STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/24/16 and completed on 10/27/16, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 18 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		12/12/16

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

Electronically Signed | 11/18/2016

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physican for 1 of 2 sampled residents (Resident #10) who experienced episodes of syncope. Failure to notify the physician of the resident's syncope episode does not allow the physican to be fully informed of the resident's status and provide input and/or changes to Resident #10's treatment plan. Findings include: Review of the facility policy titled "Change in Resident's Condition or Status" occurred on 10/27/16. This undated policy stated, ". . . 1. The charge nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . . . d. A significant change in the resident's physical/emotional/mental condition; . . . 2. A 'significan change' of condition is a decline or improvement in the resident's status . . . 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of change occurring in the resident's medical/mental condition or status. . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia, heart disease, heart failure, atrial fibrillation, and a history of falls. The current care plan stated ". . . Problem . . . is receiving	F 157	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal Law. 1. Corrective action for Residents Found to be affected by this Deficiency: The attending physician and legal representative for Resident #10 were notified of the syncope incident on 8/15/16. The physician did not issue any new orders or change the resident□s current medication and treatment orders. The resident□s care plan was revised to reflect that nursing staff will closely supervise the resident when toileting or rising from a sitting position to minimize possible injury from dizziness and fainting from a possible future syncope incident. The charge nurse will promptly report any future change in medical condition to the resident□s attending physician and legal representative.	

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F 157	Continued From page 2 diuretics on a regular basis . . . Interventions . . . Look for signs of dehydration and electrolyte imbalance (dry tongue/lips, dizziness upon standing, muscle cramping, abnormal laboratory results.) . . . Keep physician informed." Review of the nursing notes, dated 08/15/16 at 8:30 a.m., stated, "Found resident unconscious in the toilet for 2-3 minutes. Had syncope episodes. [symbol for no] pallor noted. Resident still breathing. . . . PR [pulse rate] 52, RR [respiratory rate] 28, BP [blood pressure] 96/45 . . . Transferred to wheelchair when conscious, stated, 'I feel dizzy.' Transferred resident to bed with feet elevated and had a nap. . . ." The record lacked evidence staff notified the physician of Resident #10's syncope/unconscious episode. During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to notify the physician of Resident #10's syncope and unconscious episode.	F 157	2. Corrective Action for All Other Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. An audit of the medical charts for all other residents identified with significant changes was performed on 11/21/16 and no other issues regarding significant change were identified. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: Nursing staff was in-serviced on 11/28/16 at monthly Nurses Meeting, on the facility policy titled "Change in Resident□s Condition or Status" and the requirement to notify the resident□s physician and legal representative promptly of any changes in medical condition. The Director of Nursing or designee will conduct weekly audits for one month, then monthly x3 months for one quarter then quarterly x 3 quarter for one year post survey; of resident medical charts that may contain any significant change of the residents to verify that notifications were promptly made by the charge nurse where a resident experienced a significant change in physical, emotional and mental condition. 4. Measures to be Implemented to Monitor the Plan of Correction	

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F 157	Continued From page 3	F 157	The Director of Nursing or designee will report the results of the audits to the Quality Assurance Meeting quarterly x 3 for one year post survey. 5. The Expected Date for compliance for this deficiency. The expected time frame for compliance with this deficiency will be on 12/12/2016.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the facility checklist, review of facility investiation and violation report, and staff interview, the facility failed to ensure residents were free from neglect for 1 of 5 sampled residents (Resident #1) who required the use of a stand lift. Failure to follow manufacturers instructions and the residents care plan contributed to Resident #1 sustaining an injury. Findings include: Review of the facility policy titled "Recognizing Signs & Symptoms of Abuse/Neglect" occurred	F 224	1. Corrective action for Residents Found To Be Affected by this Deficiency: Resident #1 was transferred to the hospital and an X-ray of the injury sustained from the fall from the Sit to Stand Lift revealed no fracture. The resident□s Attending Physician issued orders for pain medication for the bruising. Nursing staff was in-serviced on 10/31/16. Nursing staff will utilize 2 persons at all times when assisting resident #1 to stand using the Sit to Stand	12/12/16

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F 224	Continued From page 4 on 10/27/16. This policy, dated September 2007, stated, ". . . 2. 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm . . ." Review of the facility training checklist titled "EZ Way Smart Stand Stand-up Lift Training Checklist" and "Vera II & MedCare Stand-up Lift Training Checklist" occurred on 10/27/16. These checklists stated ". . . 4. Follow . . . care plan . . . Use 2 assist . . ." Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/05/16, identified extensive assistance of two people with transfers. The current care plan stated, ". . . requires assist with adls [activity of daily living] r/t [related to] impaired balance, cognitive impairment, and osteoarthritis . . . Interventions . . . requires mechanical lift and two assist for all transfers. . . ." Review of the nursing progress notes stated the following: * 11/14/15 at 12:45 p.m.: "While CNAs [certified nurse assistants] were toileting resident with stand up lift she let go of handles, raised her arms and because her sweater - silky like material, the strap slid up, the 2 CNAs were able to lower resident to floor without incident. [name of physician] notified. No c/o [complaints of] pain or discomfort, . . ." *11/17/15 at 10:15 a.m.: "Bruises noticed to left and right upper arms. Bruise to right arm measures 14 1/2 x 8 cm [centimeters] with numerous bruises (smaller) surrounding the area. Swelling also present on right arm. Left arm	F 224	Lift per the manufacturer□s specifications, facility policy and the resident□s plan of care. 2. Corrective Action for All Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. The Physical Therapy Assistant conducted an audit on 11/23/16. All residents who require the use of a Sit to Stand Lift were audited to identify any incidents where staff failed to use 2 people when using the Sit to Stand Lift to transfer them. None were identified. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Licensed Physical Therapy Assistant will screen all the residents for safety of using one staff member with a Sit to Stand Lift for transfer of the residents that are deemed unsafe with one staff and will be care planned for two staff with the sit to stand lifts. This is incompliance with the facilities revised sit to stand lift policy. The Unit Manager or designee will conduct audits weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey to ensure compliance with this deficiency. 4. Measures to be implemented to Monitor the Plan of Correction The Director of Nursing or designee will	

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F 224	Continued From page 5 bruise measures 4x2 cm in size. Bruises are dark purple. [name of physician] notified bruises suspected from fall that occurred on 11/14/15. . . ." * 11/17/15 at 11:33 p.m.: "Assessment of resident's right arm d/t [due to] c/o pain. Measurements done of bruising. Resident c/o pain with clothing change and even c/o pain just with measuring of discoloration. Called DON [director of nursing] to discuss pain level and options . . . Administrator called . . . Administrator requests resident be sent down for xrays . . . Resident sent to ER at 2100 [9:00 p.m.]" * 11/17/15 at 11:33 p.m.: "Returned to facility per ambulance . . . To use tylenol [pain medication] 560 mg [milligrams] . . . Resident returned from ER with wrap to upper arm. . . ." Review of the investigation report stated the following: * Summary of interview with person(s) reporting the incident: ". . . During transfer with sit to stand lift in bathroom resident slid out of lift and 2 CNAs lowered her to the floor without any incident. Slid from lift because clothes were silky-like and loose." * Summary of interview with witness(es): "Did not witness and did not help lower to floor. Not witnessed. 2nd CNA in other side of bathroom states, 'I heard [CNA #17] yell and I made sure my current resident was secure in her chair and went over. Resident was on floor in front of toilet on right side. Her shirt and undershirt were off. Assisted with getting resident off floor with [CNA #17].' Mentions [CNA #17] was on her phone off and on while toileting residents. . . ." * Did the findings indicate that abuse occurred?: "[Yes box checked] factual findings do not	F 224	report the results of the audits to the Quality Assurance Meeting quarterly x 3 quarters for one year post survey. 5. Expected Date of Compliance for this Deficiency The Expected Date for compliance with this deficiency will be 12/12/2016.	

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F 224	Continued From page 6 substantiate the previous statements made to charge nurse by person involved with direct care. Findings indicate it is highly unlikely the resident was lowered to the floor by 2 CNAs. Discolorations and pain level indicates resident fell to floor from lift." Review of the Violation Report stated, ". . . [CNA #17] did not follow policy when using lift device. . . . Resident fell out of sit to stand lift. Aide did not use 2 people for use with sit to stand lift as is policy. . . ." During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) stated the CNA (#17) failed to follow the facility policy which required two people with all sit to stand lift transfers.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the	F 225		12/12/16

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F 225	Continued From page 7 facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure alleged violations of neglect were reported to the State Agency (SA) in a timely manner for 2 of 2 allegations reviewed (Resident #1 and #28). Failure to notify the State within twenty-four hours of a resident who fell from a sit to stand mechanical lift (EZ stand) during transfer (Resident #1), and failure to submit a final investigation report within five days of occurrence of the incident (Resident #1 and #28) to the SA placed all residents at risk for neglect. Findings include:	F 225	1. Corrective action for Residents Found To Be Affected by this Deficiency: Resident #1 An abuse/neglect report was filed with the Department of Health concerning certified nursing assistant #17. Nursing assistant #17 was written up and disciplined for failing to operate a Sit to Stand Lift with another person. All nursing assistants assisting resident #1 were instructed on 11/28/16 by the QA/ED Nurse to use 2 people at all times and that the failure to do so constitutes abuse/neglect.	

