Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	74809	A. BUILDING: ___ B. WING ___	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT ORLANDO INC	2000 NORTH SEMORAN BOULEVARD ORLANDO, FL 32807

(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) COMPLETE DATE
N 000	INITIAL COMMENTS A Relicensure survey was conducted from ... to ... . Avante At Orlando had deficiencies found at the time of the visit. License #1393096	N 000		
N 042 SS=E	400.1183 FS Resident Grievances and Complaints (1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include: (a) An explanation of how to pursue redress of a grievance. (b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility's grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency. (c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance. (d) A procedure for providing assistance to residents who cannot prepare a written grievance without help. (2) Each nursing home facility shall maintain records of all grievances and a report, subject to agency inspection, of the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances. (3) Each facility must respond to the grievance within a reasonable time after its submission. (4) The agency may investigate any grievance at any time. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility	N 042	Avante at Orlando Plan Of Correction for	

AHCA Form 3020-0001

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

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N 042	Continued From page 1 failed to act upon grievances discussed in the resident council meetings and document the response and rationale for 5 of 5 months of resident council meetings reviewed. Findings: During an interview with the Resident Council President on . . . . at 10:58 AM, said she did not know that the Resident Council could file grievances. She said the facility staff person who is responsible for acting on the grievance doesn't come to the Resident Council Meetings to tell them what they are doing about the issue, so they don't know if the grievance was addressed or not. Record review of Resident Council Minutes from . 2016 to , , 2017 revealed new concerns were discussed in every meeting, but the response and rationale was not documented. Review of the grievance log from last survey to present time did not reveal any grievances from Resident Council. In an interview with the Director of Nursing on at 2:24 PM, she said she speaks individually to residents about their concerns/grievances discussed in the resident council meetings or will tell the Activity Director what to say to the Resident Council, but nothing is documented or sent directly back to the Resident Council to let them know their grievances were heard and that the facility is working to resolve them. She confirmed the facility has a process for resolving grievances from individuals, but that process was not followed for grievances from resident council meetings. Pattern	N 042	Annual Survey . , . ,2017 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of alleged deficiencies but, is prepared for the sole purpose of compliance with State and Federal regulations. Allegation of compliance . . . Tag N042 Resident Grievances and Complaints 1. How Corrective action will be accomplished for those found to have been affected. On . . . . . Administrator or Designee informed the Resident Council President the manner in which the Resident Council may file grievances and, upon invitation from the Resident Council, the staff person (Social Services Director) responsible for acting on the grievances will attend Resident Council Meetings. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. On . . . . . Resident Council Meeting was conducted and the Administrator or designee informed the Resident Council and Resident Council President the manner in which the Resident Council may file grievances and, upon invitation from Resident Council, the staff person (Social Services Director) responsible for acting on the grievances will attend Resident Council Meetings. 3. What measures will be put into place	

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N 042	Continued From page 2 Class III	N 042	or systemic changes made to ensure that the deficient practice will not occur. On ... the Regional Nurse educated Social Services Director regarding attending Resident Council Meetings upon invitation from Resident Council, logging Resident Council Concerns/Grievances on the Facility Grievance Log, informing Resident Council of the Facility s efforts to respond to grievances, as well as, the status of the Grievance resolution. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator or Designee will conduct random weekly audits of the Grievance Log and random monthly audits of Resident Council minutes for 3 Months to ensure that Resident Council Grievances are logged on the Facility Grievance Log and that Social Services Director or Designee attends Resident Council when invited and informs Resident Council of the Facility s efforts to respond to grievances, as well as, the status of the Grievance resolution.. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	
N 201 SS=E	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and	N 201		

