous times. A round was conducted in conjunction with an interview with the Maintenance Director (MD) on 4/18/19 at 3:52 PM. The MD stated he had not received any work orders regarding the slow draining sink which was observed in rooms 107 and 117. An interview was conducted with the administrator on 4/18/19 at 6:35 PM. The Administrator stated it was his expectation for sinks to drain quickly. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed promptly. 2. An observation was conducted of room 117 on 4/15/19 at 2:56 PM. An open seam in the sheetrock paper was observed above the window in room 117. An observation of the window revealed the head jam (covering made of wood or	F 584	completed prior to returning to work after May 16, 2019. The Executive Director will complete an environmental round audit weekly for three months to ensure that the facility has a safe, clean, comfortable and homelike environment. Monitoring: The Executive Director is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 584	Continued From page 9	F 584		

sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock.

Observations were conducted during a round on 4/17/19, which started at 4:49 PM. An observation conducted of room 117 revealed an open seam in the sheetrock paper was observed above the window in room 117. An observation of the window revealed the head jam (covering made of wood or sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock. An observation conducted of room 178 revealed a hole in the wall behind the bed toward the window which was approximately 4 inches wide and 18 inches high. The hole was through the sheetrock which exposed the interior cavity of the wall behind the bed.

Observations were conducted during a round on 4/18/19, which started at 8:52 AM. An observation conducted of room 106 revealed damaged sheetrock at the head jam. Further observation revealed the sheetrock metal corner bead to be exposed at the head jam of the window with no sheetrock covering which also exposed the cinderblock wall above the window. An observation conducted of room 117 revealed an open seam in the sheetrock paper was observed above the window in room 117. An

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observation of the window revealed the head jam (covering made of wood or sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock. An observation conducted of room 178 revealed a hole in the wall behind the bed toward the window which was approximately 4 inches wide and 18 inches high. The hole was through the sheetrock which exposed the interior cavity of the wall behind the bed.

During an interview and observation conducted on 4/18/19 at 9:15 AM with the Housekeeper she stated the area above the window in room 117 was damaged because of a water leak and a lot of water used to come into the room.

During an interview and observation conducted on 4/18/19 at 9:21 AM with Nursing Assistant (NA) #1 she stated she had no idea about the hole in the wall behind the bed in room 178. She further stated she would fill out a facility work order for maintenance regarding the hole in the wall.

A round was conducted in conjunction with an interview with the Maintenance Assistant (MA) on 4/18/19 at 3:52 PM. The MD stated he had not received any work orders regarding the damaged or missing sheetrock above the window in rooms 106 and 117. The MD further stated he had not received a work order nor was he aware of the damage to the sheetrock behind the bed in room 178.

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F 584	Continued From page 11 An interview was conducted with the administrator on 4/18/19 at 6:35 PM. The Administrator stated it was his expectation for the sheetrock and other construction matters to have been intact. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed promptly.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		5/16/19

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 636	Continued From page 12 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an annual comprehensive Minimum Data Set (MDS) and Care Area Assessments (CAAs) within 14 days of the assessment reference date (ARD) for 1 of 5 residents reviewed for comprehensive MDS	F 636	Resident Affected: The Minimum Data Set Consultant provided immediate corrective action for the alleged deficient practice regarding failure to complete an Annual	

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F 636	Continued From page 13 completion (Resident #102) and failed to complete a comprehensive admission assessment and CAAs within 14 days of admission for 1 of 3 residents reviewed for admission MDS completion (Resident #57). Findings included: Resident # 102 was admitted to the facility on 03/12/2018 with diagnoses that included anemia, diabetes mellitus type 2, hypertension (HTN), pain, osteomyelitis and gangrene. A medical record review was conducted on 04/18/2019 at 12:34 PM of Resident # 102 and revealed that an annual comprehensive MDS had and ARD date of 03/19/2019 and was signed as completed by the MDS nurse on 04/07/2019. The CAAS were signed and dated as completed by the MDS nurse on 04/07/2019. A review of the RAI (Resident Assessment Instrument) revealed that an annual (comprehensive) MDS and the CAAs were to be completed and signed by an RN (Registered Nurse) no later than 14 calendar days (including the ARD date). Resident # 102's medical record review revealed that the MDS and CAAs with an ARD of 03/19/2019 were not signed as completed for 20 days on 04/07/2019 and should have been signed as completed on 04/01/2019 but had not been signed until 6 days of the required RAI signature date. On 04/18/2019 at 3:26 PM an interview was conducted with MDS nurse # 1. MDS nurse # 1 revealed that MDS nurse # 2 had only been employed until about 1 month and that she (MDS	F 636	Comprehensive Minimum Data Set (MDS) and Care Area Assessments (CAAs) within 14 (fourteen) days of the Assessment Reference Date (ARD) for Resident #102. The MDS is now current as per RAI guidelines. The Minimum Data Set Coordinator provided immediate corrective action for the alleged deficient practice regarding failure to complete an Annual Comprehensive Minimum Data Set (MDS) and Care Area Assessments (CAAs) within 14 (fourteen) days of the Assessment Reference Date (ARD) for Resident #57. The MDS is now current as per RAI guidelines. Residents with Potential to be Affected: All residents have the potential to be affected by the alleged deficient practice. A 100% audit of current facility Residents MDS schedule has been reviewed for completion timing of MDS assessments. All MDS assessments will be current by 5/16/2019. Systemic Changes: The MDS Consultant educated the Executive Director, Minimum Data Set Coordinator(s), Director of Nursing, Social Worker, Dietary Manager, Director of Rehab, and Activities Director on 5/13/2019 to review the guidelines set forth in the RAI manual regarding all requirements needed to schedule, data entry, and completed based upon MDS regulations and timeframes. All new hires	

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F 636	Continued From page 14 nurse # 1) had got behind on completion of MDS and CAA as required by the RAI manual instruction. The facility administrator was interviewed on 04/18/2019 at 5:24 PM. The facility administrator revealed the expectation was that all MDSs and CAAs be completed and signed as directed by the dates as required. 2. Resident #57 was admitted to the facility on 11/8/18. The resident's cumulative diagnoses included, in part: Diabetes, seizures, depression, anxiety, and difficulty walking. Review of Resident #57's Minimum Data Set (MDS) information for 11/15/18 revealed the resident's comprehensive admission assessment and Care Area Assessments (CAAs) were not completed until 11/26/18. An interview was conducted with MDS nurse #1 on 4/18/2019 at 5:56 PM and she reported she had been working by herself for a couple of months and a new MDS nurse had just been hired to work with her. MDS Nurse #1 stated she was aware there had been MDS assessments which had been completed late. An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for the MDS assessments to be completed in compliance with the Resident Assessment Instrument (RAI) manual.	F 636	that include completion of a resident assessment will be educated on the requirements during orientation. The Comprehensive assessments scheduled will be reviewed 5 times a week for 3 months by the Executive Director or Director of Nursing for ensuring timely completion and transmittals of assessments on required due dates. The Executive Director will audit and track all assessments and transmittals using an audit tracking tool which includes: resident name, assessment type, assessment reference date (ARD), due date and completion date on a weekly basis for three months. Monitoring: The Executive Director is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		5/16/19

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F 638	Continued From page 15 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) within 14 days of the assessment reference date (ARD) of a quarterly MDS for 1 of 5 residents reviewed for MDS completion (Resident # 56). Findings included: Resident # 56 had an admission date of 12/04/2015 with diagnoses that included shortness of breath, dementia, arthritis, Alzheimer's Disease, symbolic dysfunction and dementia. A medical record review was conducted on 04/18/2019 at 12:34 PM of Resident # 56 and revealed that a quarterly MDS with an assessment reference date (ARD) of 02/14/2019 and was signed as completed the MDS nurse on 03/10/2019. A review of the RAI (Resident Assessment Instrument) revealed that a quarterly MDS was to be completed and signed by an RN (Registered nurse) no later than 14 days of the ARD date (including the ARD date). Resident # 56's medical record review revealed that the quarterly MDS had an ARD date of 02/14/2019 was not signed and completed by	F 638	Resident Affected: Corrective action has been accomplished for the alleged deficient practice in regards to failure to complete a Quarterly MDS within 14 (fourteen) days of the Assessment Reference Date (ARD) for Resident #56. Residents with Potential to be Affected: Current facility residents have the potential to be affected by the alleged deficient practice. All MDS assessments are current as per Resident Assessment Interview (RAI) guidelines to include Quarterly assessments at least every 3 (three) months. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: The MDS Consultant conducted an onsite Inservice for the interdisciplinary team on 5/13/2019 to review the guidelines set forth in the RAI manual regarding all requirements needed to schedule, data entry, and complete an MDS. Focus was placed on MDS regulations and timeframes.	

