STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255263	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN COMM LIVING CENTER	517 33RD STREET MERIDIAN, MS 39305

(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 The State Agency conducted an annual recertification survey, along with complaint(s), MS #15927 and MS #15977, from 6/11/19 to 6/13/19. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F641, F656, F657, F677, F679, F689, F812, F842, and F921 during the survey. The SA did not substantiate MS #15927 for Quality of care/treatment and quality of care/treatment/resident safety Falls, or MS# 15977 - Misappropriation of Funds and there were no citations related to the complaint. The census was 34 and the facility held a license for 60 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		7/13/19

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

Electronically Signed | 07/11/2019

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide privacy during toileting for (1) of 12 residents observed, Resident #3. Findings include: A review of facility's policy titled, "Dignity and Respect", not dated, revealed: The definition of dignity means that in their interactions with residents, staff carries out activities that assist the resident to maintain their self-esteem. It is the policy of this facility to treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his/her quality of	F 550	The plan of correction is being submitted as a requirement by the federal regulations. This submission of this plan of correction is not to be construed as an admission by the facility as to the accuracy of the citation nor the findings of facts. Please accept this as our plan of correction. F 550 Resident Rights/ Exercise of Rights 1. Resident #3 was interviewed by Regional Nurse Consultant on 06/13/19 to inquire on resident s psychosocial concerns related to not providing privacy during care and resident could not recall	

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F 550	Continued From page 2 life. The privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for safety. An observation on 06/11/19 at 9:58 AM, revealed Resident #3 was sitting on the toilet in her restroom, with the door open. Resident #3's restroom is located on the exterior of the resident's room, in view from the hallway. Resident #3's wheelchair, located outside of the open restroom door, was backed away from the door, giving full view of Resident #3 sitting on toilet. Licensed Practical Nurse (LPN) #4 was observed walking back to the medication cart, leaving the restroom door open; leaving Resident #3 sitting on the toilet, exposed to the hall. An interview on 6/11/19 at 9:58 AM, with LPN #4, revealed that Resident #3 needed assistance of one (1) person to be put on toilet and gotten off the toilet. She stated, "I just helped her on the toilet. I left the door open because I was moving her wheelchair out of the way after I put her on the toilet". LPN #4 walked back to the restroom and closed the door, then returned to the medication cart. She stated, "I should have closed the door". Resident #3 opened the door and yelled out, calling LPN #4's name and said, I'm finished". An interview on 06/11/19 at 10:12 AM, with Resident #3, revealed, "If I had known I was seen on the commode it would have been a issue. I had to pee so bad I wasn't paying attention that the door was left open. It does bother me I was seen sitting on the pot". An interview on 06/13/19 at 10:35 AM, with the	F 550	event at time of interview. A One on One in-service was conducted with Licensed Practical Nurse #4 regarding Dignity and Respect (Ensuring privacy while providing care to all residents including closing doors, closing curtains, and limiting exposure of resident s body to the area of care being provided) and completed on 06/13/19 by Regional Nurse Consultant. 2. The center recognizes that residents that require assistance with toileting could have the potential to be affected by the same deficient practice. A 100% room and care area audit were performed by the Director of Nursing and Clinical Operations Nurse completed on 06/11/19 to ensure no other residents were being provided care without privacy. No negative findings at time of audit. 3. Resident Rights in-service for care providers initiated by Director of Nursing on 07/01/19 and completed on 07/05/19. 4. The Director of Nursing will observe care for privacy of three (3) residents weekly for 3 weeks then one (1) resident weekly for two (2) weeks. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review and recommendations by the committee revisions, updates, or resolutions, updates or resolutions.	

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F 550	Continued From page 3 Regional Director of Operations, revealed, "If the staff member was there with Resident #3, and if she knew Resident #3 was sitting on the toilet and didn't shut the door, then yes, it is a dignity issue". An interview on 06/13/19 at 10:35 AM, with the Director of Nursing (DON) revealed, "The resident sitting on the toilet with the door open is a dignity issue."	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for (1) of 13 resident MDS assessments reviewed, Resident #9. An inaccurate MDS had the potential to misdirect resident care. Findings include: A review of facility's policy titled, "Resident Assessment", dated June 1, 2000, revealed: The purpose of the assessment is to describe the resident's capability to perform daily life function and to identify significant impairments in functional capacity. Functional status (ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems, including determining the resident's need for staff	F 641	F 641 Accuracy of Assessments 1. The Quarterly Minimum Data Set on 04/02/19 for Resident #9 Section G was corrected and resubmitted by the Minimum Data Set Coordinator as of 06/13/19. 2. The center recognizes that all residents could have the potential to be affected by the same deficient practice. The Minimum Data Set Coordinator, Licensed Practical Nurse #2, audited 100% of all current residents most recent Quarterly Minimum Data Sets Section G ensuring that all residents have been properly coded and correct as of 07/05/19 with no further miscoded Section G of the Quarterly Minimum Data Set noted.	7/13/19