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N 201	Continued From page 3 therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate and appropriate health care services to maintain an control program that included sufficient tracking, trending, and reporting of organisms, including multi-drug resistant organisms (MDROs). Findings: The facility's prevention and control surveillance data was reviewed on from 11:30 AM -12:30 PM with the facility's control coordinator and former control coordinator. They indicated that there had been three different control coordinators over the past year. They provided only 6 months of data for review, 2016 - , 2017, instead the full year's review. The control coordinators stated that the facility's control surveillance data was collected, reviewed and logged at the end of each month. They validated that the information was not collected, reviewed, and logged as an ongoing process during each month increasing the risk of failure to timely identify trends or clusters. Review of the facility's process for surveillance included a monthly line listing of resident , a monthly facility map tracking and trending tool, and a monthly surveillance report. The facility map tool included a color coding to identify the anatomical location	N 201	Tag N201 Right to adequate and appropriate health care 1. How Corrective action will be accomplished for those found to have been affected. By Facility' s current monthly mapping tools and surveillance reports submitted to QAA Committee will address in-house organisms including MDROs. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. On DON or Designee conducted an audit of the Control Binder to ensure the appropriate Control forms were being completed. No issues were identified. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Control Coordinator and Unit Managers were reeducated on by DON or Designee regarding completion of the control tracking and mapping forms, as well as, surveillance reports. Emphasis was placed upon addressing in-house organisms including MDROs. 4. How the facility plans to monitor its	

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N 201	Continued From page 4 of the resident such as upper , tract, lower /, and other/skin/eye. It also included color coding to identify the locations of and , but it did not include the tracking of any other organism types or MDROs for trending purposes. A comparison review of the monthly facility map tracking and trending tool and the monthly resident line listing tools was done for the months of 2016 through , 2017. The review validated that all of known resident organisms documented on each monthly resident line listing tool were not acknowledged and placed on the facility map tool in order to trend and report potentially micro-organism clusters within the facility. The control coordinators validated this finding on at about 12:15 PM. The following in-house organisms, including multi-drug resistant organisms (MDROs), were not tracked and trended on the facility's monthly mapping tools from 2016 through , 2017: 2016 - Providencia Stuartii, , Extended Spectrum Lactamase (ESBL)(MDRO), Morganella Morganii, and . 2016 - ESBL (MDRO), Enterobacter Aerogenes, Citrobacter Koseri, Klebsiella (MDRO), Serratia Marcescens, Providencia Stuartii, , and . , 2017 - , ESBL (MDRO), Citrobacter Koseri, Providencia Stuartii, and , Resistant (VRE)(MDRO).	N 201	performance to make sure that solutions are sustained. DON or designee will conduct random weekly audits of the control tracking and mapping forms, as well as, surveillance reports for 3 Months to ensure that organisms including MDROs are addressed. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	

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N 201	Continued From page 5 , 2017 - ESBL (MDRO). 2017 - Klebsiella (MDRO), Urinae, and . , 2017 - , ESBL (MDRO), Acinetobacter Baumanni (MDRO), and Morganella Morganii. Continued review of the facility's surveillance data revealed that there were not any micro-organisms, including MDROs, documented on the facility's monthly surveillance reports submitted to the facility's quality assurance committee. This was validated by the control coordinator on at about 12:15 PM. "Multi-Drug resistant organisms (MDROs) refers to microorganisms, predominantly , that are resistant to one or more classes of agents. Although the names of certain MDROs describe resistance to only one agent, these are frequently resistant to most available agents." - Center for Medicare and Medicaid Services. Pattern Class III	N 201		
N 203 SS=D	400.022(1)(n), FS Right to be Treated with Dignity The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.	N 203		

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N 203	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to treat residents in a dignified manner on the South Wing on 2 of 2 days observed for dining by having 2 diners dependent upon staff (#52 and #70) wait for 42 minutes on and wait 37 minutes on after lunch meal trays arrived while other residents around them ate lunch. Findings: The South dining area in the atrium posted meal time was 11:45 AM. On at 11:45 AM, the drink cart including juice, water, and coffee was already in the dining area. At 11:56 AM, the lunch tray hot box cart arrived on the unit. There were only 2 residents sitting at the tables at the time the cart arrived and more residents were brought to the tables in the dining area. On at 12:01 PM, the Certified Nursing Assistants (CNAs) began washing their hands while 6 residents were in the dining area- 3 residents were seated at the same table and 3 residents were seated alone at individual tables. On at 12:01 PM, the first resident was offered a drink. At 12:03 PM, a second meal cart was delivered by dietary staff to the South Wing Atrium area. At 12:04 PM, the first resident was served the lunch meal. At 12:06 PM, from the same cart, the first was brought to the . At 12:07 PM, the second resident was served the lunch meal tray in the dining area. At 12:08 PM, the third lunch meal tray was served in the dining area. At 12:09 PM, the fourth resident was served at same table. By 12:11 PM, there were 8 residents seated in the South Wing Atrium Dining Area. At 12:14 PM, one resident was still waiting for meal in dining area and was served the tray at 12:18 PM. His wife, resident #70, was	N 203	Tag N203 Dignity and Respect of Individuality 1. How Corrective action will be accomplished for those found to have been affected. On the DON or designee re-educated CNAs regarding the proper procedures for the meal serving process in order to maintain resident dignity and respect during mealtimes. Enhanced emphasis was placed upon serving dependent and independent residents their meal at the same time. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. Facility has a South and a North Unit. On DON or designated conducted rounds of the meal service on North Unit to ensure that the meal serving process was conducted in a manner which maintained Resident dignity and respect during mealtimes. No issues were identified. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. On the DON or designee re-educated CNAs regarding the proper procedures for the meal serving process in order to maintain resident dignity and respect during mealtimes. Enhanced emphasis was placed upon serving dependent and independent residents their meal at the same time.	

