STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Ingleside at Rock Creek from March 13, 2017 through March 20, 2017. Survey activities consisted of a review of 30 residents' clinical records during Stage 1; and review of 27 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue DI - deciliter	F 000	Ingleside at Rock Creek makes its best effort to operate in substantial compliance with both Federal and State Law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This plan of Correction (POCC) is prepared and/or executed soley because it is required by Federal and State Law.	

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

Dr Pauline L Wu RN-BC | Director of Health Services | 5/4/17

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

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F 000	Continued From page 1	F 000		

DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
L - Liter
Lbs. - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
SCSA Significant change status assessment
Sol- Solution
TAR - Treatment Administration Record
Trach- Tracheostomy

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F 000	Continued From page 2 TX- Treatment	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State	F 156	1. A review of residents, #33, 87 and 92 was conducted. A thorough discharge plan was in place and resident #33 was discharged without difficulty. Unable to retrospectively correct Beneficiary Notice. The Beneficiary Notice for resident # 87 and #92 was completed, unable to retrospectively change the date for these residents. 2. A review of residents who utilized their Medicare benefits was conducted. No other resident was impacted. 3. The admissions, social work, MDS and nursing staff were re-educated regarding the Notice of Medicare Non coverage process including timely submission. 4. The Social Work department will monitor resident's discharges from Medicare. This will be done during discharge planning meetings and monthly social work documentation audits. This information will be presented to the QAPI Committee quarterly	5/5/17

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F 156	Continued From page 3 Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]	F 156		

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F 156	Continued From page 4 (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation; misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a	F 156		

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F 156	Continued From page 5 complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must--	F 156		

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F 156	Continued From page 6 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 156		

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F 156	Continued From page 7 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of three (3) residents, it was determined that facility failed to provide the "Advance Beneficiary Notice of Medicare Non-coverage" (ABN) within the required 48-hour time period. Residents' #33, 87, and 92. The findings include: Resident #33 was admitted on September 8, 2016 and was discharged to home on October 27, 2016. A review of the clinical record lacked evidence that the Resident was given a Notice of Medicare Non-Coverage. There was no evidence that the ABN notice was issued and no evidence the resident was provided an opportunity to exercise appeal rights.	F 156	**483.10 Notice of Rights, Rues Services, Charges**	5/5/17

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F 156	Continued From page 8 Resident #87 was admitted on September 17, 2016 and discharged to home on October 14, 2016. A review of the clinical record revealed the Resident was given his/her Notice of Medicare Non-Coverage on October 13, 2016. The facility staff provided the letter one (1) day prior to discharge. There was no evidence that the ABN notice was issued far enough in advance of potentially non-covered services to allow sufficient time for the beneficiary to consider available options, such as appeal. Resident #92 was admitted on October 3, 2017 and discharged to home on October 15, 2016. A review of the clinical record revealed the Resident was given his/her Notice of Medicare Non-Coverage on October 14, 2016. The facility staff provided the letter one (1) day prior to discharge. There was no evidence that the ABN notice was issued far enough in advance of potentially non-covered services to allow sufficient time for the beneficiary to consider available options, such as appeal. There is no evidence the facility staff followed the guidelines for timely notification of Notice of Medicare Non-Coverage to the residents during the discharge process. An interview was conducted with Employee # 22 on March 20, 2017 at approximately 2:30 PM. The employee agreed with the findings.	F 156		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this	F 176		

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F 176	Continued From page 9 practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, for one (1) of 27 Stage 2 sampled residents, it was determined that Resident #65 was self-administering over-the-counter medications without the physician's or the interdisciplinary team's assessment that the resident was safe to self-medicate. Resident #65. The findings include: "Self-Administration of Medications" policy review date January 4, 2017, stipulates, Assessment for self-administration of medications ... As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administrating medications." On Tuesday, March 14, 2017, at approximately 2:00 PM, during a face-to-face interview with Resident # 65, three (3) bottles of Tums (an over the counter antacid medication) were opened and observed in various areas in his/her room. The surveyor conducted a follow-up interview with Resident #65 on March 14, 2017, at approximately 4:00 PM. He/she stated, "When I was in the assisted living facility they [the staff] said since this was not a prescription medication it was okay for me to have them. When I moved in here, I brought them along and took them when I have heartburn. The staff is aware of them because they are out in the open for all to see." A review of the resident's medical record lacked	F 176	**483.10 Resident Self –Administer Drugs If Deemed Safe** 1. The tums located in resident #65's room were removed immediately. Resident #65 was assessed for self-administration of medication and it was determined that he/she was not a candidate. Met with resident #65 and friend (RP) who brings in tums, and both agreed they prefer for facility to administer them. 2. A review of all resident's rooms was conducted. No over the counter medications were identified in any other resident's rooms. 3.Observation for medications was added to check list when doing rounding. The nursing staff were re-educated regarding medications in resident's rooms as well as self-administration of medication policy and regulatory requirements. 4. During the purposeful rounding the nurse manager and Supervisors will audit for medications. The findings will be provided to DON. The information will be presented to QAPI committee quarterly.	5/5/17

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F 176	Continued From page 10 evidence of an evaluation by facility staff to determine if the resident was mentally and physically capable of self- administration of medications. The surveyor conducted a face-to-face interview on March 16, 2017, at approximately 2:00 PM with Employee #2. S/he acknowledged the findings. The surveyor reviewed the record on March 16, 2017.	F 176		
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on a review of records, resident and staff interviews for one (1) of 27 stage 2 sampled residents, it was determined that the facility staff failed to ensure that Resident #74 was free from verbal abuse as evidenced by Resident #74's verbalization that Employee #19 "yelled" at her/him which in turn hurt her/his feelings. The findings include:	F 223	**483.12 Free from abuse/involuntary seclusion** 1. A meeting was conducted with resident #74 immediately (during survey) Resident verbalized that she did have concerns regarding the manner one staff person ask her to move when she was in the dining room, but she did not want to report this nor did she want her name utilized. She further stated that staff were wonderful to her. She verbalized that she did not feel she was abused. A follow-up call was conducted following her discharge. She again stated that we had wonderful staff, and she did not feel the conversation with the dining staff was abuse. She also stated if she had to go to a nursing center she would come back to Ingleside and she would recommend her friends/family to Ingleside. 2. The Director of Social Services conducted interviews with other residents who utilized dining room for meal services. The resident verbalizes that all staff have been cordial and respectful to them. 3. Facility staff was re-educated on abuse prohibition with emphasis on verbal abuse. The dining servers were also re-educated on abuse and Platinum Service/Customer Service . Training occurred with all servers to ensure we are engaging with residents in a hospitable manner. 4. The Director of Social services monitor all complaints. A review of the complaints will be conducted to determine if it could potentially be abuse. Findings will be presented to the QAPI quarterly meeting for review and actions.	5/12/17

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F 223	Continued From page 11 "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. A review of the facility's Abuse Prohibition Policy revised February 2017 stipulates: "The facility promotes the resident's right to be free from verbal, sexual, physical and mental abuse, including involuntary seclusion and misappropriation of property ...Verbal Abuse- is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to the resident or their families or within their hearing distance, regardless of their age ability to comprehend or disability ...Each staff is responsible for reporting concerns, incidents, and grievances to their respective department immediately ..." A review of the medical record conducted on March 17, 2017, revealed the facility admitted Resident #74 on January 12, 2017. Section C of the admission Minimum Data Set completed January 19, 2017 revealed the facility staff coded Resident #74 as cognitively intact with current diagnoses of Anemia, Heart Failure, Hypertension, and Urinary Tract Infection, in Section I. On March 14, 2017, at 1:00 PM, during a resident interview, Resident #74 stated, "The CT [referring	F 223		

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F 223	Continued From page 12 to Certified Nursing Assistant - CNA] rolled me into the dining room. After about five (5) minutes, the kitchen worker came over to me and yelled, 'You do not take other residents seat.' It hurt me. I did not know what I did wrong. The person had an accent...I returned to my room at that time. A [CNA] then brought the [kitchen worker] in here [the resident's room] to apologize. This [incident] happened last week." On March 17, 2017, at approximately 5:00 PM, the surveyor conducted a telephone interview with Employee #20. He/she provided the following explanation of the incident with Resident #74; "I brought the resident to the dining room for dinner. I was taking food to other residents. I saw [the resident] going to [their] room in a wheelchair. I took [the resident's] food to [him/her]. [The resident] said a person from the kitchen shouted at [him/her] that is not your place [seat at the dining room table]. The resident was upset. I asked [the kitchen] worker to come to the resident's room to apologize. I did not report it because I thought everything was over because they hugged." The surveyor asked the employee to describe the different types of abuse and reporting process. Employee #20 was able to state the types of abuse. However, he/she did not recognize this incident as a form of verbal abuse, as a result, did not report it. Also, the surveyor conducted a face-to-face interview on March 17, 2017, at approximately 5:12 PM, with Employee #19. The details of the incident according to Employee #19 is as follows: "Here on the Lower Level we have Dementia residents, so we try to maintain their space. I	F 223		

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F 223	Continued From page 13 said ma'am; I have to move you. This [seat] is reserved. [The resident] turned around in [his/her] wheelchair and said I have to move out of [his/her] way. [The resident] started crying, and said I do not want to eat in here anymore. [The resident] wanted to go back to [his/her] room. [Employee #20] asked me to go to the resident. I went to [his/her] room to apologize. I did not report it because [he/she] hugged me." Employee #19 was asked to describe the types of abuse and the reporting process. The employee was able to state the types of abuse. However, he/she did not recognize this was a form of verbal abuse and did not report it. Review of the personnel files, on March 17, 2017, revealed Employees #19 and 20 underwent abuse-related training as follows: Employee #19 completed "Elder Abuse" in-service on March 10, 2017. Employee #20 completed "Preventing, Recognizing and Reporting Abuse" in-service on February 10, 2017. Each of the in-services above contained instructions; "The person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the charge nurse." There was no evidence that Employee #20 reported to the facility supervisory staff, the incident that Employee #19 spoke to Resident #74 in a manner that hurt her/his feelings. The surveyor conducted a face-to- face interview	F 223		

