STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WILKESBORO TRANSITIONAL CARE & REHAB CNTR	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop and maintain a comprehensive emergency preparedness (EP) program which contained required information to meet the health, safety and security needs of the resident population and staff. This failure had the potential to affect all resident and staff.	E 001	Based on record review and staff interview the facility failed to develop and maintain a comprehensive emergency preparedness (EP)program which contained required information to meet the health, safety and security needs of the resident population and staff. This	4/8/20

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

Electronically Signed | 04/04/2020

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E 001	Continued From page 1 The findings included: 1. The facility's EP plan was reviewed on 03/11/2020. This review revealed the EP plan did not contain the following required information: a. The EP plan did not contain the subsistence need for staff and population. The plan did not contain the provision of subsistence need for staff and patient whether they evacuate or shelter in place, include but not limited to food, water, medical, and pharmaceutical supplies. Alternate sources of energy to maintain the following: temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarms system, and sewage and waste disposal. b. The EP plan did not contain the roles under a waiver declared by the secretary. The role of the long-term care facility under a waiver declared by the Secretary for the provision of care and treatment at an alternate care site identified by emergency management officials. c. The EP plan did not contain the names and contact information for staff, resident physicians, other long-term care facilities and volunteers. d. The EP plan did not contain emergency officials contact information for the state licensing and certification agency, the office of the state long term care ombudsman and other sources of assistance. e. The EP plan did not have a method for sharing information from the emergency plan that the facility has determine is appropriate with residents and their families or representative. An interview was conducted with the	E 001	failure had the potential to affect all resident and staff. The items that were not included were: subsistence need for staff and population, alternate sources of energy, contain the roles under a waiver declared by the secretary, contact information of staff, resident physicians and volunteers, state licensure contact information, state long term care ombudsman, and an method for sharing information with residents and families and/or representative. There was a complete systemic review of all information that was involved with the creation of the EP program. The following areas were added and/or updated: Appendix Q - Disaster Supply Inventory, Appendix R - Disaster Water Supplies, Appendix Z □ Ep Collaboration And Training/Drills, Appendix AA □ Communication Plan, Appendix AB □ CMS Secretary Waiver 1135, Appendix AC □ Occupancy And Surge Occupancy, and Appendix AD □ Emergency Power. In-service training was given to the administrator and maintenance director by the Regional Director of Operations on the need of the EP plan to be complete and to be accurate IAW the EP checklist for healthcare. Facility plans on reviewing the plan on a quarterly basis in QAPI to ensure feasibility and sustainability of plan. The Administrator and/or Maintenance Director will ensure that the EP program stays up-to-date and maintained.	

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E 001	Continued From page 2 Administrator on 03/11/2020 at 3:47 PM. The Administrator stated that the facility had recently had a mock survey and during that discovered he was missing pieces of the EP plan. The Administrator stated he had made several changes to the EP plan but was obviously still missing some required information. He stated that they trained the staff during orientation and every 6 months thereafter on the EP plan and felt like they were prepared if something occurred but stated he would certainly add the missing components to the EP plan.	E 001	The Administrator is responsible for this plan of correction and the date of compliance will be April 8, 2020.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility failed to place a call light in reach for 1 of 2 residents sampled for falls (Resident #38). The findings included: Resident #85 was admitted to the facility on 08/12/19 with diagnoses that included: cerebral vascular accident (CVA), expressive aphasia, dementia, and history of falls. A review of the quarterly Minimum Data Set (MDS) dated 02/18/20 revealed Resident #85 had short and long-term memory problems and	F 558	Based on observations, record reviews, and resident and staff interviews the facility failed to place a call light in reach for 1 of 2 residents sampled for falls (Resident #38). Care Plan was updated to reflect resident□s desire to unclip call light from her bed and place it over her glove holder at the head of bed. Resident #38 call light was placed within reach immediately upon notification on 3/8/2020. Audited current residents in facility to assure call lights were within reach on	4/8/20

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F 558	Continued From page 3 moderately impaired cognitive skills for daily decision making. In addition, she was usually able to make herself understood, and could usually understand others. The MDS indicated Resident #85 was independent for all activities of daily living (ADL) which included transfers and walking. A review of Resident #85's care plan revealed two care plans for falls. One was dated 08/13/19 and the other on 08/26/19 which read: At risk for falls related unaware of safety needs with history of falls. The interventions included call bell in reach for assistance requests, encourage resident to call for assist, personal items in reach, anticipate and meet the resident's needs, increase observation, a sign in the room to call for assistance, and a psychiatric referral/medication review. During an observation on 03/08/20 at 12:23 PM revealed resident #85 was lying on the edge of her bed facing the window. Her call light was draped across a wire rack and attached to the wall which was approximately 4-5 feet off the floor next to the privacy curtain and not within Resident #85's reach. An additional observation on 03/09/20 at 10:44 AM revealed Resident #85's call light was again draped across the wire rack on the wall when Medication Aide (MA) #1 brought her medications in the room. Resident #85 was complaining of her head and low back hurting from a recent fall she had. MA #1 administered the medications and left the room to make the nurse aware without placing the call light within reach. An observation on 03/10/20 at 2:44 PM revealed Resident #85 standing by the window in her	F 558	3/13/20, no other residents were affected by the alleged deficient practice. Ten additional residents have been identified as like residents to Resident #38 that have the potential to be affected by the same alleged deficient practice. Residents with similar BIMS, ADL scores and ability to make needs known are to be audited. Assistant Director of Nursing to in service nursing staff by 4/3/2020 on the importance of assuring that residents□ call lights are within reach when they leave residents□ rooms. Current staff to receive education on the importance of call lights being within reach of residents when residents are in their rooms. Staff will also receive education on the importance of assuring those residents that do not utilize their call lights to make their needs be known, will need to be reported to the IDT (Interdisciplinary Team), in order for the team to identify the root cause as to why the resident chooses not utilize their call light as provided to them. Those residents that choose not use call light or move their call light from within reach, IDT will review in order to identify resident□s rationale as to why they continuously remove their call light from within their reach and communicate their needs to staff in different ways. The IDT will review and make decisions based upon the resident□s needs and preferences on a as needed basis. IDT will update individual resident□s plan of care. Director of Nursing/Assistant Director of	