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F 641	Continued From page 4 assistance, assistive devices or equipment to maintain or improve functional abilities. Review of Resident #9's MDS, dated 4/2/19, revealed Resident #9 experienced a decline in Activities of Daily Living (ADL's) in the areas of dressing, bed mobility, and personal hygiene. An interview on 06/13/19 at 12:40 PM, with Licensed Practical Nurse (LPN) #2 revealed, "Resident #9 did not have a decline in the areas of dressing, bed mobility, and personal hygiene. I just miscoded the Minimum Data Set (MDS) in the computer". LPN #2 stated, "I know she went to the hospital in March or April and she was eating up until then. On her return to the facility she had a feeding tube so the area of eating should have declined. All three (3) therapy disciplines screened the resident on 3/19/19, and did not pick her up for services". LPN #2 reviewed the resident's MDS and stated, "The MDS coded 4/2/19, is inaccurate. I just miscoded the MDS". An interview on 06/13/19 at 1:40 PM, with Registered Nurse (RN) #1 revealed, "Based on information I just found out about Resident #9 being a functional Quadriplegic, the MDS dated 4/2/19, is inaccurate for the resident".	F 641	3. The Regional Nurse Consultant, a Registered Nurse, performed a one on one in-service with Minimum Data Set Coordinator (Licensed Practical Nurse #2) on 06/13/19, on proper coding of Minimum Data Set per the Resident Assessment Instrument (RAI) Manual with emphasis on Section G. 4. The Director of Nursing, a Registered Nurse, will audit beginning on 07/02/19, all new weekly Minimum Data Sets, section G for two (2) weeks to ensure proper coding of Section G, then audit two (2) Minimum Data Sets per week for six (6) weeks to ensure proper coding of Section G. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		7/13/19

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F 656	Continued From page 5 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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 record review, staff interview, and facility policy review, the facility failed to follow the comprehensive care plan for personal hygiene for (1) of 13 residents reviewed, Resident #9.	F 656	F 656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 6 Findings include: A review of facility's policy titled, "Care Plan Goals and Objectives", dated June 1, 2000, revealed, It is the policy of this facility that care plans incorporate goals and objectives which lead to the residents highest obtainable level of independence as determined by the interdisciplinary team and in accordance with the resident's personal wishes and cultural preferences. Goals and objectives are defined as the desired outcome for a specific resident focus. Goals and objectives are consistent with the resident or resident representative wishes, as able. Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition, when a resident has readmitted to facility from the hospital stay, Quarterly, Annually, and upon completion of each required assessment. Review of the comprehensive care plan for Resident #9, with a revision date of 4/12/19, revealed a focus of "I have ADL self-care performance deficit related to Quadriplegia", with an intervention to provide personal hygiene/oral care. The care plan documented that Resident #9 is dependent for one (1) person assistance. An observation on 06/11/19 at 10:03 AM, revealed Resident #9's lips were dry and scaly, with skin peeling off the lips. The resident also had mouth odor. An observation on 06/12/19 at 4:35 PM, revealed Resident #9 had dry peeling lips and mouth odor. The Director of Nursing (DON), Registered Nurse (RN) RN #1, and the Corporate Director of	F 656	1. The Minimum Data Coordinator reviewed and updated Care plan for Resident # 9 on 06/12/19 to address the frequency and level of assistance that resident requires for performance of oral care. 2. The facility recognizes the potential for all residents requiring assistance with oral hygiene may be affected by the same deficient practice. Minimum Data Set Coordinator performed 100% audit of residents care plan and care tasks requiring assistance with oral care to ensure that level of care required and frequency of performance of tasks was initiated on 06/12/19 and completed by 07/12/19. 3. The nursing staff was in-serviced on oral care and following each individual resident's care plan task to provide level of assistance needed by each resident on 06/12/19 by the Regional Director of Operations. 4. The Medical Records Nurse will audit beginning on 07/12/19 four care plans and care plan tasks a week for four weeks of those requiring assistance with oral care to ensure care plans are correct and that care plan tasks are correct. Minimum Data Set Coordinator will audit, beginning 07/12/19, all residents needing assistance with oral care weekly for four weeks then every other week for four weeks to ensure care plans and care plan tasks are in place for those needs of those residents. Negative findings will be reported to the	

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F 656	Continued From page 7 Operations was present for this observation. An interview on 06/12/19 at 4:35 PM, with Licensed Practical Nurse (LPN) #2 revealed she had observed Resident #9's lips as "dry and peeling". An interview on 06/12/19 at 5:29 PM, with the Corporate Regional Director of Operations revealed, "I see her lips. I'll check everyone else right now". An interview on 06/12/19 at 5:30 PM, with the Corporate Nurse revealed, "I do see that she needs oral hygiene. Her lips are dry and she has peeling skin on her lips". An interview on 06/13/19 at approximately 10:45 AM, with LPN #2, revealed, "A care plan should be updated when conditions change for a resident. I feel if a care plan is created for a resident, it should be followed by staff". An interview on 06/13/19 at 10:35 AM, with the DON revealed, "Resident #9 having dry, peeling lips, is a hygiene issue. I did do an in-service with Certified Nurse Aids (CNAs) on doing oral care". An interview on 06/13/19 at 11:20 AM, with LPN #2 revealed, "I consider personal hygiene on the care plan to be combing hair, oral care, and face washing. By them not providing oral care they did not follow the care plan".	F 656	Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		7/13/19

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F 657	Continued From page 8 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to update the comprehensive care plan to include the use of a smoking apron for one (1) of six (6) residents observed for smoking, Resident #3. Findings include: A review of facility's policy titled "Care Plan Goals and Objectives" dated June 1, 2000, revealed, It is the policy of this facility that care plans	F 657	F 657 Care plan Timing and Revision 1. Minimum Data Set Coordinator reviewed and revised smoking care plan to indicate the need for a smoking apron on 06/13/19 for Resident #3. 2. The facility recognizes the potential that all residents who smoke may be affected by the same deficient practice.	