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F 223	Continued From page 14 with Employee # 1 on March 20, 2017, at approximately 11:00 AM. He/she acknowledged the finding; however, did not agree.	F 223	**483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE /NEGLECT, ETC POLICIES**	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.	F 226	1. A meeting was conducted with resident #74 immediately (during survey) Resident verbalized that she did have concerns regarding the manner one staff person ask her to move when she was in the dining room, but she did not want to report this nor did she want her name utilized. She further stated that staff were wonderful to her. She verbalized that she did not feel she was abused. A follow-up call was conducted following her discharge. She again stated that we had wonderful staff, and she did not feel the conversation with the dining staff was abuse. She also stated if she had to go to a nursing center she would come back to Ingleside and she would recommend her friends/family to Ingleside. 2. The Director of Social Services reviewed concerns and complaints. There was no indication that reporting requirement was not done 3. Facility staff was re-educated on abuse and reporting requirements. The dining servers were also re-educated on abuse and Platinum Service/Customer Service . Training occurred with all servers to ensure we are engaging with residents in a hospitable manner. 4. The Director of Social services monitor all complaints. A review of the complaints will be conducted to determine if it could potentially be abuse and if it was reported. Findings will be presented to the QAPI quarterly meeting for review and actions. 5/12/17	

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F 226	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 27 Stage 2 sampled residents, it was determined that the facility staff failed to implement the facility's Abuse Prohibition Policy as evidenced by failing to report that a resident communicated that a staff person "yelled/shouted" at her/him. The resident was subsequently described as "upset." Resident #74. The findings include: "Abuse Prohibition: Policy Revised February 2017: [The facility] promotes the residents right to be free from verbal, sexual, physical and mental abuse, including involuntary seclusion and misappropriation of property...Each staff is responsible for reporting concerns, incidents and grievances to their respective department immediately ...Anyone who has knowledge of any kind of abuse should report it immediately to their immediate Supervisor. During weekend, report the alleged abuse to the Weekend Administrator (Manger on Duty) or in his/her absence, the Nursing supervisor or his/her designee ...Staff will complete a Grievance/Complaint form for any unusual occurrence and submit it to the Director of Nursing or Designee ..." A review of the medical record revealed Resident #74 was admitted to the facility on January 12, 2017. The Admission Minimum Data Set, dated January 12, 2017 with an Assessment Reference Date of January 19, 2017 revealed the resident was assessed as being cognitively intact Under	F 226		

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F 226	Continued From page 16 Section C, Cognitive Patterns. On March 14, 2017 at 1:00 PM, during a resident interview, Resident #74 stated, "The CT [referring to a Certified Nursing Assistant - CNA] rolled me into the dining room. After about five (5) minutes, the kitchen worker came over to me and yelled, 'You do not take other residents seat.' It hurt me, I did not know what I did wrong. The person had an accent ...I returned to my room at that time. A [CNA] then brought the [kitchen employee] in here [the resident's room] to apologize. This happened last week." On March 17, 2017 at approximately 5:00 PM a telephone interview was conducted with Employee #20. He/she stated, "I brought the resident to the dining room for dinner. I was taking food to other residents. I saw [the resident] going to [his/her] room in a wheelchair. I took [the resident's] food to [him/her]. [The resident] said a person from the kitchen shouted at [him/her] that is not your place [seat at the dining room table]. The resident was upset. I asked [the kitchen] worker to come to the resident's room to apologize. I did not report it because I thought everything was over because they hugged." The surveyor then asked the employee to describe the different types of abuse and who to report it to? The employee was able to tell what the different types of abuse were. However, he/she did not recognize this was a form of verbal abuse and did not report it. On March 17, 2017 at approximately 5:12 PM, a face-to-face interview as conducted with Employee #19 regarding the aforementioned.	F 226		

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F 226	Continued From page 17 Employee #19 stated, "Here on the Lower Level we have Dementia residents, so we try to maintain their space. I said mam, I have to move you, this is reserved, [he/ she] turned around in [his/her] wheelchair I had to move out [his/her] way. [He/she] started crying, [he/she] said I do not want to eat in here anymore. [He/she] wanted to go back to [his/her] room. [Employee #20] asked me to go to the resident. I went to [his/her] room to apologize. I did not report it because [he/she] hugged me." The surveyor then asked the employee to describe the different types of abuse and who to report it to. The employee was able to tell what the different types of abuse were. However, he/she did not recognize this was a form of verbal abuse and did not report it. There was no evidence that Employee #20 reported to the facility supervisory staff that Employee #19 "yelled at Resident #74 as per the facility's policy. A face-to- face interview was conducted with Employee # 1 on March 20, 2017 at approximately 11:00 AM regarding the aforementioned findings. The record was reviewed on March 17, 2017.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		

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F 241	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for two (2) of 27 Stage 2 sampled residents, it was determined that facility staff failed to respect the resident's dignity when an employee entered the resident's room without first knocking on the door and asking for permission to enter the room; and another employee spoke to a resident in a manner that the resident interpreted as disrespectful. Residents' #119 and #124. The findings include: 1. Facility staff failed to respect the resident's dignity when an employee entered Resident #119's room without first knocking on the door and asking for permission to enter the room. On March 15, 2017 at approximately 12:30 PM, during a resident between the resident and the surveyor, Employee #12 opened Resident # 119's door and entered the the room. The employee said, "Excuse me" and backed out of the room. The resident was asked, "Do staff treat you with respect and dignity?" The resident replied, "Usually, except when someone opened the door without knocking a while ago." A face-to-face interview was conducted with Employee #2 at approximately 3:00 PM on March 15, 2017. The employee was informed of the occurrence and he/she acknowledged the finding.	F 241	**483.10 (a) (1) Dignity and Respect of Individuality** 1. The staff member was on the unit for the first time on the day when he entered #119's room without knocking. He apologized to resident #119 immediately. A follow-up meeting and interview was conducted with resident #124 who verbalized that he/she gets along with all staff and is happy about the care provided. 2. Residents were interviewed regarding staff knocking before entering and they voiced no issues. Residents interviewed and had no concerns regarding staff communication. 3. Staff were re-educated regarding customer service, residents rights and respect. Dignity was included in the training. 4. Monitoring of the residents as it pertains to dignity is a part of the QA program. This includes random reviews of staff knocking and communication which is done by DON or designee. All findings are reported to QAPI committee quarterly.	5/5/17

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F 241	Continued From page 19 2. Facility staff failed to respect the resident's dignity when an employee spoke to a resident in a manner to which the resident interpreted as disrespectful. During a face-to-face interview with Employees #1 and #2 on March 20, 2017 at approximately 10:30 AM. The employees informed this surveyor that on Saturday afternoon (March 18, 2017- no time indicated). Resident #124 alleged that Employee #11 spoke to him/her in a manner that caused him/her to be sad/unhappy. According to the report the resident requested some assistance. The employee responded and carried out the request but spoke in a manner that caused the resident to be upset. A face-to-face interview was conducted with Resident #124 at approximately 1:00PM on March 20, 2017. The resident was asked to describe what occurred on Saturday afternoon March 18, 2017 [no time indicated]. The resident stated that Employee #11 responded to the call bell and asked him/her what he/she needed. The resident informed the employee he/she needed a diaper [incontinent brief] changed and to return to bed. The employee responded, "You [are] trying to break my back. You [are] too demanding." The resident responded, "I know it's hard to take care of me because I am not able to stand." The resident was asked what upset him/her about the employee's statement. The resident responded, "I was hurt when [he/she] said I was trying to break	F 241		

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F 241	Continued From page 20 [his/her] back and I cried. I try to help because I do not want to hurt anyone, but I cannot stand." The resident also added, "The nurse and the supervisor came in to talk to me and told me they would give me another nurse, a gentleman. [He/she] was okay." When asked whether the employee was verbally abusive towards [him/her] the resident stated, "No," but added "[He/she] could have been more respectful." A facility report reviewed on March 20, 2017 at approximately 9:00AM revealed a resident had reported that an employee spoke to (him/her) in what the resident interpreted as a disrespectful manner that caused him/her to be upset. Resident #124. A face-to-face interview was conducted with the resident's family member at approximately 4:30 PM on March 20, 2017. The family member said that he/she was not present when the incident occurred but learned about it upon arrival at his/her relative's room. The relative stated, "I could tell [he/she] was unhappy. I asked [him/her] if something was wrong and (he/she) responded that (he/she) did not like the way in which the nurse spoke to [him/her]. I think the nurse probably can use some more training but I don't want anything to happen to [him/her]." A face-to-face interview was conducted with Employee #14 at approximately 3:30 PM on March 20, 2017. The employee acknowledged providing care to Resident #124 when the caregiver was changed on March 18, 2017. The	F 241		

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F 241	Continued From page 21 employee stated that he/she had no knowledge of what occurred between the resident and Employee #11. "I was asked to take care of the resident and I did. The resident did not tell me what happened and I did not see [him/her] crying at any time." A telephone interview was conducted with Employee #11 at approximately 12:30 PM on March 22, 2017. When queried about the incident of Saturday March 18, 2017, the employee said, "I answered the light twice. The first time [he/she] asked to go to the bathroom but changed [his/her] mind and decided to have the diaper [incontinent brief] changed instead. I changed the brief but I did not say anything to [him/her]. Later, the resident called again but I was told that another CNA was going to take care of the resident and that [he/she] was upset over something I said to [him/her]. I did not say anything to[him/her]." A telephone interview was conducted with Employee #15 at approximately 12:30 PM on March 27, 2017. The employee acknowledged that he/she was the Charge nurse on the afternoon of March18, 2017 at approximately 4:30 PM. He/she stated, "When I entered the resident's room to administer medications [he/she] looked unhappy. He/she was not crying but I could tell he/she was upset. I asked [him/her] what happened and [he/she] responded that the CNA had told [him/her that he/she was demanding." The Charge Nurse said [he/she] called the CNA and inquired of him/her what had transpired. According to what the CNA told the Charge Nurse, Resident #124 asked to be taken	F 241		