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F 558	Continued From page 4 room. Resident #85's call light was clipped to her blanket and her telephone was lying next to her pillow on the bed. When they surveyor asked Resident #85 about what the items were, Resident #85 pointed to the phone and call light and responded that the staff had given her those today so she could call if she needed any help so she does not get hurt again. An interview with Nurse #1 on 03/10/20 at 9:03 AM revealed she was the nurse assigned to provide care for Resident #85 and reported Resident #85 could make her needs known but had occasional periods of confusion. Nurse #1 reported Resident #85 should have her call light within reach, due to both a history of falls and a recent fall with injury. An interview with MA #2 on 3/10/20 at 3:47 PM revealed MA #2 usually provided showers but was assigned to provide care for Resident #85 on 3/10/20 on day shift. MA #2 stated Resident #85 was able to make her needs known, but MA #2 stated she stated she had never given Resident #85 a call light because she wouldn't use it. An interview with Nurse Aide (NA) #4 on 3/10/20 at 3:53 PM revealed she was assigned to provide care for Resident #85 on 03/10/20. NA #4 stated Resident #85 was alert with some confusion but able to make her needs known to staff. NA #4 stated she did not give Resident #85 a call light because she didn't think she could use it. An interview with NA# 5 on 3/11/20 at 9:05 AM revealed she was familiar with Resident #85 and was aware Resident #85 had a call light to be used to call for assistance although did not recall if Resident #85 had used it in the past. NA# 5	F 558	Nursing/Unit Managers/Weekend Supervisor will audit the ten additional residents plus Resident #38 6 days a week to assure those resident□s call lights are within reach. If the residents□ call lights are found not to be within reach a member of the nurse management team is to identify the root cause whether it is a staff issue or a resident preference, staff re-education to occur and/or documentation of resident□s preference in the Care Plan by IDT. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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F 558	Continued From page 5 acknowledged Resident #85 had a history of falls and the call light was to aid in prevention of falls for Resident #85. An interview with MDS Coordinator #2 on 03/10/20 at 5:27 PM revealed Resident #85 had a care plan for falls to include provide Resident #85 a call light within reach. MDS Coordinator #2 stated Resident #85 was to have a call light in reach to assist in prevention of falls and felt that the intervention was appropriate because she could make her needs known. An interview with the Director of Nursing (DON) on 03/11/20 at 9:11 AM revealed Resident #85 to be alert and oriented with periods of confusion. The DON stated Resident #85 was highly functional and particular about her routine. She stated she was aware Resident #85 had a call light for assistance, although she could not recall if Resident #85 had used it before. The DON further revealed Resident #85 had periods of confusion and the call light was in place to assist in the prevention of falls.	F 558		
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	F 636		4/8/20

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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.
(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.

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F 636	Continued From page 7 (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 interview the facility failed to complete the comprehensive Minimum Data Set assessment within 14 days of admission for 1 of 4 residents reviewed with pressure ulcers (Resident #78). The findings included: Resident #78 was admitted to the facility on 02/11/2020 with diagnoses that included heart disease, diabetes mellitus, contractures of right and left lower leg and others. Review of the comprehensive Minimum Data Set (MDS) dated 02/18/2020 indicated that Resident #78 had long- and short-term memory loss and was moderately impaired for daily decision making. The MDS further revealed that the Resident #78 required extensive assistance with activities of daily living and had no pressure ulcers. The MDS indicated it was completed on 03/02/2020 by MDS Coordinator #1. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated that she had worked at the facility for 6 months and had completed her training that was provided by MDS Coordinator #1. MDS Coordinator #2 stated that they had 14	F 636	Based on record review and staff interview the facility failed to complete the comprehensive Minimum Data Set assessment within 14 days of admission for 1 of 4 residents reviewed with pressure ulcers (Resident #78). Audited all new admits from 3/12/2020 forward to assure that all admission MDSs were submitted within 14 days. No other admission MDSs were found to be past the 14-day time period. MDS nurses to be educated by 4/3/2020 on F-Tag 636 pertaining to submitting an Admission Assessment within 14 days of resident□s admission date. Education to include how to verify timeliness and deadlines within the MDS section of PCC (Point Click Care), to ensure that an Admission Assessment is submitted within 14-days of the resident□s admission date. MDS nurses will be educated on the new process to monitor and audit new admissions with the help of the Director of Nursing. MDS nurses will be required to give a running list of new and re-admits to the Director of Nursing 5 times a week. The director of Nursing will	

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F 636	Continued From page 8 days from the assessment reference date (ARD) to complete the MDS assessment and indicated that was for all types of assessments. She added except entry assessments and those needed to be completed within 6 days. A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. MDS Coordinator #2 confirmed that admission MDS assessments had to be completed within 14 days of admission to the facility. She stated that MDS Coordinator #1 was out of work and unavailable for interview but indicated the MDS assessment for Resident #78 should have been completed no later than 02/24/2020. MDS Coordinator #2 confirmed that the MDS assessment was completed on 03/02/2020. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that both MDS coordinators were new to their positions and were still very much learning all the responsibilities that came with the position. The DON stated she had no idea why the MDS assessment for Resident #78 was not completed within 14 days of admission but stated she would expect that it would be completed timely by 02/24/2020. She added that MDS Coordinator #1 was out of work and unavailable for interview.	F 636	audit 5 times a week to assure that new admits and re-admits MDSs will be completed within the 14-day time frame. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		4/8/20

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that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:

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F 655	Continued From page 10 Based on record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 4 residents (Resident #78 and Resident #237) reviewed for pressure ulcers. The findings included: 1. Resident #78 was admitted to the facility on 02/11/2020 with diagnoses that included: heart disease, diabetes mellitus, dementia, contracture of right and left lower leg and others. Review of a facility document dated 02/11/2020 and titled Baseline Care Plan revealed that part of the assessment was complete and part of it was not. The following sections were blank: communication care planning, vision care planning, hearing care planning, fall care planning, cognitive impairment care planning, urinary incontinence care planning, bowel incontinence care planning and base line care plan summary along with the signature section. The baseline care plan contained no staff signature for completion and the section the resident or family had been provided a copy of the baseline care plan was blank. Review the Minimum Data Set (MDS) dated 02/18/2020 revealed that Resident #78 had long/short term memory problem and was moderately impaired for daily decision making. The MDS further revealed that Resident #78 required extensive assistance with activities of daily living. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated baseline care plans were	F 655	Based on record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 4 residents (Resident #78 and Resident #237) reviewed for pressure ulcers All new admits baseline care plans will be audited to assure it is completed within 48 hours of admission. Comprehensive Care Plans were completed on resident #78 and #237 that included Potential for Falls and Skin Breakdown 3/23/2020. All new admits have the potential to be affected by the alleged deficient practice. All new admits will be assessed and evaluated by the admitting nurse utilizing the Admission and the Baseline Care Plan assessment. A Baseline care plan will be created within 48 hours from admission. Assistant Director of Nursing and Director of Nursing will educate nurses by 4/3/2020, on the necessity to complete an Admission Assessment and Baseline Care Plan Assessment upon resident s admission. Nurses then are to create a Baseline Care Plan within 48 hours of admission date. Education provided to the nurses on how and where to locate the Admission and Baseline Care Plan Assessment in PCC (Point Click Care), in order to obtain resident specific information and preferences to create a Care Plan which is to include the resident s Potential for Falls and Potential for Skin Breakdown.	

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F 655	Continued From page 11 completed as a team during the morning meeting when all disciplines were gathered together and have input to the care plan. The form was located in the electronic medical record and it was printed off and signed by the resident or the family and then uploaded to the electronic record. The MDS Coordinator #2 stated that she could not explain why the base line care plan for Resident #78 was not completed and why it did not contain signature for completion or the resident/family signature. A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. She confirmed that Resident #78 baseline care plan was not completed and was not scanned into the system after obtaining family or resident signature. She stated that base line care plan should have been completed within 48 hours of admission and once signed by the family/resident uploaded into his electronic medical record. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that baseline care plans were completed as a team during the morning clinical meeting. She stated that after they reviewed the hospital record and admission assessment, they develop the baseline care plan. Once the plan had been developed the plan was discussed with the resident and/or family and signed and then scanned into the resident medical record. The DON stated that she was aware that there were issues with the care planning process and that she was working closely with the MDS Coordinators to get the process up to speed. The DON stated she expected the baseline care plan to be developed, completed, and scanned into the resident's medical record within 48 hours of	F 655	Director of Nursing/Assistant Director of Nursing and MDS nurses will audit all new admissions to assure that the Admission Assessments and the Baseline Care Plans are completed in order to develop a baseline Care plan within 48 hours of their admission. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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F 655	Continued From page 12	F 655		

admission to the facility.

2. Resident #237 was admitted to the facility on 03/02/2020 with diagnoses that included: chronic obstructive pulmonary disease, stage 4 pressure ulcer, malignant neoplasm of skin and others.

Review of a facility document dated 03/02/2020 and titled Baseline Care Plan revealed that part of the assessment was complete and part of it was not. The following sections were blank: mood and psychosocial wellbeing, special instructions, baseline care plan summary and signature lines for completion. The baseline care plan contained no staff signature for completion and the section the resident or family had been provided a copy of the baseline care plan was blank.

No Minimum Data Set (MDS) information was available for Resident #237.

An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated baseline care plans were completed as a team during the morning meeting when all disciplines were gathered together and have input to the care plan. The form was located in the electronic medical record and it was printed off and signed by the resident or the family and then uploaded to the electronic record. The MDS Coordinator #2 stated that she could not explain why the base line care plan for Resident #237 was not completed and why it did not contain signature for completion or the resident/family signature.

A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. She confirmed that Resident #237 baseline care plan

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F 655	Continued From page 13 was not completed and was not scanned into the system after obtaining family or resident signature. She stated that base line care plan should have been completed within 48 hours of admission and once signed by the family/resident uploaded into his electronic medical record. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that baseline care plans were completed as a team during the morning clinical meeting. She stated that after they reviewed the hospital record and admission assessment, they develop the baseline care plan. Once the plan had been developed the plan was discussed with the resident and/or family and signed and then scanned into the resident medical record. The DON stated that she was aware that there were issues with the care planning process and that she was working closely with the MDS Coordinators to get the process up to speed. The DON stated she expected the baseline care plan to be developed, completed, and scanned into the resident's medical record within 48 hours of admission to the facility.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		4/8/20

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F 656	Continued From page 14 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to develop a comprehensive care plan for pressure ulcers as directed by the care area assessment for 1 of 4 residents reviewed with pressure ulcers (Resident #78). The facility also failed to implement fall interventions for 1 of 2 resident reviewed for	F 656	Based on observation, record review and staff interview the facility failed to develop a comprehensive care plan for pressure ulcers as directed by the care area assessment for 1 of 4residents reviewed with pressure ulcers (Resident #78). The facility also failed to implement fall	

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supervision to prevent accidents (Resident #85).

The findings included:

1. Resident #78 was admitted to the facility on 02/11/2020 with diagnoses that included: heart disease, diabetes mellitus, dementia, contracture of right and left lower leg and others.

Review the Minimum Data Set (MDS) dated 02/18/2020 revealed that Resident #78 had long/short term memory problem and was moderately impaired for daily decision making. The MDS further revealed that Resident #78 required extensive assistance with activities of daily living and had no pressure ulcers during the assessment reference period.

Review of the Care Area Assessment (CAA) dated 02/24/2020 read in part, Resident #78 triggered for pressure ulcers due to him needing extensive assistance with bed mobility and was always incontinent of bowel and bladder. Resident #78 has right lower leg contracture of muscle and left lower leg contracture of muscle and required assistance with personal care. The CAA indicated that they would proceed to the care plan. The CAA assessment was completed by MDS Coordinator #1.

Review of Resident #78's care plan revealed no care plan for pressure ulcers or the prevention of pressure ulcers.

An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. She explained that MDS Coordinator #1 who completed Resident #78's MDS dated 02/18/2020 and CAA dated 02/24/2020 was out of work and

interventions for 1 of 2 resident reviewed for supervision to prevent accidents (Resident #85).

Resident# 78 and Resident# 85□s Comprehensive Care Plans were audited and corrected on 3/16/20 to reflect each resident□s Potential for Falls and Skin Breakdown. All current residents□ Care Plans were audited on 3/16/2020. All Care Plans identified as missing Potential for Falls and Potential for Skin Breakdown were updated to reflect the needs of each resident.