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F 638	Continued From page 16 02/27/2019 (day 14) but it had not been signed by the MDS RN until 25 days after the ARD. On 04/18/2019 at 3:26 PM an interview was conducted with MDS nurse # 1. MDS nurse # 1 revealed that MDS nurse # 2 had only been employed until about a month ago and that she (MDS nurse # 1) had got behind on completion of quarterly MDSs as required by the RAI manual. The facility administrator was interviewed on 04/18/2019 at 5:24 PM. The facility administrator revealed the expectation was that all MDSs and CAAs be completed and signed as directed by the dates as required.	F 638	The Quarterly assessments scheduled will be reviewed 5 times a week for 3 months by the Administrator/Director of Nursing for due dates and assessment completion date. All assessments will be tracked with the Resident name, assessment type, Assessment Reference Date (ARD), due date and completion date using an audit tracking tool. Monitoring: The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	
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	F 640		5/16/19

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F 640	Continued From page 17 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, 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 a quarterly Minimum Data Set (MDS) assessment for 1 resident (Resident #33) and failed to complete a 5-day Prospective Payment System (PPS) assessment for 1 resident (Resident #91) on or before the	F 640	Resident Affected: The Minimum Data Set Consultant provided immediate corrective action for the alleged deficient practice regarding Encoding/Transmitting Resident	

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F 640	Continued From page 18 14th day after the Assessment Reference Date (ARD), failed to transmit an annual Minimum Data Set assessment for 1 resident (Resident #102), and failed to transmit a significant change of status MDS for 1 resident (Resident #11), out of 26 residents reviewed for timeliness of MDS submission. Findings included: 1. Resident #33 was admitted originally admitted to the facility on 1/29/16 and was most recently readmitted on 6/9/17. The resident's diagnoses included, in part: Dementia, anxiety, osteoporosis, depression, delusions, and generalized weakness. The quarterly MDS assessment had an ARD of 3/25/19 and a completed date of 4/13/19. An interview was conducted with MDS nurse #1 on 4/18/2019 at 5:56 PM and she reported she had been working by herself for a couple of months and a new MDS nurse had just been hired to work with her. MDS Nurse #1 stated she was aware there had been MDS assessments which had been completed late. An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for the MDS assessments to submitted in compliance with the Resident Assessment Instrument (RAI) manual. 2. Resident #91 was admitted originally admitted to the facility on 1/10/19 and was most recently readmitted on 3/11/19. The resident's diagnoses included, in part: Diabetes, dementia, stroke, and lack of coordination. The 5-day PPS assessment had an ARD of 3/18/19 and a completed date of	F 640	Assessments for Resident #33, #91, #102, #11. The Minimum Data Set (MDS) is now current per Resident Assessment Instrument (RAI) guidelines. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. A 100% audit was completed on 5/13/19 by the MDS Consultant and all assessments are current as per RAI guidelines to include encoding and transmission of resident assessments. Systemic Changes: The MDS Consultant educated the Executive Director, Minimum Data Set Coordinator(s), Director of Nursing, Social Worker, Dietary Manager, Director of Rehab, and Activities Director on 5/8/19 on proper and timely assessment transmittals. The MDS assessments will be audited and reviewed 5 times a week for 3 months by the Executive Director/Business Office Manager for completion of encoding/transmittal dates. Monitoring: The Executive Director is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the	

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F 640	Continued From page 19 4/5/19. An interview was conducted with MDS nurse #1 on 4/18/2019 at 5:56 PM and she reported she had been working by herself for a couple of months and a new MDS nurse had just been hired to work with her. MDS Nurse #1 stated she was aware there had been MDS assessments which had been completed late. An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for the MDS assessments to submitted in compliance with the Resident Assessment Instrument (RAI) manual. 3. Resident #102 was admitted to the facility 3/12/2018 with diagnoses to include hypertension, peripheral vascular disease and diabetes. The annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/19/2019 and a completed date of 4/7/2019. An interview was conducted with MDS nurse #1 on 4/18/2019 at 4:42 PM and she reported the MDS department was short-staffed and many assessments were late, and the department was starting to get caught up. An interview was conducted with the Administrator on 4/18/2019 at 6:08 PM and he reported it was his expectation the MDS assessments were submitted in a timely manner. 4. Resident #11 was admitted to the facility 8/18/2018 and readmitted 3/8/2019 with diagnoses to include fractured femur, difficulty walking, muscle weakness and adult failure to thrive. The most recent significant change	F 640	Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 640	Continued From page 20 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/24/2019 and a completed date of 4/15/2019. An interview was conducted with MDS nurse #1 on 4/18/2019 at 4:42 PM and she reported the MDS department was short-staffed and many assessments were late, and the department was starting to get caught up. An interview was conducted with the Administrator on 4/18/2019 at 6:08 PM and he reported it was his expectation the MDS assessments were submitted in a timely manner.	F 640		
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 reviews and staff interviews the facility failed to accurately code the Minimum Data Sets (MDSs) of 2 of 7 residents reviewed for MDS accuracy (Resident # 94 and Resident # 81.) Resident # 94 was not coded for tobacco use and Resident # 81 was not coded with a level II PASSR (Preadmission Screening and Resident Review). Findings included: 1.Resident # 94 was admitted to the facility with diagnoses that included symbolic dysfunction, muscle weakness, cerebral infarct and lack of coordination.	F 641	Resident Affected: Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #81. Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) 3/13/2019 has been modified to include Level II Preadmission Screening and Resident Review (PASRR) status. The MDS for Resident #81 is now current as per Resident Assessment Interview (RAI) guidelines to include Level II PASRR status. Corrective action has been accomplished for the alleged deficient practice regarding	5/16/19

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F 641	Continued From page 21 A review of an admission/comprehensive MDS dated 04/03/2019 revealed that Resident # 94 was cognitively intact. Section J 1300for current tobacco use coded that Resident # 94 was not a tobacco user. A review of a facility form titled Smoking Assessment dated 03/28/2019 revealed that Resident # 94 was assessed as a dependent smoker. A Smoking Assessment form dated 04/15/2019 for Resident # 94 revealed he was assessed as an independent smoker. On 04/16/2019 at 8:58 AM Resident # 94 was observed in the smoking area of the facility courtyard and Resident # 94 revealed that he smoked every day since admission and that he was able to smoke independently at the time but required supervision when he was admitted. On 04/18/2019 at 3:26 PM an interview was conducted with MDS nurse # 1 and MDS nurse # 2. MDS nurse # 1 revealed that the MDS had been coded in error in section J 1300 for Resident # 94. The facility administrator was interviewed on 04/18/2019 at 5:24 PM. The facility administrator revealed the expectation was that all MDSs be coded accurately. 2. Resident #81 was admitted to the facility on 4/2/14. The resident's cumulative diagnoses included, in part: Schizoaffective disorder, anxiety, epilepsy, arthritis, depression, hemiplegia (paralysis of one side of the body), stroke,	F 641	Accuracy of Assessment for Resident #94. Minimum Data Set Assessment with Assessment Reference Date 4/08/2019 was modified to include tobacco use. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Residents with Level II Preadmission Screening and Resident Review (PASRR) status and tobacco use have the potential to be affected by the alleged deficient practice. All Residents with Level II PASRR status will be reviewed for MDS compliance regulations and all MDS assessments will be current by 5/16/2019. All Residents with tobacco use will be reviewed for MDS compliance regulations and all MDS assessments will be current by 5/16/2019. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: The Clinical Management Team including Executive Director, Director of Nursing, Unit Managers, MDS Coordinator, Social Work Director, Activity Director and have been in serviced on accuracy of MDS Assessments on 5/8/19 by the MDS Consultant. Residents with Level II Preadmission Screening and Resident Review (PASRR) status with Assessment Reference Dates	