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N 203	Continued From page 7 moved to another table with no meal tray. At 12:31 PM, another resident was served the meal and her tablemate was brought to the table and served lunch 2 minutes later. At 12:15 PM another resident was brought to dining area and was served lunch 3 minutes later. At 12:20 PM, a new resident was brought to table and served her lunch tray before she was seated at the table. At 12:21 PM, another new resident was brought to dining area and served immediately. At 12:33 PM, another resident was brought to dining area and served immediately. At 12:35 PM, resident #70 was finally served her pureed lunch meal tray and a CNA sat down to help her because resident #70 needed total assistance to eat her meal. There was no CNA-to-resident interaction during that lunch meal observation as resident #70 spoke Vietnamese and the CNA did not speak Vietnamese. Resident #70 waited from 11:45 AM until 12:35 PM to be served and assisted to eat her lunch meal tray after being moved away from the table with her husband because there was not enough staff to help resident #70 eat her meal. On at 12:38 PM, CNA A talked over resident #52, who she was helping to eat her lunch meal, "you know how it is, they, resident #70 and #52, have to wait until everyone is finished eating" before staff can help the assist the dependent diners. The second lunch meal dining observation of the South Wing Atrium dining area was conducted on . The drink cart with coffee, ice water and juice was already placed in that area at 11:34 AM and there were 7 residents waiting for lunch in the dining area and 12 residents seated across from the dining area with the TV on who ate in the dining area. At 11:43 AM, the first cart was delivered to the South Wing Atrium dining area with 8 residents seated in the dining area. At	N 203	4. How the facility plans to monitor its performance to make sure that solutions are sustained DON or Designee will conduct random weekly audits of the meal service process for 3 Months to ensure that meals are served in a manner which maintains resident dignity and respect. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	

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N 203	Continued From page 8	N 203		

Continued From page 8

11:47 AM, Resident #70 was removed from the dining area by the Assistant Director of Nursing (ADON)-2 and placed in the TV area of the atrium. At 11:48 AM, there were no employees in the Atrium to pass out the meal trays that had been sitting in the area for 5 minutes. At 11:52 AM, the second lunch tray cart was delivered to the Atrium by dietary. At 11:52 AM, the first resident was served heir lunch meal and 4 minutes later the second was served their lunch meal. At 11:57 AM, the 3rd resident was served and at that time there were only 8 residents seated in the Atrium dining area, 5 of which were seated at individual tables. At 12:01 PM, 9 residents were in the dining area sitting at tables. At 12:05 PM, a new resident was brought to the area and served within one minute. At 12:13 PM, another resident brought to the dining sit down to her tray waiting for her. At that time there were 12 residents in the dining area eating. Beginning at at 12:16 PM, lunch meal trays were being served to the resident . At 12:17 PM, there were 5 CNAs and 1 nurse waiting in the area, but all 12 residents had already been served their lunch meals. At 12:19 PM, resident #70 was wheeled back into the dining area from the TV area, 32 minutes after she was removed from the dining area and 36 minutes after her puree lunch meal tray arrived in the Atrium Dining area, and assisted to eat by family. At 12:19 PM, resident #52 was brought to the dining area from the TV area and a minute later another resident was brought from the TV area to the dining area and served her meal while resident #52 still waited for her meal.