All new admits will be assessed and evaluated by the admitting nurse utilizing the Admission assessment and the Baseline Care Plan assessment. A Baseline care plan will be created within 48 hours from admission. Baseline Care Plans will include the resident□s Potential for Falls and for Skin Breakdown. Assistant Director of Nursing and Director of Nursing will educate nursing staff by 4/3/2020, on the necessity to complete the Admission and Baseline Care Plan assessment upon admission in order to finalize the resident□s comprehensive care plan. In addition, the Assistant Director of Nursing and Director of Nursing will educate nurses on the necessity to complete an Admission and Baseline Care Plan Assessment upon resident□s admission in order for a resident center Care Plan to be created within 48 hours of admission. Education to include where to locate the Admission and Baseline Care Plan Assessment can

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F 656	Continued From page 16 unavailable for interview. She stated that once the MDS was completed the comprehensive care plan was developed by reviewing the baseline care plan and the triggers off the CAA section of the MDS. MDS Coordinator #2 stated that if the care plan decision for the CAA was "yes" then the care plan would be developed and if the decision was "no" the care plan would not be developed. She stated that it was possible just an oversight that MDS Coordinator #1 did not initiated the care plan as she elected to on the CAA. She added that she would expect a care plan to have been developed as directed by CAA. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that the both MDS Coordinator #1 and #2 were fairly new and still very much learning their responsibilities in the facility. The DON stated she was certain the lack of care plan as directed by the CAA was an oversight by MDS Coordinator #1. She further stated that if the CAA was written and the care plan decision was "yes" then she would expect to see a care plan initiated but confirmed Resident #78 did not have a care plan for pressure ulcers or the prevention of pressure ulcers. 2. Resident #85 was admitted to the facility on 08/12/19 with diagnoses that included: cerebral vascular accident (CVA), expressive aphasia, dementia, and history of falls. A review of the quarterly Minimum Data Set (MDS) dated 02/18/20 revealed Resident #85 had short and long-term memory problems and moderately impaired cognitive skills for daily decision making. In addition, she was usually able to make herself understood, and could usually	F 656	be located in PCC (Point Click Care) in order to obtain specific information and preferences for creating a resident specific Care Plan. Nursing will further be educated on how to utilize the 48-hour Baseline Care Plan and continue to develop the resident□s Comprehensive Care Plan, making sure to include the resident□s Potential for Falls and Potential of Skin Breakdown as adapted or changed from the 48-Hour Baseline Care Plan. Director of Nursing and MDS nurses will audit all new admissions to assure that the Admission Assessments and the Baseline Care Plans are completed in order to develop a comprehensive care plan to include potential for falls and potential for skin breakdown. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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understand others. The MDS indicated Resident #85 was independent for all activities of daily living (ADL) which included transfers and walking

A review of Resident #85's care plan revealed two care plans for falls. One was dated 08/13/19 and the other on 08/26/19 which read: At risk for falls related unaware of safety needs with history of falls. The interventions included call bell in reach for assistance requests, encourage resident to call for assist, personal items in reach, anticipate and meet the resident's needs, increase observation, a sign in the room to call for assistance, and a psychiatric referral/medication review.

An observation of Resident #85 on 03/08/20 at 12:23 PM revealed resident was lying on the edge of her bed facing the window. Her call light was draped across a wire rack and attached to the wall which was approximately 4-5 feet off the floor next to the privacy curtain and not within Resident #85's reach.

An additional observation of Resident #85 on 03/09/20 at 10:44 AM revealed the call light was again draped across the wire rack on the wall when Medication Aide (MA) #1 brought her medications in the room. Resident #85 was complaining of her head and low back hurting from a recent fall she had. MA #1 administered the medications and left the room to make the nurse aware without placing the call light within reach.

An observation on 03/10/20 at 2:44 PM revealed Resident #85 standing by the window in her room. Resident #85's call light was clipped to her blanket and her telephone was lying next to her

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pillow on the bed. When they surveyor asked Resident #85 about what the items were, Resident #85 pointed to the phone and call light and responded that the staff had given her those today so she could call if she needed any help so she does not get hurt again.

An interview with MA #2 on 3/10/20 at 3:47 PM revealed MA #2 usually provided showers but was assigned to provide care for Resident #85 on 3/10/20 on day shift. MA #2 stated Resident #85 was able to make her needs known, but MA #2 stated she stated she had never given Resident #85 a call light because she wouldn't use it.

An interview with Nurse Aide (NA) #4 on 3/10/20 at 3:53 PM revealed she was assigned to provide care for Resident #85 on 03/10/20. NA #4 stated Resident #85 was alert with some confusion but able to make her needs known to staff. NA #4 stated she did not give Resident #85 a call light because she didn't think she could use it.

An interview with NA# 5 on 3/11/20 at 9:05 AM revealed she was familiar with Resident #85 and had been assigned to provide her showers in the past. NA#5 stated was aware Resident #85 had a call light to be used to call for assistance although did not recall if Resident #85 had used it in the past. NA# 5 acknowledged Resident #85 had a history of falls and the call light was to aid in prevention of falls for Resident #85.

An interview with Nurse #1 on 03/10/20 at 9:03 AM revealed she was the nurse assigned to provide care for Resident #85 and reported Resident #85 could make her needs known but had occasional periods of confusion. Nurse #1 reported Resident #85 should have her call light

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F 656	Continued From page 19 within reach, due to both a history of falls and a recent fall with injury. An interview with MDS Coordinator #2 on 03/10/20 at 5:27 PM revealed Resident #85 had a care plan for falls. MDS Coordinator #2 provided a paper copy of Resident #85's plan of care and acknowledged Resident #85's fall care plan included an intervention for her call light to be in reach. MDS Coordinator #2 was unable to verify which MDS Coordinator added the intervention; however, felt that the intervention was appropriate because Resident #85 could make her needs known. An interview with the Director of Nursing (DON) on 03/11/20 at 9:11 AM revealed Resident #85 to be alert and oriented with periods of confusion. The DON stated Resident #85 was highly functional and particular about her routine. The DON indicated she expected care plans to be followed by all staff as they are written. She stated she was aware Resident #85 had a call light for assistance although, she could not recall if Resident #85 had used it before. The DON further revealed Resident #85 has periods of confusion and the call light was in place to assist in the prevention of falls.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		4/8/20