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F 657	Continued From page 9 incorporate goals and objectives which lead to the residents highest obtainable level of independence as determined by the interdisciplinary team and in accordance with the resident's personal wishes and cultural preferences. Goals and objectives are defined as the desired outcome for a specific resident focus. Goals and objectives are consistent with the resident or resident representative wishes, as able. Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition. Review of Resident #3's "Smoking" care plan, revised 9/26/18, with a target date of 6/18/19, revealed the care plan did not include the need for the resident to have a smoking apron, per evaluation and/or assessment. Review of smoking evaluations, dated 10/15/16 and 5/7/19, revealed Resident #3 needed adaptive equipment of supervision and a smoking apron. An observation on 06/11/19 at 10:24 AM, revealed Resident #3 was outside smoking, without the use of a smoking apron. Review of Minimum Date Set (MDS) Section C dated 9/14/19, revealed Resident #3 has a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. An interview on 06/13/19 at 10:35 AM, with the Administrator, revealed it was an issue that the care plan was not updated for Resident #3 to wear a smoking apron, when the Smoking Assessment documented that it was needed.	F 657	The Minimum Data Set Coordinator, Licensed Practical Nurse #2, conducted a 100% audit of care plans for all residents who choose to smoke to ensure that care plan reflects level of assistance and safety precautions required for residents who smoke and found all care plans to have been correct. This audit was completed by 06/18/19. 3. The Minimum Data Set Coordinator received one- on- one education regarding updating care plans per policy to reflect a resident s individual care requirements. The one- on- one education was conducted by Regional Nurse Consultant and completed on 06/13/19. 4. The Medical Records Nurse will audit two (2) care plans of residents that choose to smoke weekly for four (4) weeks, then one (1) care plan weekly for four (4) weeks to ensure that care plans reflect a resident s individual care requirements at the time of each audit. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	

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F 657	Continued From page 10 An interview on 06/13/19 at 10:35 AM, with the Director of Nursing (DON) revealed, "I took her out the day y'all came in the facility and she refused the apron. I didn't document that she refused, nor was the care plan updated, that she refuses the apron. The facility didn't follow policy by not updating the care plan". An interview on 06/13/19 at approximately 10:45 AM, with LPN #2 revealed, "A care plan should be updated when conditions change for a resident. I feel if a care plan is created for a resident it should be followed" by staff. We didn't follow policy when Resident #3's care plan was not updated to show the need for a smoking apron".	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based observation, record review, staff interview, and facility policy review, the facility failed to provide oral care to one (1) of 12 residents observed for mouth care, Resident #9. Findings include: A review of facility's policy titled, "Oral Hygiene", dated August 24, 2015, revealed The purpose of the policy is to clean the mouth, teeth, and dentures, prevent infection and irritation, and to moisten the mucous membranes. During an observation on 06/11/19 at 10:03 AM,	F 677	F 677 ADL Care Provided for Dependent Residents 1. Oral Care was performed for Resident # 9 on 06/12/19 by the Director of Nursing. Director of Nursing assessed oral cavity for any issues and was noted that Resident #9 had signs and symptoms of Oral Candidiasis. Medical Doctor was contacted via phone by Licensed Practical Nurse on 06/12/19 and received order on 06/13/19 for Nystatin swab to oral cavity two (2) times a day until resolved.	7/13/19

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F 677	Continued From page 11 Resident #9 received Glucerna per feeding tube. Resident #9 lips were observed as dry and scaly, with skin peeling off the lips. Mouth odor was present. An observation on 06/12/19 at 4:35 PM, revealed Resident #9 continued to have dry lips with peeling skin and mouth odor. During an interview on 06/12/19 at 4:35 PM, LPN #2 confirmed that Resident #9's lips were dry and peeling. An interview with the Corporate Regional Director of Operations on 06/12/19 at 5:29 PM, revealed "I see her lips. I'll check everyone else right now". An interview on 06/12/19 at 5:30 PM, with the Corporate Registered Nurse (RN), revealed, "I do see that she needs oral hygiene. Her lips are dry and she has peeling skin on her lips". During an interview on 06/13/19 at 10:35 AM, the Director of Nursing (DON) stated, "Resident #9 having dry peeling lips is a hygiene issue".	F 677	2. The facility recognizes that all residents requiring assistance with oral care could have the potential to be affected by the same deficient practice. The Corporate Regional Registered Nurse conducted a 100% audit on 06/13/19 of residents requiring assistance with oral care with no negative findings. 3. An in-service for nursing staff regarding providing oral care was initiated on 06/13/19 by the Director of Nursing and was completed on 07/05/19. 4. The Director of Nursing will observe oral care beginning on 07/03/19 with five residents requiring assistance with oral care weekly for two weeks then two residents weekly for four weeks to ensure oral care is being completed according to residents plan of care. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		7/13/19