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F 241	Continued From page 22 to the bathroom. After wheeling the resident into the bathroom and removing his/her shoes the resident decided [he/she] no longer wished to use the bathroom. However, the resident called again as soon as the CNA left the room. The CNA also told the Charge Nurse that she did what the resident requested and never told [him/her] that "he/she was demanding." Another telephone interview was conducted with Employee #24 at approximately 4:45 PM on March 27, 2017. This employee was the Nursing Supervisor on duty on the afternoon of March 18, 2017. In response to a query of the aforementioned occurrence involving Resident #124; the employee stated "I was called by the Charge Nurse and asked to speak with the resident. Upon entering the resident's room I enquired of the problem and was told by the resident that [his/her] assigned CNA had told [him/her] he/she was demanding because [he/she] was calling too much. The resident was upset but not crying. I informed the resident that I would remove the CNA and assign another if that was agreeable. The resident was in agreement with that arrangement and that change was made." The employee was also asked whether any other residents had complained about the employee. He/she responded, "None that I am aware of." A review of the personnel files of Employees' #11, #14, #15 and #24 revealed no evidence of disciplinary actions/or complaints related to allegations of abuse. The employees' last received the Residents' Rights, Abuse and Neglect training on November 29, 2016.	F 241		

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F 241	Continued From page 23 A telephone interview was conducted with Employee #1 at approximately 12:30 PM on March 27, 2017. The employee acknowledged the findings. There was no evidence that facility staff spoke to the resident in a respectful manner.	F 241		
F 246 SS=E	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (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 review, resident and staff interviews for six (6) of 27 Stage 2 sampled residents, it was determined that facility staff failed to ensure that residents received services within the facility with reasonable accommodation of individual needs and preferences as evidenced by: Facility staff failed to respond to one (1) resident's call for assistance to meet the needs of the residents' in a timely manner; failed to provide showers as scheduled for three (3) residents; failed to ensure the call bell was equipped with a pull cord and was available for user in one (1) resident's bathroom; failed to ensure that the clock in one (1) resident's	F 246	**483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/ PREFERENCES** 1. Resident #65 needs were met during the survey and he was assisted to bed. Resident #122 call bell cord was replaced. The survey team activated resident's call bell system, thus resident did not need assistance. During initial assessment of resident #119 bed baths were requested, and were provided daily. Resident #119 received shower and showers were scheduled at he/she's request. The staff for resident #124 were interviewed and advised that resident had been refusing showers. Resident #124 was re-interviewed and shower schedule was implemented until she was discharged home. The nursing and therapy staff were interviewed and advised that resident was receiving training on ADL's by therapy team including bed baths. After training completed resident received a shower on March 13 and March 16th and was discharged on March 18th. As it pertains to resident #126's clock, the date this occurred was the day following daylight savings time and all clocks had been adjusted; however, the clock did not work in that room even after replacing the batteries. A new clock was placed in residents #126's room. 2. A review of call system, ADL's and clocks were conducted, adjustments were made as indicated. No resident was affected by this practice. 3. The staff were re-educated regarding the call system as well as documentation of ADL. Staff were also re-educated to re-evaluate resident's request as it pertains to bath/showers. The maintenance team were reminded when resetting time following time moving forward/going backward that they must ensure clock is functioning before going to next room. 4. The DON or designee will monitor showers and ADL's. The maintenance team will monitor the call bell cords and clocks. This information will be presented at the quarterly QAPI meeting.	5/5/17

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F 246	Continued From page 24 room was set to the correct time. Residents' #65, #119, #122, #124, #126, and #128. The findings include: 1. Based on observation and interview facility staff failed to provide reasonable accommodation of resident needs by not responding to a call bell. Resident # 65. On March 14, 2017 at approximately 3:00 PM a review of the MDS (Minimum Data Set) dated February 8, 2017 revealed resident # 65 was admitted into hospice care on December 12, 2017 with diagnoses which included, congestive heart failure and hypertension. Section I Cognitive patterns revealed a BIMS score of [9] Moderately impaired Section G - resident requires assistance of 2 or more staff, and is dependent for his self-care requiring extensive assistance with toileting and at risk for falls related to muscle weakness. On March 14, 2017 at approximately 2:45 PM during an interview with Resident # 65, the call bell was initiated by the surveyor on behalf of the resident who requested assistance with returning to bed. The call bell was repeatedly pressed at 2:50 PM , 2:55 PM and 3:00 PM with no response from facility staff. The surveyor approached Employee # 16 who was at the front desk and he/she was asked about the status of the call bell he/ she pointed to Employee # 23 who was the	F 246		

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F 246	Continued From page 25 assigned caregiver. He/she pointed to Employee #23 who is the residents' assigned caregiver. When queried if he/she saw the pages, he/she stated "no I signed off at 3:00 PM ". When asked to see the pager he/she reached into a box on the front desk, the pager was noted with multiple pages/ call requests from room # 171. When the Employee # 23 was asked why he/she did not respond to the pages he/she did not respond to the question. There was no evidence the facility staff answered the Resident# 65's call bell in a timely manner. 2. Facility staff failed to ensure that Resident #122, was accommodated with the use of a bathroom pull cord to activate the call system. A resident observation was conducted on March 13, 2017 at approximately 4:00 PM. An attempt was made to activate the resident's bathroom call system in room #99, however the bathroom did not have a pull cord attached to activate the call system. Employee #20 was present at the time of the observation , on March 13 , 2017 at approximately 4:00 PM. He/she was asked if the resident uses this bathroom. He/she responded "yes", the resident does use this bathroom, we assist him/her to the commode." There was no evidence that the facility accommodated the resident with a bathroom pull	F 246		

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F 246	Continued From page 26 cord to activate the bathroom call system. Facility staff failed to ensure that one (1) resident was accommodated with a pull cord in his/her bathroom to aide in the activation of the alarm. 3.Facility staff failed to provide Resident #119 with showers as scheduled. During a face-to-face interview at approximately 12:15PM on March 15, 2017, the resident was asked whether [he/she] chose the number of times per week that (he/she) received showers. The resident responded that [he/she] "has had no showers since [he/she] was admitted to the facility". A review of the resident's admission record revealed that [he/she] was admitted to the facility on February 22, 2017 approximately 22 days ago. A follow-up interview was conducted with the resident on March 16, 2017 at approximately 10:30 AM. The resident was asked whether he/she had received shower/showers since I last spoke to him/her on March 15, 2017. Resident #119 responded "No" and added, "I would sure love to feel water all over my body." A face-to-face interview was conducted with Employee #10 at approximately 10:45 AM on March 16, 2017. During the interview this writer requested copies of any documentation that	F 246		

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F 246	Continued From page 27 showed that the resident had received showers. The employee presented this writer with a document which identified the days each resident on the unit should receive showers. The employee also stated that the showers are documented in the computer system. A face-to-face meeting was also conducted with Employee #13 (Who was covering for the regularly assigned CNA) at approximately 11:00 AM on March 16, 2017. The employee informed this surveyor in the presence of Employee #10 that the resident had not received any showers since admission. Employee #13 stated "that because Resident #119 was paralyzed on the left side and could not stand, the assigned caregiver (Employee #29) had planned to request training on how to get the resident into the shower" Employee #10 acknowledged that the facility staff failed to provide showers to Resident #119 for a total of 22 days. 4. Facility staff failed to accommodate Resident #124's choice to receive showers. A face-to-face interview with Resident # 124 on March 14, 2017 at approximately 2:30 PM. In response to the question "Do you choose how many times a week you take a bath or shower?" the resident responded "no and I have not had any showers." Would you like to have showers? "That would be nice. They do a good job washing me up with a basin but it would be nice to get a shower now and then. "	F 246		

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F 246	Continued From page 28 A follow-up interview was conducted with the resident on March 17, 2017 at approximately 10:00 AM. Resident #124 was queried whether he/she had received showers since I last spoke to him/her on March 14, 2017. The resident responded that [he/she] "had not received any showers since admission date March 10, 2017". A face-to-face interview was conducted with Employee #10 at approximately 10:15 AM on March 17, 2017. When queried regarding the resident's shower schedule, the employee acknowledged that the resident has not had showers. He/she is new to the facility and the nurses are awaiting recommendation from Rehab. (The Rehabilitation Department) on how to shower the resident safely. Employee #10 acknowledged that the facility staff failed to provide showers for Resident #124. 5. Facility staff failed to accommodate Resident #128's choice to receive showers. During a resident interview conducted on March 16, 2017 at approximately 3:30 PM, when resident was queried, "Do you choose whether you take a shower, tub, or bed bath? He/she responded, "No, I have never been asked, since I got here". The history and physical dated March 7, 2017 revealed resident's diagnoses included: L2 (lumbar) compression fracture and pain management. According the annual Minimum Data Set (MDS)	F 246		

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F 246	Continued From page 29 dated March 14, 2017, Resident #128 was coded under Section G (Functional Status) as requiring extensive assistance of (1) for support and care during bath and shower. A review of the unit's shower schedule revealed that the resident was scheduled to have showers on Monday and Thursday evenings. A review of the electronic ADL (Activities of Daily Living) flow sheet revealed from March 7 through March 12, 2017, the resident had received a total of zero (0) showers. There was no evidence that facility staff accommodated the Resident #128's choice to receive showers. A face-to-face interview was conducted on March 17, 2017 at approximately 4:00 PM with Employee #2, he/she acknowledged the findings. The record was reviewed on March 17, 2017. 6. Facility staff failed to ensure that a clock in Resident #126's room was set to the correct time. On March 13, 2017 at approximately 11:30 AM while the writer was speaking with Resident # (126 in his/her room. The resident commented, "I don't even know what time it is. Look at the clock. It is not correct." Upon observation the clock on the wall displayed 10:30 AM but the correct time was 11:30 AM. A face-to-face interview was conducted with Employee #10 at approximately 11:40 AM. The employee acknowledged the finding and stated, "I will change it right now."	F 246		
F 250	483.40(d) PROVISION OF MEDICALLY	F 250		

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F 250 SS=D	Continued From page 30 RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled stage 2 residents it was determined that facility staff failed to provide medically-related social services to address psycho-social needs as it relates to discharge planning services for Resident #16. The findings include: Resident #16 was admitted to the facility on November 10, 2016 with diagnoses of Hypertension, Arthritis, Osteoporosis and Non-Alzheimer's Dementia. The quarterly Minimum Data Set (MDS) dated February 16, 2017 revealed that the Resident #16 was coded as "Cognitively Intact" based on a Brief Interview of Mental Status Score (BIMS) of 15/15 in Section C [Cognitive Patterns]. A review of Section Q Participation in Assessment of Goal Setting, under Section Q0500 [Return to Community] in response to question "Do you want to talk to someone about the possibility of leaving this facility to live and receive services in the community, the resident responded "Yes". In response to Section Q0600 (Referral), 'Has a referral been made to the Local Contact Agency? The section was coded "No." A face-to-face interview was conducted with Resident #16 on March 20, 2017 at	F 250	**483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** 1. Resident #16 requested additional closet prior to moving to Assisted Living. He/She was assisted with purchase /selection of closet. Social worker continued to assess her discharge need and documented the findings. Resident transferred to Assisted Living. 2. A review of all residents to determine if documentation in place regarding discharge. No other resident impacted by this practice. 3. The social work staff was re-educated regarding ensuring that the care and services they provide is documented in the Electronic Health Record. (HER) 4. A review of social work documentation including discharge plan is done monthly. This information is presented to QAPI committee quarterly.	5/5/17