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F 690	Continued From page 20 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to keep a urinary catheter drainage bag off the floor for 1 of 1 sampled resident reviewed for urinary catheters (Resident #1). Findings included: Resident #1 was admitted to the facility on 12/30/19 with diagnoses which included heart	F 690	Based on observations, record review and staff interviews, the facility failed to keep a urinary catheter drainage bag off the floor for 1 of 1sampled resident reviewed for urinary catheters (Resident #1). Resident #1□s catheter bag was raised up off the floor immediately upon notification during survey. All residents	

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F 690	Continued From page 21 disease, obstructive and reflux uropathy (blocked flow of urine) and dementia. A Physician's order dated 12/20/19 indicated to provide catheter care every shift. A Physician's order dated 01/03/20 indicated a 16 French urinary catheter due to urinary obstruction. A review of an admission Minimum Data Set (MDS) dated 01/06/20 revealed Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for toileting and he had an indwelling urinary catheter. An observation on 03/08/20 at 11:47 AM revealed Resident #1 was sitting in a wheelchair next to his bed. A urinary catheter bag was hooked under Resident #1's wheelchair and the urinary catheter drainage bag was lying on the floor under the wheelchair. An observation on 03/08/20 at 12:03 PM revealed Resident #1 was lying in bed and his bed was in the lowest position to the floor. A urinary catheter drainage bag was hooked to the bottom frame of the bed and the urinary catheter bag was touching the floor. An observation on 03/08/20 at 3:17 PM revealed Resident #1 was lying in bed with his bed in low position to the floor. A urinary catheter drainage bag was hooked to the bottom frame of the bed and the bottom of the catheter bag was on the floor. An interview on 03/11/20 at 10:02 AM with Nurse	F 690	currently having indwelling catheters were audited on 3/12/2020 to assure that the urinary catheter drainage bag and catheter tubing were not touching the floor while in bed or while up in a wheelchair. No other residents were found to be affected by the alleged deficient practice. The Director of Nursing on 3/12/2020, audited all residents that have indwelling catheters to assure that catheter bags and catheter tubing is not touching the floor while in bed or when up in a wheelchair. Director of Nursing/Assistant Director of Nursing/Unit Managers/Weekend Supervisor will complete random audits 5 times a week on those residents having an indwelling catheter to assure the catheter bag and tubing is not touching the floor while in bed or while up un wheelchair. Nursing and therapy staff to be educated by 4/3/20 on the importance of keeping catheter bags and tubing from touching the floor while resident is in bed or while up in a wheelchair/chair and the rationale for doing so. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. Um□s will audit the resident□s orders to assure that	

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F 690	Continued From page 22 Aide #1 revealed she was assigned to care for Resident #1. She stated urinary catheter bags were supposed to be hooked under the resident's wheelchair so they would not drag on the floor. She explained when residents were in bed, she fastened the catheter bag to the bed frame, and they were not supposed to touch the floor. She further explained sometimes when staff got Resident #1 out of bed, they did not hook the catheter securely and it slipped down to the floor. She confirmed she was assigned to care for Resident #1 on 03/08/20 and she recalled she saw Resident #1's catheter bag once on 03/08/20 and she moved it, so it wasn't touching the floor. An interview on 03/11/20 at 11:18 AM with Nurse #1 revealed she was assigned to the hall on 03/08/20 where Resident #1 lived. She stated urinary catheter bags were supposed to be kept off the floor. She explained catheter bags should be hooked under the wheelchair to the frame or on the bed frame when residents were in bed so that the catheter bag did not touch the floor. She stated she remembered getting Resident #1 up out of bed on 03/08/20, but she did not recall looking at his catheter bag. An interview on 03/11/20 at 2:52 PM with the Director of Nursing revealed urinary catheter bags should be kept below the level of the bladder. She stated catheter bags should not be on the floor. She explained most residents were in low beds for fall precautions and it was a challenge to keep the catheter bag off the floor. She confirmed it was the facility policy that the catheter tubing and drainage bag were kept off the floor.	F 690	a physician order was obtained. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		4/8/20

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F 695 SS=D	Continued From page 23 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews, and Nurse Practitioner interview the facility failed to obtain a physician's order for oxygen therapy for 1 of 4 sampled residents reviewed for respiratory care. The findings included: Resident #61 was admitted to the facility on 12/13/19 with diagnoses of congestive heart failure, atrial fibrillation, pulmonary embolism, and hypoxic respiratory distress. Physician's orders for Resident #61 dated 12/13/19, revealed no physician order for oxygen therapy. Physician's orders from 12/14/19 through 03/10/20 also revealed there was not an order for Resident #61 to receive oxygen. Resident #61's quarterly Minimum Data Set (MDS) assessment dated 02/11/20 revealed the resident's cognition was mildly impaired for daily decision making and was dependent on staff for all activities of daily living. Oxygen therapy was	F 695	Based on observation, record reviews, staff interviews, and Nurse Practitioner interview the facility failed to obtain a physician's order for oxygen therapy for 1 of 4 sampled residents reviewed for respiratory care. A physician□s order was obtained for Resident # 61 on 3/11/2020 to have continuous oxygen at 4 liters via nasal canal. All residents that utilize oxygen in the facility were audited by the Director of Nursing for a physician order on 3/31/2020. No further residents were found to be affected by the alleged deficient practice. Assistant Director of Nursing and Director of Nursing will educate nurses by 4/3/2020 on the need to obtain a physician/ NP order for oxygen when required by a resident. Education to include nurses assuring a Physician/NP/PA order is given and followed when administering oxygen. Nurses to be educated on the necessity and legality of obtaining and following an	