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F 679	Continued From page 12 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to provide activities to meet the interest, and physical, mental and psychosocial well-being of the residents for three (3) of three (3) days observations for activities. This was also voiced during the Resident Council meeting, which included Resident #22, Resident #7, Resident #8, and Resident #13; and also through interviews/observations with Resident #16, Resident #21, Resident #22, Resident #28, and Resident #30. This was eight (8) of 34 residents in the facility. Findings include: Review of the facility's activity policy, dated April 26, 2010, titled "Activity Program", revealed the activity program is designed to encourage maximum individual participation and geared to the individual resident's needs. Activities are scheduled seven (7) days a week and residents are given an opportunity to contribute to the planning preparation, conducting cleanup, and critique of the programs. Activity programs consist of individual, small and large group activities that are designed to meet the needs and interests of each resident. Activities are not necessarily limited to formal activities being provided only by the activities staff. Other facility staff, volunteers, visitors, residents and family members may also provide the activities. Activities participation for each resident is approved by the attending physician, based on	F 679	F 679 Activities Meet Interest/Needs Each Resident 1. The Group activities of Smoothie Social for Resident #22, Resident # 7, Resident #8, Resident #13, Resident #21, Resident #16, Resident #28, and Resident #30 were restarted as of 06/13/19 by the Life Connections Coordinator. 2. The facility recognizes that all residents could have the potential to be affected by the same deficient practice. The Life Connections Coordinator initiated interviews on 06/13/19 of all residents that can be interviewed regarding interests, likes, dislikes, and enjoyed activities and completed updating activity events to reflect interests of residents as of 07/08/19. 3. The Life Connections Coordinator received a one-on-one in-service by Nursing Home Administrator on 06/13/19 on providing group activities on a routine basis and how to develop group activities to meet the interest of the residents. The Nursing Home Administrator in-serviced Life Connections Coordinator and facility staff about the importance of group activities that meet the interest of the residents of the facility on 06/13/19. 4. Beginning on 07/08/19, the Nursing Home Administrator will observe group	

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F 679	Continued From page 13 information in the resident's comprehensive assessment. Schedules are posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulleting board (e.g.. bed bound or visually impaired residents). Review of the facility's "Life connections program", revealed the life connections program is based on the comprehensive assessment (life story), care plan, and the preferences of each resident to support their choice of activities both facility-sponsored group and individual activities, as well as independent activities. It is designed to meet the interests of and support physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Resident Council Meeting During a meeting with the Resident Council committee on 6/11/19 at 4:06 PM, residents complained of not having enough activities to keep them busy. The Resident Council President, (Resident #22) said that they haven't had very many activities since the previous Activity person got promoted to Social Services. The Council Members (Resident #13, Resident #7 and Resident #8) said they have Bingo every other Tuesday. The Council Members said they sit around and look at each other everyday. Review of the Resident Council members' most recent Brief Interview for Mental Status (BIMS) scores revealed Resident #13 (BIMS=15), Resident #8 (BIMS=15), Resident #7 (BIMS=15), which indicated they had no cognitive impairment. Resident #16	F 679	activities two times a week for four weeks then weekly for four weeks to ensure that group activities are being conducted and meet the interests of the residents. The Life Connections Coordinator will interview residents at Monthly Resident Council meetings regarding the activity program and implement suggestions as appropriate for group activities for three months. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	

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F 679	Continued From page 14 Observation and interview on 06/12/19 at 2:12 PM, revealed Resident #16 was sitting in his room watching television. Resident #16 was alert and oriented, speech clear, and he was able to make his needs known. Resident #16 stated that he stayed in his room and watched television, because they don't have anything to do for activities. Resident #16 said he smoked cigarettes and would like to do more than smoke cigarettes everyday. Resident #16 was asked if he told anyone about his concerns, and he stated that he had not. He stated that he thought the facility provided the Activity Program and the residents only do what's offered to them. Resident #16 said nobody asked him about what activities he liked. Review of the comprehensive care plan revealed Resident #16 enjoyed Dominoes, playing Spades, fishing and hunting. Resident #16 required some assistance with activities for physical and social needs, related to a left above the knee amputation and Dementia. Resident #21 Observation and interview, on 06/12/19 at 2:14 PM, revealed Resident #21 was sitting in a wheel chair in the hallway. Resident #21 stated that the facility does not have enough activities. Resident #21 said he likes to paint and he likes cars. Resident #21 revealed he has been depressed because his wife had filed for divorce and his health had declined. Review of the current care plan revealed Resident #21 enjoyed religious activities, cars and animals (dogs).	F 679		

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F 679	Continued From page 15 Resident #22 Observation and interview on 06/11/19 at 9:56 AM, revealed Resident #22 was sitting in the hallway with her eyes closed. Resident #22 was alert and oriented, speech was clear, and she was able to make her needs known. Resident #22 revealed she is the Resident Council President. Resident #22 said she wished they had something to do. Resident #22 said they did have a lot of activities when the prior person was the Activity Director, who is now the Social Worker. Resident #22 said she enjoyed arts and crafts. Review of the current care plan revealed Resident #22 enjoyed church, playing bingo, reading her Bible, and doing arts and crafts. Resident #28 Observation and interview on 06/12/19 at 5:27 PM, revealed Resident #28 was sitting in a wheel chair in his room watching television. Resident #28's speech was clear and he was able to make his needs known. Resident #28 revealed he wanted to go home because he's bored and there wasn't much to do in the facility. Resident #28 said nobody had asked him what type of activities he wanted to do. Resident #28 said the only outings or activities that he participated in was going to Dialysis Tuesday, Thursday, and Saturday. Review of the current activity care plan revealed Resident #28 liked to watch westerns, loved to hunt, fish, and enjoyed religious activities. Resident #30 Observation and interview on 06/12/19 at 5:31	F 679		

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F 679	Continued From page 16	F 679		

PM, revealed Resident #30 was sitting in a wheel chair in his room watching television. Resident #30 was alert and oriented, speech clear, and he was able to make his needs known. Resident #30 revealed he sat in his bedroom watching television, because there was nothing else to do.