On at 12:20 PM, CNA B stated "The residents who need total assistance to eat are fed when staff have finished with dining for everyone

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N 203	Continued From page 9 else." On at 12: 25 PM, the Unit Manager for South Wing verified five residents who required total assistance to eat, observed sitting at the far end of the dining area with no food, drink or assistance to eat while others residents dined and stated "the residents sitting at the end of the dining waiting until staff can feed them." On at 12:35 PM, the concern regarding residents dining with dignity was brought to the attention of ADON-2. He stated "I see what you mean about the residents having to wait." On at 2:11 PM, the Director of Nursing indicated she understood the dining concern about residents waiting to be assisted to eat and acknowledged they need to provide all residents with a better dining experience. On at 12:15 PM, interview with ADON-2 said the dining area can't have residents waiting to eat because they didn't have enough help to assist them with dining all at once so they sat them in the TV area to wait for enough staff. On at 4:31 PM, ADON-2 stated "that day, some residents were seated in front of the TV waiting to be served and assisted by staff. Normally, restorative dining and independent diners eat at the same time. Usually, families come to serve the assisted diners their meals, but if the family doesn't come at meal time, the staff will help the assisted diners." During the same interview, he said there was no conversation between resident #70 and the CNA during lunch on because resident #70 spoke Vietnamese and the staff would have had to use a communication board to interact with resident #70.	N 203		

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N 203	Continued From page 10 Class III	N 203		

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F 000	INITIAL COMMENTS Recertification survey was conducted from to . Avante At Orlando was not in compliance with 42 CFR 483 and 488, requirements for Long Term Care Facilities.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. ( ) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 167	Avante at Orlando Plan Of Correction for	

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

Electronically Signed

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

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F 167	Continued From page 1 failed to inform the residents of the location of the survey results book. Findings: Review of the Resident Council Minutes provided from 2016 to , 2017 there was no mention of the survey book or location of the survey results. Interview with the Resident Council President on at 11:21 AM, the President, who has been President for 4 years, said "I haven't seen that book at all around here." On at 2:19 PM, the Director of Nurses said the residents would not know where to find the survey book, they would have to ask to see the survey results.	F 167	Annual Survey , ,2017 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of alleged deficiencies but, is prepared for the sole purpose of compliance with State and Federal regulations. Allegation of compliance . Tag F167C Right to survey results- readily accessible 1. How Corrective action will be accomplished for those found to have been affected. On Administrator or Designee informed the President of resident council of the location of the survey results book. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. On Resident Council Meeting was conducted and the Administrator or designee informed the Resident Council and Resident Council President of the location of the survey results book. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. On the Administrator or designee placed the survey results book at the front receptionist desk with a sign addressing its availability. Additionally, signs were posted at each Nursing station which state Survey results with Plan of Correction are available for your review at	

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F 167	Continued From page 2	F 167	any time. These results are located on the front receptionist area in the front lobby along with the Grievance Policy and forms. Ombudsman contact phone number is located on the posters in the Hallway. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator or designee will conduct random weekly audits of the front receptionist desk and Nursing Stations for 3 Months to ensure that the survey results book is available at the front desk and that signs are posted at each Nursing Station addressing location of the Survey results with Plan of Correction. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	
F 208 SS=C	483.15(a)(1)-(7) PROHIBITING CERTAIN ADMISSION POLICIES (a) Admissions policy. (1) The facility must establish and implement an admissions policy. (2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and	F 208		

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F 208	Continued From page 3 (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. (3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. (4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and	F 208		

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F 208	Continued From page 4 (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. (5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. (6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. (7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to [illegible] between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on admission agreement review and interview, the facility waived responsibility for lost or stolen items in the Admission Agreement.. Findings: On non-numbered pages of the Avante Admission Agreement and Admission Packet the Policy for	F 208	Tag F208C Prohibiting certain admission policies 1. How Corrective action will be accomplished for those found to have been affected. [illegible] Facility Admission Policy regarding theft or loss of personal property of Residents was amended and	

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F 208 Continued From page 5

the Theft or Loss of Personal Property of Residents includes a Waiver of Liability "I further understand that Avante will not be responsible for valuables and I agree to waive any and all liability against Avante, its owners, directors, officers, employees, management companies, parent companies, and affiliated companies for any theft or loss of my valuables and instead agree to accept full responsibility and entirely assume any and all risk and liability for any such theft or loss." On a separate page, "Valuables: Avante at Orlando cannot be responsible for valuable items." On a third page, Personal Property Policy: "Avante at Orlando is not responsible for a Resident's valuables, money, lost clothing, glasses, hearing aides, , equipment, radios, televisions, jewelry, , plants, or any other personal items/valuables of any kind brought from home" and further down the same page, "If theft should occur, we will make you and the resident aware of the problem. We will notify the police so that a report may be filled out on loss of any large,identifiable items. And we will work closely with the resident and family to locate lost items."