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F 641	Continued From page 22 generalized weakness, and impaired communication. Review of Resident #57's most recently completed comprehensive Minimum Data Set (MDS) assessment revealed an annual assessment with an Assessment Reference Date (ARD) of 3/13/19. Review of the assessment revealed the resident was not coded as having had been evaluated by level II Preadmission Screening and Resident Review (PASRR) and determined to have a serious mental illness and/or mental retardation or a related condition. Review of the Electronic Medical Record (EMR) for Resident #57 revealed a North Carolina Department of Health and Human Services (DHHS) Division of Medical Assistance PASRR Level II Determination Notification dated 4/9/15. The notification documented the resident received a placement determination of having been appropriate for Nursing Facility Placement. The notification provided a PASRR number for Resident #57 with no expiration date. An interview was conducted on 4/16/19 at 3:40 PM with the facility Social Worker (SW). The SW stated Resident #57 had a permanent level II PASRR which had been in place for a while and the resident had been a level II PASRR resident since her admission. The SW stated she did not code the PASRR level II section of the MDS assessment. An interview was conducted with MDS nurse #1 on 4/18/2019 at 5:56 PM and she reported she had been working by herself for a couple of months and a new MDS nurse had just been hired to work with her. MDS Nurse #1 stated she	F 641	of Minimum Data Set Assessments will be audited weekly for 3 months by Director of Nursing/Social Worker/Nurse Management/Executive Director. Updates on PASRR will be reviewed during the Interdisciplinary Team morning meetings. Resident with tobacco use status with Assessment Reference Dates of Minimum Data Set Assessments will be audited weekly for 3 months by Director of Nursing/Social Worker/Nurse Management/Executive Director Monitoring: The Executive Director is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 641	Continued From page 23 had not filled out the annual MDS assessment for Resident #57 and she believed it had been completed by a corporate consultant. An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for the MDS assessments to be accurate and in compliance with the Resident Assessment Instrument (RAI) manual.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		5/16/19

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F 657	Continued From page 24 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to review and revise the care plans after each MDS (Minimum Data Set) for 2of 4 residents reviewed for care plan review and revision. Resident # 25 for fluid restriction, Resident # 26 for elopement and wander guard, Findings included: 1.Resident # 25 was readmitted to the facility on 11/23/2018 and 03/02/2019 with diagnoses that included end stage renal disease (ESRD), renal dialysis, failure to thrive, pain, depression and anxiety. A review of a quarterly MDS for Resident # 25 dated 01/18/2019 revealed that Resident # 25 had severe cognitive impairment and received dialysis during the review period. A review of the care plans for Resident # 25 revealed a care plan initiated on 10/12/2015 and revised on 01/29/2019. The care plan revealed that Resident # 25 had ESRD and needed renal dialysis with an intervention that stated fluid restriction per MD (physician orders). Resident # 25 had a care plan initiated on 05/26/2016 and was revised on 01/29/2019. The care plan revealed in part that Resident # 25 was a nutrition risk and needed sodium and fluid restrictions related to ESRD and dialysis. An intervention included fluid restriction per MD order. Resident # 25 had a care plan initiated on 11/23/2017 and revised on 01/29/2019. The care plan revealed that Resident # 25 had renal failure and ESRD	F 657	Resident Affected: Corrective action has been accomplished for the alleged deficient practice in regards to Care Plan Timing and Revision for Resident #25. Care plan intervention has been modified to remove intervention for fluid restriction on 5/8/2019. Corrective action has been accomplished for the alleged deficient practice in regards to Care Plan Timing and Revision for Resident #26. Care plan intervention for wanderguard and elopement risk has been modified to remove the care plan on 4/18/2019. Residents with Potential to be Affected: Current facility residents have the potential to be affected by the alleged deficient practice. Residents with fluid restrictions and wanderguard use and elopement risk have the potential to be affected by the alleged deficient practice. All care plans for residents with fluid restrictions have been reviewed and modified as required for care plan interventions on 5/13/2019 All care plans for residents with wanderguard use and elopement risk have been reviewed with modifications to the care plan as needed on 5/13/2019 Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur	

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F 657	Continued From page 25 and required dialysis. An intervention was to provide fluids as ordered and restrict or give fluids as ordered. A review of the MD orders and MARs (medication administration orders) dated from 01/01/2019 through 04/18/2019 revealed that there was no MD order for a fluid restriction for Resident # 25. On 04/17/2019 at 3:45 PM an interview was conducted with nurse unit manager (UM) # 1. UM #1 revealed that Resident # 25 was not on a fluid restriction and a fluid restriction had not been ordered by the MD for Resident # 25. A telephone interview was conducted with the facility's registered dietician (RD) on 04/18/2019 at 10:15 AM. The RD revealed that she did not review or update care plans for any residents unless the facility asked her to. The RD revealed that she was not certain if he MD ordered that Resident # 25 be on a fluid restriction or not. On 04/18/2019 at 3:26 PM an interview was conducted with MDS nurse # 1and MDS nurse # 2. MDS nurse # 1 revealed that each discipline was responsible to review and revise the care plans that they initiated and that MDS nurse # 1 did not review or revise the dialysis care plans for Resident # 25 and thought that the RD or dietary manager would have. MDS nurse # 1 was not aware that the RD or dietary manager did not initiate, review or revise the referenced care plans for Resident # 25. MDS nurse # 1 revealed she had not reviewed the care plans in question for Resident # 25. MDS nurse #1 and MDS nurse #2 revealed that they were not certain if Resident # 25 was on an MD ordered fluid restriction or not.	F 657	include: Clinical management team including Administrator, Director of Nursing (DNS), UMs (Unit Managers), Social Work Director, Activity Director, and Dietician have been inserviced on Care Plan interventions and updates on 5/8/2019 by the MDS Consultant. Orders and assessments will be reviewed 5 times a week for 3 months in the Morning Clinical Nursing Meeting. Care plans for each Resident with any changes in orders or status will be reviewed to ensure that the Care Plan has been updated. Monitoring: The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 657	Continued From page 26	F 657		

The facility administrator was interviewed on 04/18/2019 at 5:24 PM. The facility administrator revealed the expectation was that each member of the interdisciplinary team was responsible to review and update all care plans as required and as needed to keep care plans current for each resident.

2.Resident # 26 was admitted to the facility 0n 09/25/2018 with diagnoses that included Alzheimer's disease, dementia, anemia, and anxiety.

A review of a quarterly MDS dated 01/28/2019 for Resident # 26 that revealed that Resident # 26 had severe cognitive impairment, needed extensive staff assist to transfer and had no wandering behavior coded.

A review of a care plan for Resident # 26 initiated on 09/27/2018 revealed in part that Resident # 26 wandered and was at risk for elopement an intervention revealed in part that Resident # 26 wore a wander guard to be checked every day. The care plan remained in place through 04/18/2019.

A form titled Elopement Assessment dated 12/27/2018 for Resident # 26 revealed in part that Resident # 26 wandered aimlessly and required a wander guard device.