Review of the current care plan revealed the facility will continue to encourage Resident #30 to attend activities of his choice, resident enjoys church, cooking, western movies, cards, country music, news, social parties, cook outs, holidays, bird watching, casino, park/zoo, and shopping.

During an interview on 06/13/19 at 9:09 AM, the Activity Director (AD) revealed that she was told by the old Administrator that the resident's played too much Bingo. The AD said the residents do "roll and stroll" daily; they Roll and Stroll to breakfast, lunch, and dinner by the staff. The AD stated that it helped the residents to communicate with the staff.

During an interview on 06/13/19 at 9:42 AM, the Social Worker (SW) revealed she was promoted to Social Services from activities. The SW said she would Google and make up games for the residents. The SW confirmed the residents used to have bingo games several times a week. The SW also revealed the residents enjoyed card games, dominoes, trivia, arts and crafts.

During an interview on 06/13/19 at 9:48 AM, the Director of Nursing (DON) confirmed the facility had very little activities. The DON confirmed the residents had been sitting in the hallway and rooms without anything to do. The DON also said she had just started in that position and she has ideas to incorporate with the resident's activities.

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F 679	Continued From page 17 During an interview on 06/13/19 at 9:52 AM, the Corporate Regional Director of Operations confirmed the residents did not have any group activities during the three (3) days of survey. The Corporate Regional Director of Operations said the facility is bringing another AD from another facility to train the AD, so the residents will enjoy living in this facility.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based observation, staff interview, record review, and facility policy review, the facility failed to provide a smoking apron, to help prevent smoking accidents, for one (1) of six (6) residents observed, who was assessed for smoking risks, Resident #3. Findings include: Review of a facility's policy titled, "Smoking", dated 12/02/16, revealed: It is the policy of this facility to provide a safe environment for residents who smoke. Additional precautions may apply to some residents due to safety awareness concerns or medical conditions. Such additional precautions will be noted on the residents' plan of	F 689	F 689 Free of Accident Hazards/Supervision/Devices 1. On 06/13/19, Resident #3 was assessed by Director of Nursing for any injuries associated to resident smoking without apron with no negative findings. The smoking assessment and care plan was re-evaluated on 06/13/19 by Minimum Data Set Coordinator and confirmed the need of a smoking apron to ensure the safety of the resident. The care plan task was updated to indicate that resident #3 is to utilize a smoking apron for smoking activities on 06/13/19. Resident #3 was educated on 06/13/19	7/13/19

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F 689	Continued From page 18 care. Residents with known history of smoking, those that express a desire to smoke on admission, or those who wish to start smoking will be evaluated on admission, quarterly, and as needed for safety awareness and any physical limitations related to smoking safety. The interdisciplinary team will make the determination of interventions needed for the resident during smoking. These interventions will be entered into the resident's care plan. Instructions regarding individual residents safety needs are available to the staff member who supervises the smoking, Providing and maintaining this information is the responsibility of the Director of Nursing (DON) or designated nursing personnel. An observation on 06/11/19 at 10:24 AM, revealed Resident #3 was outside smoking with no smoking apron on. Staff were observed outside with the resident. An observation on 06/12/19 at 10:30 AM, revealed Resident #3 was outside smoking and did not have a smoking apron on. Review of the Minimum Date Set (MDS) assessment, Section C, dated 9/14/19, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Review of a Smoking evaluation, dated 10/15/16, as well as an evaluation dated 5/7/19, revealed Resident #3 needed supervision and a smoking apron for safety during smoking. An interview on 06/13/19 at 10:35 AM, with the Administrator, revealed, "It is an issue that Resident #3 wasn't wearing the smoking apron, if	F 689	about the importance of use of smoking apron and possible negative outcomes for refusal of use of smoking apron during smoking activities. 2. The facility recognizes that all residents that choose to smoke have the potential to be affected by the same deficient practice. The Director of Nursing and the Minimum Data Set Coordinator completed 100% audit of smoking assessment, smoking care plan, and care plan task to ensure that the care plan and the care plan task reflect the safety precautions indicated by the smoking assessment. This audit was initiated on 06/13/19 and was completed on 06/18/19. 3. The Director of Nursing initiated an in-service on 07/01/19 for all nursing staff regarding the use of smoking aprons and the safety precautions for residents that choose to smoke and completed in-service on 07/04/19. 4. Beginning on 07/03/19, the Director of Nursing will observe smoking activities daily for 4 weeks then three smoking activity a week for 4 weeks to ensure that safety precautions indicated for each individual resident that chooses to smoke are observed. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review and recommendations by the committee for revisions, updates, or resolutions.	