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F 250	Continued From page 31 approximately 10:20 AM. In response to question, "Were you given notice before a room change or a change in roommate ? " He/she responded "Yes, I am supposed to move to Assisted Living but they have not told me when, last I was told, they are waiting to clean the room out first." A face-to-face interview with Employee# 9 occurred on March 20, 2017 at approximately 1:00 PM. He/she stated, "The resident was supposed to go back to Assisted Living on March 1, 2017, but due to the construction in the facility, the resident was not able to be moved". Employee# 9 did not provide a reschedule date for resident's discharge. A review of the medical record lacked evidence of the social worker's assisitance with making arrangements for the resident to return to assisted living. Additionally, there was no evidence that the social worker documented any plans regarding the resident's discharge. On March 20, 2017 at approximately 2:00 PM, a face-to-face interview was conducted with Employee# 9 he/she acknowledged the findings. The medical record was reviewed on March 20, 2017.	F 250		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by:	F 253		

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F 253	Continued From page 32 Based on observations made during an environmental tour of the facility on March 16, 2017 at approximately 2:00 PM, it was determined that facility staff failed to provide necessary maintenance services to maintain a sanitary interior as evidenced by marred walls in three (3) of 25 resident's rooms. The findings include: Walls were marred in three (3) of 25 resident's rooms including rooms # 083, #177 and #188. These observations were made in the presence of Employee #6 who acknowledged the findings.	F 253	**483.10 Housekeeping & Maintenance Services** 1. The marred walls in rooms # 83,177 and 128 have been repaired. 2. A review of all residents rooms were conducted, no additional rooms were noted to have damaged or marred walls. 3. During the maintenance preventative rounds the walls are monitored. The maintenance staff were re-educated on the monitoring of walls. The nursing staff were re-educated on notifying of maintenance when walls are damaged. 4. The maintenance team will conduct environmental and preventative maintenance rounds, to include but not limited to the walls. This information will be reported to the Director of QA and presented at the quarterly QAPI meetings.	4/30/17
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 Stage 2 sampled residents, it was determined, that facility staff failed to complete the significant change status assessment (SCSA) within the regulatory time frames for one resident	F 274		

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F 274	Continued From page 33 who was enrolled in a hospice program. Resident # 65. The findings include: "According to the CMS's RAI Version 3.0, Manual October 2016- Significant Change in Status Assessment(SCSA) ...A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program ...The ARD [Assessemnt Reference Date]must be within 14 days from the effective date of the hospice election statement ..." A review of the resident's clinical record revealed the resident enrolled in the hospice program with a certification date of December 12, 2016. Further review revealed an admission minimum data set assessment (MDS) dated October 22, 2016 and a SCSA dated February 08, 2017. There was no evidence the facility staff submitted the SCSA with in the 14-day time frame as required. A face-to-face interview was conducted with Employee #7 at approximately 11:00 AM on March 17, 2017. He/she acknowledged that the SCSA was not submitted in a timely manner. The record was reviewed on March 17, 2017.	F 274	**483.20 Comprehensive Assess after significant change** 1. Resident #65 was assessed and a review of the clinical record was conducted. It was determined that the significant change in status assessment (SCSA) was completed on 2/8/17 prior to QIS survey. Unable to retrospectively correct date of SCSA. 2. A review of all residents receiving hospice benefit was conducted. No other resident was affected by this practice. 3. The MDS and nurse managers were re-educated on the hospice benefit and the required completion of the SCSA. 4. All residents on hospice are monitored during PPS meeting. This information is monitored and compiled monthly and presented to the QAPI committee quarterly.	5/12/17
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination	F 278		

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F 278	Continued From page 34 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 Stage 2 sampled residents it was determined that facility staff failed to accurately code the quarterly MDS (Minimum Data Set) for one (1) resident's speech status. Resident #81. The findings include:	F 278	**483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED** 1. An assessment of resident #81 was conducted. A modification was done for the quarterly MDS assessment for resident #81 with the Assessment Reference Date (ARD) 1/27/17 which has been submitted and accepted. The MDS section B accurately reflected the residents (hearing/speech/vision) at the time of assessment period. 2. MDS manager reviewed MDS section B quarterly assessments for all in-house LTC Quarterly assessments that were completed from January to March 2017. No other resident was affected by this practice. 3. The MDS Coordinator was re-educated by MDS Manager on the MDS and Importance of accuracy in all areas of assessment. 4. A monthly audit is completed by the MDS Manager. This information is reported to the QAPI committee quarterly.	5/12/17

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F 278	Continued From page 35 During an initial tour of the facility on March 13, 2017 at approximately 9:30 AM, Resident #81 was observed in the resident's lounge area sitting in a wheelchair. When asked how s/he was, the resident smiled and nodded affirmatively but did not offer a verbal response. During a review of Resident #81's quarterly MDS (Minimum Data Set) dated 01/27/2017 on March 16, 2017 at approximately 10:00 AM, it was noted that section B0600 (Hearing, Speech and Vision) was coded with a '2" (no speech- absence of spoken words), section B0700 with a "3" (rarely/never understood), and section B0800 with a "3" (rarely/never understands). A face-to-face interview with Employee #17 was conducted on March 16, 2017 at approximately 10:10 AM. Employee #17 stated that he/she is permanently assigned to Resident #81 unless he/she is off or on vacation. The resident is given a menu before every meal, and will choose what he/she wants to eat. The resident is able to express his/her preferences. A review of the interdisciplinary notes dated January 20 to January 26, 2017 revealed the following: January 20, 2017 at 3:22 AM 'Resident denied any pain on this shift ...' January 20, 2017 at 4:40 PM 'Resident alert and responsive ...' January 21, 2017 at 4:40 AM 'Resident alert and verbally responsive ...' January 22, 2017 at 3:24 PM 'Resident alert and	F 278		

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F 278	Continued From page 36 smiling able to identified people and voiced their name.' January 23, 2017 at 8:10 PM 'Resident alert and verbally responsive ...' January 24, 2017 at 3:35 AM 'Resident alert and stable throughout the shift.' January 26, 2017 at 4:46 AM 'Resident alert and verbally responsive.' There were no indications that Resident #81 was unable to make himself/herself understood or was unable to understand others as recorded on the MDS dated January 27, 2017. A face-to-face interview with Employee #16 was conducted on March 17, 2017 at approximately 3:30 PM. When queried as to Resident #81 speech status, Employee #16 said "that the resident can and does speak when [he/she] wants to, responds verbally to questions regarding pain, [his/her] health or anything [he/she] is asked". The record was reviewed on March 16 and on March 17, 2017.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 279		

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F 279	Continued From page 37 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 279	**483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS** 1. Resident #16 and 25 were reassessed the care plan for resident #16 was updated to reflect activity of choice. The care plans for resident #65 was updated to reflect collaboration for hospice service. 2. Review of activity care plans for all residents was done and activities of choice are included. A review of care plans for all residents on hospice has been done and hospice collaboration is included. 3. The Interdisciplinary team (IDT) will be re-educated on the resident assessment process, with emphasis on the care plan. 4. A review of the care plan is a part of the medical record audit which is Completed monthly. The DON or designee reviews findings and information is presented to the QAPI committee quarterly.	5/12/17

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F 279	Continued From page 38 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 resident interview, staff interview and record review for two (2) of 27 Stage 2 sampled residents, it was determined that facility staff failed to develop and implement an activities care plan consistent with the resident's preferences, choices and interests for one (1) resident and failed to develop a hospice care plan with goals and approaches to address the coordination of care and services for one (1) resident. Resident's #16 and #65. The findings include: 1. Facility staff failed to develop and implement an activities care plan consistent with the resident's preferences, choices and interests. Resident #16 On March 13, 2017 at approximately 12:05 PM a face-face-face interview was conducted with Resident #16 and in response to question "Do the activities meet your interest? "He/she responded "No, I want to go out sometimes on the shuttle like I used to when I was in Assisted Living. I would like go out to get my personal items like my cosmetics. I told them, but I can never go out and I really would like to go out".	F 279		

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F 279	Continued From page 39 On March 20, 2017 at approximately 10:30 AM a face-face interview was conducted with Employee# 3. He/she responded, " [Resident #16] is able to go out on bus rides twice a week and every other Friday. [He/she] will go on a trip on the shuttle. [He/she] can go to the Giant and Safeway on our shuttle that [he/she] can take any time". The quarterly Minimum Data Set [MDS] dated February 16, 2017, under Section C [Cognitive Patterns] revealed Resident #16 was coded as "Cognitively Intact" based on a Brief Interview of Mental Status Score (BIMS) of 15/15. A review of the annual MDS with an Assessment Reference Date (ARD) of November 17, 2016 revealed under Section F [Preferences for Customary Routine and Activities] in response to Section F0500G question "while you are in this facility, how important is it to you to get fresh air when the weather is good? The resident was coded a 1 "very important". Section F0600, ([Daily and Activity Preferences Primary Respondent] is coded as "1", Resident is the primary respondent for Daily and Activity Preferences (F0400 and F0500). Activity Assessment review date of January 4, 2017, policy statement reads, "In order to promote the physical, mental and psychosocial well-being of residents an activity assessment is conducted and maintained for each resident. Conducting Activity Assessment: "Within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help develop an activities plan that reflects the choices and	F 279		