A review of the Medication Administration Records (MARs) for Resident # 26 dated 01/ 01/2019 through 02/28/2019 revealed that nurse staff checked the wander guard of Resident # 26 on every day shift from 01/01/2019 through 02/05/2019. The wander guard for Resident # 26 was recorded as checked for placement by

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F 657	Continued From page 27 licensed nursed every shift from 01/01/2019 through 02/05/2019. An Elopement Assessment form for Resident # 26 dated 02/05/2019 2/5/19 revealed in part that Resident # 26 did not wander and did not require a wander guard device. The facility social worker (SW) was interviewed at 3:15 PM on 04/18/2019 and revealed that Resident # 26 had not wandered for a long time. The SW revealed that the care plan for Resident # 26'swanderguard and elopement risk should have been reviewed and revised at least quarterly by the SW or the MDS nurses. The SW revealed that she did not recall that Resident # 26 continued to have an active care plan for a wander guard. On 04/18/2019 at 3:26 PM an interview was conducted with MDS nurse # 1and MDS nurse # 2. MDS nurse # 1 revealed that each discipline was responsible to review and revise the care plans that they initiated and that MDS nurse # 1 did not know that Resident # 26 had an active care plan for wandering or the use of a wander guard. The facility administrator was interviewed on 04/18/2019 at 5:24 PM. The facility administrator revealed the expectation was that each member of the interdisciplinary team was responsible to review and update all care plans as required and as needed to keep care plans current for each resident.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		5/16/19

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F 686	Continued From page 28 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation the facility failed to provide monitoring of a pressure ulcer for 1 of 4 residents, Resident #30, for pressure ulcer care. A pressure ulcer was found on Resident #30's sacrum on 3/8/19 and the wound had not been staged or measured. Findings included: Resident #30 admitted to the facility on 9/1/17 with diagnoses of Alzheimer's Dementia and Parkinson's Disease. The most recent Minimum Data Set (MDS) Assessment, dated 1/25/19, revealed Resident #30 extensive to total care with all activities of daily living. The Treatment Record for March 2019 revealed Resident #30 had a wound dressing treatment of "Hydrocolloidal dressing to sacrum every 5 days and as needed for decubitus". The Treatment Record revealed the treatment started on 3/9/19.	F 686	Resident Affected: Corrective action has been accomplished for the alleged deficient practice regarding Resident #30. Resident #30 wound is resolved. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Nurse Management completed an 100% audit on all pressure wounds on 5/8/19 to ensure that proper documentation to include measurements and staging. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator initiated education on 5/9/19 for all	

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F 686	Continued From page 29 The Treatment Record for April 2019 indicated Resident #30 continued to have a wound dressing treatment of "Hydrocolloidal Dressing to sacrum every 5 day and as needed for decubitus." A Care Plan dated 3/27/19 stated Resident #30 had a potential for skin breakdown due to deconditioning, incontinence, and decreased mobility. During an interview with Resident #30's family member on 4/15/19 at 12:22 PM. The family member stated she had visited the facility on 4/14/19. She found a dressing lying on Resident #30's bed and asked the Nurse if Resident #30 had a wound. She stated the nurse told her Resident #30 had a pressure ulcer to her sacrum. An interview conducted on 4/16/19 at 2:09 PM with Nurse Aide (NA) #1 revealed Resident #30 had a small open area on her sacrum. During an interview with Nurse #1 on 4/16/19 at 2:26 PM Nurse #1 stated Resident #30 had an open area to her sacrum, but the wound care nurse usually changed the dressing, so she had not seen the wound, but she knew it was almost healed. On 4/18/19 at 9:20 AM during a dressing change observation, Nurse #2 stated Resident #30 had a stage 2 pressure ulcer to her sacrum. During an interview with the wound care nurse on 4/18/19 at 1:40 PM the wound care nurse indicated she had not staged or measured Resident #30's wound when it was reported to her on 3/8/19. The wound care nurse stated	F 686	licensed nurses on proper documentation on pressure ulcers. All new hire nurses will be in serviced during orientation. The Director of Nursing/Staff Development Coordinator will audit all pressure wounds weekly for 3 months to ensure proper documentation is completed to include measurements and staging. Licensed nursing staff in-services will be completed prior to returning to work after May 16, 2019. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services	

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F 686	Continued From page 30	F 686		

Nurse #1 found the wound on Resident #30's sacrum, obtained a treatment order from the physician (MD) and notified the wound care nurse of the wound. The wound care nurse also stated she had not staged or measured Resident #30's wound after she was notified.

On 4/18/19 at 1:30 PM a phone interview with the Wound Physician revealed he had not been notified of Resident #30's wound. He stated he doubted failing to measure and assess the wound had caused any harm since they had followed the treatment orders obtained from the MD.

A second interview with Nurse #1 on 4/18/19 at 3:01 PM revealed she found the wound to Resident #30's sacrum on 3/8/19. She stated she notified the wound care nurse and called the MD for a treatment order when the wound was found. Nurse #1 stated she thought the wound care nurse would follow up by measuring and staging the wound.

During an interview with the Director of Nursing (DON) on 4/18/19 at 3:00 PM the DON indicated she expected the nurses to immediately assess a wound, measure it, and document the findings; and then notify the wound care nurse and the DON of the findings. The DON stated she further expected the nurses to notify the MD and the Responsible Party (RP) of the wound. The DON stated the facility did not have any standing orders for wound treatments.

An interview with the MD on 4/18/19 at 3:32 PM revealed he was told Resident #30 had a wound on her sacrum and gave the nurse an order for treatment to the wound. He stated he was told the wound was very small and gave a treatment

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F 686	Continued From page 31 of an occlusive dressing to the wound to be changed every 5 days. The Physician stated the wound should have been measured, staged, and monitored for changes weekly. During an interview with the Administrator on 4/18/19 at 6:00 pm, he indicated he expected the nurses to assess, monitor, and document findings on wounds appropriately.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer	F 693	Resident Affected:	5/16/19

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F 693	Continued From page 32 medications through a gastrostomy tube (G-tube) by diluting in water prior to administering the medications and failed to replace piston irrigation syringe every 24 hours for 1 of 1 residents reviewed for G-tube maintenance and medication administration (Resident #92). Findings included: Resident #92 was admitted to the facility 3/13/2019 and readmitted 3/20/2019 with diagnoses to include chronic respiratory failure, pneumonia and diabetes. The most recent admission Minimum Data Set dated 3/27/2019 assessed Resident #92 to be cognitively intact and he received 51% or more of his nutrition through a G-tube, and 501 or more milliliters (ml) of fluid per day through the G-tube. The facility policy for administering medications through an enteral tube (G-tube) policy revised April 2007 was reviewed and the policy stated, in part: dilute powered, crushed or split medications at the beside; dilute the crushed medication with water; administer the medication by gravity flow. 1. The physician orders for Resident # 92 were reviewed and an order for Valtrex (an antiviral medication) 500 mg administer 2 enteric-coated tablets by G-tube was noted with a start date of 4/11/2019. A medication administration by Nurse #2 for Resident #92 was observed on 4/17/2019 at 8:22 AM. Nurse #2 prepared and crushed medications at the medication cart. She then prepared cups of water and took to the bedside. Nurse #2 disconnected the continuous tube feeding and then poured approximately 30 ml of water into the	F 693	Corrective action has been accomplished for the alleged deficient practice in regards to resident #92. Nurse replaced piston immediately on 4/17/19. Nurse #2 was educated on 4/19/2019 on correct dilution of medications for G-Tubes and checking placement before administration. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Nurse Management completed an 100% audit on 4/19/19 on G-Tube residents to ensure that all piston syringes were changed. All residents had correct piston syringes with dates. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator initiated in service on 4/19/19 with Licensed Nursing Staff on Administration of Medication through Enteral Feeding Tube to include proper dilution of medications per policy and order, and proper storage of piston syringes. All new hire nurses will be in serviced during orientation. Nurse Management will audit 2 G-Tube resident a week of 3 months to ensure piston syringe is date correctly and separated in bag, placement checked before medication administration and proper medication administration to include proper dilution of medications. Licensed nursing staff in-services will be	