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F 689	Continued From page 19 the assessment states that as an intervention". An interview on 06/13/19 at 10:35 AM, with the Director of Nursing (DON) revealed she took Resident #3 outside the first day of survey and the resident refused the apron. The DON confirmed the resident didn't have the smoking apron on.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately calibrate the food thermometer, to ensure safety of serving food, for (1) of (2) days of food temperature observations. This had the potential to affect 32 of 34 residents who receive	F 812	F 812 Food Procurement Store/Prepare/Serve-Sanitary 1. On 6/12/19 the food was warmed to adequate serving temperatures prior to serving the lunch meal to 32 residents.	7/13/19

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F 812	Continued From page 20 meal trays. Findings include: A review of facility's policy titled, "How to Calibrate a Thermometer", not dated, revealed: Thermometers should be calibrated regularly to make sure the readings are correct. The ice-point method is the most widely used method to calibrate a thermometer. The Policy revealed Step 1 in calibrating the thermometer is to fill a large container with crushed ice and add clean tap water until the container is full. Stir the mixture. Put the thermometer stem or probe into the ice water. Make sure the sensing area is under the water. Wait 30 seconds or until the reading stays steady. Adjust the thermometer so it reads 32 degrees Fahrenheit or zero (0) degrees Celsius. Hold the calibration nut securely with a wrench or other tool and rotate the head of the thermometer until it reads 32 degrees Fahrenheit; zero (0) degrees Celsius. A review of instructions pulled from the back package of the new dial read bimetallic thermometer titled, "How to calibrate your thermometer", revealed: Prepare a cup of ice with a small amount of water. Insert the stem into the water, do not touch the ice. Temp should read 32 degrees Fahrenheit (0 degrees Celsius). If it needs adjustment, turn the nut behind the face until the proper reading is shown. During an observation on 06/12/19 at 11:30 AM, Dietary Staff #2 had four (4) thermometers in ice water to calibrate the thermometers for checking the temperature (temp) of food. The thermometer that Dietary Staff #2 pulled out of the ice water to	F 812	Dietary manager verified the serving temperatures of food with a digital thermometer. 2. The Facility recognizes that all residents receiving meals could have the potential to be affected by this deficit practice. On 06/12/19, all mechanical thermometers were removed and replaced with digital-read thermometers and all food was verified to be at the correct serving temperature by the Dietary Manager prior to distribution of the evening meal. 3. The Dietary Manager in-serviced dietary staff on the proper procedure to calibrate thermometers to accurately measure food serving temperatures on 06/12/19. The Regional Dietary Manager conducted an in-service on 07/03/19 regarding the proper procedure for Thermometer calibration on a digital thermometer and a mechanical thermometer. The Regional dietary manager conducted an in-service on 07/08/19 regarding the recording food temperatures and log check off. 4. Beginning on 07/02/19, the Dietary Manager will perform supervised thermometer calibrations performed by dietary staff five times a week for four weeks then three (3)times a week for four (4) weeks to ensure that dietary staff perform thermometer calibration by proper procedure. Negative findings will be reported to the Quality Assurance and	

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F 812	Continued From page 21 use didn't show that it was calibrated to 32 degrees. Dietary Manager #1 told Dietary Staff #2, who was beginning to prepare to temp the foods, to turn the thermometer dial on the end of thermometer to calibrate the thermometer to 32 degrees, after the cold water was not dropping the temperature on the dial to 32 degrees. Dietary Staff #2 stated out loud, "That's the way we calibrate the thermometer sometimes". Dietary Staff #2 turned the dial on two (2) dial read (bimetallic) thermometers to 32 degrees holding the thermometer in his hand. The Dietary Manager asked Dietary Staff #2 to calibrate the thermometers using ice water, instead of turning the dial. Dietary Staff #2 placed the thermometers back into the ice water and the thermometers showed calibration to 32 degrees, after turning the dial with his hand. Dietary Staff #2 then took the temperature of the foods. The temperatures were as follows: Chicken and dumplings, 144 degrees Green peas, 160 degrees Cheese Quiche,-100 degrees with a reheat x one (1) - temperature of 136 degrees Capri Vegetable blend-150 degrees After each check of the temperature of pureed chicken and dumplings, the pureed green peas were checked, with the same dial read thermometer used to check the pureed chicken and dumplings. The chicken and dumplings were checked, and then the pureed peas was checked, cleaning the dial read thermometer after each use. The first container of pureed chicken and dumplings temp was checked with the dial-read thermometer and had an initial temperature of 106 degrees. The pureed chicken and dumplings	F 812	Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	

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	255263	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 22	F 812		

were reheated in an oven, set on 400 degrees, for approximately 30 minutes. The pureed chicken and dumplings temp was re-checked, with the thermometer, with a temp of 118 degrees. The first container of chicken and dumplings were discarded. (Pureed green peas were tempt with the same thermometer at 102 degrees, with a re-heat temp of 102. The peas were discarded). Dietary Staff #2 pulled another dial- read thermometer from the ice water, which showed a temp of 42 degrees. Dietary Staff #2 then tuned the dial on the dial-read thermometer with his hand until the dial showed 32 degrees. Dietary Staff #2 retrieved another container of pureed chicken and dumplings. Dietary Staff #2 checked the temperature of the pureed chicken and dumplings with the dial-read thermometer and a temperature of 102 degrees was shown on the thermometer. Dietary Manager #1 verified all temperatures of food to this point. The pureed chicken and dumplings were reheated one (1) time in the oven, at a temperature of 500 degrees, for approximately 45 minutes, with a temperature of 128 degrees on the dial-read thermometer upon re-check. The second container of pureed chicken and dumplings were thrown away. (Pureed green peas tempt with the same thermometer at 90 degrees, with a re-heat temp of 106 degrees. The second container of pureed green peas were thrown away). Dietary Staff #2 obtained a third container of pureed chicken and dumplings and pulled the third dial-read thermometer from the ice water and it showed a reading of 48 degrees, after being in the ice water for approximately 45 minutes. Dietary Staff #2 turned the dial of the thermometer, with his hand, to show a calibration of 32 degrees. The third container of pureed chicken and dumplings temperature showed 120