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F 695	Continued From page 24 not coded on the MDS. An observation of Resident #61 on 03/08/20 at 3:34 PM revealed the resident's oxygen cannula was not in her nose and the oxygen tubing was attached to an oxygen concentrator. The concentrator was set at 4 ½ liters per minute. An observation of Resident #61 on 03/09/20 at 8:27 AM revealed she was in bed with a nasal cannula in her right nostril. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 ½ liters per minute. An observation of Resident #61 on 03/09/20 at 2:49 PM revealed the oxygen cannula was in place in both nostrils and the oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 ½ liters per minute. An observation of Resident #61 on 03/10/20 at 9:32 AM revealed the oxygen cannula was not in the resident's nostrils and was hanging down the left side of Resident #61's chest. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 ½ liters per minute. An observation of Resident #61 on 03/10/20 at 3:04 PM revealed the oxygen tubing wrapped around the resident's left ear, the oxygen cannula was not in the resident's nostrils. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 ½ liters per minute. A review of Resident #61's oxygen saturations on	F 695	order given by MD/ NP or PA. Education to include obtaining the oxygen order and assuring it includes the liter flow the resident is to receive, by what means (NC or mask), and for what duration (routine or PRN). Education provided to nurses to include the necessity to notify unit managers when a resident needs oxygen and or a new order for oxygen has been obtained. Um□s will audit the resident□s orders to assure that a physician/NP order was obtained and is present in the electronic medical record (EMAR). Weekly audits will be completed by the medical supply coordinator, giving a list of all residents that have oxygen tanks and concentrators in their room. Director of Nursing will audit each new list and compare to the previous week□s list to assure that all residents requiring oxygen have a physician order in EMAR. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. Unit managers will audit the resident□s orders to assure that a physician order was obtained. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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F 695	Continued From page 25	F 695		

03/10/20 at 5:35 PM revealed the resident's oxygen saturations were 94 to 98 percent on room air and 92 to 99 percent when on oxygen.

An observation of Resident #61 on 03/11/20 at 8:21 AM revealed the oxygen cannula was in place in both of the resident's nostrils. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 ½ liters per minute.

An interview with Nursing Assistant (NA) #3 on 03/11/20 at 9:17 AM revealed the resident was supposed to have oxygen on but the resident was constantly taking it off. The NA further stated every time any of the staff saw it off, they would go in and put it on.

An interview with NA #2 on 03/11/20 at 9:28 AM revealed Resident #61 was supposed to wear oxygen, but she wouldn't leave it on. She further revealed the resident would take it off and put it under her pillow or hang it around her ear. The NA stated we've tried to keep the oxygen on her but at times she would take it off.

An interview with Nurse #1 on 03/11/20 at 10:11 AM revealed if a resident was on oxygen, they would need an order as it was considered a medication. Nurse #1 reviewed the orders for Resident #61 and stated she did not see an order for oxygen.

An interview with the Director of Nursing (DON) on 03/11/20 at 11:46 AM revealed if a resident used oxygen therapy, an order was needed. The DON reviewed Resident #61's chart and stated she did not see an order and the resident had used it enough to have an order. She further

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F 695	Continued From page 26 stated she would get the order now and once the order was received it would be care planned. An interview with the Nurse Practitioner on 03/11/20 at 3:15 PM revealed she would not expect any untoward effects from Resident #61 receiving oxygen without an order due to the resident having a diagnosis of hypoxic respiratory distress.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/8/20

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F 761	Continued From page 27 by: Based on observation, record review and staff interview the facility failed to discard expired medications from 1 of 2 (central supply) medication storage areas observed. This allowed those medication to be availabe for use. The findings included: An observation of the central supply closet was made on 03/10/2020 at 4:11 PM with the Central Supply Clerk. The observation revealed the following: - 1 unopened bottle of Fiber therapy 16 ounce that expired 01/20. - 2 unopened bottle of Arthritis pain relief 650 milligram (mg) that expired 12/19. - 1 unopened bottle of Oyster shell calcium 500 mg that expired 01/20. - 1 opened bottle of Mucus Relief DM that expired 02/20. - 1 unopened bottle of Vitamin B-2 that expired 12/19. An interview was conducted with the Central Supply Clerk on 03/10/2020 at 4:14 PM. The Central Supply Clerk stated that she went through the central supply closet every week after which she would order needed medications and then when they arrived at the facility, she would put them up. She added that she would stock not only the central supply closet, but she would also take needed items to the medication rooms and medication carts as needed. The Central Supply Clerk stated that she just overlooked the expired medication because there was so many bottles of medication in the central supply closet. An interview was conducted with the Director of	F 761	Based on observation, record review and staff interview the facility failed to discard expired medications from 1 of 2 (central supply) medication storage areas observed. This allowed those medication to be available for use Expired medications were discarded on 3/10/2020. Audit of OTC drugs in Central Supply was completed on 3/12/2020. No other medications stored in the medication rooms and the Central Supply were found to be expired. A list of frequently utilized over the counter drugs was compiled by Director of Nursing and the Supply Clerk. Infrequently medications will not be ordered and stored in Central Supply. Supply clerk was educated on 3/10/2020 on the necessity of identifying and removing all expired medications. Education included the need to reduce the availability of numerous OTC medications stored in Central Supply. Supply clerk will audit for potential expired medications 3 times a week. Audits that are completed weekly will be turned into the Director of Nursing for review. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance,	

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F 761	Continued From page 28 Nursing (DON) on 03/11/2020 at 10:12 AM. The DON stated that the Central Supply Clerk stocked the medication in the central supply closet and the staff would get what they needed. The DON further stated that the staff were expected to check each bottle before they were opened, and she was confident that the expired medication would not have made it to the medication carts for administration to the residents. She added that she spoke to the Central Supply Clerk to find out why the expired medications were in the central supply closet and was told just how many bottles of medication were in there. The DON stated first thing they were going to do was compile a list of frequently used medication and get rid of the other stuff to cut down on the volume of medications in the central supply closet. However, the DON stated she would expect the expired medication to have been discarded and not available for use in the central supply closet.	F 761	the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. Um□s will audit the resident□s orders to assure that a physician order was obtained. The Director of Nursing is responsible for this plan of correction and the date of compliance will be April 8, 2020.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to serve food and coffee at lunch and supper meals that were palatable and at an appetizing temperature for 1	F 804	Based on observation, record review, resident and staff interview, the facility failed to serve food and coffee at lunch and supper meals that were palatable and	4/8/20