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F 225	Continued From page 8 Review of the facility policy titled "Definition & Reporting Abuse to Management" occurred on 10/27/16. This policy, dated September 2011, stated, ". . . 13. A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator within twenty-four (24) hours of the occurrence of an incident of suspected abuse. . . . In all cases, an immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within five (5) working days of the occurrence of such incident. . . . " Review of the facility policy titled "Accidents and Incidents Investigating & Reporting" occurred on 10/27/16. This policy, dated September 2011, stated, " . . . 2. . . b. if the event that cause reasonable suspicion does not result in serious bodily injury to a resident, law enforcement is involved or not, the event needs to be reported within 24 hour [sic] after forming the suspicion to the ND [North Dakota] Dept [department] of Health. c. Final report by the Administrator or Designee will be completed and submitted to the ND Dept of Health within 5 days of the incident being reported. . . ." - Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/05/16, identified extensive assistance of two people with transfers. The current care plan stated, ". . . requires assist with adls [activity of daily living] r/t [related to] impaired balance, cognitive impairment, and osteoarthritis . . . Interventions . . . requires mechanical lift and two assist for all transfers. . . ."	F 225	Resident #28 The 5 day final report for the abuse allegation concerning resident #28 was filed one day late. The administrator and pertinent facility staff will be in-serviced on 11/28/16 on the requirement that all future 5 day final reports must be filed timely with the Department of Health. 2. Corrective Action for all Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. Sit to Stand Lift All residents who require assistance with a Sit to Stand Lift were screened on 11/01/16 by the Licensed Therapy Assistant to identify any incidents where staff failed to use 2 persons when operating the lift. None were reported. 5 Day Final Report An audit will be performed by the Administrator starting on 11/21/2016 to identify any 5 day final reports that were not timely filed with the Department of Health and none were identified. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: Sit to Stand Lift	

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F 225	Continued From page 9 Review of the nursing progress notes showed the following: * 11/14/15 at 12:45 p.m.: "While CNAs [certified nurse assistants] were toileting resident with stand up lift she let go of handles, raised her arms and because her sweater - silky like material, the strap slid up, the 2 CNAs were able to lower resident to floor without incident. [name of physician] notified. No c/o [complaints of] pain or discomfort, . . ." *11/17/15 at 10:15 a.m.: "Bruises noticed to left and right upper arms. Bruise to right arm measures 14 1/2 x 8 cm [centimeters] with numerous bruises (smaller) surrounding the area. Swelling also present on right arm. Left arm bruise measures 4x2 cm in size. Bruises are dark purple. [name of physician] notified bruises suspected from fall that occurred on 11/14/15. . . ." * 11/17/15 at 11:33 p.m.: "Assessment of resident's right arm d/t [due to] c/o pain. Measurements done of bruising. Resident c/o pain with clothing change and even c/o pain just with measuring of discoloration. Called DON [director of nursing] to discuss pain level and options . . . Administrator called . . . Administrator requests resident be sent down for xrays . . . Resident sent to ER [emergency room] at 2100 [9:00 p.m.]" * 11/17/15 at 11:33 p.m.: "Returned to facility per ambulance . . . To use tylenol [pain medication] 560 mg [milligrams] . . . Resident returned from ER with wrap to upper arm. . . ." Review of the investigation report showed the following: * Summary of interview with person(s) reporting	F 225	The Director of Nursing or designee will conduct audits for any residents requiring a Sit to Stand Lift weekly beginning on 11/21/16 to identify any incidents where only one person operated the lift. All nursing staff will be in-serviced on 11/28/16 regarding the requirement that 2 people must operate the Sit to Stand Lift at all times and that failure to do so constitutes abuse/neglect and must be reported immediately to supervisors. 5 Day Final Report The Administrator, the Director of Nursing and other pertinent staff were in-serviced by the consulting Social Worker that was conducted on 12/08/16 on the requirement to file the final investigation report within 5 working days. The Administrator will perform weekly audits of the due dates and actual filing dates of required investigation reports to the Department Of Health beginning on 11/21/2016. 4. Measures to be Implemented to Monitor the Plan of Correction Sit to Stand Lift The Director of Nursing or designee will report the results of the weekly audits on all residents regarding the use of Sit to Stand Lifts to the quarterly Quality Assurance Committee x 3.	

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F 225	Continued From page 10 the incident: ". . . During transfer with sit to stand lift in bathroom resident slid out of lift and 2 CNAs lowered her to the floor without any incident. Slid from lift because clothes were silky-like and loose." * Summary of interview with witness(es): "Did not witness and did not help lower to floor. Not witnessed. 2nd CNA in other side of bathroom states, 'I heard [CNA #17] yell and I made sure my current resident was secure in her chair and went over. Resident was on floor in front of toilet on right side. Her shirt and undershirt were off. Assisted with getting resident off floor with [CNA #17].' Mentions [CNA #17] was on her phone off and on while toileting residents. . . ." * Did the findings indicate that abuse occurred?: "[Yes box checked] factual findings do not substantiate the previous statements made to charge nurse by person involved with direct care. Findings indicate it is highly unlikely the resident was lowered to the floor by 2 CNAs. Discolorations and pain level indicates resident fell to floor from lift." The Violation Report stated, ". . . [CNA #17] did not follow policy when using lift device. . . . Resident fell out of sit to stand lift. Aide did not use 2 people for use with sit to stand lift as is policy. . . ." The facility investigation report showed the facility reported this incident, which occurred on 11/14/15 at 12:45 p.m., to the SA on 11/17/15 at 8:45 p.m., eighty hours after the initial incident. The facility sent the final investigation report to the SA on 11/23/15 at 5:00 p.m., six days after the incident occurred.	F 225	5 Day Final Report The Administrator or designee will report the findings of the weekly audit of the timely filing of investigation results to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency The expected date of compliance for this deficiency will be December 12, 2016.	

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(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 225	Continued From page 11 - Review of Resident #28's allegation of neglect investigation report occurred on Oct 26-27, 2016. This allegation report stated a CNA (#18) neglected to help Resident #28 when she reported she had pain in her thigh and pelvic region on 11/17/15 at 1:30 a.m. The facility sent the final investigation report to the SA on 11/23/15 at 11:13 a.m., six days after the incident. During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) confirmed the facility should have reported the allegations of neglect for Resident #1 and #28 to the SA within twenty-four hours, and the final investigation report submitted to the SA within five days.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity/self-esteem on 4 of 4 days of survey (October 24-27, 2016). Failure to remove cloth incontinence protectors from residents' chairs in the lounge/dining room (East and West areas) and store incontinence briefs in the residents' room in a dignified manner (Residents #2, #3, #5, and #12) does not promote resident's dignity or enhance their	F 241	1. Corrective action for Residents Found To Be Affected by this Deficiency: Recliners in East and West Lounges The cloth protectors on the recliners in the East and West Lounges were removed and the recliners were cleaned and sanitized on 11/12/16. Cloth incontinence protectors will be immediately removed from all recliners in	12/12/16

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	355042	A. BUILDING _____ B. WING _____	10/27/2016

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F 241	Continued From page 12 quality of life. Findings include: Observation showed the following: * During the initial tour of the facility on 10/24/16 at 10:33 a.m., observation showed cloth incontinence protectors on recliners in the East and West lounge areas. * 10/25/16: Twenty-two cloth incontinence protectors observed on recliners in the East lounge area. Observation showed a random family member sitting on a recliner with a cloth incontinence protector. * 10/26/16: Twenty-two cloth incontinence protectors observed on the recliners in the East lounge area and five cloth incontinence protectors observed on the recliner in the West lounge area. Observation showed several unidentified visitors sitting in recliners with a cloth incontinence protector. * 10/27/16: Twenty-two cloth incontinence protectors observed on the recliners in the East lounge area and three cloth incontinence protectors observed on the recliner in the West lounge area. Observation showed the cloth incontinence protectors remained on the recliners throughout the survey. These chairs are available for use and publicly viewed for all residents and visitors. - Observations from the hallway outside Resident #2, #3, and #12's rooms on 10/26/16 at 1:30 p.m. and 10/27/16 at 10:20 a.m. showed briefs stored on the upper shelf of the open closet area. The closet lacked a door or other covering to prevent	F 241	the resident rooms or common areas. Residents #2, #3, #5, and #12 The briefs that were stored on the top shelf of the closet in the resident rooms assigned to Residents #2, #3 and #5 were removed and placed in the resident drawers and out of public view. Privacy curtains will be installed in resident closets to hide the items stored in the closet from public view on 12/12/2016. The briefs and incontinence pads that were stored on the top shelf of the resident□s closet were removed and placed in a dresser drawer out of view of the public and visitors. A curtain will be installed in the closet to screen the contents of the closet from public view on 12/12/16. 2. Corrective Action for All Residents that May be Affected by this Deficiency: All resident have the potential to be affected by this deficiency. All resident rooms and common areas were inspected on 11/07/16 to identify any incontinence pads and briefs stored in open view or previously used incontinence pads being left on recliners and chairs after a resident is no longer using the pad. No other violations were found. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur:	

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F 241	Continued From page 13 observation of the briefs. - Observation in Resident #5's room on the morning of 10/24/16 showed a package of incontinence briefs and a stack of incontinence pads on an open shelf in the closet. The closet lacked a door or other covering to prevent observation of the contents. Observation showed the briefs and incontinence pads remained on the open shelf throughout the survey. During an interview, on 10/26/16 at 3:30 p.m. an administrative nurse (#1) agreed staff should store the incontinence products out of sight.	F 241	All nursing staff will be in-serviced on 11/28/16 on the need to ensure incontinence pads and briefs are not stored in public view, and to make sure cloth incontinence pads are not placed on a recliner or chair in resident rooms and common areas. The Director of Nursing or designee will conduct a weekly audit beginning on 11/21/16 of resident rooms and common areas to identify briefs and incontinence pads stored in public view, and used incontinence pads remaining on recliners and chairs after use by a resident. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will report the results of the weekly audit of the storage and use of briefs and incontinence pads to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency The expected compliance for this deficiency is December 12, 2016.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		12/12/16

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F 253	Continued From page 14 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on review of the facility's housekeeping schedule, family interview, and staff interview, the facility failed to provide housekeeping services at a frequency required to maintain a sanitary and orderly interior as expressed during 1 of 2 family interviews (Family Member #1). Failure to provide housekeeping services to maintain a sanitary and orderly interior may result in odors within the facility and does not provide a comfortable living environment for the residents. Findings include: A confidential interview with a resident's family member (#1) occurred during the survey. The family member (#1) expressed concerns with the facility's housekeeping services. He/She stated the full-time cleaning staff have every other week-end off and, on that week-end off, no-one takes their place and the facility does no cleaning. The family member (#1) stated they can especially see it in their relative's bathroom. Review of the housekeeping schedule occurred on 10/25/16 at 9:25 a.m. with an environmental services manager (#2). The schedule showed that, every other weekend, the only environmental staff member on duty is the person doing laundry. The staff member (#2) stated this person "does double duty" on that week-end and all he/she has time to do is clean the floors and empty the garbage. The staff member stated,	F 253	1. Corrective Action for Residents Found To Be Affected by this Deficiency: Resident bedroom and bathroom were deep cleaned on 10/29/16 and will be cleaned every day. The housekeeping staffing schedule has been revised to have two staff members to provide necessary housekeeping services every weekend and to keep the resident□s room clean and odor free. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. All resident rooms were inspected for cleanliness on November 1, 2016 and no other deficiencies were found. All resident rooms will be deep cleaned on a quarterly basis and when there is a discharge from the facility. The Environmental Services Director will keep an audit of the rooms that have been cleaned and those that need to be cleaned in his/her office. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur:	