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F 693	Continued From page 33 tube and sprinkled a Valtrex tablet on top of the water, then added more water to the syringe as it flowed by gravity into the G-tube. The enteric coating of the pill settled at the bottom of the syringe and collected in the tip, preventing the water and medication from flowing into the tube by gravity. Nurse #2 was interviewed on 4/17/2019 at 8:35 AM and she reported she was not certain why she had not dissolved the medications in water prior to administering the medications. Nurse #2 went on to report she should have diluted the pills with water prior to administering to Resident # 92 to prevent the enteric-coating from collecting in the tip of the syringe. The Director of Nursing was interviewed on 4/18/2019 at 4:52 PM and she reported it was her expectation that medication and tube feeding procedures were performed according to policy. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported he expected medication to be administered according to policy and infection control to be maintained. 2. The packaging label for the piston irrigation syringe was observed on 4/17/2019 at 8:22 AM and read "discard after 24 hours" and was dated 4/16/2019. The plunger was inserted into the syringe and the syringe was noted to be in a plastic bag hanging from the tube feeding pole. Nurse #2 removed the piston irrigation syringe from the plastic bag and attached the syringe to the G-tube and used the piston to pull out stomach contents to check for residual of the tube feeding. Nurse #2 completed the	F 693	completed prior to returning to work after May 16, 2019. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 693	Continued From page 34 medication administration using the piston syringe and rinsed the syringe in the sink, placed the plunger in the syringe and returned to the bag hanging on the pole. Nurse #2 was interviewed on 4/17/2019 at 8:35 AM and reported she had not noted the dates or times on the piston irrigation syringe because that was night shift ' s job to change the syringe and she didn ' t think to look at the dates on the equipment. The Director of Nursing was interviewed on 4/18/2019 at 4:52 PM and she reported it was her expectation that medication and tube feeding procedures were performed according to policy. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported he expected medication to be administered according to policy and infection control to be maintained.	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation the facility failed to provide pain management during a pressure ulcer treatment for 1 of 4 residents, Resident #30, observed for pressure ulcer care.	F 697	Resident Affected: Corrective action has been accomplished for the alleged deficient practice regarding resident #30. Resident #30 reported no pain upon assessment for pain from the	5/16/19

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F 697	Continued From page 35 Findings included: Resident #30 admitted to the facility on 9/1/17 with diagnoses of Alzheimer's Dementia and Parkinson's Disease. The most recent Minimum Data Set (MDS) Assessment, dated 1/25/19, revealed Resident #30 required extensive to total care with all activities of daily living. The assessment further revealed Resident #30 did not have a pressure ulcer during the assessment period. The Treatment Record for March 2019 revealed Resident #30 had a wound dressing treatment of "Hydrocolloidal Dressing to sacrum every 5 day and as needed for decubitus." The Treatment Record revealed the treatment started on 3/9/19. The Treatment Record for April 2019 indicated Resident #30 continued to have a wound dressing treatment of "Hydrocolloidal Dressing to sacrum every 5 day and as needed for decubitus." A Care Plan dated 3/27/19 stated Resident #30 had a potential for skin breakdown due to deconditioning, incontinence, and decreased mobility. During an interview on 4/16/19 at 2:09 pm Nurse Aide #1 stated Resident #30 had a small open area to her sacrum. An observation of wound care for Resident #30 by Nurse #2 was completed 4/18/19 at 9:20 am. Nurse #2 was removing the old dressing from Resident #30's sacral wound and Resident #30 yelled out "oh, oh, oh" twice and continued to moan after the dressing was removed. Nurse #2	F 697	licensed nurse. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Nurse Management conducted 100% audit of all resident with wound treatment orders to ensure that they have pain management in place. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator initiated education on 5/9/19 for all licensed nursing staff on proper pain management. All newly hire licensed nurses will be educated on pain management during orientation. Nurse Management will observe 5 wound care treatments a week for 4 weeks than 3 wound care treatments a week for 4 weeks than 1 wound care treatments a week for 4 weeks to ensure pain management is in place. Licensed nursing staff in-services will be completed prior to returning to work after May 16, 2019. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the	

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F 697	Continued From page 36 did not offer Resident #30 pain medication or alternative pain interventions. After the dressing was changed Nurse #2 stated she did not know if Resident #30 had pain medication before the treatment. During an interview with Nurse #1 on 4/18/19 at 9:30 am she indicated Resident #30 had orders for Tylenol 650 milligrams every 4 hours as needed for pain. She stated Resident #30 had not administered pain medication before Resident #30's dressing change and she had not administered pain medication since her shift began at 7:00 am. Nurse #1 stated Resident #30 would call out in pain if she was moved. Nurse #1 also stated she did not usually give Resident #30 pain medication before her dressing changes. An interview with the Director of Nursing on 4/18/19 at 3:00 pm revealed she expected the Nurse would ask the resident if they were having pain or needed pain medication before a dressing change. She stated she further expected the Nurse to notify the Physician if the resident did not have pain medication ordered. The Director of Nursing stated if a resident yells out or appears to be in pain during a dressing change the Nurse should stop and make the resident comfortable before continuing. On 4/18/19 at 6:00 pm the Administrator was interviewed and indicated he expected the Nurses to monitor the residents for pain and respond appropriately.	F 697	Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		5/16/19

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F 732	Continued From page 37 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms and nursing schedules and staff interviews, the	F 732	Resident Affected:	

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F 732	Continued From page 38 facility failed to accurately report care hours provided by licensed and unlicensed personnel for 8 out of 11 daily posted nurse staffing forms reviewed. Findings included: 1. Review of the facility ' s daily nursing staffing forms and daily nursing schedules for 2/1/2019, 2/2/2019, 2/3/2019, 2/4/2019, 3/4/2019, 3/5/2019, 3/6/2019, 4/13/2019, 4/14/2019, and 4/15/2019 revealed the daily nursing staffing forms were not accurate on the following 8 of 11 days: a. The nursing schedule for the facility dated 2/1/2019 was reviewed and 8 Nursing Assistants (NA) were scheduled to work 2nd shift (3:00 PM to 11:00 PM) shift. The daily posted nurse staffing sheet dated 2/1/2019 indicated 9 NAs had provide 67.5 hours of care. b. The nursing schedule for the facility dated 2/3/2019 was reviewed and 8 NAs were scheduled to work 2nd shift. The daily posted nurse staffing sheet dated 2/3/2019 indicated 9 NAs had provided 67.5 hours of care. c. The nursing schedule for 2/4/2019 was reviewed and 11 NAs were scheduled to work 1st shift (7:00 AM to 3:00 PM). The daily posted nurse staffing sheet dated 2/4/2019 indicated 9 NAs had worked and the total hours of care provided were not calculated. The nursing schedule for 2/4/2019 for 3rd shift (11:00 PM to 7:00 AM) was reviewed and 3 Licensed Practical Nurses (LPN) and 4 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 2 LPNs had provided 16 hours of care and 5 NAs had provided 37.5 hours of care.	F 732	Current facility residents have the potential to be affected by the alleged deficient practice. Corrective action has been accomplished for the alleged deficient practice regarding proper posting of Licensed Nurse & Unlicensed Staff. The staff posting was corrected to reflect the current census and staff. Residents with Potential to be Affected: All residents had potential to be affected. Systemic Changes: Director of Nursing, Nurse Management and Scheduler will ensure the nursing staffing is posted by Nursing Management or Designee and updated per policy 5 times a week for 3 months. Staff Development Coordinator initiated in service on April 19, 2019 for nursing staff on proper posting of Licensed and unlicensed nursing staff. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 732	Continued From page 39	F 732		

d. The nursing schedule dated 3/4/2019 was reviewed and 2 Registered Nurses (RN), 5 LPNs and 9 NAs were scheduled to work 1st shift. The daily posted nurse staffing sheet dated 3/4/2019 indicated 3 RNs had provided 24 hours of care, 3 LPNs had provided 24 hours of care and 10 NAs had provided 75 hours of care for 1st shift. Additionally, a NA was noted to leave 2 hours early on 1st shift on 3/4/2019 and the total hours of care provided were not adjusted. The nursing schedule for 2nd shift on 3/4/2019 revealed 7 NAs scheduled to work. The daily posted nurse staffing sheet indicated 8 NAs had provided 60 hours of care for 2nd shift on 3/4/2019. The nursing schedule for 3rd shift 3/4/2019 revealed 4 NAs were scheduled to work and 1 NA was orienting for that shift. The daily posted nurse staffing sheet indicated 5 NAs had provided 37.5 hours of care for 3rd shift on 3/4/2019.

e. The nursing schedule for 3rd shift on 3/5/2019 was reviewed and no RN were scheduled to work, 3 LPNs, 4 NAs and 1 NA was orienting for that shift were scheduled to work. The daily posted nurse staffing sheet indicated 1 RN had provided 8 hours of care and 2 LPNs had provided 16 hours of care, and 5 NAs had provided 37.5 hours of care for 3rd shift.

f. The nursing schedule for 3rd shift 3/6/2019 indicated 1 NA had been 30 minutes late. The daily posted nurse staffing indicated 4 NA had provided 30 hours of care for 3rd shift.