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F 279	Continued From page 40 interests of the resident, under section Comprehensive Assessment " each resident's activity care plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs; Documentation: The completed activity assessment will be part of the resident's medical record and shall be updated as necessary, but at least annually." A review of the resident's Interdisciplinary Care Plan Conference Summary dated November 29, 2016 under areas reviewed (activities) comment section "resident expressed an interest in activities offered and the facility will invite and escort resident to all activities of choice". The resident's Interdisciplinary Care Plan Conference Record dated February 21, 2017 revealed, "participates in activities of choice music, enjoys movies, goes out on bus trips, shopping etc." A review of the active medical record lacked evidence that a care plan with individual activities goals and approaches was developed to address the resident's activity needs. A face-to-face interview was conducted with Employee #1 on March 20, 2017 at approximately 2:00 PM regarding the aforementioned findings and he/she acknowledged the findings. The medical record was reviewed on March 20, 2017. 2. Facility staff failed to develop a hospice care plan with goals and approaches to address the coordination of care and services for one (1) resident receiving hospice care. Resident # 65 A review of the admission information on the	F 279		

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F 279	Continued From page 41 clinical record revealed that Resident #65 was admitted to the facility with the following diagnoses: Congestive heart failure Hypertension, Diabetes Mellitus. The resident was also coded for Hospice Care under Section O of the Significant Change MDS (Minimum Data Set) dated February 8, 2017. A review of the care plan dated December 12, 2016 lacked evidence of collaborative goals and approaches to manage the prescribed hospice care for Resident #65. The clinical record lacked evidence that an integrated care plan with measurable goals and interventions was developed for Resident # 65 as it relates to hospice services. A face-to-face interview was conducted with Employee #2 on March 17, 2017 at 3:00 PM. He/she reviewed and acknowledged the findings. The record was reviewed on March 17, 2017.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280		

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F 280	Continued From page 42 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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.	F 280	**483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** 1. The record for resident #81 was reviewed. The resident was also re-assessed. The care plan for resident #81 has been revised and updated. Resident #108 is no longer in the facility thus unable to retrospectively correct. 2. Resident who sustained falls were identified and their care plans reviewed. Care plans were updated if indicated. A review of all care plans was done and comprehensive care plans were completed timely. 3.The interdisciplinary team (IDT) were re-educated on the care planning process. 4. A review of the care plan is a part of the review of the medical record completed monthly by the DON or designee. This information is presented to the QAPI committee quarterly.	5/12/17

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F 280	Continued From page 43 (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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 27 Stage 2 sampled residents, it was determined that facility staff failed to review and revise care plans for one (1) resident for a period greater than 90 days and failed to amend the Fall prevention care plan for one (1) resident who sustained multiple falls. Residents' #81 and #108 The findings include: 1. Facility staff failed to review and revise Resident #81's comprehensive care plans.	F 280		

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F 280	Continued From page 44 A review of Resident #81's clinical record revealed that the resident was admitted to the facility on November 2, 2016. The physician's history and physical examination dated and signed November 4, 2016, revealed resident's diagnoses included, Acute CVA (Cerebrovascular Accident)-Right Sided paresis, Status Post Craniotomy and Seizures." A review of the comprehensive care plans initiated on November 2, 2016 revealed the following problems: "Cognitive Deficit, Impaired Communication related to Aphasia, Impaired Physical Mobility, Incontinence, Behavioral Problem, Activities, Nutrition, Pressure Ulcer, Altered Skin Integrity, and Return to Community Referral. The clinical record revealed Interdisciplinary Team Meetings (IDT) were held on November 15, 2016 and February 7, 2017. A review of the comprehensive care plans revealed that all of the aforementioned care plans had not been reviewed and revised since November 2, 2016. A face-to-face interview was conducted with Employee #8 at approximately 2:00 PM on March 17, 2017. He/she acknowledged that the aforementioned care plans were not updated since November 2, 2016. The record was reviewed on March 17, 2017. 2. Facility staff failed to review and revise Resident #108's care plan for Fall prevention with	F 280		

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F 280	Continued From page 45 goals and interventions to promote safety and prevent repeated falls. The resident was admitted to the facility on February 6, 2017 with diagnoses which included Anemia, CHF (Congestive Heart Failure), Coronary Heart Disease, Crohn's Disease, Hypertension, Hyperlipidemia and GERD (Gastroesophageal Reflux Disease). A review of the care plans revealed that a Potential to Fall due to Impaired Balance was identified as a problem for the resident and approaches were documented as (1) completing fall risk assessments quarterly and as needed (2) Scheduling Physical Therapy Assessments as needed (3) Wearing non-skid footwear (4) Resident to notify staff to assist [him/her] when going to visit spouse (5) Toileting to be done according to resident's toileting schedule and as needed (5) low bed for safety (6) Mobility monitor (bed alarm) to be checked for proper functioning each shift. A review of the Incident Reports the resident sustained four falls since being admitted to the facility. Fall #1 occurred on February 24, 2017. The fall care plan was in place having been initiated on February 6, 2017 when the resident was admitted to facility. Fall #2 occurred on March 3, 2017. No new approaches were added to the care plan after the second fall and the resident sustained a third fall on March 9, 2017. Fall # 4 occurred on March 15, 2017. The first and second fall occurred during the night. One at 3AM when the resident was observed lying on the floor mat. The second fall occurred during the night when the resident was	F 280		

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F 280	Continued From page 46 observed sitting on the floor beside his/her bed at 4:50AM. Fall #3 occurred at approximately 10:00PM at night when the resident was observed lying on the fall mat in the room with his/her head resting on a pillow. The fourth fall occurred on March 15, 2017 when staff responded to an alarm and observed the resident lying partially on the floor mat and leaning against the bed Further review of the care plans failed to reveal any evidence that any added measures were implemented to prevent the resident from having future falls. A face-to-face interview was conducted on March 17, 2017 at approximately 3:00 PM with Employees #1 and #2. They acknowledged the findings.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309	**483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** 1. Resident #65 was reassessed and continues to utilize nasal spray which is being administered correctly. Unable to retrospectively correct prior administration of nasal spray. Resident #128 received Miralax, however, the resident has been discharged. Unable to retrospectively correct transcribing of Miralax. 2. A review of residents receiving, Flonase nasal spray and Miralax was conducted. No other residents were found to be affected by this practice. 3. The licensed staff were re-educated on, proper administration of nasal spray and proper protocol of order transcription in the Medication Administration Record (MAR). 4. Monitoring of medication administration and medication transcription is conducted monthly by the nursing management team and reported to the QAPI team quarterly.	5/5/17

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F 309	Continued From page 47 care plan, and the residents' choices, including but not limited to the following: (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. (l) Dialysis. The facility must ensure that residents who require dialysis receive 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 observation, record review and staff interview for three (3) of 27 Stage 2 sampled residents, it was determined that facility staff failed to assess one (1) resident's pain level after pain medication was administered; failed to administer an intranasal spray medication according to manufacturer's specifications for one (1) resident and failed to administer a laxative in accordance with physician's orders for one (1) resident. Residents' #26, #65 and #128 The findings include: 1. Facility staff failed to conduct a pain assessment for Resident #26 who received pain medication. During a resident interview on March 13, 2017 at approximately 12:19 PM; when queried, "Do you have any discomfort now or have you been having discomfort such as pain, heaviness,	F 309		

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burning, or hurting with no relief?". Resident #26 stated; "I had pain this morning ...it makes you say ouch. Staff is taking care of it."

The "Physician's Order" dated and signed March 13, 2017 at 8:00 AM directed; "Ibuprofen (antiinflammatory used for pain management) 400mg 1 tab po (by mouth) three times (a day) for five (5) days for pain.

A review of the facility's SBAR (nursing documentation recorded as: Situation, Background, Appearance and Review and Notify) communication form dated March 13, 2017 at 5:28 PM revealed; "Situation: The change in condition, symptoms; or signs I'm calling about is/are: Left ankle pain /swelling... Appearance- Summarize your observation and evaluation: Left ankle swollen, red in color and Pt (Patient) c/o (complain of) pain ... Review and Notify: Nursing Notes ... Resident left ankle noted red in color, swollen with pain. MD (Medical Doctor) ..."

The March 2017 Medication Administration Record (MAR) revealed that Ibuprofen 400mg was given on March 13, 2017 at 9:00 AM; however, the resident's pain severity scale was coded as "0" (indicative of no pain) on the 7-3 shift.

There were no interdisciplinary notes or any assessment that included a description of the location of the pain, the intensity of the pain (e.g. numeric scale) before or after administration of the Ibuprofen on March 13, 2017 at 9:00 AM. The next subsequent note was March 14, 2017 at 14:39 (2:39 PM).

A face-to-face interview was conducted with

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F 309	Continued From page 49 Employee #2 on March 17, 2017 at approximately 12:00 PM. After reviewing the clinical record, he/she acknowledged the aforementioned findings. The record was reviewed on March 17, 2017. 2. Facility staff failed to administer Resident #65's Flonase intranasal spray (Corticosteroid medication used for the management of allergy nasal symptoms) in accordance to manufacturer's specifications. On March 16, 2017 at approximately 9:30 AM, Employee #25 was observed administering an Allergy Relief intranasal spray [medication], Flonase to Resident #65. At this time, Employee #25 instructed the resident that he/she was going to administer the Flonase nasal spray. Employee #25 inserted the applicator into the left nostril, pressed down on the applicator and released one spray. Employee then inserted the applicator into the right nostril and released one spray. A review of the manufacturer's specifications revealed: "Information for Patients"- How to Use Your Nasal Spray- ... (3)- Blow your nose to clear your nostrils, (4) Close one nostril. Tilt your head forward slightly and, keeping the bottle upright, carefully insert the nasal applicator into the other nostril, (5) Start to breathe in through your nose, and while breathing in press firmly and quickly down once on the applicator to release the spray ...." A face-to-face interview was conducted with Employees #2 and #25 on March 16, 2017 at approximately 10:30 AM. Both acknowledged the aforementioned findings. The clinical record was reviewed on March 16, 2017.	F 309		