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F 253	Continued From page 15 "We can't get it all done." During an interview, on 10/26/16 at 10:45 a.m. the environmental staff member (#2) confirmed, on the full-time housekeeper's week-end off, the laundry staff member does not clean or mop the floors in residents' rooms. He stated there "is no time" to clean the rooms.	F 253	The Environmental Services Manager and housekeeping and laundry staff were in-serviced on the requirement to provide adequate housekeeping and laundry services every day of the week. The staffing schedule was revised to schedule sufficient resources on the weekend to provide adequate housekeeping and laundry services. The Environmental Services Manager or designee will perform weekly audits of the cleanliness of the facility and will document any service issues or resident concerns. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Environmental Services Manager will report the findings of the weekly audit to the quarterly Quality assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency The expected compliance date for this deficiency is Decembers 12, 2016.	
F 273 SS=E	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which	F 273		12/12/16

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F 273	Continued From page 16 there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the Centers for Medicare and Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to complete admission assessments within 14 days of admission for 1 of 12 sampled residents (Resident #7) and 5 supplemental residents (Resident #16, #24, #25, #30, and #31). Failure to complete the admission Minimum Data Sets (MDSs) in a timely manner delays obtaining the assessment information necessary to develop a care plan and to provide the appropriate care and services for these residents. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, revised October 2015, page 2-8 stated, "Admission refers to the date a person enters the facility and is admitted as a resident. . . . Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. . . ." Page 2-18 - 2-19 stated, "Admission Assessment . . . The Admission assessment is a comprehensive assessment for a new resident . . . that must be completed by the	F 273	1. Corrective action for Residents Found To Be Affected by this Deficiency: The initial 14 day MDS assessment for Residents #7, #16, #24, #25, #30, and #31 was filed with the CMS but were completed late. The MDS Coordinator entered subsequent quarterly review dates and annual assessment due dates for these residents into the MDS tracking calendar to achieve timely completion of future due dates. 2. Corrective Action for Residents that May be Affected by this Deficiency: All new admissions have the potential to be affected by this deficiency. An audit of the initial 14 day MDS completion dates for current residents did not reveal any other late assessments. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director and Therapy Assistant will be in-serviced on	

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F 273	Continued From page 17 end of day 14, counting date of admission to the nursing home as day 1 . . . The MDS completion date (Item Z0500B) must be no later than day 14. . . ." - Resident #7's medical record, reviewed on October 24-27, 2016, identified the facility admitted the resident on 09/28/16 and completed the admission assessment on 10/26/16 - 29 days after admission. - Resident #25's medical record, reviewed on October 26-27, 2016, identified the facility admitted the resident on 08/24/15 and completed the admission MDS on 09/10/15 - 18 days after admission. Review of CMS Submission Reports identified the following: * The facility admitted Resident #16 on 07/11/16 and completed the admission assessment on 08/31/16 - 56 days after admission. * The facility admitted Resident #24 on 08/01/16 and completed the admission assessment on 08/15/16 - 15 days after admission. * The facility admitted Resident #31 on 09/21/16 and completed the admission assessment on 10/07/16 - 17 days after admission. *The facility admitted Resident #30 on 09/30/16 and completed the admission MDS on 10/18/16 - 19 days after admission. During an interview on the afternoon of 1024/16, an administrative nurse (#4) confirmed facility	F 273	12/05/16 on completing the initial 14 day MDS assessments timely. IDT team members will meet weekly to review the MDS flow sheet detailing the 14 day MDS assessments coming due that week and to focus on getting those assessments completed timely. The Director of Nursing or designee will conduct weekly audits of the timely completion of the initial MDS assessments. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will report the results of the weekly audits to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency: The expected compliance for this deficiency is December 12, 2016.	

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F 273	Continued From page 18 staff had not yet completed Resident #7's admission MDS. During an interview on 10/26/16 at 12:15 p.m. an administrative nurse (#4) confirmed staff did not complete Resident #16's assessment within 14 days of admission. During an interview on the afternoon of 10/24/16, the MDS Coordinator (#4) confirmed facility staff had not yet completed Resident #7's admission MDS.	F 273		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure staff completed annual Minimum Data Set (MDS) assessments not less than once every twelve months for 2 of 12 sampled residents (Resident #9 and #12). Failure to complete assessments as scheduled may result in the residents' care plans not reflecting their current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, page 2-19 stated, ". . . The Annual Assessment is a	F 275	1. Corrective action for Residents Found To Be Affected by this Deficiency: The annual comprehensive assessment for Residents #9 and #12 were filed with the CMS but were completed late. The MDS Coordinator entered subsequent annual assessment dates for these residents into the MDS tracking calendar to achieve timely completion of future due dates. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents are potentially affected by	12/12/16

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F 275	Continued From page 19 comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA [significant change in status assessment] . . . has been completed since the most recent comprehensive assessment was completed. . . ." - Resident #9's medical record, reviewed on October 26-27, 2016, identified the most recent comprehensive MDS as an admission assessment dated 04/16/15. The record lacked evidence staff completed the annual assessment due on 04/17/16. - Review of Resident #12's medical record reviewed on October 26-27, 2016, identified an annual assessment completed on 01/05/15, and the most recent comprehensive assessment completed on 01/13/16 - 373 days after the previous annual assessment. During an interview on 10/26/16 at 1:17 p.m. an administrative nurse (#4) confirmed staff failed to complete the annual assessment for Resident #9 due on 04/17/16 and completed Resident #12's assessment late.	F 275	this deficiency. An audit of the annual comprehensive assessment due dates for all residents was completed on 10/31/16 and it did not reveal any other late annual assessments. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director and Therapy Director will be in-serviced on 12/05/16 on completing the annual comprehensive assessment timely. IDT team members will meet weekly to review the MDS flow sheet detailing the annual MDS assessments coming due that week and to focus on getting those assessments completed timely. The Director of Nursing or designee will conduct weekly audits of the timely completion of all scheduled annual assessments. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will report the results of the weekly audits to the quarterly Quality Assurance Committee x 3.	

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F 275	Continued From page 20	F 275	5. Expected Date of Compliance for this Deficiency: The expected compliance for this deficiency is December 12, 2016.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the Centers for Medicare and Medicaid Services (CMS) Submission Reports, and staff interview the facility failed to ensure staff completed quarterly Minimum Data Set (MDS) assessments at least once every three months for 1 of 12 sampled residents (Resident #4) and 2 of 18 supplemental residents (Resident #26 and #27). Failure to complete assessments as scheduled may result in the residents' care plans not reflecting their current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, page 2-30 stated, "The Quarterly Assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days	F 276	1. Corrective action for Residents Found To Be Affected by this Deficiency: The quarterly review of the comprehensive assessment for Residents #4, #26 and #27 were filed with the CMS but were completed late. The MDS Coordinator entered subsequent quarterly review dates for these residents into the MDS tracking calendar to achieve timely completion of future due dates. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents are potentially affected by this deficiency. An audit of the quarterly MDS review dates for all residents was completed on 10/31/16 and it did not reveal any other late annual assessments.	12/12/16

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F 276	Continued From page 21 following the previous OBRA assessment of any type. . . ." - Review of Resident #4's medical record occurred on all days of survey. The record showed staff completed an annual assessment on 07/01/16 and a quarterly assessment on 10/02/16 - 93 days later. Review of the (CMS) Submission Reports identified: * Staff completed a quarterly assessment for Resident #26 on 05/19/16 and the next quarterly assessment on 08/20/16 - 95 days later. * Staff completed a quarterly assessment for Resident #27 on 06/21/16 and the next quarterly assessment on 09/24/16 - 95 days later. During an interview on 10/26/16 an administrative nurse (#4) stated he confirmed staff completed some assessments beyond the 92 day schedule.	F 276	3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director and Therapy Director will be in-serviced on 12/05/16 on completing the quarterly MDS assessments timely. IDT team members will meet weekly to review the MDS flow sheet detailing the quarterly MDS assessments coming due that week and to focus on getting those assessments completed timely. The Director of Nursing or designee will conduct weekly audits of the timely completion of all scheduled quarterly MDS assessments. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will report the results of the weekly audits to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency: The expected compliance for this deficiency is December 12, 2016.	
F 278	483.20(g) - (j) ASSESSMENT	F 278		12/12/16

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F 278 SS=F	Continued From page 22 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEYS CONDUCTED ON 10/29/15 AND 09/24//14 ACCURACY OF ASSESSMENTS	F 278	1. Corrective action for Residents Found To Be Affected by this Deficiency: A. Accuracy of MDS Assessments	

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	355042	A. BUILDING _____ B. WING _____	10/27/2016

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F 278	Continued From page 23 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the Centers for Medicare Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 6 of 12 sampled residents (Resident #1, #2, #3, #6, #11, and #12) and 1 supplemental resident (Resident #18). Failure to accurately complete portions of the MDS does not allow each resident's assessment to reflect their current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: WEIGHT LOSS The Long-Term Care Facility RAI User's Manual, revised October 2015, pages K-5 stated. "K0300: Weight Loss . . . Physician Prescribed Weight-Loss Regimen: A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. . . . It is important that weight loss is intentional. . . ." Review of Resident #6's medical record occurred on all days of survey. An admission MDS, dated 04/02/16 identified a weight of 120 pounds (#) with no weight loss. A quarterly MDS, dated 09/20/16 indicated the resident weighed 108 # and on a physician prescribed weight loss regimen. The resident's medical record lacked evidence the physician had prescribed a weight loss regimen.	F 278	Resident #1 The resident□s MDS was revised on 12/05/16 to correct the inaccurate coding in the prior quarterly MDS assessment that indicated the resident exhibited disruptive behaviors that were not documented in the medical record. Resident #2 The resident□s MDS was revised on 12/05/16 to correct the inaccurate coding in the most recent quarterly MDS assessment that indicated the resident experienced delusions during the 7 day look back period which was not documented in the medical record. Resident #3 The resident□s MDS was revised on 12/05/16 to correct the miscoding of J1900B and J1900C on the quarterly MDS assessment dated 7/18/16 that failed to document that the resident□s fall did result in injury as evidenced by the medical record. Resident #6 The resident□s MDS was revised on 12/05/16 to correct the inaccurate coding in the prior quarterly MDS assessment that indicated the resident exhibited disruptive behaviors that were not documented in the medical record. The recent weight loss was prescribed by the attending physician and it was not. Resident #11□ The resident□s MDS was revised on 12/05/16 to correct Section K that was inaccurately coded to reflect that the resident□s recent weight loss was	