g. The nursing schedule for 2nd shift on 4/13/2019 noted 1 NA arrived at 4:30 PM. The daily posted nurse staffing sheet indicated 8 NA had provided 60 hours of care for 2nd shift on

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F 732	Continued From page 40 4/13/2019. h. The nursing schedule for 1st shift on 4/15/2019 was reviewed and 2 RNs were scheduled to work. The daily posted nurse staffing sheet indicated 3 RNs had provided 24 hours of care for 1st shift 4/15/2019. The Director of Nursing (DON) was interviewed on 4/18/2019 at 4:52 PM and she reported she completed the daily posted nurse staffing sheets and posted the sheet when she arrived for work. The DON went on to explain she adjusted the reported hours of care if staff called out when she was in the building, and she usually adjusted weekend daily posted nurse staffing on Monday after the weekend. The DON further reported she was not aware orienting staff should not be included in the total of hours of care provided and she also reported she was not aware the posted nurse staffing should be updated for each nursing shift. The DON reported it was her expectation the daily posted nurse staffing sheets were accurate and reflected the facility ' s staffing. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported it was his expectation the daily posted nurse staffing sheets were updated and accurate.	F 732		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		5/16/19

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F 759	Continued From page 41 by: Based on record review, observation, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 7 residents (Resident #92 & 27) observed during medication administration. Findings included: 1. Resident #92 was admitted to the facility on 3/13/2019 and readmitted on 3/20/2019 with diagnoses to include chronic respiratory failure, pneumonia and diabetes. The physician orders were reviewed for Resident #92 and revealed an order dated 4/10/2019 for Acyclovir ointment 5% apply topically two times a day until 4/17/2019. A review of the treatment administration record (TAR) revealed Resident #92 was to receive 2 more doses of Acyclovir ointment at 9:00 AM and 9:00 PM on 4/17/2019. A medication administration was observed on 4/17/2019 at 8:21 AM with Nurse #2. The nurse did not apply Acyclovir ointment to Resident #92. An interview was conducted with Nurse #2 4/17/2019 at 8:35 AM and she reported she was not aware Resident #92 was to receive topical Acyclovir. The Director of Nursing was interviewed on 4/18/2019 at 9:56 AM and she reported it was her expectation the nurses read the physician orders and double-check the medication administration	F 759	Resident Affected: Corrective action has been accomplished for the alleged deficient practice regarding resident #92, the Acyclovir for that resident has been completed. Resident #27 received the second tablet of Mag-ox within the time allowed during a medication pass. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. Systemic Changes: Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator initiated education on 5/9/19 for licensed nursing staff on policy of Medication Management with posttest. All newly hired licensed nurses will be educated during orientation. Nurse management will conduct 5 medication observations a week for 4 weeks, then 3 medication observation a week for 4 weeks, then 1 medication observation a week for 4 weeks, and 1 medication observation a month for 3 months. Licensed nursing staff in-services will be completed prior to returning to work after May 16, 2019 Monitoring: The Director of Nursing is responsible for	

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F 759	Continued From page 42 record to administer all medications that were due for each resident. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported it was his expectation the medication error rate was less than 5% for the facility. 2. Resident #27 was admitted to the facility 11/30/2017 with diagnoses to include atrial fibrillation, and diabetes. The physician orders for Resident #27 revealed an order dated 4/9/2019 for Mag-ox 400 mg 2 tablets by mouth three times per day. A medication administration was observed on 4/17/2019 at 4:49 PM. Nurse #6 prepared medications for Resident #27 and administered Mag-ox 400 mg 1 tablet by mouth. An interview was conducted with Nurse #6 on 4/17/2019 at 5:15 PM and she reported she was not aware Resident #27 received 2 tablets of Mag-ox. The Director of Nursing was interviewed on 4/18/2019 at 9:56 AM and she reported it was her expectation the nurses read the physician orders and double-check the medication administration record to administer all medications that were due for each resident. The Administrator was interviewed on 4/18/2019 at 6:08 PM and he reported it was his expectation the medication error rate was less than 5% for the facility.	F 759	the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	
F 814	Dispose Garbage and Refuse Properly	F 814		5/16/19

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F 814 SS=D	Continued From page 43 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 observations and staff interviews the facility failed to maintain a clean garbage can in the kitchen, failed to maintain an outdoor can wash in a clean and sanitary condition, and failed to maintain the dumpster area free of debris. Findings included: 1. An observation conducted of the kitchen on 4/15/19 at 9:34 AM revealed one of four trash cans to not have a trash can liner, have food debris on the inside surface of the trash can, and have trash at the base of the can by the handwash station next to the two-door cooler. 2. An observation of the outdoor can wash was conducted on 4/15/19 at 9:51 AM in conjunction with an interview with the Dietary Manager (DM). The observation revealed a two of two 44-gallon trash cans, right side up, without covers, open, with partially filled black garbage bags in them, water or other clear liquid in them, and visible mosquito larvae actively swimming in the water. Further observation revealed crushed leaves, debris, cardboard boxes, and food wrappers scattered throughout the mop sink area. Continued observation revealed a spicket protruding from the wall which had water leaking out of it and the (DM) was unable to turn the water off to cease the water from leaking from the spicket. The DM stated the dietary department was responsible for the cleaning and maintaining the can wash area. The DM stated the can wash	F 814	Resident Affected: The Dietary manager immediately corrected observed deficient practice on 04/15/19 and placed a trash can liner within waste basket following deep clean and sanitization of trash can by cooler. The Dietary Manager immediately corrected observed deficient practice on 04/15/19 and deep cleaned and sanitized wash pit station and the two 44-gallon trash cans located in the wash pit area. The Maintenance Director corrected observed deficient practice on 05/05/19 and removed trash bin with construction debris and cement on 4/16/19 and replaced previous trash compacter with black matter and food debris on the cement pad with a new trash compactor and deep cleaned cement pad base which compactor sits upon on 05/05/19. Residents with Potential to be Affected: All residents have the potential for being affected. The Executive Director completed a 100% facility audit of trash cans for cleanliness, sanitization, and liners within the kitchen. The Executive Director completed a 100% facility audit of trash cans and wash pit located outside of the kitchen. The Executive Director completed a 100%	

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F 814	Continued From page 44 was cleaned weekly, but her expectation was there should not have been partially filled trash cans left outside and allowed to collect water and the area should be kept clean of debris. 3. An observation of the garbage compactor area was conducted on 4/15/19 at approximately 10:00 AM in conjunction with an interview with the DM. The observation revealed black matter and food debris under and around the base of the cement pad the compactor sat on. In addition, there was a trash can which had a visible garbage bag, soda bottles, and other assorted garbage in it. The DM states she believed the trash can was affixed to the fence which went around the compactor because she was unable to move the trash can. The DM stated she did not know how the trash can would be emptied if it were affixed to the fence. An observation of the garbage compactor area was conducted on 4/15/19 at approximately 10:00 AM in conjunction with an interview with the Housekeeping Supervisor (HS). The HS stated the trash can next to the fence at the garbage compactor actually had rocks in it. The HS was observed to have removed the bags, soda bottles, and other assorted garbage from the trash can and the trash can was observed to be approximately three quarters full of gray stone which appeared to look like broken up concrete. The HS stated the trash can had been there. The HS stated it was the responsibility of the Housekeeping staff to maintain the area around the dumpster and he did not know the reason the stones were being saved. The HS stated garbage had been placed into the garbage can, but the garbage can had not been emptied because it had stones in it and it was very heavy.	F 814	facility audit of external disposal of garbage/refuse and cleanliness around the garbage compactor area. No other areas of concern were noted. Systemic Changes: The Executive Director and District Dietary Manager educated the Maintenance Director and Dietary Manager on the requirements of disposal of garbage and refuse. The Dietary Manager will audit cleaning schedule daily for four weeks, then weekly for three months, then monthly for three months. The Dietary Manager will audit the conditions of the outdoor wash area and trash cans for cleanliness and sanitization daily for four weeks, then weekly for three months, then monthly for three months. The Executive Director will complete environmental round audit weekly for three months to ensure that standards are within requirements. Monitoring: The Executive Director is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the	

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F 814	Continued From page 45 An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for the garbage and refuse to be up to code all refuse should be disposed of properly and timely.	F 814	need for further audits/in-services.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		5/16/19