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F 309	Continued From page 50 3. Facility staff failed to administer Resident #128's Miralax (Laxative used for treatment of occasional constipation) in accordance with physician ' s orders. According to a " History and Physical " dated March 7, 2017 Resident #128's current diagnoses included: " Lumbar Compression Fx (Fracture), Pain Management, Urinary Retention [and] Constipation (resolved) and Bowel Management ..." An interim order dated March 13, 2017 at 1500 (3:00 PM) directed: " Miralax 17 G (Gram) PO (by mouth) Q 24 [every 24 hours] ..." A review of the March 2017 Medication Administration Record (MAR) lacked evidence that Miralax was transcribed onto the MAR during the period of March 13, 14, 15, and 16. There was no evidence in the clinical record that the staff administered the Miralax from March 13 through March 16, 2017. There was no evidence that the resident sustained any untoward effects from the omission of Miralax. A face-to-face interview was conducted with Employees #2 and #26 on March 16, 2017at approximately 10:30 AM. They acknowledged the aforementioned findings. The observation and clinical record review was conducted on March 16, 2017.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence.	F 315		

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F 315	Continued From page 51 (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. (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. (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 record review and staff interview for one (1) of 27 stage 2 sampled residents, it was determined that facility staff failed to ensure	F 315	**483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER** 1. A detailed re-assessment of resident #78 was completed, upon review of medical condition and consultation with physician it was determined he/she was not a candidate for bladder retraining. 2. A bladder assessment audit was completed on all residents and no other residents were impacted by this practice. 3. The director of Nursing re-educated the unit managers on the use of the bladder assessment tool and its relationship to programming for residents. 4. The Unit manager will audit the bladder evaluation/assessment quarterly and report findings to QAPI committee.	5/5/17

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F 315	Continued From page 52 Resident #78 was placed on a bladder/toilet training program after being assessed for being a good candidate for bladder training. The findings include: A review of the Incontinence Assessment dated July 19, 2016 states Resident #78 has a score of 6, indicating that he/she is " A good candidate for individual [toilet] training (refer to Rehabilitation Department".) Review of the Minimum Data Set (MDS) dated January 12, 2017 revealed the following: Section C - Cognitive Patterns C0500 BIMS (Brief interview for mental status) Score 14, indicative that the resident was cognitively intact. Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, the resident was coded for limited assistance for toilet use. G0300 (D) (Balance during transitions and walking) Moving on and off toilet coded for not steady, but able to stabilize without staff assistance. G0400 Functional Limitation in Range of Motion (ROM) coded as No impairment for upper extremities and lower extremities. G0600 Mobility Devices B. Walker, C. Wheelchair. Under Section H0200 Urinary Toileting Program, part A was coded as No, for resident being on a toileting program. H0300 Urinary Continence coded 2 for frequent incontinence. Interdisciplinary Care Plan Conference Record dated January 24, 2017 stated the following:	F 315		

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F 315	Continued From page 53 Transfers and toilets with supervision. Occupational Therapy Notes: Occupational Therapy Treatment Encounter Note(s) dated March 3, 2017 states: Summary of skill demonstrated good safety awareness for transferring to commode in bathroom and back to chair in room. Occupational Therapy Discharge Summary dated March 6, 2017 states: "Highest Practical Level Achieved" for discharge reason. Patient will complete commode transfers with supervised [assistance] and occasional visual cues for implementation of safety techniques. Toileting minimal assist or mild impairment, Toilet Hygiene independent. There is no evidence that the facility established a bladder training/ toilet training program to improve bladder function or prevent urinary incontinence, consistent with the resident's assessed need. A face-to-face interview was conducted with Employee # 8 on March 20, 2017 at 10:38 AM. He/she acknowledged the findings. The records were reviewed on March 15, 2017.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		

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F 323	Continued From page 54 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 27 Stage 2 sampled residents, it was determined that facility staff failed to accurately assess Resident #108's risk for falls and implement effective safety precautions as to promote safety and freedom from accidents/injury. The findings include: According to section I (Active Diagnoses) of the admission Minimum Data Set (MDS) the resident was admitted to the facility on February 6, 2017 with diagnoses which included Anemia, CHF (Congestive Heart Failure), Coronary Heart Disease, Crohn's Disease, Hypertension, Hyperlipidemia and GERD (Gastroesophageal Reflux Disease).	F 323	**483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** 1. A review of resident #108 at was conducted at the time of survey. An updated fall assessment was competed at that time. Unable to retrospectively correct prior fall assessments. The surge protector in residents rooms #097 & 098 were mounted. The extension cords in resident #197 room was removed. 2. A review of all fall assessment was done and no other resident was impacted by this practice. Room checks conducted and no other extension cords were noted. All other surge protectors were mounted correctly. 3. Nursing staff were re-educated on completion of fall risk evaluation form. Maintenance department staff was re-educated on application of surge protectors. Monitoring of surge protector and extension cords has been added to the preventative maintenance schedule. 4. Monitoring resident documentation as it pertains to the fall risk evaluation is a part of the unit manager's audit tools. The maintenance staff monitor residents rooms and facility for safety issues. The data obtained from review of fall evaluation forms and room/facility safety evaluation is presented to QAPI meeting quarterly.	5/5/17

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F 323	Continued From page 55 According to Section G (Activities of Daily Living) of the admission MDS with an Assessment Reference Date (ARD) of February 13, 2017 the resident was coded as extensive assistance with self-performance in the areas bed mobility, transfer, locomotion (getting around), toilet use and personal hygiene and required support from staff. In comparison with the MDS Type '99' completed on February 20, 2017 (two weeks after the resident's admission), it was noted that in the area of locomotion the resident had deteriorated from a three to a four (indicating that the resident transitioned from requiring extensive assistance to total dependence on others for locomotion). A review of Incident Reports involving Resident #108 revealed that he/she had four (4) falls from the date of admission February 6, 2017 through March 15, 2017. According to the nurse's documentation falls occurred on the following dates: February 24, 2017 - fall with no injury March 3, 2017- bruises were observed on the resident's body after the fall. The fall occurred at 4:50 AM and the resident told the staff that he/she was attempting to go to the bathroom. The resident uses continuous Oxygen via nasal cannula. March 9, 2017 - fall with no injury March 15, 2017-fall with no injury The "Falls Risk Evaluation" was completed upon	F 323		

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F 323	Continued From page 56 the resident's admission and after each fall. A resident's risk score of 10 or higher classifies the resident as being at high risk for a fall according to the "Fall Risk evaluation" form. The Fall evaluations were coded inaccurately as follows: February 6, 2017 the resident was given a score of 8 (eight) which was an indication that he/she was at a low risk for a fall. However, the resident was not scored under the area of "Gait and Balance". The instruction in this area was to "Indicate appropriate point value for each item that applies." The resident has a shuffling gait which carries a score of one (1) point. The resident uses assistive devices, a wheel chair. This area carries another point. The resident also uses continuous Oxygen. Oxygen tubing carries another point. None of the areas mentioned were coded thereby rendering the form inaccurate. Accurate completion of the form would have given the resident a score of 11 instead of a score of 8. A score of 11 would have classified the resident at a high risk for falls. February 24, 2017 - Fall Risk Evaluation form revealed a score of 11. Under the area of Gait and Balance, the resident's shuffling gait was not checked for (1) point. Under the area of "Predisposing Diseases," the following conditions are listed: Hypertension, Vertigo, Parkinson's Disease, Loss of Limbs, Seizures, Arthritis, Osteoporosis and Fractures. The form should have been checked for 1-2 present as the resident's diagnoses included Arthritis and Hypertension. This area required a score of (2) points but was scored as a 0 (zero).	F 323		

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F 323	Continued From page 57 Under the area of "Equipment Issues," the resident's oxygen tubing was not checked. It required a score of (1) point. The incorrect coding of this Falls Risk Evaluation form missed four (4) points. The facility scored the form as (11) points but the score should have been 15. March 3, 2017 the Falls Evaluation Form was scored with a total of 11 points. If the shuffling gait and the oxygen tubing were correctly coded, the score on that evaluation form would have been 13. March 9, 2017- the Falls Risk Evaluation form was 13. With the inclusion of the points for Shuffling Gait and Oxygen tubing (2 points). The score should have been 15. The Falls Risk Evaluation form was completed after the fall on March 15, 2017, the total score on this form was 13. The oxygen tubing was not included as equipment on this assessment form. If the oxygen tubing had been included the resident's score would have been 14. The Falls Risk Evaluation upon the resident's admission and those completed after each fall were inaccurate. A review of the Fall care plan last updated March 5, 2017 lacked evidence of goals and approaches to address the resident's gait and use of nasal cannula when using the rest room during the night. On admission, the facility staff failed to accurately	F 323		

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F 323	Continued From page 58 assess and document Resident #108's fall risk. Subsequently, facility staff failed to implement safety measures in a timely manner to help prevent the resident from sustaining falls. A face-to-face interview was conducted on March 17, 2017 at approximately 3:00 PM with Employees #1 and #2. They acknowledged the findings. Based on observations made during an initial tour of the facility on March 13, 2017 at approximately 9:00 AM, and during an environmental tour of the facility on March 16, 2017 at approximately 2:00 PM, it was determined that facility staff failed to maintain resident's environment free of accident hazards as evidenced by surge protectors that were not mounted in two (2) of 25 resident's rooms and an extension cord that was plugged into an electrical outlet in one (1) of 25 resident's rooms. The findings include: 1. Surge protectors located in two (2) of 25 resident's rooms (#097, #098) and in the upper level dayroom were in use and were not mounted. 2. An extension cord was observed in use, in resident room #197, one (1) of 25 resident's rooms These observations were made in the presence of Employee #6 who acknowledged the findings.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General.	F 329		

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F 329	Continued From page 59 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that– (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for	F 329	**483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** 1. Resident #11 was seen by Psychiatrist on 4/20/17 and ordered a (GDR) gradual dose reduction program. 2. A review of records for all residents receiving antipsychotic medication was done. Additionally, pharmacy reviews as it was related to use of antipsychotic medication was conducted. Based upon their reviews resident requiring GDR was done. 3. The clinical team was re-educated on mental health evaluation and documentation on GDR. 4. Monthly audits of residents on psychotropic medication is conducted, as well as pharmacy recommendations. The information is presented to QAPI quarterly.	5/5/17