On at 2:57 PM, the Internal Admissions Coordinator said the facility has to "complete the inventory. Missing items are reported to Social Services and they try to do everything possible for missing items. If those missing items are not found, the resident signs a waiver of responsibility for missing items. As a courtesy, we replace the missing items that cant be found- but only as a courtesy. The residents have to sign a waiver of liability."

On at 4:05 PM, the Administrator validated the facility contract says the facility does

F 208

the statement addressing Facility waiver responsibility for lost or stolen items was removed.

2. How corrective action will be accomplished for those having potential to be affected by the same practice.
Facility Admission Policy regarding theft or loss of personal property of Residents was amended as stated above.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.
Administrator or Designee on educated Admissions Coordinator regarding the amended Admission Policy regarding theft or loss of personal property of Residents.

4. How the facility plans to monitor its performance to make sure that solutions are sustained.
Administrator or Designee will conduct random weekly audits of the Admissions Packets for 3 Months to ensure that Admission Packets contain the amended Admission Policy regarding the theft or loss of personal property of Residents. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

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F 208	Continued From page 6 not replace items and waives liability.	F 208		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to treat residents in a dignified manner on the South Wing on 2 of 2 days observed for dining by having 2 diners dependent upon staff (#52 and #70) wait for 42 minutes on and wait 37 minutes on after lunch meal trays arrived while other residents around them ate lunch. Findings: The South dining area in the atrium posted meal time was 11:45 AM. On at 11:45 AM, the drink cart including juice, water, and coffee was already in the dining area. At 11:56 AM, the lunch tray hot box cart arrived on the unit. There were only 2 residents sitting at the tables at the time the cart arrived and more residents were brought to the tables in the dining area. On at 12:01 PM, the Certified Nursing Assistants (CNAs) began washing their hands while 6 residents were in the dining area- 3 residents were seated at the same table and 3 residents were seated alone at individual tables. On at 12:01 PM, the first resident was offered a drink. At 12:03 PM, a second meal cart	F 241	Tag F241 Dignity and Respect of Individuality 1. How Corrective action will be accomplished for those found to have been affected. On the DON or designee re-educated CNAs regarding the proper procedures for the meal serving process in order to maintain resident dignity and respect during mealtimes. Enhanced emphasis was placed upon serving dependent and independent residents their meal at the same time. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. Facility has a South and a North Unit. On DON or designated conducted rounds of the meal service on North Unit to ensure that the meal serving process was conducted in a manner which maintained Resident dignity and respect during mealtimes. No issues were identified.	

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F 241	Continued From page 7 was delivered by dietary staff to the South Wing Atrium area. At 12:04 PM, the first resident was served the lunch meal. At 12:06 PM, from the same cart, the first [illegible] was brought to the [illegible]. At 12:07 PM, the second resident was served the lunch meal tray in the dining area. At 12:08 PM, the third lunch meal tray was served in the dining area. At 12:09 PM, the fourth resident was served at same table. By 12:11 PM, there were 8 residents seated in the South Wing Atrium Dining Area. At 12:14 PM, one resident was still waiting for meal in dining area and was served the tray at 12:18 PM. His wife, resident #70, was moved to another table with no meal tray. At 12:31 PM, another resident was served the meal and her tablemate was brought to the table and served lunch 2 minutes later. At 12:15 PM another resident was brought to dining area and was served lunch 3 minutes later. At 12:20 PM, a new resident was brought to table and served her lunch tray before she was seated at the table. At 12:21 PM, another new resident was brought to dining area and served immediately. At 12:33 PM, another resident was brought to dining area and served immediately. At 12:35 PM, resident #70 was finally served her pureed lunch meal tray and a CNA sat down to help her because resident #70 needed total assistance to eat her meal. There was no CNA-to-resident interaction during that lunch meal observation as resident #70 spoke Vietnamese and the CNA did not speak Vietnamese. Resident #70 waited from 11:45 AM until 12:35 PM to be served and assisted to eat her lunch meal tray after being moved away from the table with her husband because there was not enough staff to help resident #70 eat her meal. On [illegible] at 12:38 PM, CNA A talked over resident #52, who she was helping to eat her lunch meal, "you know how it is, they, resident	F 241	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. On [illegible] the DON or designee re-educated CNAs regarding the proper procedures for the meal serving process in order to maintain resident dignity and respect during mealtimes. Enhanced emphasis was placed upon serving dependent and independent residents their meal at the same time. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. DON or Designee will conduct random weekly audits of the meal service process for 3 Months to ensure that meals are served in a manner which maintains resident dignity and respect. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	