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 842	Continued From page 46 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide consistent information regarding a resident's code status for	F 842	Resident Affected: Corrective action has been accomplished	

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F 842	Continued From page 47 one of one resident's (Resident #57) reviewed for code status. Findings included: Resident #57 was admitted to the facility on 11/8/18. The resident's admission cumulative diagnoses included, in part: Diabetes, seizures, depression, anxiety, and difficulty walking. Review of Resident #57's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 2/26/19. The resident was coded as having had mild cognitive impairment and as having required extensive assistance for some Activities of Daily Living (ADLs) including bed mobility, personal hygiene and toileting. While he required supervision or set up help for other ADLs such as transfer (such as from a bed to a wheelchair), walking in the room, walking in the corridor, dressing, and eating. A review was completed of Resident #57's Electronic Medical Record (EMR) revealed the report version of the April Medication Administration Record (MAR) revealed the following under the Advance Directive row; Do Not Resuscitate (DNR)/Do Not Intubate (DNI) (discontinued as of 4/10/19 11:03 AM), Full Code (discontinued as of 4/10/19 2:57 PM). A review completed of Resident 57's EMR revealed a Medical Orders for Scope of Treatment (MOST) form with an effective date of 12/24/18 which had documentation for the resident to receive Cardio Pulmonary Resuscitation (CPR), intubation, advanced airway interventions, mechanical ventilation, and other	F 842	for the alleged deficient practice regarding resident #57. Resident #57 code status was verified and corrected on 4/17/19 to reflect resident is a full code. Residents with Potential to be Affected: All facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing completed a 100% audit on resident code status to ensure proper identification 5/8/19. No other residents were affected by observed deficient practice. Systemic Changes: The Staff Development Coordinator initiated in-service to Licensed nursing staff on 5/8/19 on policy on Resident Medical Records to ensure correct code status. All new hire nurses will be in serviced during orientation. The facility Nurse Management will be responsible for reviewing the order summary report before every morning meeting to ensure correct code status. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum	

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F 842	Continued From page 48 life extending activities. The MOST form was signed by Resident #57, the facility Social Worker (SW), and the resident's physician. A review completed of Resident 57's order summary revealed a DNR/DNI order with a start date of 4/10/19 and the order status was listed as active. Further review revealed a Full Code order dated 4/10/19 and as having been discontinued on 4/10/19. An observation conducted on 4/17/19 at 11:22 AM of Resident #57's Code Status under the Clinical tab of the EMR revealed the resident's code status was listed as DNR/DNI. Review of Resident #57's care plan which was most recently revised on 4/1/19 revealed the resident had a focus area for the resident as a full code status. The goal of the care plan was listed as the resident would have his advanced directives followed through the review date. The listed intervention was to collaborate with all disciplines and family to meet his needs code status of full code. During an interview conducted in conjunction with an observation on 4/18/19 at 3:35 PM with Nurse #4 she stated she did not use the printable MAR. The nurse stated she entered information into the EMR such as physician's orders. She further stated once the order is entered the information populates on the resident's face sheet and on their Electronic Medication Administration Record (EMAR). The nurse brought up and displayed Resident #57's EMAR on the computer and the resident was listed as a full code. During an interview conducted on 4/18/19 at 3:40	F 842	Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 842	Continued From page 49 PM with the Director of Nursing (DON) she stated she did not know how the printable MAR had a conflicting code status for Resident #57. She stated the nursing staff would use the EMAR and not the printable MAR. The DON further stated it was her expectation for the code status of a resident to be consistent throughout the Medical Record. An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM and he reported it was his expectation for a resident's code status to be consistent throughout the medical record	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff	F 865	Resident Affected:	5/16/19

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F 865	Continued From page 50 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 3/23/18 recertification survey. This was for one deficiency in the area of: Free of Medication Error rates of 5% or more, which was originally cited in March 2018. The deficiency was recited again on the current recertification with an exit date of 4/18/19. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program The findings included: This tag is cross referenced to: F759-Based on record review, observation, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 7 residents (Resident #92 & 27) observed during medication administration. During the recertification survey of 3/23/18 the facility was cited for failure to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 16% (4 errors our of 25 opportunities). An interview was conducted with the Administrator on 4/18/2019 at 6:35 PM. The Administrator stated deficiencies from the last recertification were reviewed during a Quality Assurance (QA) meeting since he had become the Administrator at the facility in September	F 865	The Director of Nursing immediately corrected deficient practice observed in citation F759 for Resident #97 & 27). The Executive Director and Director of Nursing immediately corrected deficient practice by immediate implementation of re-written plans of correction for the previously and currently observed deficiency, Free of Medication Error Rates of 5% or more. Residents with Potential to be Affected: All residents have the potential to be affected by deficient practice. The Executive Director will complete a 100% audit of previous citation action plans within the past year to include F759. This audit is to ensure that the quality assurance and performance improvement committee has maintained and monitored interventions that were put into place by 05/16/19. The Executive Director will write, submit, revise and update all plans of correction for the observed deficiency, Free of Medication Error Rates of 5% or more. Systemic Changes: The Executive Director, Director of Nursing (DON), and Registered Nurse Supervisors (RN Supervisor), will be educated by the corporate consultant on the quality assurance (QA) policy, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the QA process, including identifying issues that warrant development and establish a	

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F 865	Continued From page 51 2018. He stated each deficiency had been individually reviewed related to the cited deficient practice. The Administrator stated all deficiencies discovered during the current recertification would be discussed in upcoming QA meetings and a special focus would be placed on the repeat deficiency utilizing root cause analysis, Performance Improvement Plan (PIP), Quality Assurance Performance Improvement (QAPI), drill down, and continued monitoring through the process. The Administrator further stated it was his expectation if changes needed to be made, they would be made to make sure the building was maintained in compliance.	F 865	system to monitor the corrections and implement changes when the expected outcome is not achieved. All data collected for identified systemic concerns and current citations to include areas of cited deficiencies will be taken to the Quality Assurance and Performance Improvement Committee by the Executive Director for review on an ongoing basis. The Quality Assurance and Performance Improvement Committee will review the data and determine if written plans of correction are being followed, if changes in plans of action are required to improve outcomes, if further staff education is required, and if increased monitoring is required. Minutes of the Quality Assurance and Performance Improvement Committee will be documented monthly at each meeting by the Medical Records Manager and filled in the Executive Director□s Office. Monitoring: The Executive Director and Medical Director are responsible for the success of this plan of correction and will discuss the effectiveness of implemented plans of correction on observed recertification and complaint survey citations to the monthly Quality Assurance and Performance Improvement Committee meeting each quarter, consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for	

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F 865	Continued From page 52	F 865		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain an effective pest control program as evidenced by visible live insect larvae in two of two trash cans at the can wash outside of the kitchen, spider webs with dead insects in the vicinity of damaged sheetrock for two of seven rooms (Rooms 117 and 178) reviewed for environment, and the presence of dead and live roaches during one of two observations in the kitchen. Findings included: 1. An observation of the outdoor can wash, located at the rear exterior entrance to the kitchen, was conducted on 4/15/19 at 9:51 AM in conjunction with an interview with the Dietary Manager (DM). The observation revealed a two of two 44-gallon trash cans, right side up, without covers, open, with partially filled black garbage bags in them, water or other clear liquid in them, and visible insect larvae actively swimming in the water. The DM stated the dietary department was responsible for the cleaning and maintaining the can wash area. The DM stated the can wash was cleaned weekly, but her expectation was there should not have been partially filled trash cans left outside and allowed to collect water and the area should be kept clean of debris.	F 925	further audits/in-services. Resident Affected: Dietary Manager immediately deep cleaned and sanitized trashcans stored in the wash-pit station on 04/15/19. Dietary Manager immediately removed pests from kitchen serving station upon observation on 04/17/19. The Maintenance Director and Maintenance Assistant repaired drywall and eliminated spiderwebs and observed insects in the suspended ceiling fixture on 4/19/18. Residents with Potential to be Affected: All residents have the potential for being affected. The Dietary Manager conducted a 100% audit on all trash cans located in the kitchen and wash pit for cleanliness and sanitization. No other areas of concern were observed. The Maintenance Director conducted a 100% audit for damaged dry wall, spider webs, and insects within the suspended ceiling fixtures. No other areas of concern were observed. Systemic Changes:	5/16/19