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F 804	Continued From page 29 of 2 resident meals sampled for palatability (Resident #8). The findings included: Resident #8 was admitted to the facility on 04/06/18 with diagnoses that included failure to thrive, depression, and gastrointestinal reflux. An undated nutritional care plan reveals Resident #8 to have interventions that included empowering Resident #8 to make food choices and staff were to offer and provide food substitutes. A quarterly Minimum Data Set (MDS) dated 01/09/20 revealed Resident #8 to be able cognitively intact, able to make her needs known, and require setup assistance with her tray for eating. An observation on 03/08/20 at 12:34 PM of Resident #8 sitting on the side of the bed with her lunch tray on the bedside table in front of her. The tray contained a slice of pork tenderloin and 2 thin slices of tomatoes. She was attempting to use a butter knife to cut the pork but was unsuccessful and began trying to bite and tear the pork with her fingers. During an interview on 03/08/20 at 12:34 PM, Resident #8 stated she the pork was to tough for her to cut and she had to bite it and tear it apart with her hands. She revealed she felt the tomato slices were thin, soggy and had previously requested the kitchen staff deliver tomatoes in a separate dish because the warm plate made them lose their firmness. She felt she had been fussed at when she voiced her concerns and felt	F 804	at an appetizing temperature for 1 of 2 resident meals sampled for palatability (Resident #8). We offered resident #8 alternatives to what they received. Also, we sent the Regional Food Services Director down to the resident□s room and took a new list of preferences and wants and placed them into the dietary menu system. We conducted a 100% audit asking all residents if they had any concerns about the temperature and palatability with the food served. After the initial audit, the Food Services Director, cook, or assistants will conduct 25 customer service audits per week for 1 month. Then the audits will be reduced to 15 customer service audits per week for 1 month. The audits will then be reduced to 1 audit per workday for the month and the FSD or designee will attend all resident council meetings with approval from the resident council. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The systemic changes that will be put into place is that when a grievance is filed that	

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F 804	Continued From page 30 there was no longer any point in asking because the kitchen did not listen to her. An observation and interview with Resident #8 on 03/09/20 at 5:09 PM revealed she opened the lid of the supper tray that contained a hot dog and a pack of chips. A cup of coffee was placed to the edge of the plate without a lid and no visible steam present. Resident #8 picked up the cup of coffee and indicated it was cold. The hotdog had been cut in half and she ate a couple of bites from one portion of the hotdog and then pointed the uneaten half hotdog in the direction of the surveyor and said "feel and taste this, it's terrible. I can't eat this." The inner portion of the hot dog wiener contained pink meat with a darker red circular area in the center. The hotdog wiener was not warm, and the bun was also cold, very dry and firm to the touch. She stated she had made many requests known to kitchen staff but had been told she needed to quit wasting food when she voiced her concerns. An interview with the Social Worker (SW) on 03/10/20 at 09:36 AM revealed she was aware that Resident #8 had many concerns in the past that included food not being at the correct temperature and not wanting the Dietary Manager (DM) in her room. The SW states Resident #8 had attended and previously voiced these complaints during a resident council meeting. During an interview with the DM and Regional Dietary Consultant (RDC) conducted on 3/10/20 at 10:00 AM, the DM and RDC were made aware of the observations of Resident #8's meals on 03/08/20 and 03/09/20. The DM voiced she was unaware of any concerns with the pork tenderloin served on 03/08/20. The DM revealed the hotdog	F 804	the FSD, SSD or Administrator will follow up with that resident for 6 meals to ensure that we are meeting their dietary needs/concerns. The Administrator is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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F 804	Continued From page 31 wieners were delivered pre-cooked and were boiled by the cooks before they were served. She further acknowledged the hotdog buns used to serve the supper meal on 03/09/20 were stamped with a label of 12/20/19 which she was unable to verify the date the hot dog buns were pulled from the freezer to be thawed. The DM stated she was unsure why the hotdog bun would have been hard, the bun and wiener cold, or the coffee served cold to Resident #8. She acknowledged Resident #8 had voiced food concerns in the past but did not recall what they were during the interview.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 812	Based on observations, staff interviews,	4/8/20

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CURIS AT WILKESBORO TRANSITIONAL CARE & REHAB CNTR	1000 COLLEGE STREET WILKESBORO, NC 28697

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F 812	Continued From page 32 record review, the facility failed to properly label, date, and seal stored food items and failed to discard stored foods after the manufacturer's expiration date in 1 of 1 dry storage areas, 1 of 1 walk-in freezers, and 1 of 1 walk in refrigerators. The facility further failed to store pots, knives, and adaptive plates under sanitary conditions in the kitchen. These practices had the potential to affect all residents who receive oral food nutrition. The findings included: A brief tour of the kitchen was conducted on 03/08/20 at 10:41 AM with Cook #1. The tour of the dry storage room revealed items as followed: three 1-gallon plastic bags containing an unidentified dry substance. Each of the bags were labeled with an open date written with a black marker, but no item identification or discard date could be located. An unsealed 1- gallon plastic bag containing three opened bottles of liquid ice cream toping (fudge, caramel, and cherry) was located on a dry shelf and did not contain an open or discard date on the bag. Three 48 oz jars of Dijon mustard with the date 5/10 written in black marker on the lid and an expiration date on the back of the jar of 14 Sept 19. An undated twenty-five-pound box of Par Boiled Long Grain Rice contained a blue liner bag that was unsealed. A 1- gallon plastic bag containing an unidentified yellow colored noodle was labeled with the dates of 1/16 and 1/19. A 160 oz package containing a half a bag of multi-color pasta was labeled with a date of 2/18 and no expiration or discard date could be located on the package. A bread rack containing two 12-count bags of golden hamburger buns with a best by "March 03", two 12-count bags of golden hotdog buns with a best by date of "March	F 812	and record review, the facility failed to properly label, date, and seal stored food items and failed to discard stored foods after the manufacturer□s expiration date in 1 of 1 dry storage areas, 1 of 1walk-in freezers, and 1 of 1 walk in refrigerators. The facility further failed to store pots, knives, and adaptive plates under sanitary conditions in the kitchen. These practices had the potential to affect all residents who receive oral food nutrition. Affected food items were immediately discarded. The food preparation areas were completed cleaned to prevent further contamination. The systemic changes that are going to be put in place are: " The Food Services Director and/or designee will round every day with a checklist for cleaning and labeling. " The facility Administrator will round on a once a week on an unannounced day to determine cleanliness and food labeling. " 100% in servicing for all kitchen staff on proper cleaning, the cleaning schedule, and proper dating/storage on all food products/ingredients. " All frozen bread products coming from Sysco will be marked with the date that the product is pulled and discarded 6 calendar days after item is pulled. Audits to be brought to and reviewed monthly by Quality Assurance Performance Improvement team overseen by the facility Administrator to review and assure continued compliance. QAPI team will review audits every month and once there has been 3 consecutive	