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F 812	Continued From page 23 degrees on the dial-read thermometer. The pureed chicken and dumplings were re-heated in the oven for approximately 45 minutes. Dietary Staff #2 used a digital thermometer to temp the pureed chicken and dumplings after the re-heat of one (1) time. The digital thermometer showed the pureed chicken and dumplings to have a temperature of 208 degrees. (Third container of pureed green peas, with the dial-read thermometer, read 122 degrees. They were re-heated and using the digital thermometer, the temperature was 180 degrees). Dietary Manager #1 viewed all attempts of obtaining food temperatures, attempts at calibration of dial-read thermometers, re-heating of food in oven, the amount of time the food was re-heated in oven, and Dietary Manager #1 verified all temperatures of pureed chicken and dumplings and pureed green peas. An interview on 06/12/19 at 2:39 PM, with Dietary Manager (DM) #1, revealed she definitely thought that calibrating the thermometers wrong could affect the appropriate food temps. DM #1 stated that Dietary Staff #1 did turn the dial on the thermometer without using a wrench to hold the nut on the dial. DM #1 stated that she threw all the thermometers away and had obtained new thermometers. She stated, "I will in-service all staff on calibrating the thermometer the correct way. It could definitely affect the temps of food the residents are receiving". During an interview on 06/12/19 at 4:05 PM, the Dietary Manager revealed that Dietary Staff #2 turned the whole face of the thermometer and did not use a wrench like the directions said to do. The Dietary Manager stated, "I bet that is what messed the thermometer calibration up".	F 812		

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F 812	Continued From page 24 An interview on 06/13/19 at 11:20 AM, with Dietary Manager #1, revealed that Dietary Staff #1 didn't go by the directions to calibrate the thermometers yesterday. She stated that she saw the instructions on calibrating the thermometer and it said to use a wrench to hold the nut on the thermometer when turning the dial on the thermometer. Dietary Manager #1 stated that a couple of the thermometers they were using didn't even bring the temp down to 32 degrees in the ice water. Dietary Manager #1 stated that the thermometers not reading the temperatures accurately could have caused all of the food temperatures to be inaccurate; the food could have been hotter than it was showing and could have caused a accident. An interview on 06/13/19 at 11:25 PM, with Dietary Staff #1 revealed, "I turned the dial and didn't use a tool to hold the screw. We did have trouble getting the thermometers to 32 degrees". An interview on 06/13/19 at 10:40 AM, with the Corporate RN revealed that the food could have been extremely hot and could have caused burns with the thermometers not reading accurately.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		7/13/19

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F 842	Continued From page 25 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842		

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F 842	Continued From page 26 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately document an appropriate related diagnosis for the use of a medication for one (1) of 13 records reviewed, (Resident #17). Findings include: Review of the facility's policy titled, "Healthcare Information Management," dated 7/27/2007, provided by Licensed Practical Nurse (LPN) #3/Medical Records Director, revealed that this facility policy does not address the accurate documentation of appropriate related diagnoses for the use of medications given to residents. Review of the medical records for Resident #17, revealed a Medication Administration Record (MAR), dated 06/01/2019 - 06/30/2019, which indicated that an order for the medication Dilantin	F 842	F 842 Resident Records-Identifiable Information 1. The medical record for Resident #17 was reviewed on 06/13/19 by the Medical Records Nurse and the medical diagnosis for use of Dilantin updated with the correct diagnosis as ordered by the Medical Director. 2. The facility recognizes that all residents receiving anti-seizure medication have the potential to be affected by this deficient practice. The Medical Records Nurse conducted a 100% audit on 06/13/19 of residents receiving anti-seizure medication and noted all residents receiving anti-seizure medication had the correct diagnosis.	

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F 842	Continued From page 27 to be given three (3) times per day, with related diagnoses of Other Abnormalities of Gait and Mobility and Other Symbolic Dysfunctions. Review of Resident #17's medical records, revealed an undated Accumulative Medical Diagnosis Report, where it was indicated that a diagnosis for Other Seizures was present upon Initial Admission on 1/18/2017. During an interview, on 6/13/2019 at 10:34 AM, Licensed Practical Nurse (LPN) #3/Medical Records Director revealed that the related diagnoses of Other Abnormalities of Gait and Mobility and Other Symbolic Dysfunctions were not appropriate diagnoses for the use of the medication Dilantin. LPN #3 stated she didn't know who put the order in the record, but the diagnoses were not correct for the use of Dilantin. During an interview, on 6/13/2019 at 1:39 PM, the facility's Registered Pharmacist (RPh) Consultant stated that he reviewed the resident's medical records monthly and this included medications and their related diagnoses. The RPh stated that his primary focus has been on the antipsychotic medications prescribed for Resident #17. The RPh stated, "I guess I may have over-looked Dilantin and those diagnoses for Resident #17." He confirmed the diagnosis was not correct for the use of Dilantin. During an interview, on 6/13/2019 at 2:11 PM, Resident #17's Medical Doctor (MD) stated that the order of Dilantin was for Resident #17's seizure disorder diagnosis. The MD stated, "The current diagnosis that is showing on the chart, of Abnormalities of Gait and other symbolic dysfunction, is not accurate."	F 842	3. The Medical Records nurse initiated an in-service on 06/27/19 for nurses regarding order entry and ensuring proper diagnosis for medications as indicated by Physician will be utilized. This in-service was completed on 07/08/19. The Medical Records Nurse will complete 100% medical diagnosis audits on all new admissions/readmissions within 72 hours of admission to ensure that medications have the appropriate diagnosis as indicated by the physician. 4. Beginning on 07/03/19, the Director of Nursing will audit medical diagnosis in relationship to medication use on five random residents weekly for four weeks then two random residents weekly for six (6) weeks to ensure that medications have correct diagnosis for use as indicated by the physician. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	