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F 925	Continued From page 53 An interview was conducted with the administrator on 4/18/19 at 6:35 PM. The Administrator stated it was his expectation to address any bugs seen in the building immediately and to have them removed. The Administrator further stated is was his expectation for the pest control company to make regular visits to provide preventive treatments for pest control. 2.An observation was conducted of room 117 on 4/15/19 at 2:56 PM. An observation of the window revealed the head jam (covering made of wood or sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock. In the vicinity of the cavity spiderwebs with dead insects were visible. An observation of the suspended ceiling light cover revealed 4 insect appearing objects which were not moving. Observations were conducted during a round on 4/17/19, which started at 4:49 PM. An observation of the window revealed the head jam (covering made of wood or sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock. In the vicinity of the cavity spiderwebs with dead insects were visible. An observation of the suspended ceiling light cover revealed 4 insect appearing objects	F 925	The facility had pest control vendor onsite for full pest control treatment of the dietary department on 04/18/19. The facility will have a pest control vendor conduct a full pest control treatment for three months in kitchen, ongoing monthly facility treatments, and spot treatments as needed. The Maintenance Director and Maintenance assist checked and cleaned all light fixtures in the hallways and resident rooms and will continue to clean light fixtures as scheduled monthly. The Executive Director will complete environmental round audit weekly for three months to ensure that the environmental pest control standards are within requirements. Monitoring: The Executive Director will be responsible for the success of this plan of correction and will discuss the audit results to the Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	

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F 925	Continued From page 54	F 925		

which were not moving. An observation conducted of room 178 revealed a hole in the wall behind the bed toward the window which was approximately 4 inches wide and 18 inches high. The hole was through the sheetrock which exposed the interior cavity of the wall behind the bed. In the vicinity of the cavity spiderwebs with dead insects were visible.

Observations were conducted during a round on 4/18/19, which started at 8:52 AM. An observation of the window revealed the head jam (covering made of wood or sheetrock at the top of the window) was missing. The missing head jam exposed the cinderblock wall and the edge of the sheetrock from the wall. There was a gap between the sheetrock and the cinderblock wall exposing the inside cavity of the space between the sheetrock and the cinderblock. In the vicinity of the cavity spiderwebs with dead insects were visible. An observation of the suspended ceiling light cover revealed 4 insect appearing objects which were not moving. An observation conducted of room 178 revealed a hole in the wall behind the bed toward the window which was approximately 4 inches wide and 18 inches high. The hole was through the sheetrock which exposed the interior cavity of the wall behind the bed. In the vicinity of the cavity spiderwebs with dead insects were visible.

During an interview and observation conducted on 4/18/19 at 9:15 AM with the Housekeeper she stated there were spiderwebs and dead insects in the area where the sheetrock was missing above the window in room 178 and she stated the objects in the suspended ceiling light looked like they were bugs.

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F 925	Continued From page 55	F 925		

An interview was conducted with the administrator on 4/18/19 at 6:35 PM. The Administrator stated it was his expectation to address any bugs seen in the building immediately and to have them removed. The Administrator further stated is was his expectation for the pest control company to make regular visits to provide preventive treatments for pest control.

3.Review of a service ticket from the contract pest control company revealed the date of the visit was 3/19/19. Review of the ticket revealed a recommendation for heavier treatment in the kitchen which included fogging due to cockroach activity discovered in the kitchen. Further review of the ticket revealed insecticide had been applied in the kitchen area during the visit.

Review of a service ticket from the contract pest control company revealed the date of the visit was 3/19/19. Review of the visit included treatment for large flies and general treatment throughout the facility.

An observation was conducted of the kitchen and tray line preparing lunch in the kitchen on 4/17/19 at 11:53 AM. During the observation a small insect was observed crawling on the floor toward a double gang outlet box under the steam table.

An observation of the kitchen conducted on 4/17/19 at 11:54 AM revealed a second larger insect was seen on top of the outlet box under the steam table. The DM was made aware of the insect sighting and the dietary employee took a broom and proceeded to squash the insect.

An observation of the kitchen conducted on

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4/17/19 at 11:56 AM revealed a third insect crawling on the bottom shelf of the steam table. When the dietary employee observed the insect, she proceeded to squash the insect with a broom.

An observation of the kitchen conducted on 4/17/19 at 11:56 AM a revealed a fourth insect crawling on top of the electrical outlet under the steam table.

An observation of the kitchen conducted on 4/17/19 at 12:01 PM a revealed a fifth insect crawling under the electrical outlet under the steam table.

During an interview conducted with Dietary Aide (DA) #2 conducted on 4/17/19 at 12:01 PM she stated she had seen the insects around.

An observation of the kitchen conducted on 4/17/19 at 12:02 PM a revealed a sixth insect crawling near the electrical outlet under the steam table.

During an interview conducted on 4/17/19 at 12:03 PM with the DM stated the exterminator (pest control company) had been at the facility on 3/19/19 and she was going to have the Maintenance Director (MD) call the exterminator to come back. The DM stated the insects were roaches.

During an interview conducted on 4/17/19 at 12:04 PM with DA #1 she stated the exterminator had been out spraying and she thought they the insects under control.

An observation of the kitchen conducted on 4/17/19 at 12:05 PM a revealed a seventh insect

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crawling on the conduit of the electrical outlet under the steam table.

During a round of the kitchen conducted on 4/17/19 starting at 12:09 PM the following was observed: Dead roach on the floor in the corner by the walk in cooler, dead roach on the floor behind the hand wash sink by the two door cooler, 4 dead roaches on the floor behind the door in the mop room, and a dead roach on the floor by the steam table.

During an interview conducted with the DM on 4/17/19 at 12:20 PM the DM stated she had seen roaches in the kitchen in the past.

An interview was conducted with the Administrator on 4/17/19 at 2:21 PM. The Administrator stated when insects were discovered in the facility the practice had been to contact the representative at the contracted pest control company. The Administrator stated the pest control company had been out to the facility and treated for insects on 3/19/19. He stated the pest control company had recommended further treatment in the kitchen but were not scheduled to return to the facility and conduct the treatment until 4/22/19.

An interview was conducted on 4/17/19 at 2:27 PM with the Maintenance Director (MD). The MD stated the pest control company had been coming to the facility to treat every 2 weeks since the month of March. The MD stated whenever he discovered roach or insect activity he called the pest control company and they would come out and do a service visit to address the insect siting. The MD stated the last time the pest control company was at the facility was on 3/26/19 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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the invoice was in the business office being processed for payment. The MD stated the pest control company came to the facility on 3/22/19 and provided the last treatment which consisted of the large fly program and treating for insects throughout the whole building. The MD stated the pest control company would be back out to the facility to treat again on 4/22/19 to treat the kitchen and it was going to be a 3-night treatment, 4/22/19, 4/23/19, and 4/24/19. The MD stated the pest control company was unavailable to provide the treatment prior to 4/22/19 because they were short-staffed.

An interview was conducted on 4/17/19 at 2:59 PM with the representative from the contracted pest control company. The representative stated a 3-night treatment was scheduled for the kitchen starting on 4/22/19. The representative stated the 3-night treatment was necessary to address current live roaches, infant roaches, roaches that may survive the initial treatment, roaches which may hide in cracks and crevices, and roaches which will eat dead roaches. The representative further stated the treatment consisted of baiting, fogging, treating cracks and crevices, "wet coating" the floor, and dusting. He said the treatment could not be applied during the day and required an extended period of time and a different crew who worked the evening or night shift. The representative stated he had just taken the account over and this was his first month of handling the facility. The representative stated he had just found out about the set up for treatment of the kitchen scheduled for 4/22/19 on the day of the interview.

An interview was conducted with the administrator on 4/18/19 at 6:35 PM. The

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F 925	Continued From page 59 Administrator stated it was his expectation to address any bugs seen in the building immediately and to have them removed. The Administrator further stated is was his expectation for the pest control company to make regular visits to provide preventive treatments for pest control.	F 925		