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F 329	Continued From page 60 one (1) of 27 Stage 2 sampled residents, it was determined that facility staff failed to ensure a gradual dose reduction (GDR) was attempted for the use of an anti-psychotic medication (Zyprexa) for Resident #11. The findings include: A review of the physician ' s orders revealed that Resident #11 was prescribed the antipsychotic medication Zyprexa 2.5 mg every other day for psychosis. The psychiatric consultation dated February 22, 2016 revealed, " ... Instructions: Advised to continue current medications at the prescribed dose and frequency ... Revisit in six months; Updated Medication List: Olanzapine (Zyprexa) 2.5mg tabs-one tab every other day at bedtime ...." A review of the monthly pharmacy "Drug Regimen Review" revealed; "NI (no irregularities) from June 2, 2016 through March 2017. [Family member] wants [him/her] on psych meds ..." A review of the pharmacy " Consultation Report " revealed the following: " May 4, 2016-Recommendations- Please consider a gradual dosage reduction to 2.5mg three times a week, with the end goal of discontinuation of therapy. If therapy is to continue at this dose, the prescriber must document a clinical contraindication, defined as a patient-specific rationale including: 1) documentation that target symptoms returned or worsened during a dose reduction attempted during the most recent facility admission, 2) why additional attempted dose reduction would be likely to impair the resident's function or increase	F 329		

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F 329	Continued From page 61 distressed behavior ..." "June 8, 2016 - Physician ' s response: I decline the recommendations (s) above because GDR is clinically contraindicated for this individual... According to POA (Power of Attorney), this med (medication) is effective and desired effects are beneficial. Signed by Attending Physician." A review of Resident #11's Psychoactive Drug Use Care Plan updated December 6, 2016 revealed: "May 24, 2016 ... Zyprexa 2.5mg - 1 tab po (by mouth) QOD (every other day) for psychosis ... Next Psych (psychiatric) F/U (follow up) appointment on August 1, 2016 at 1:30 PM ..." The clinical record lacked evidence that a second attempt of gradual dose reduction for the use of Zyprexa was attempted after June 8, 2016. Additionally, there were no subsequent clinical notes or evaluation from psychiatry after February 22, 2016 to present. A face-to-face interview was conducted with Employees #2 and #10 on March 20, 2017 at approximately 2:00 PM regarding the aforementioned findings. After review of the clinical record, both acknowledged the aforementioned findings. The clinical record was reviewed on March 20, 2017.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its-	F 332		

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F 332	Continued From page 62 (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, it was determined that the facility failed to administer medications at an error rate of five percent or less for two residents. Residents' #65 and #128. Twenty-six opportunities were observed with two errors for a medication error rate of 7.69%. The findings include: 1. On March 16, 2017 at 9:30 AM, medications were observed being given to Resident #65. Employee #25 administered Flonase intranasal spray (a corticosteroid used for the management of the nasal symptoms of seasonal and perennial allergic and non-allergic rhinitis). A review of the "Physician's Order Form" dated February 26, 2017 directed; "Fluticasone Prop (Propionate) 50mcg Spray Susp (Suspension)... (Flonase Nasal)- One spray to each nostril twice daily for nasal congestion ..." Employee #25 instructed the resident that [he/she] was going to administer the Flonase nasal spray. Proceeded to insert the applicator into the left nostril and pressed down on the applicator and released one spray, proceeded to administer the nasal spray in the right nostril. According to the manufacturer's specifications, instructed before administering an intranasal spray ... (3)- Blow your nose to clear your nostrils, (4) Close one nostril. Tilt your head forward slightly and, keeping the bottle upright, carefully insert the nasal applicator into the other nostril,	F 332	**483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE** 1. Resident #26 was reassessed and was not in pain during assessment unable to retrospectively correct prior pain assessment. Resident #65 was reassessed and continues to utilize nasal spray which is being administered correctly. Unable to retrospectively correct prior administration of nasal spray. Resident #128 received Miralax, however, the resident has been discharged. Unable to retrospectively correct transcribing of Miralax. 2. A review of residents receiving pain medication, flonase nasal spray and Miralax was conducted. No other residents were found to be affected by this practice. 3. The licensed staff were re-educated on pain assessment, pre and post administration, of pain medication, proper administration of nasal spray and proper protocol on transcription of medication in the Medication Administration Record (MAR). 4. Monitoring of pain assessment, medication administration and medication transcription is conducted monthly by the nursing management team and reported to the QAPI team quarterly.	5/5/17

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F 332	Continued From page 63 (5) Start to breathe in through your nose, and while breathing in press firmly and quickly down once on the applicator to release the spray ...." Staff failed to administer the nasal spray in accordance with manufacturer's specifications. 2. During reconciliation of the medications for Resident #128 on March 16, 2017, a physician's order dated March 13, 2015 at 1500 (3:00 PM) directed: "Miralax (laxative for treatment of occasional constipation) 17 Gm (Grams) po (by mouth) Q 24 (every 24 hours). This medication was not observed given during the medication pass. Review of the March 2017 Medication Administration Record (MAR) with Employee #26, revealed the Miralax order was not listed. On March 16, 2017 at approximately 11:00 AM, during an interview with Employees #8 and #26, they confirmed that the order for the Miralax had not been written on the MAR. The resident did not receive the medication as prescribed. Employee #8 notified the physician of the omission of the medication and a new order was written for Miralax 17 GM po (by mouth) daily for bowel regimen.	F 332		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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.	F 371		

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	095028	A. BUILDING _____ B. WING _____	03/20/2017

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F 371	Continued From page 64 (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations made on March 13, 2017 at approximately 9:30 AM, it was determined that the facility failed to prepare and store foods under sanitary condition as evidenced by one (1) of one soiled greased fryer and two (2) of three (3) soiled food warmers. The findings include: 1. One (1) of one (1) grease fryer was soiled with cooked food residue. 2. Two (2) of three (3) food warmers were soiled on the bottom and throughout. These observations were made in the presence of Employee #5 who acknowledged the findings.	F 371	**483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** 1. The soiled grease fryer and food warmers were cleansed by the utility team immediately. Representation from the survey team noted that they were cleaned immediately; however, unable to retrospectively correct initial findings. 2. A comprehensive inspection was conducted of all pots and pans and food warmers, no other pots, pans and food warmers were identified to be soiled. 3. The utility staff were re-educated regarding the master cleaning schedule, cleaning process and inspection following cleaning. 4. Food service manager conducts daily rounds and completes a food safety and sanitation audit monthly. This information is tracked and presented to the QAPI committee quarterly.	5/5/17
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 65 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	**483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** 1. The medication at #126's bedside was removed immediately. Resident #126 agreed that medication would be given by staff and sent all medications home with family. 2. A review of all resident's room was conducted. No other prescribed medications were in residents rooms. 3. The nursing staff were re-educated regarding medications in residents room as well as importance of ensuring that residents do not keep and/or take medication brought in from home. 4. During the purposeful rounding the nurse manager and supervisor will audit for medications. Staff development, unit manager and/or designee will conduct random medication pass observation. This will be presented to QAPI committee quarterly	5/5/17

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F 431	Continued From page 66 controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation staff and record interview for one (1) of 27 Stage 2 sampled residents, it was determined that facility staff failed to safely store medications as evidenced by one (1) pill that was observed in a medication cup on Resident #126's bedside table. The findings include: During a face-to-face interview with Resident #126 at approximately 11:00 AM on March 14, 2017 one (1) brown pill was observed in a medication cup on the resident's over bed table. The resident was queried why the pill was on the table. He/she responded, "The nurse gave it to me this morning along with some other medications. I took the other medications but kept that one because I had already taken one of my own." The resident was asked whether he/she had told the nurse that he/she did not take the pill and he/she responded, "No. I did not." The resident was asked the name of the pill and stated, "I cannot remember the name but I know that the doctor gives it to me for Gout." Permission was requested and granted from the	F 431		

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F 431	Continued From page 67 resident to remove the medication from the room. A face-to-face interview was conducted with Employee #28 (Charge Nurse) at approximately 12:00 PM on March 14, 2017. The employee was shown the cup with the pill and asked to identify it. He/she said it was "Colchicine." The employee was also asked whether he/she was aware that the resident had his/her own medications. He responded "No. I gave [him/her] several medications and I thought [he/she] took all of them." A review of the Physician's order sheet for the resident revealed that the following medications were ordered on March 11, 2017 when the resident was admitted to the facility: Aspirin 325mg (milligram) 1 (one) tab (tablet) PO (by mouth) daily for DVT (Deep Vein Prophylaxis); Bumex 1mg 1 tab PO daily for Edema; Colchicine 0.6mg 1 tab PO daily for Gout; Vitamin D 1000 Units PO daily for Supplement; Gabapentin 300mg 1 cap (capsule) PO Bid (twice daily) for Neuropathic Pain and Glipizide 2.5mg 1 tab PO Bid for DM (Diabetes Mellitus). All of the aforementioned medications were documented on the MAR (Medication Administration Record) as having been administered by the nurse at 9:00 AM on March 14, 2017. Further review of the resident's clinical record failed to reveal any of the following: A physician's order to allow the resident to administer his/her own medications.	F 431		

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F 431	Continued From page 68 An Interdisciplinary Team Assessment to determine if the resident was capable of administering his/her own medications. A face-to-face interview was conducted with Employee # 10 at approximately 12:10 PM. The employee was asked whether Resident #126 administers his/her own medication. The employee responded "No. No one on this unit self-medicates. I will speak with the resident and find out about the medications." At approximately 12:20 PM Employee #10 informed this surveyor that the resident acknowledged having personal medications in [his/her] possession, refused to show the medications to the employee and agreed to send them home with [his/her] spouse. Employee #10 acknowledged the finding.	F 431		
F 463 SS=F	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made during the initial tour of the facility on March 13, 2017 at approximately 9:00 AM it was determined that facility staff failed to maintain the call bell system in good working conditions as evidenced by: failure of the call bell system to consistently alert	F 463		