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F 812	Continued From page 33 04", five loaves of whole grain white bread with a best by date of "March 04", and seven 16-count hotdog buns with a stamped label date of 12/20/19. During the tour, all expired, and post discard dated food items were removed from the dry storage room in the kitchen by Cook #1. During a continuous tour of the kitchen on 03/08/20 at 10:40 AM, the walk-in freezer revealed an open and unlabeled bag containing seven pieces of an unidentified light brown meat and another half bag of a diced meat. It also revealed a 1-gallon plastic bag containing two pie crust with no labels on the package. The kitchen tour continued on 03/08/20 at 10:40 AM with the Dietary Manager (DM) and further revealed the walk-in refrigerator contained a large plastic container of peaches. The container of peaches was labeled with a discard date of 03/07/20. A cardboard box of hotdogs was located on the bottom shelf in the refrigerator and was unsealed and unlabeled with an open or discard date. An interview with Cook #1 was conducted on 03/08/20 at 10:41 AM. Cook #1 revealed all items should be labeled with an open and discard date and should include an item identification. She stated items should be checked and discarded at the end of the use by or expiration dates from the manufacturers. She identified the substances in the three 1-gallon plastic bags to be cereal: Rice Krispy, Cornflakes, and Cheerios. Cook #1 further revealed the blue bag inside the box that contained rice should have been resealed after each use. She acknowledged the stamped date of 12/20/19 and stated she had not ever looked at the best by dates on the bread because the	F 812	months of 100% compliance, the QAPI team, will decide whether audits need to continue, or substantial compliance has been achieved and audits may stop. The Administrator is responsible for this plan of correction and the date of compliance will be April 8, 2020.	

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facility received a bread delivery every week and she thought the delivery worker removed the old bread at that time. Cook #1 indicated she believed the hot dog buns were delivered by the bread delivery person and she was unsure why the hot dog buns stamped 12/20/19 would be on the shelf and not discarded by the bread delivery worker each week. Cook #1 identified the 7 pieces of unidentified meat to be country fried steak and the diced meat to be chicken. She stated both food items were to have been labeled to identify the food identification, open and discard dates. Cook #1 said the bag containing the pie crusts should have been labeled with an open and discard date.

During an interview with the DM conducted on 03/08/20 at 11:31 AM, the DM revealed items were to be labeled with the item identification, dated opened, and a discard date and staff had been educated on proper food storage policies. She indicated all food items were to be discarded according to the discard label placed when the item is opened or the manufacturers expiration dates and not made readily available for use in the dry storage room after that date. The DM stated most of the facility bread deliveries were brought to the facility fresh; however, she believed the hot dog buns with the stamped label of 12/20/19 were delivered frozen through their standard food delivery company. She further stated the frozen hot dog buns would have been thawed by staff prior to use but was unable to verify the date the hotdog buns were removed from the freezer for thawing to ensure the staff discarded any unused portion on the appropriate date because they had not been labeled when removed from the freezer. During the interview, she said she was unsure of the shelf life of the

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buns in the freezer or after thawed. She verified the original box the hotdog buns were shipped in had been discarded. The DM confirmed the items were unlabeled and stated items stored in the walk-in freezer and refrigerator were to be labeled with a food identification, open date, and a discard date.

A follow-up tour of the kitchen was conducted on 3/10/20 at 10:00 AM with the DM and the Regional Dietary Consultant (RDC). The tour revealed there were four 16-count packages of hotdog buns containing a stamp label of 12/20/19 and four loaves of white bread dated with a best by date of "Mar 09" readily available for use on the bread rack in the dry storage room. The tour further revealed an overhead rack above the food preparation area with a quarter inch thick layer of a dust attached to hooks where the large cooking pots were being hung for storage.

During an interview with the DM and RDC conducted on 3/10/20 at 10:00 AM, the DM and RDC acknowledged the hotdog buns with the stamped date of 12/20/19 and the bread with the best by "Mar 09" label on the bread racks in the dry storage room and removed them from circulation. The DM confirmed the facility served hot dogs during lunch and supper as an alternative every day. The RDC revealed she tried contacting the bread delivery service and the standard food service delivery company for clarification about the bread stamp labels and was awaiting a follow-up. The DM confirmed the overhead rack containing the large cooking pots contained a thick layer of dust. She stated she provided staff with a list of areas that are to be deep cleaned weekly and expected all areas in the kitchen to be kept clean and sanitary. The DM

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and RDC verified the visible dust had been there longer than a week.

During an interview with Cook #2 conducted on 3/10/20 at 4:00 PM, Cook #2 revealed the cook assigned to work on 2nd shift was responsible for panning bread each day and were to place it on the designated racks in the dry storage room to thaw. She stated the pans are labeled when the items are panned. These labels contain the item identification, the pan date, and the discard date which is 2 days after the pan date. Cook #2 stated the buns and slice bread are always kept in the dry storage room on racks and she has never known either to be in the freezer. She further indicated the only bread items that are kept frozen for panning were rolls and biscuits. Cook #2 said the facility receives a bread delivery each week on Thursdays and it was not in the frozen form. She indicated she had never looked at the best by date on any bread label while working as a cook in the facility.

During an interview with Cook #3 conducted on 3/10/20 at 4:15 PM, Cook #3 revealed she had worked as a cook on 03/09/20 during lunch and supper and prepared hot dogs as an alternative to the menu item. Cook #3/Dietary Aide further indicated she served the hotdogs on the buns she retrieved from the bread racks in the dry storage room. She stated she did not look at the package for a use by, an expiration or discard date to determine if the hotdog buns should be served to the residents. Cook #3/Dietary Aide said she did not ever recall thawing hotdog buns from the freezer because the buns were always located on the bread racks in the dry storage area.

An additional follow-up tour was conducted in the

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F 812	Continued From page 37 kitchen during the meal delivery service assembly line on 3/11/20 beginning at 11:40 AM. A quarter inch thick layer of dust was observed to be covering the surface of the knife storage block to the left of the hand washing sink in the food preparation area and on two layers of shelves on the meal tray line where adaptive plates were located. During an interview with the DM and RDC conducted on 03/11/20 at 1:00 PM, both the DM and the RDC acknowledged the thick layer of dust covering the surface of the knife storage block and the shelved on the meal tray line and these should have been cleaned during the weekly deep cleaning.	F 812		