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F 278	Continued From page 24 An interview occurred on 10/25/16 at 2:00 p.m. with a dietary manager (#11) and an administrative nurse (#4). The staff members confirmed staff should not have coded Section K of the 09/20/16 MDS as a physician prescribed weight loss. END OF THERAPY ASSESSMENT The Long-Term Care Facility RAI User's Manual, revised October 2015, page 2-13 stated, "Medicare-required PPS [prospective payment system] Assessments provide information about the clinical condition of beneficiaries receiving Part A SNF [Skilled Nursing Facility] - level of care in order to be reimbursed . . . These assessments are Coded on the MDS 3.0 in Items A0310B . . . and A0310C . . . They include: . . . Start of Therapy (SOT) Other Medicare Required (OMRA) . . . End of Therapy (EOT) OMRA . . ." Review of CMS Submission reports occurred on all days of survey and identified the facility submitted an EOT assessment, dated 08/24/16, for Resident #18. However, the reports indicated Resident #18 did not receive SNF services prior to the 08/24/16 EOT assessment. During an interview on 10/26/16 at 12:15 p.m. an administrative nurse (#4) confirmed Resident #18 did not receive SNF services prior to the 08/24/16 EOT assessment. The staff member (#4) stated when therapy staff inform him they have discharged a resident from therapy, he submits an EOT assessment, but does not check to see if the resident received SNF services prior to submitting the assessment.	F 278	prescribed by the attending physician and it was not. Resident #12□ The resident□s MDS was revised on 12/05/16 to correct the inaccurate coding of the annual assessment as a new admission assessment which it was not. Resident #18 The resident□s MDS was revised on 12/05/16 to correct the inaccurate coding in the CMS submission reports that reflected that an EOT was submitted indicating that the resident had ended skilled nursing facility services although the resident had not received SNF services. B. Miss-Coding of MDS Section Z Resident #4 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 3/30/16 quarterly MDS assessment and 7/01/16 annual MDS assessment. Resident #6 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 9/20/16 quarterly MDS assessment. Resident #10 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 10/16/15 annual MDS assessment.	

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F 278	Continued From page 25 BEHAVIORS The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 pages E-2, E-4, E-8, E-11, E-13, and E-17, stated, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the Resident holds true even in the face of evidence to the contrary. . . . E0200: Behavioral Symptom - Presence and Frequency . . . C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . . E0500: Impact on Resident . . . Coding Instructions for E0500C. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Participation in Activities or Social Interactions? . . . Code 1, yes: if any of the identified behavioral symptom(s) interfered with the resident's participation in activities or social interactions. E0600: Impact on Others . . . Coding Instructions for E0600C. Did Any of the Identified Symptom(s) Significantly Disrupt Care or the Living Environment? . . . Code 1, yes: if any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized	F 278	Resident #11 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 8/3/16 significant change comprehensive assessment. Resident #12 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 1/13/16 annual MDS assessment. Resident #13 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 5/13/16 quarterly MDS assessment. Resident #25 The resident□s MDS was revised on 12/05/16 to correct the error in the dates entered for A2300 and Z0500B on the 8/24/16 annual MDS assessment. C. Failure to Accurately Complete Discharge Assessments Residents #16, #20 and #28 were discharged DRA with return anticipated but they did not return to the facility and a second assessment was completed that was coded Discharge Return Not Anticipated which was done in error since the second assessment was not necessary. 2. Corrective Action for Residents that May be Affected by this Deficiency: A. Accuracy of MDS Assessments	

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F 278	Continued From page 26 activities by other residents. . . . E0800: Rejection of Care-Presence & Frequency . . . Did the resident reject evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. . . ." - Review of Resident #1's medical record occurred on all days of survey. The quarterly MDS, dated 07/05/16, identified other behavior symptoms occurred during the seven-day look-back period. The medical record lacked evidence of Resident #1's other behavioral symptoms. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 06/04/16, identified delusions which occurred during the seven-day look-back period. The medical record lacked evidence of Resident #2's delusions. - Review of Resident #11's medical record occurred on October 26-27, 2016. An annual MDS, dated 08/18/16, a significant change MDS, dated 08/03/16, and an admission MDS, dated 07/31/16, identified severe cognitive impairment, displayed other behavioral symptoms directed toward others that interfered with the resident's participation in activities or social interactions and significantly disrupted the care or living environment for one to three days of the 7-day assessment period. The medical record lacked	F 278	All residents are potentially affected by this deficiency. An audit of the accurate coding of MDS assessments for all residents was completed on 12/05/16 and it did not reveal any other coding errors. B. Miss-Coding of MDS Section Z All residents are potentially affected by this deficiency. An audit of the accurate coding of Section Z of the MDS assessments for all residents was completed on 12/05/16 and it did not reveal any other coding errors. C. Failure to Accurately Complete Discharge Assessments All residents are potentially affected by this deficiency. An audit of the MDS discharge assessments for all residents was completed on 12/05/16 and it did not reveal any other inaccurate discharge assessments. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: A. Accuracy of MDS Assessments The Director of Nursing, MDS Coordinator, Social Services Director, dietary manager, activities director and therapy director will be in-serviced on 12/05/16 in accurately completing MDS assessments. IDT team members will meet weekly to review the MDS flow	

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F 278	Continued From page 27 evidence to support coding of behaviors and the impact on the resident and others in the facility. During an interview on 10/27/16 at 10:25 a.m. an administrative nurse (#1) confirmed the medical record lacked documentation to support coding Resident #11's MDSs of 07/31/16, 08/03/16, and 08/18/16 for behaviors which affected the resident and other residents. FALLS The Long-Term Care Facility RAI User's Manual, revised October 2015, pages J-31 to J-32, stated "J1900: Number of Falls Since . . . Prior Assessment . . . Coding instructions . . . Determine the number of falls that occurred since . . . prior assessment . . . and code the level of fall-related injury for each. . . . Coding Instructions for J1900A, No injury . . . Coding instructions for J1900B, Injury (Except Major) [which includes lacerations] . . . Coding instructions for J1900C, Major Injury [which includes fractures] . . ." Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 07/18/16, identified Resident #3 sustained a fall with no injury. The nursing progress notes stated the following: *06/03/16 at 1:10 p.m.: "Resident attempted to stand in day area wheel chair tipped and resident hit his head on support beam has a laceration resident sent to E.R. [emergency room] wife notified told about incident and that resident was sent to E.R. - Cont. [continued] [4:15 p.m.] Resident returned from E.R. has sutures intact	F 278	sheet detailing the quarterly MDS assessments coming due that week and to focus on getting those assessments completed timely. The Director of Nursing or designee will conduct weekly audits of the MDS assessments for all residents to verify accuracy of those assessments. B. Miss-Coding of MDS Section Z The Director of Nursing, MDS Coordinator, Social Services Director, dietary manager, activities director and therapy director will be in-serviced on 12/05/16 on coding errors in Section Z of the MDS assessments. The Director of Nursing and the MDS Coordinator will conduct weekly audits of the MDS assessments for all residents to identify coding errors in Section Z. C. Failure to Accurately Complete Discharge Assessments The Director of Nursing, MDS Coordinator, Social Services Director, dietary manager, activities director and therapy director will be in-serviced on 12/05/16 on coding errors in MDS discharge assessments. The Director of Nursing and the MDS Coordinator will conduct weekly audits of the MDS assessments for all residents to identify MDS discharge assessment coding errors. 4. Measures to be Implemented to Monitor the Plan of Correction	

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F 278	Continued From page 28 on laceration on forehead . . ." *06/04/16 at 6:30 a.m.: "CNA [certified nursing assistant] reported that [name of resident] wasn't feeling well. This nurse visited with [name of resident], he voiced [complaint of] head and neck pain. . . . [left] eye seemed unresponsive . . . sent to ER." *06/04/16 at 7:45 a.m.: ". . . Resident did refracture [left] clavicle . . ." The facility failed to code the MDS J1900B and/or J1900C section to reflect Resident #3's fall with injury. During an interview on the afternoon of 10/26/16, an administrative nurse (#4) confirmed the medical record lacked evidence of other behaviors for Resident #1, delusions for Resident #2, and staff did not correctly code the MDS to reflect Resident #3's fall with injury. IDENTIFICATION INFORMATION The Long-Term Care Facility RAI Manual, revised October 2015, Chapter 3 pages A-1, A-4, Chapter 2 pages 2-18 to 2-19, and Chapter 3 pages A-21 to A-22, stated, "Section A: Identification Information . . . A0310 Type of Assessment . . . Coding Instructions for A0310A, Federal OBRA [Omnibus Budget Reconciliation Act] Reason for Assessment . . . Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessment, see Chapter 2 on assessment schedules . . . Enter the number corresponding to the OBRA reason for assessment. . . . 01. Admission assessment	F 278	A. Accuracy of MDS Assessments The Director of Nursing or designee will report the results of the weekly audits of inaccurate or incomplete MDS assessments to the quarterly Quality Assurance Committee x 3. B. Miss-Coding of MDS Section Z The Director of Nursing or designee will report the results of the weekly audits of coding errors in Section Z of all MDS assessments to the quarterly Quality Assurance Committee x 3. C. Failure to Accurately Complete Discharge Assessments The Director of Nursing or designee will report the results of the weekly audits of coding errors in discharge assessments to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency: The expected compliance for this deficiency is December 12, 2016.	

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F 278	Continued From page 29 required by day 14) . . . 01. Admission Assessment (A0310A=1) The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, . . . if: this is the resident's first time in the facility, OR the resident has been admitted to the facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. A1600 . . . Most Recent Admission/Entry or Reentry into this Facility . . . A1600 Entry Date . . . Item Rationale: To document the date of admission/entry or reentry into the facility" - Review of Resident #11's medical record occurred on October 26-27, 2016. Resident #11's medical record identified a hospital stay July 19-20, 2016. The facility completed a discharge return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #12's medical record occurred on October 26-27, 2016. Facility staff completed a quarterly MDS on 10/31/15 and an admission MDS on 01/13/16. During an interview on the afternoon of 10/25/16, an administrative nurse (#4) identified staff should have coded the 01/13/16 MDS for Resident #12 as an annual and not an admission MDS. - Review of Resident #11's medical record occurred on October 26-27, 2016. Resident #11	F 278		

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returned from a hospital admission on 07/20/16. A significant change MDS, dated 08/03/16, and an annual MDS, dated 08/18/16, identified an entry date of 04/01/1969, not the correct date of 07/20/16.