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F 842	Continued From page 28 During an interview, on 6/13/2019 at 2:42 PM, Registered Nurse (RN) #1/ Corporate RN stated that she doesn't know about any policy on how to enter diagnoses correctly, but she would see. RN #1 stated, "The listed diagnosis for the Dilantin, ordered for Resident # 17, was probably there, because someone keyed it in wrong." RN #1 also stated, "I'll have them fix it." Review of the Face Sheet revealed Resident #17 was admitted by the facility on 1/18/2017, and re-admitted on 2/9/2019, with diagnoses which include Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation and Other Seizures.	F 842		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide a sanitary room environment, free of strong urine odor, for four (4) out of six (6) observations conducted for Resident #29. Findings include: During the initial tour of the facility on 6/11/2019 at 9:05 AM, observation revealed a strong odor of urine was present in the hall outside of Resident #29's room. Upon entering Resident #29's room, the odor became stronger. Resident #29 was the	F 921	F 921 Safe/Functional/Sanitary/Comfortable Environment 1. Environmental Services performed deep cleaning of the room and restroom of Resident #29 on 06/11/19, 06/12/19, and 06/13/19. Resident #29 was provided with an additional urinal on 06/13/19 by the Regional Nurse Consultant. 2. The facility recognizes that all residents that require assistance with	7/13/19

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F 921	Continued From page 29 only occupant of the room; he did not have a roommate. During an observation, on 6/11/2019 at 12:15 PM, Resident #29 was sitting on the side of his bed in his room. The strong odor of urine was still present in Resident #29's room. During an observation, on 6/12/2019 at 10:34 AM, of the area outside Resident #29's room, the strong odor of urine was still present. Resident #29 was lying in bed and his eyes were closed. During an observation, on 6/13/2019 at 1:40 PM, the odor of urine was still strong in Resident #29's room and the surrounding area. It was observed that Resident #29 was sitting on the side of his bed. During an observation and interview, on 6/11/2019 at 12:17 PM, Resident #29 was sitting on the side of his bed and he stated that he was doing okay. When asked if someone had been in to check on him and see if he needed to go to the bathroom, Resident #29 stated, "I don't have to go to the bathroom right now." During an interview, on 6/11/2019 at 4:17 PM, the Director Nursing (DON) confirmed that there was a strong odor in the area outside of Resident #29's room. The DON stated, "I know, I noticed it too." During an interview, on 6/11/2019 at 4:22 PM, the facility's Corporate Regional Director of Operations (CRDOC) confirmed that she had also noticed the odor. The CRDOC stated, "I'll have it taken care of today."	F 921	toileting have the potential to be affected by this deficient practice. The Director of Nursing and Regional Nurse Consultant conducted 100% room and restroom audits of residents that require assistance with toileting on 06/11/19, 06/12/19, and 6/13/19 with no negative findings. 3. The Environmental Services Manager initiated an in-service for environmental staff regarding odors and increased cleaning schedule for high risk of odor areas within the facility. This in-service was completed on 06/13/19. The cleaning schedule was modified for Resident #29 s restroom and room to include an additional cleaning daily to prevent odors by the Environmental Services Manager. 4. Beginning on 06/13/19, the Environmental Services Manager will conduct environmental rounds five (5) times a week for four (4) weeks then three (3) times a week for four (4) weeks to ensure that no offensive odor is present within the facility. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for Review and recommendations by the committee for revisions, updates, or resolutions.	

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F 921	Continued From page 30 During an observation and interview, on 6/13/2019 at 1:45 PM, Resident #29 was sitting on the side of his bed. Resident #29 stated that he was doing fine. Resident #29 also stated, "I don't need anything." During an interview, on 6/13/2019 at 5:09 PM, the facility's Activity Director (AD) revealed that sometimes Resident #29 will urinate in his trash can, on the floor of his room, or on the walls of his room. The AD stated, "We try to keep a check on his room, because it smells of urine all the time." During an interview, on 6/13/2019 at 5:35 PM, Registered Nurse (RN) #1/Corporate RN, revealed that she had not been able to locate a facility policy regarding odors. Review of the Face Sheet revealed Resident #29 was admitted by the facility on 10/5/2016, and re-admitted on 1/29/2019, with diagnoses to include Cerebrovascular Disease and Aneurysm of Renal Artery. Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/2019, revealed Resident #29 had a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS also revealed that Resident #29 was coded to be frequently incontinent.	F 921		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 07/13/2019

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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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 6/13//19 reveals the above facility does not meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		

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