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F 463	Continued From page 69 facility staff when call bells were activated; facility staff failed to consistently respond to the audible alert when the resident was in need of assistance; and the display screen on the pagers (device used for alerting staff that the resident is in need of assistance) did not accurately display the correct date and time when the call for assistance was initiated. The findings include: On March 13, 2017 it was observed and noted by the State Agency that the call light system in resident's room and bathrooms did not correctly alert staff when the residents' call bell was activated. 1. Facility staff failed to ensure that Resident #26's call system functioned as intended in his/her resident room and bathroom. During a resident room observation on March 13, 2017 at approximately 12:30 PM in Room (UL 186). The call system was activated in the resident's room and bathroom. After five minutes (12:35PM) no one responded. At 12:40 PM, Employee #26 presented to the resident's room, stated that [his/her] pager did display resident's room number, but [he/she] was in the Assisted Living Building (adjacent to the skilled care unit) at the time. When queried about the time displayed on pager when activated, the time displayed was 10:04 AM. Also, Employee#27 stated that his/her	F 463	**483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH** 1. A new call system had been initiated approximately 2-3 weeks prior to survey. The staff was on high alert as well as notices were in place throughout the building advising residents and families of the change. During the survey several of the call systems required adjustments by maintenance and/or IT staff. This included the call station in room #26. The adjustments were made to ensure functionality of call system and that residents need were met. The maintenance staff ensured a pull cord was placed in. #122. The resident was not present when the survey team activated the call light. The IT team responded to room, #84, 85, 86, 87 and 88 and stayed too ensure functionality of call system. Resident #78 was checked and all needs were met. The call system for resident #78 was checked by IT and system adjusted to ensure functionality. 2. All residents call system were checked. Outside vendor contacted and adjustments made to system as necessary no resident was impacted by this practice. 3. Manual bells were placed in all resident rooms and residents were educated on their use. While call bell system was being repaired and /or adjustments made purposeful rounding was done every 30 minutes until all call systems were functioning. Staff were re-educated on pager/call system including how to reset immediately after responding to resident. Call bell escalation system put in place to ensure if call bell not responded to in 5 minutes the charge nurse and unit managers pagers are activated. Review of call system completed and additional visual dome system to be implemented. The staff will check residents during rounds for proper placement of call lights. 4. The nurse management team will audit call system daily, then weekly and finally monthly until updates to system are in place. A performance improvement plan (PIP) regarding call bell system implemented and will be reported to QAPI committee quarterly.	5/18 /17

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F 463	Continued From page 70 pager did activate and displayed Resident #26's room number, but he/she could not respond; because he/she was assisting resident's in the dining area. A face-to-face interview was conducted with Employee # 10 who acknowledged the findings at the time of the observation. Further stated; that if there is no response, the call goes out to the charge nurse and Director of Nursing to ensure the residents' needs are met. 2. Facility staff failed to ensure that Resident #122, was accommodated with the use of a bathroom pull cord to activate the call system. A resident observation was conducted on March 13, 2017 at approximately 4:00 PM. An attempt was made to activate the resident's bathroom call system in room #99, however the bathroom did not have a pull cord attached to activate the call system. Employee #20 was present at the time of the observation (date and time, location was the Employee in the resident's room). He/she was asked if the resident uses this bathroom. He/she responded "yes, the resident does use this bathroom, we assist him/her to the commode." There was no evidence that the facility accommodated the resident with a bathroom pull cord to activate the bathroom call system if	F 463		

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F 463	Continued From page 71 necessary. Facility staff failed to ensure that one (1) resident was accommodated with a pull cord in his/her bathroom to aide in the activation of the alarm if necessary. 3. Facility staff failed to ensure that the resident's call system functioned as intended in five (5) or five (5) resident rooms and bathrooms #84, #85, #86, #87, and #88. A resident room observation was conducted on March 14, 2017 at approximately 12:59 PM in room #84. The call system in resident room and bathroom. After ten minutes there was no response from facility staff. A face-to-face interview was conducted with Employee #2 who observed the malfunction of the call system. At this time Employee #2 checked rooms #85, #86, #87 and #88. He/she then acknowledged that none of the resident rooms or bathroom call systems functioned as intended. The facility staff failed to ensure proper functioning of the call system in five (5) of five (5) rooms and bathrooms observed. The observation was made on March 13, 2017.	F 463		

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F 463	Continued From page 72required adjustments by 4.Facility staff failed to provide a call bell system that staff consistently responded to in a timely manner. An observation of Resident # 78's room (#178) was conducted on March 13, 2017 at 3:15 PM. At this time the call bell was pushed/activated and there was no visual or audible alarm system in place that could be seen or heard by the State Agency Representatives to alert staff that a call for assistance was requested. At 3:27 PM, Employee #21 entered room #178 to answer the call bell (11 minutes later). At this time Employee #21 was asked how the call system works, and how long has the facility had the new call system. Employee # 21 replied, "The new call system has been here for about 2 to 3 weeks. It works when the resident hits the call bell, the beeper [pager] will beep for all CNA's to respond. If no answer after five minutes, the beepers for the RN's (registered nurses) on the floor will get beeped. After 25 minutes the beeper will beep the nurse manager for the unit. All of the CNA's must answer any page for any resident on the unit to ensure there is a quick response to the page. We all are responsible for all beeps". There was no evidence that facility staff (certified nurse aide or a licensed nurse) responded to the call bell between 3:15 PM to 3:27 PM on March 13, 2017. During a face-to-face interview with Employee #1 on March 13, 2017 at approximately 5:30 PM, it was revealed that the facility had installed a new call bell system that, when initiated, sends an audible alarm to pagers that have been assigned	F 463		

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F 463	Continued From page 73 to all CNA's, nurses and administrators. On numerous occasions, surveyors activated call bells in resident's rooms and staff either responded in an untimely manner or failed to respond at all because they were otherwise occupied, assumed that others would respond or did not get a notification from the pagers. List of Residents who activated the call bell system between March 10 through 12, 2017 and the facility staff response time to assist the resident was greater than five minutes: Residents' #26 and #122	F 463		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (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 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		

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F 514	Continued From page 74 (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 staff interview and record review for two (2) of 27 Stage 2 sampled residents, it was determined that facility staff failed to ensure medical records were complete and accurate in accordance with acceptable professional standards and practices as evidenced by failure to accurately code the Falls Risk Evaluation for two (2) residents. Residents' #70 and #108 The findings include: According to the facility's nursing policy "Fall Risk Assessment", reviewed January 4, 2017 stipulates: " ...The nursing staff...will seek to identify and document resident risk factors for falls...Policy Interpretation and Implementation: (1). The nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. The nursing staff will ask the resident and/or his/her family about any history of the resident falling..."	F 514		

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F 514	Continued From page 75 1. Facility staff failed to accurately complete Resident #70's "Fall Risk Evaluation" form. According to a physician "History and Physical" dated September 6, 2016 revealed, Resident #70's diagnoses included: "Debility, Fall Precautions and Safety Awareness..." An interim physician's order dated January 29, 2017 [no time indicated] directed; "Bed Alarm at all times for safety." According to a physical therapist "Fall Screen" form dated December 24, 2016 revealed the resident had intermittent confusion at time of fall, history of 1-2 falls in past 30 days, and gait/ balance was unsteady without support. The comprehensive care plan with goals and approaches; updated January 29, 2017 revealed the resident had falls on September 17, 2016, November 29, 2016 and December 24, 2016. According to the nursing "Fall Risk Evaluation" form the resident was assessed status post fall as the following: "November 29, 2016- Total Score- 15 (high risk for fall) "December 24, 2016 - Total Score- 5 (low risk for fall) "January 29, 2017 - Total Score- 14 (high risk for fall) ..."	F 514	**483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE** 1. Resident #70 and #108 are no longer in the facility. Unable to retrospectively correct assessment. 2. A review of all fall Risk Evaluation was conducted. New fall risk evaluation were done if indicated. 3. All licensed nursing staff were re-educated regarding completion of Fall Risk Evaluation and importance of ensuring that all components of form are completed. 4. A review of the fall risk evaluation is a part of the medical record audit and is completed monthly by the DON or designee. This information is presented to the QAPI committee quarterly.	5/517

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F 514	Continued From page 76 According to the facility's nursing policy "Fall Risk Assessment", reviewed January 4, 2017 stipulates: " ...The nursing staff...will seek to identify and document resident risk factors for falls..." A review of the "Falls risk Evaluation" form dated December 24, 2016 revealed no check marks in the allotted spaces to reflect resident's history of falls within the past 3 months, Gait Balance and mental status at the time of the fall. A face-to-face interview was conducted with Employees #2 and #10 on March 20, 2017 at approximately 2:00 PM. Both acknowledged that the forms were not accurately completed. The record was reviewed on March 20, 2017. 2. Facility staff failed to accurately complete Resident #108's "Fall Risk Evaluation" form. A review of the medical record revealed that Resident #108 sustained several falls. According to the facility's criteria for assessing the resident's risk a score of 10 or higher classified the resident as being at high risk for a fall. A review of the Falls "Risk Evaluation" forms for the resident revealed that the facility staff failed to code each category of the form thereby causing the total score to be inaccurate.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 77 February 6, 2017 the resident was given a score of 8 (eight) which was an indication that he/she was at a low risk for a fall. However, the resident was not scored under the heading of "Gait and Balance. The instruction in this area was to "Indicate appropriate point value for each item that applies." The resident has a shuffling gait which carries a score of one (1) point. The resident uses assistive devices (wheel chair). This carries another point. The resident also uses continuous Oxygen. Oxygen tubing carries another point. Accurate completion of the form would have given the resident a score of 11 instead of a score of 8. A score of 11 would have classified the resident at a high risk for falls. A review of the Falls Risk Evaluation for February 24, 2017 (completed after a fall) revealed a score of 11. Under the area of Gait and Balance The resident's shuffling gait was not checked (1) point. Under the area of Predisposing Diseases the following conditions are listed: Hypertension, Vertigo, Parkinson's Disease, Loss of Limbs, Seizures, Arthritis, Osteoporosis and Fractures. The form should have been checked for 1-2 present as the resident's diagnoses included Arthritis and Hypertension. This area required a score of (2) points but was scored as a 0 (zero). Under the area of Equipment Issues the resident's Oxygen tubing was not checked. It required a score of (1) point. The incorrect coding of this Falls Risk Evaluation form missed four (4) points. The facility scored the form as	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 78 (11) points but the score should have been 15. The Falls evaluation form for March 3, 2017 was scored with a total of 11 points. The shuffling gait and the Oxygen tubing were correctly coded the score on that evaluation form would have been 13. The total score for the Falls Risk Evaluation of March was 13 on March 9, 2017. With the inclusion of the points for Shuffling Gait and Oxygen tubing (2 points). That score should have been 15. Another Falls Risk Evaluation form was completed after the fall on March 15, 2017. The total score on this form was 13. The Oxygen tubing was also not included (scored) on this form With the inclusion for the point for the Oxygen tubing the resident's score should be 14 instead of 13. Facility Staff failed to accurately code Resident #108's Falls Risk Evaluation Forms. Employees	F 514		