During an interview on 10/27/16 at 9:20 a.m., an administrative nurse (#4) confirmed the coding errors for Resident #11 regarding coding of the 01/13/16 MDS as an admission and putting the incorrect date at entry/reentry for the 08/03/16 and 08/18/16 MDSs.

CODING SECTION Z

2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the Centers for Medicare Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to ensure accurate coding of Section Z of the Minimum Data Sets (MDSs) for 5 of 12 sampled residents (Resident #4, #6, #10, #11, #12, 1 closed record (Resident #13), and 1 supplemental resident (Resident #25). Failure to include all days of the assessment period when completing sections of the MDS may result in an inaccurate assessment.

Findings include:

The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, revised October 2015, page A-29 stated, "A2300: Assessment Reference Date [ARD] . . . designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time.

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F 278	Continued From page 31 As the last day of the look-back period, the ARD serves as the reference point for determining the care and services captured on the MDS assessment, . . .The look-back period includes observations and events through the end of the day (midnight) of the ARD. . ." page Z-8 stated, "Z0500: Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion . . . Coding Instructions * For Z0500B, use the actual date that the MDS was completed . . ." Review of sampled resident's MDS's and the CMS Submission Reports identified staff dated Item A2300 and Z0500B on the same date for the following MDSs: * Resident #4: 03/30/16 quarterly and 07/01/16 annual * Resident #6: 09/20/16 quarterly * Resident #10: 10/16/15 annual * Resident #11: 08/03/16 significant change in status * Resident #12: 01/13/16 annual * Resident #13: 05/13/16 quarterly * Resident #25: 08/24/16 annual During an interview on 10/26/16 at 12:15 p.m. an administrative nurse (#4) stated he was not aware that since the assessment period ends at midnight on the ARD the MDS could not be considered complete sooner than 12:01 a.m. the day after the ARD. DISCHARGE ASSESSMENTS 3. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the	F 278		

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Centers for Medicare Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to ensure staff accurately completed discharge assessments for 3 of 3 supplemental residents (Resident #16, #20, and #28) identified with an Inconsistent Record Sequence on the CMS Submission Reports. Failure to complete the discharge assessments per the RAI User's Manual instructions affects quality monitoring activities and data.

Findings include:

The Long-Term Care Facility RAI User's Manual, revised October 2015, page 2-34 to 2-37 stated, ". . . Discharge assessments consists of discharge return anticipated [DRA] and discharge return not anticipated [DRNA]. These are OBRA [Omnibus Budget Reconciliation Act] required assessments . . . Discharge Assessment-Return Anticipated (A0310F=11) Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days . . . When a resident had a prior Discharge assessment completed indicating that the resident was expected to return (A0310E=11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another Discharge assessment . . . "

Review of sampled and supplemental residents' MDSs identified the following:
- For Resident #16, #20, and #28 the facility completed discharge assessments as follows:
* Resident #16: a DRA assessment, dated 09/16/16, followed by a DRNA, dated 09/22/16

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(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 278	Continued From page 33 * Resident #20: a DRA assessment, dated 09/19/16 followed by a DRNA, dated 09/23/16 * Resident #28: a DRA assessment, dated 02/16/14 followed by a DRNA, dated 02/19/14 During an interview on 10/26/16 at 12:15 p.m. an administrative nurse (#4) stated he was not aware CMS does not require a second discharge assessment when a resident discharged with return anticipated does not return to the facility.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy	F 280	1. Corrective action for Residents Found	12/12/16

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F 280	Continued From page 34 review, and staff interview, the facility failed to review and revise the care plan for 4 of 12 sampled residents (Resident #2, #3, #6, and #8). Failure to revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity of care. Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 10/27/16. This policy, revised 09/01/15, stated, ". . . Our facility's Interdisciplinary Team, . . . develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. . . . 8. Care plans are revised as changes in the resident's condition dictate. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia. The quarterly Minimum Data Set (MDS), dated 09/04/16, identified extensive assistance of two people with transfers. The physical therapy notes, dated 08/19/16, stated, ". . . Will cont [continue] to have staff transfer resident with assist of 2 and may use sit to stand lift if approved by charge nurse . . ." The current care plan stated, ". . . Problems . . . Resident requires assist with adls [activity of daily living] r/t [related to] severe dementia, limited movement in upper extremities, and cancer. . . . Interventions . . . requires extensive assist of two and use of gait belt for all transfers, and toileting. . . ."	F 280	To Be Affected by this Deficiency: Resident #2 The care plan for Resident #2 was revised on 11/01/16 to reflect that resident is to receive extensive assistance by 2 persons with a gait belt or Sit to Stand Lift. Nursing staff, the MDS Coordinator and the Therapy Director were in-serviced on 12/05/16 regarding the requirements to update and follow the resident□s care plan which must accurately reflect the extensive assistance to be provided to the resident by 2 persons with a gait belt or Sit to Stand Lift. Resident #3 The care plan for Resident #3 was revised on 11/01/16 to reflect that resident is to receive extensive assistance by 2 persons with a gait belt. Resident #6 The care plan for Resident #6 was revised on 11/01/16 to reflect that resident is to receive extensive assistance by 2 persons with a gait belt. Nursing staff, the MDS Coordinator and the Therapy Director were in-serviced on 12/05/16. Resident #8 The care plan for Resident #8 was revised on 11/01/16 to reflect that the resident is to receive extensive	

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F 280	Continued From page 35 Observation on 10/25/16 at 9:16 a.m. showed two certified nurse assistants (CNA's) (#6 and #8) transferred Resident #2 from his wheelchair to the toilet and from the toilet back into his wheelchair utilizing a sit to stand lift. Observation on 10/25/16 at 9:52 a.m. showed two CNAs (#8 and #10) transferred Resident #2 from his wheelchair to the recliner utilizing a gait belt. The facility failed to update the care plan to reflect the use of a sit to stand lift for Resident #2's transfers if approved by the charge nurse. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, impaired balance, and osteoporosis. The quarterly Minimum Data Set (MDS), dated 07/18/16, identified extensive assistance for transfers and toileting. The current care plan lacked interventions for transfers. Observation on 10/25/16 at 11:29 a.m. showed a CNA (#6) transferred Resident #3 from his wheelchair to the toilet utilizing a gait belt. Observation on 10/25/16 at 1:35 p.m. showed a CNA (#6) transferred Resident #3 from the wheelchair to the recliner utilizing a gait belt. Observation on 10/26/16 at 8:28 a.m. showed a CNA (#7) transferred Resident #3 from the wheelchair to the toilet utilizing a gait belt. The facility failed to update the care plan to reflect Resident #3's transfer needs.	F 280	assistance by 2 persons with a gait belt or Sit to Stand Lift. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents needing assistance with transfers have the potential to be affected by this deficiency. The DON, unit managers and the MDS Coordinator reviewed the care plans for all residents on 11/01/16. No other deficiencies were found. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: Nursing staff, the MDS Coordinator and Therapy Director were in-serviced on 12/05/16 on the requirements to revise the care plan timely to accurately reflect the care to be provided each resident. The DON or designee will conduct weekly audits starting on 10/31/16 to ensure that each care plan accurately reflects the assistance each resident requires and how staff will specifically provide that assistance. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The DON or designee will report the	

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F 280	Continued From page 36 During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) confirmed staff should have updated the residents care plans to reflect the current transfer status for Residents #2 and #3. - Observation of cares for Resident #6 occurred on 10/25/16 at 1:12 p.m. A CNA (#6) transferred Resident #6 from her wheel chair to the toilet utilizing a gait belt. Observation showed the resident held on to the towel bar and did not stand erect, but maintained a seated position during the transfer. Review of the resident's medical record occurred on all days of survey. The current care plan, dated 04/12/16, identified a problem: ". . . [Resident #6] requires assist with adls [Activities of Daily Living] r/t [related to] Osteoporosis and Disc Degeneration." Interventions for the problem included: "[Resident #6] requires extensive assist of one for . . . transfers . . ." The care plan failed to identify if staff should use any assistive devices during transfers. During an interview on 09/27/16 at 9:30 a.m., an administrative nurse (#1) confirmed the residents's care plan lacked specifics regarding assistive devices staff should use when transferring Resident #6. - Review of Resident #8's medical record on October 24-27, 2016. The current care plan stated "Problems . . . Transfers . . . Interventions . . . [Name of Resident] to be transferred [with] assist of 1 or [with] sit [to] stand lift per charge nurse discretion." Resident #8's quarterly MDS,	F 280	findings of the weekly audits of the resident care plans to the Quality Assurance Committee quarterly x 3. 5. Expected Date of Compliance for this Deficiency The expected compliance for this deficiency is December 12, 2016.	

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F 280	Continued From page 37 dated 07/27/16, identified the resident requires extensive assistance of one staff member for transfer. Observations of transfers during cares on 10/25/16 at 10:10 a.m. and 10/26/16 at 10:05 a.m., showed two staff members assisted Resident #8 with pivot transfers from bed to wheelchair and from wheelchair to recliner using a gait belt. Observation on 10/26/16, at 9:40 a.m., showed two CNAs (#7 and #12) transferred Resident #8 to the toilet using a sit to stand lift. When asked about input from the nurse prior to the transfer, the CNAs (#7 and #12) indicated staff always transfer Resident #8 with the sit to stand lift when using the toilet in the bathhouse. During an interview on 10/27/16 at 9:10 a.m., an administrative nurse (#1) confirmed the care plan did not reflect the current transfer status for Resident #8 since the resident's decline following a hospitalization.	F 280		
F 287 SS=E	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there	F 287		12/12/16

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F 287	Continued From page 38 is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 287		

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F 287	Continued From page 39 Based on review of facility policy, the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), Centers for Medicare and Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to electronically transmit encoded and completed Minimum Data Set (MDS) data to the CMS Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within 14 days of completing the assessments for 3 of 12 sampled residents (Resident #4 and #7 and #11) and 10 supplemental residents (Resident #16, #17, #18, #19, #21, #22, #23, #25, #29, and #31). Failure to transmit the MDSs within the required time frame may result in inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, page 2-15 to 2-16 defines the submission deadline as 14 days after completion for all MDS types. Review of the facility policy titled, "MDS, Electronic Transmission of" occurred on 10/26/16. The policy, revised April 2003, stated, ". . . Electronic Submission Governance: . . . MDS electronic submissions shall be conducted in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations governing the transmission of such data. . . ." Review of the CMS Final Validation Reports occurred on October 25-27, 2016 and identified Assessment Reference Dates (ARDs) and submission dates as follows:	F 287	1. Corrective action for Residents Found To Be Affected by this Deficiency: The MDS data for residents #4, #7, #11, #16, #17, #18, #21, #22, #23, #25, #29 and #31 were encoded and transmitted to the CMS past the 14 day deadline. The MDS Coordinator entered subsequent submission dates for these residents into the MDS tracking calendar on 10/31/16 to achieve timely completion of future due dates. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents are potentially affected by this deficiency. An audit of all resident charts completed on 10/31/16 did not reveal any other late submissions. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director and Therapy Director will be in-serviced on 12/05/16 on encoding and transmitting resident MDS data to the CMS timely. IDT team members will meet weekly to review the MDS flow sheets indicating which resident MDS data must be encoded and transmitted to the CMS that upcoming week and to focus completing transmission of those records timely by the due date. The Director of Nursing or designee will conduct weekly compliance	

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F 287	Continued From page 40 * Resident #4: ARD 10/02/16 - submitted 10/25/16 * Resident #7: ARD 10/11/16 - submitted 10/26/16 * Resident #11: ARD 07/31/16 - submitted on 09/14/16 and ARD 08/03/16 - submitted on 09/01/16 * Resident #16: ARD 08/22/16 - submitted on 09/08/16 * Resident #17: ARD 07/24/15 - submitted on 09/06/16 * Resident #18: ARD 08/24/16 - submitted on 09/14/16 * Resident #19: ARD 08/12/16 - submitted on 08/29/16 * Resident #21: ARD 01/02/16 - submitted on 09/07/16 * Resident #22: ARD 04/03/16 - submitted on 09/07/16 * Resident #23: ARD 07/21/15 - submitted on 09/07/16 * Resident #25: ARD 08/24/16 - submitted on 09/08/16 and ARD 08/24/16 - submitted 09/27/16 * Resident #29: ARD 02/19/14 - submitted on 09/07/16 * Resident #31: ARD 10/04/16 - submitted on 10/25/16 During an interview on 10/25/16 at 8:45 a.m. an administrative nurse (#4) stated he was aware staff had transmitted some MDSs beyond the CMS deadline and stated business office staff transmit the MDSs. An interview with a business office staff member (#16) occurred on 10/25/16 at 10:55 a.m. When asked about her time frame for transmitting MDSs, the staff member (#16) stated she	F 287	audits of the timely coding and transmission of MDS Data to the CMS. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will report the results of the weekly audits to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency: The expected compliance for this deficiency is December 12, 2016.	

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F 287	Continued From page 41 transmits the MDSs "whenever I have time."	F 287		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer guidelines, review of facility policy, and staff interviews, the facility failed to ensure adequate supervision of assistive devices for 7 of 11 sampled residents (Resident #1, #2, #3, #4, #6, #8, #10) who required assistance with transfers. Failure to appropriately utilize a gait belt (Resident #2, #3, #4, #6, and #10) and a mechanical stand lift (Resident #1), and assess the resident before utilizing a mechanical stand lift (#2 and #8) placed the residents at risk for sustaining a fall or injury. Findings include: MECHANICAL LIFTS Review of the manufacturers guidelines titled "E/Z Way Smart Stand" occurred on 10/27/16. This guideline, page 5, stated, ". . . Attach harness 1) Position the harness around upper body of the patient so the sides of the harness are between the patient's torso and arm, resting	F 323	1. Corrective action for Residents Found To Be Affected by this Deficiency: Resident #1 The certified nursing assistants assigned to resident #1 as well as all other nursing assistants will be in-serviced on 11/28/16 on the proper procedure in securing a resident into the harness to be used for the Sit to Stand Lift. Resident #2 The certified nursing assistants assigned to Resident #2 will be in-serviced on the proper use of a gait belt on 11/28/16. Resident #3 The certified nursing assistants assigned to resident #3 as well as all other nursing assistants will be in-serviced on 11/28/16	12/12/16

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F 323	Continued From page 42 2-3 inches below the underarm. 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. . . ." Review of the facility policy titled "Stand Up Lifting Machine, Using a Portable" occurred on 10/27/16. This undated policy stated, ". . . 3. Basic Standing Transfer . . . Fasten the inner safety belt snuggly. . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, cognitive impairment, and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 07/05/16, identified extensive assistance of two people with transfers. The current care plan stated, ". . . Resident requires assist with adls [activity of daily living] r/t [related to] impaired balance, cognitive impairment, and osteoarthritis. . . . requires mechanical lift and two assist for all transfers. . . ." Observation on 10/25/16 at 12:59 p.m. showed two certified nurse assistants (CNAs) (#8 and #9) transferred Resident #1 from her wheelchair to the toilet utilizing a sit to stand lift. The CNAs placed the safety strap loosely around the resident's torso. As the CNAs raised Resident #1 to a standing position, the safety strap slid up the resident's chest to her axilla, raising her shoulders to ear level. Observation on 10/26/16 at 8:41 a.m. showed two CNAs (#10 and #12) transferred Resident #1 from her wheelchair to the toilet utilizing a sit to stand lift. The CNAs placed the safety strap loosely around the resident's chest. As the CNAs	F 323	on the proper procedure to use a gait belt when transferring a resident. Resident #4 Resident #4 was assessed by therapy on 11/23/16 and per therapy notes and the care plan resident is to be transferred using a Sit to Stand Lift with assist by 2 people. The nursing assistants assigned to Resident #4 were in-serviced on the proper way to use a Sit to Stand Lift. Resident #6 The care plan for Resident #6 was revised 10/31/16 to provide that the resident can be assisted with transfers using a gait belt. Resident #8 The certified nursing assistants assigned to Resident #2 will be in-serviced on the proper use of a gait belt or sit to stand lift when transferring the resident on 11/28/16. Resident #10 The certified nursing assistants assigned to resident #3 as well as all other nursing assistants will be in-serviced on 11/28/16 on the proper procedure to use a gait belt when transferring a resident. 2. Corrective Action for Residents that May be Affected by this Deficiency:	

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F 323	Continued From page 43 raised Resident #1 to a standing position, the safety strap slid up the resident's chest, causing her shoulders to shrug upward. The CNAs failed to securely fasten the safety strap around the resident's torso while utilizing a sit to stand lift. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, weakness, and impaired balance. The quarterly MDS, dated 09/04/16, identified extensive assistance of two people with transfers. The current care plan stated, ". . . Problems . . . Resident requires assist with adls r/t severe dementia, limited movement in upper extremities . . . Interventions . . . requires extensive assist of two and use of gait belt for all transfers, and toileting. . . ." The physical therapy notes, dated 08/19/16, stated, ". . . Will cont [continue] to have staff transfer resident with assist of 2 and may use sit to stand lift if approved by charge nurse . . ." Observation on 10/25/16 at 9:16 a.m. showed two CNAs (#6 and #8) transferred Resident #2 from his wheelchair to the toilet and from the toilet to his wheelchair utilizing a sit to stand lift. The CNAs (#6 and #8) failed to seek approval from the charge nurse before utilizing a sit to stand lift. - Review of Resident #8's medical record on October 24-27, 2016. Resident #8's quarterly MDS, dated 07/27/16, identified the resident requires extensive assistance of one staff member for transfer. The current care plan	F 323	All residents could have been potentially affected by this deficiency. An audit was performed of resident medical charts to identify incomplete care plans that required extensive assistance with transfers but did not specify how those transfers were to be safely made. No incomplete care plans were identified in the audit. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: All nursing staff will be in-serviced on the proper procedure to use gait belts and to operate a Sit to Stand Lift on 11/28/16. The Director of Nursing or designee will perform weekly random audits/observations of 5 nursing assistants transferring residents with a gait belt or Sit to Stand Lift. The Director of Nursing or designee will perform monthly audits of the CNA's on proper transferring of residents requiring assistance to verify that the staff are using the appropriate devices to safely transfer the residents. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director of Nursing or designee will	

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F 323	Continued From page 44 stated "Problems . . . Transfers . . . Interventions . . . [Name of Resident] to be transferred [with] assist of 1 or [with] sit [to] stand lift per change nurse discretion." Observation on 10/26/16, at 9:40 a.m., showed two CNAs (#7 and #12) transferred Resident #8 to the toilet using a sit to stand lift. When asked the CNAs (#7 and #12) stated they did not talk with the nurse prior to transferring Resident #8. Staff failed to consult the nurse before transferring Resident #8. GAIT BELTS Review of the facility policy titled "Gait Belt Safety" occurred on 10/27/16. This policy, dated October 2012, stated, ". . . 2. Place the belt around the resident's waist . . . 4. Grasp the belt, as you would in a strong handshake, palm up. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, weakness, and impaired balance. The quarterly MDS, dated 09/04/16, identified extensive assistance of two people with transfers. The current care plan stated, ". . . Problems . . . Resident requires assist with adls r/t severe dementia, limited movement in upper extremities . . . Interventions . . . requires extensive assist of two and use of gait belt for all transfers, and toileting. . . ." Observation on 10/25/16 at 9:52 a.m. showed two CNAs (#8 and #10) transferred Resident #2 from his wheelchair to the recliner. The CNAs applied the gait belt, but during transfer, placed	F 323	report the results of the 1) weekly random audits of the observations of nursing assistants using gait belts and Sit to Stand Lifts, 2) and the monthly audits of care plans for residents requiring assistance with transfers to verify the care plans specify how the residents are to be transferred to the quarterly Quality Assurance Committee for 3 quarters. 5. Expected Date of Compliance for this Deficiency The expected compliance for this deficiency is December 12, 2016.	

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their hands under the resident's axilla as they assisted the resident to a standing position.

Observation on 10/25/16 at 11:30 a.m. showed two CNAs (#14 and #15) transferred Resident #2 from the recliner to his wheelchair. The CNAs applied the gait belt, but during transfer, placed their hands under the resident's axilla as they assisted the resident to a standing position.

Observation on 10/26/16 at 10:43 a.m. showed two CNAs (#7 and #12) transferred Resident #2 from his wheelchair to the recliner. The CNAs applied a gait belt, but during transfer, the CNA (#12) grabbed onto the resident's pant and buttock as the resident was pivoted into the recliner.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, osteoporosis, Parkinson's disease, and impaired balance. The quarterly MDS, dated 07/18/16, identified extensive assist of one person with transfers. The current care plan lacked information on the resident's transfer needs.

Observation on 10/25/16 at 11:29 a.m. showed a CNA (#6) transferred Resident #3 from his wheelchair to the toilet utilizing a gait belt. During the transfer, when the CNA lowered the resident to a sitting position and raised the resident to a standing position, she grabbed under the resident's right axilla.

Observation on 10/25/16 at 1:35 p.m. showed the CNAs (#6 and #8) transferred Resident #3 from his wheelchair to the recliner. The CNAs applied

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the gait belt, but during transfer, placed their hands under the resident's axilla to assist the resident to a standing position.

- Review of Resident #10's medical record occurred on October 26-27, 2016. Diagnoses included dementia, osteoarthritis, and weakness. The quarterly MDS, dated 07/06/16, identified extensive assistance of one person with transfers. The current care plan stated, ". . . Problem . . . requires extensive assist with adls r/t generalized pain, osteoarthritis, dementia, and weakness. . . . Interventions . . . one or two assist with transfers using her walker. . . ."

Observation on 10/25/16 at 11:30 a.m. showed two CNAs (#14 and #15) transferred Resident #10 from the recliner to her wheelchair. The CNAs applied a gait belt, but during transfer, placed their hands under the resident's axilla to assist the resident to a standing position.

Observation on 10/26/16 at 12:27 p.m. showed a CNA (#7) transferred Resident #10 from her wheelchair to the recliner utilizing a gait belt. During the transfer, the CNA placed her hand on the resident's buttocks as she lowered the resident into the recliner.

The CNAs failed to appropriately utilize the gait belt during transfers.

- Resident #6's medical record, reviewed on all days of survey, identified diagnoses including arthritis and osteoporosis. The resident's current care plan, dated 04/12/16, identified a problem: ". . . [Resident #6] requires assist with adls [Activities of Daily Living] r/t [related to]

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Osteoporosis and Disc Degeneration." Interventions for the problem included: "[Resident #6] requires extensive assist of one for . . . transfers . . ." The care plan failed to identify if staff should use any assistive devices during transfers.

Observation of cares for Resident #6 occurred on 10/25/16 at 1:12 p.m. A CNA (#6) transferred Resident #6 from her wheel chair to the toilet utilizing a gait belt. Observation showed the resident held on to the towel bar and did not stand erect, but maintained a seated position during the transfer.

- Resident #4's medical record, reviewed on all days of survey, identified diagnoses including osteoarthritis. The resident's current care plan identified a problem: "resident requires assist with all adls r/t recent surgery, impaired balance, immobility, and memory loss." Interventions included: "6/27/16 - Transfers - Bathroom - Resident to use Bathroom in his room [with] 1 assist during the day. If resident is fatigued or at noc [night], to use big bathroom [with] sit-stand lift and assist 2."

Observations of cares for Resident #4 occurred on 10/25/16 at 10:55 a.m. A CNA (#8) transferred the resident from his wheel chair to the toilet. The CNA applied a gait belt, but during the transfer, placed her hands on the resident's back over his rib cage rather than utilizing the gait belt.

During an interview on 10/27/16 at 9:30 a.m. an administrative nurse (#1) stated the facility admitted Resident #6 from a Basic Care facility and had not performed a transfer assessment

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F 323	Continued From page 48 since her admission on 03/21/16. The nurse (#1) also stated the CNA should have held the gait belt, rather than placing her hands on Resident #4's rib cage during the transfer on 10/25/16. During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to hold onto to the gait belt when utilizing a gait belt during transfers. She also stated the harness belt should be tight and secure around the resident and that the resident should not be in a chicken wing position during transfers utilizing a sit to stand lift.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of the kitchen checklist, and staff interview, the facility failed to store foods in a safe and sanitary manner in 1 of 1 activity kitchen. This practice placed foods at risk of contamination, and placed residents at risk of consuming expired beverages and/or food. Findings include:	F 371	1. Corrective action for Residents Found To Be Affected by this Deficiency The following items in Activity Room refrigerator were immediately discarded: 1) the 64 oz. bottle of honey opened on 10/11/16 has been discarded, 2) the 64 oz. bottle of nectar opened on 10/14/16 has been discarded, and 3) the 16	12/12/16

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F 371	Continued From page 49 Review of the facility "Q.A. Checklist for Kitchen," not dated, stated "THIS MUST BE DONE . . . Check/Clean all Appliances Weekly!! . . . Microwave . . . Food items checked for proper storage, and expiration dates checked - discard if necessary." The manufacturer's product label for nectar and honey thick water identified the product is to be refrigerated after opening and discarded if not used within 10 days. Observation of the activity room kitchen occurred on 10/26/16 at 10:15 a.m. and showed the following: * The microwave soiled with dried splattered food * A 64 ounce bottle of honey consistency water, open date 10/11/16, 15 days earlier. * A 64 ounce bottle of nectar consistency water, open date 10/14/16, 12 days earlier. * 16 individual serving fruit yogurt cups, all dated 10/16/16, 10 days earlier. During an interview, at the time of the observation, an administrative activity staff member (#13) identified staff are to clean the activity kitchen area weekly, including removing expired food from the refrigerator.	F 371	individual cups of fruit yogurt opened on 10/16/16 have been discarded. The microwave in the activity room was cleaned on 10/28/16 and will be cleaned weekly per the cleaning schedule. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. The Dietary Manager and Activities Director conducted a search of the Activities Kitchen area to ensure that there were no more expired food and beverages in the refrigerators and pantries located in the kitchen, the activity room, and other locations in the facility. The microwave appliance located in the kitchen and other locations in the facility were inspected and no other violations were identified. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: All activities, dietary and nursing staff were in-serviced on the requirement to consistently inspect opened food items or beverages for expiration dates in refrigerators and pantries and the need to discard those items prior or to on the expiration date indicated on the label. Staff was also in-serviced on the requirement to clean all microwave appliances weekly according to the cleaning schedule for that appliance starting on 11/21/2016. The in-services	

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F 371	Continued From page 50	F 371	will be conducted by the QA nurse on 11/29/2016. The Activities Director or designee will conduct weekly compliance surveys for the refrigerator and pantry located in the activity Room and the Dietary Manager is responsible to conduct weekly compliance checks of the refrigerator, freezer and pantry in the Kitchen for expired opened foods and beverages. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Activities Director or designee will report the results of the appliance cleaning schedule and compliance audits to verify expired items were discarded timely in the refrigerator and pantry in the Activity Room to the quarterly Quality Assurance Committee x 3. The Dietary Manager or designee will report the results of the appliance cleaning schedule and compliance audits to verify expired items were discarded timely in the Kitchen refrigerator(s), freezer and pantry to the quarterly Quality Assurance Committee x 3. 5. The expected Date of Compliance for this Deficiency	

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F 371	Continued From page 51	F 371	The expected compliance for this deficiency is December 12, 2016.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		12/12/16

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F 441	Continued From page 52 infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 7 of 12 sampled residents (Resident #1, #2, #3, #4, #8, #9, and #10) observed during resident care and laundry practice. Failure to follow infection control practice related to proper hand hygiene (Resident #3, #4, #9, and #10), proper glove use (Resident #2, #3, #8, and #10), proper cleaning of equipment (Resident #1), and proper handling of soiled linen has the potential to spread infection. Findings include: Review of the facility policy titled "Personal Protective equipment - Gloves" occurred on 10/27/16. This policy, dated September 2015, stated, ". . . 1. All employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin. . . . 3. The use of gloves will vary according to the procedure involved. The use of gloves is indicated: . . . d. When handling soiled linen or items that may be contaminated; . . . h. During all cleaning of blood, body fluids, and decontaminating procedures. . . . 8. Wash your hands after removing gloves. . . ." Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 10/27/16. This undated policy stated, ". . . 1.	F 441	1. Corrective action for Residents Found To Be Affected by this Deficiency: Proper Hand Hygiene and Gloves All certified nursing assistants assigned to Residents #1, #2, #4, #8, #9 and #10 were in-serviced on 10/31/16, on the proper procedure for hand washing and glove use to prevent cross contamination and potential spread of infection, the proper use of gowns, masks, and hand sanitizer, to encourage residents to wash hands after touching soiled briefs or contaminated surfaces, and how to clean and disinfect shower chairs, toilet seats and toilet riser that have been contaminated with fecal matter. Resident Equipment All nursing assistants were in-serviced on 10/31/16 on how to clean and disinfect shower chairs, toilet seats and toilet riser that have been contaminated with urine and fecal matter. Soiled Linen Staff□s working in the laundry now has gowns and masks in addition to gloves to use when handling soiled linen.	

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F 441	Continued From page 53 Appropriate fifteen (15) second handwashing with antimicrobial or non-antimicrobial soap and water must be performed under the following conditions: a. Before and after direct contact with residents . . . c. After contact with blood, bloody fluids, secretions, mucous membranes, or non-intact skin; d. After removing gloves; . . . 4. . . . If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. Before and after direct contact with residents; . . . f. Before moving from a contaminated body site to a clean body site during resident care; g. After contact with resident's intact skin; . . . j. After removing gloves. . . . 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. . . ." HAND HYGIENE and GLOVE USE - Observation on 10/25/16 at 9:16 a.m. showed two certified nurse assistants (CNAs) (#8 and #10) assisted Resident #2 with toileting. The CNAs assisted the resident to the toilet, donned gloves, removed the resident's urine soaked brief, removed their gloves, washed their hands, donned new gloves, provided perineal care, and with the same gloved hands applied a clean brief. - Observation on 10/25/16 at 10:10 a.m., showed two CNAs (#6 and #8) provided morning cares for Resident #8. One CNA (#6), wearing gloves, provided perineal care. The resident's incontinent brief was saturated with urine. After perineal care, while wearing the same gloves, the CNA (#6) assisted the other CNA (#8) to apply a clean brief and the resident's pants. The CNA (#6), wearing the same gloves, combed the resident's	F 441	2. Corrective Action for Residents that May be Affected by this Deficiency: All residents are potentially affected by this deficiency. All nursing, housekeeping and laundry staff will be in-serviced on 11/28/16 on the proper procedure for hand washing and glove use to prevent cross contamination and potential spread of infection, the proper use gowns, face shields and hand sanitizer, and to encourage residents to wash hands after touching soiled briefs or contaminated surfaces, and how to clean and disinfect shower chairs, toilet seats and toilet riser that have been contaminated with fecal matter. Through random audit/observations of nursing staff weekly to identify deficient practices by individuals and on-going education and training, staff will achieve improved levels of infection control and resident safety. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Director of Nursing or designee will perform weekly audits/observations on nursing assistants or nurses to verify infection control compliance. The Administrator and the Environmental Services Manager or their designee will conduct monthly audits of laundry and housekeeping staff to ensure they are following proper infection control procedures and that the laundry room	

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F 441	Continued From page 54 hair, checked her glasses for cleanliness, and carried the water basin and the resident's glasses to the bathroom. Returning from the bathroom the CNA (#6) no longer wore gloves and put the glasses on Resident #8. - Observation on 10/25/16 at 11:29 a.m. showed a CNA (#6) assisted Resident #1 with toileting. The CNA assisted the resident to the toilet, applied gloves, removed the urine soaked brief, removed her gloves, donned new gloves, provided perineal cares, removed her gloves and left the room. The CNA (#6) failed to perform hand hygiene as per policy and before leaving the room. Observation on 10/26/16 at 8:28 a.m. showed a CNA (#7) assisted Resident #1 with toileting. The CNA assisted the resident to the toilet, removed the resident's urine soaked brief without gloves, then applied gloves, provided perineal cares, with the same gloved hands, applied a clean brief and pulled up the resident's pants. The CNA then removed her gloves and left the room without performing hand hygiene. - On 10/26/16 at 8:57 a.m. observation showed a CNA (#7) assisted Resident #9 to the toilet. Observation showed the resident voided and had a bowel movement. Following toileting the CNA provided perineal cares and removed her gloves. Without performing hand hygiene, the CNA (#7) transferred Resident #9 to the wheel chair, put the wheel chair pedals on, and transported the resident to the activity room. The CNA moved a chair in the activity room, positioned Resident #9's wheel chair near a table, and handed the resident a tissue. The CNA (#7) then left the	F 441	maintains adequate supplies of gloves, gowns and masks to safely handle soiled linen. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Director proper infection control protocols to the quarterly Quality Improvement Committee x 3. The Administrator and Environmental Services Manager or their designee will report the results of the monthly audit of the laundry and housekeeping staff in observing proper infection control protocols to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency The Expected Date of Compliance with this deficiency will be December 12, 2016.	

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F 441	Continued From page 55 activity room without performing hand hygiene. - On 10/26/16 at 10:46 a.m. observation showed a CNA (#9) assisted Resident #4 to the toilet. Following toileting, the resident placed his hands inside his brief while standing in front of the toilet. The CNA (#9) transferred Resident #4 to his wheel chair and left the room without encouraging Resident #4 to perform hand hygiene. - Observation on 10/26/16 at 12:27 p.m. showed a CNA (#7) assist Resident #10 with toileting. The CNA assisted the resident to the toilet, removed the resident's brief and pants without gloves, sanitized her hands with antimicrobial gel cleaner, donned gloves, provided perineal care, with the same gloved hands applied a clean brief, pulled up the resident's pants, and left the room without performing hand hygiene. During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to wash their hands before providing cares to a resident, apply gloves, perform perineal cares, remove gloves, and then apply a clean brief. She stated she expected staff to wash their hands after providing cares. During an interview on 10/27/16 at 9:30 a.m. an administrative nurse (#1) stated she would expect the CNA (#7) assisting Resident #9 to perform hand hygiene after removing gloves and prior to touching items in the resident's room and activity room. The nurse also stated she would expect the CNA (#9) to offer hand hygiene to Resident #4 after he placed his hands inside his brief.	F 441		

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(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 441	Continued From page 56 EQUIPMENT - Observation on 10/25/16 at 12:59 p.m. showed two CNAs (#8 and #9) assisted Resident #1 into the main bathroom in the East lounge area. The toilet seat riser was soiled with bowel movement (BM) inside and on the top of the seat. The CNAs assisted the resident to the toilet, removed the resident from the toilet, and transferred the resident into the lounge area. The CNAs failed to clean and sanitize the toilet seat riser before and after the resident's use. During an interview on 10/27/16 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to clean the toilet seat riser located in the main bathrooms before and after each resident use. SOILED LINEN - Review of the facility policy titled "Laundry and Bedding, Soiled" occurred on 10/17/16. The policy, revised October 2009, stated, "Policy Interpretation and Implementation . . . 4. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g. [example given] gowns if soiling of clothing is likely.) . . ." Review of the housekeeping schedule occurred on 10/25/16 with an environmental services manager (#2). The schedule showed one staff member scheduled to work in the laundry each day of the current schedule. Observations in the laundry occurred on 10/26/16	F 441		

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	355042	A. BUILDING _____ B. WING _____	10/27/2016

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F 441	Continued From page 57 at 9:30 a.m. with the environmental services manager (#2). When asked what type of protective equipment staff use when sorting soiled linen and clothing, the staff member (#2) stated laundry staff wear gloves. When asked if staff wear gowns he stated, "It depends on how bad it is." Observation showed no gowns available in the soiled linen room. Staff's failure to wear a protective garment when sorting soiled linen may result in contamination of clean linen handled by the same staff member. This failure may result in spread of infection within the facility.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 and staff interview, the facility failed to provide a safe, sanitary and comfortable environment for residents, staff, and the public on 4 of 4 days of survey (October 24-27, 2016). Failure to maintain a safe and sanitary environment impacts the health and safety of residents, staff, and visitors; and does not create a comfortable living space for residents. Findings include: - Observations during the initial tour of the facility, on the morning of 10/24/16, identified chipped	F 465	1. Corrective action for Residents Found To Be Affected by this Deficiency: Chipped Paint on Door Frames of Resident Room in East Unit The door frames were cleaned, sanded and then painted on 12/05/16. Chairs in East Lounge The chairs were cleaned and the cloth protectors were removed on 11/05/16.	12/12/16

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F 465	Continued From page 58 paint on door frames of residents' rooms throughout the East unit. Observation on 10/25/16 at 7:37 a.m. showed the following: * Three chairs in the East Lounge had cloth incontinence protectors with the padding exposed * Chipped and scraped door frames and doors on the soiled utility and tub room on the East unit * A beige recliner in the East lounge with a soiled headrest and footrest - During an interview on 10/25/16 at 8:30 a.m. Resident #5 pointed out a cream colored recliner in her room. The resident stated it was her personal chair, but until recently, when she moved to a private room, she had kept the chair in the West Lounge and utilized it there. The resident stated, while staff had the chair in the lounge, someone spilled liquid on the left side of the chair. Observation showed a large light brown stain covering nearly the entire left side of the chair and dark stains on the right side. Resident #5 stated she would like staff to clean the chair. Observations in Resident #5's room occurred on the morning of 10/26/16 with an environmental services manager (#2). The staff member agreed staff should clean the chair. A tour of the environment occurred on 10/26/16 from 9:30 a.m. to 10:15 a.m. with an environmental services manager (#2). Observation during the tour showed the following: In the laundry:	F 465	The door frames were cleaned, sanded and repainted on 12/05/16. Stained Recliner Belonging to Resident #5 The recliner was professionally cleaned and the stains were removed on 12/05/16. Peeling Paint on Corner of South and West Walls in laundry The walls were cleaned, sanded and painted on 12/05/16. Worn/Stained Surface on Hand Washing Sink in Laundry The stained surface of the hand washing sink was painted and sealed on 12/05/16. Exposed Sheet Rock in Dryer Room The walls were cleaned, sanded and repainted on 12/05/16. Unfinished Cabinets in Activity Room The cabinets were painted on 11/05/16. Chipped Door Frame to Activity Room The door frames were cleaned, sanded and repainted on 12/05/16. Broken Shelf in Clean Utility Room in	

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F 465	Continued From page 59 * Peeling paint on the corner of the south and west wall near the washing machines * A worn/stained surface on the handwashing sink near the washing machines * Exposed areas of sheet rock on the walls in the dryer room and clean linen room where staff had removed items attached to the walls In the activity room: * An approximate 16 foot row of cabinets along the south wall made of unfinished wood - The environmental staff member (#2) stated the facility had recently had the cabinets installed and confirmed staff had not yet stained and sealed the cabinets. * Chipped paint on the frame of the north door to the activity room, exposing bare wood On the East unit: * A broken shelf in the clean utility room next to the refrigerator with approximately one inch of a nail sticking out of the shelf and bare wood exposed - The staff member (#2) stated he expects nursing staff to inform maintenance staff of areas that need repair. * An approximate two by two foot stain on the west wall of the dining room * The soiled beige recliner remained in the lounge - The environmental staff member (#2) stated staff should dispose of the chair. In the North Hall: * A broken handrail where the north hall connects with the West dining room with the end sawed off exposing bare wood During the tour, the environmental staff member (#2) stated the facility had not established a	F 465	East Unit The shelf was repaired and repainted on 11/05/16. 2 Foot Stain on west Wall of East Dining Room The wall was cleaned and repainted on 12/05/16. Soiled Beige Recliner in Lounge The recliner was removed from the facility on 10/28/16. Broken handrail in North Hall The handrail was repaired, cleaned, sanded and repainted on 12/05/16. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents could have been potentially affected by this deficiency. An audit of the facility did not reveal any other violations. 3. Corrective Measures Put Into Place to Ensure This Deficiency Will Not Recur: The Environmental Services Department will be in-serviced on 11/28/16 on the requirement to provide routine maintenance and perform routine environmental and safety assessments and to schedule repairs and touchup painting as needed to repair chipping	

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F 465	Continued From page 60 schedule for touch-up painting. The above concerns in the laundry, activity room, East unit and north hall created uncleanable surfaces and risks for injuries; and does not create a clean, comfortable living space for residents.	F 465	paint, chipped door frames, exposed sheet rock and stained walls and broken hand rails. The Environmental Services Director or designee will conduct a monthly audit of needed repairs to walls, floors, railings, shelving and furniture and create a schedule for repairs. The audits will be conducted weekly for one month, then monthly for 3 months, then quarterly for 3 quarters for one year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction The Environmental Services Director and/or his designee will report the monthly environmental audit to the quarterly Quality Assurance Committee x 3. 5. Expected Date of Compliance for this Deficiency The expected compliance for this deficiency is December 12, 2016.	