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F 241	Continued From page 8 #70 and #52, have to wait until everyone is finished eating" before staff can help the assist the dependent diners. The second lunch meal dining observation of the South Wing Atrium dining area was conducted on . . . . . . The drink cart with coffee, ice water and juice was already placed in that area at 11:34 AM and there were 7 residents waiting for lunch in the dining area and 12 residents seated across from the dining area with the TV on who ate in the dining area. At 11:43 AM, the first cart was delivered to the South Wing Atrium dining area with 8 residents seated in the dining area. At 11:47 AM, Resident #70 was removed from the dining area by the Assistant Director of Nursing (ADON)-2 and placed in the TV area of the atrium. At 11:48 AM, there were no employees in the Atrium to pass out the meal trays that had been sitting in the area for 5 minutes. At 11:52 AM, the second lunch tray cart was delivered to the Atrium by dietary. At 11:52 AM, the first resident was served heir lunch meal and 4 minutes later the second was served their lunch meal. At 11:57 AM, the 3rd resident was served and at that time there were only 8 residents seated in the Atrium dining area, 5 of which were seated at individual tables. At 12:01 PM, 9 residents were in the dining area sitting at tables. At 12:05 PM, a new resident was brought to the area and served within one minute. At 12:13 PM, another resident brought to the dining sit down to her tray waiting for her. At that time there were 12 residents in the dining area eating. Beginning at at 12:16 PM, lunch meal trays were being served to the resident . At 12:17 PM, there were 5 CNAs and 1 nurse waiting in the area, but all 12 residents had already been served their lunch meals. At 12:19	F 241		

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PM, resident #70 was wheeled back into the dining area from the TV area, 32 minutes after she was removed from the dining area and 36 minutes after her puree lunch meal tray arrived in the Atrium Dining area, and assisted to eat by family. At 12:19 PM, resident #52 was brought to the dining area from the TV area and a minute later another resident was brought from the TV area to the dining area and served her meal while resident #52 still waited for her meal.

On ... at 12:20 PM, CNA B stated "The residents who need total assistance to eat are fed when staff have finished with dining for everyone else."

On at 12: 25 PM, the Unit Manager for South Wing verified five residents who required total assistance to eat, observed sitting at the far end of the dining area with no food, drink or assistance to eat while others residents dined and stated "the residents sitting at the end of the dining ... waiting until staff can feed them."

On at 12:35 PM, the concern regarding residents dining with dignity was brought to the attention of ADON-2. He stated "I see what you mean about the residents having to wait."

On ... at 2:11 PM, the Director of Nursing indicated she understood the dining concern about residents waiting to be assisted to eat and acknowledged they need to provide all residents with a better dining experience.

On ... at 12:15 PM, interview with ADON-2 said the dining area can't have residents waiting to eat because they didn't have enough help to

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F 241	Continued From page 10 assist them with dining all at once so they sat them in the TV area to wait for enough staff. On at 4:31 PM, ADON-2 stated "that day, some residents were seated in front of the TV waiting to be served and assisted by staff. Normally, restorative dining and independent diners eat at the same time. Usually, families come to serve the assisted diners their meals, but if the family doesn't come at meal time, the staff will help the assisted diners." During the same interview, he said there was no conversation between resident #70 and the CNA during lunch on because resident #70 spoke Vietnamese and the staff would have had to use a communication board to interact with resident #70.	F 241		
F 244 SS=E	483.10(f)(5)( )(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. ( ) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to act upon grievances discussed in the	F 244	Tag F244 Listen/Act on Group Grievance/Recommendation	

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F 244	Continued From page 11 resident council meetings and document the response and rationale for 5 of 5 months of resident council meetings reviewed. Findings: During an interview with the Resident Council President on at 10:58 AM, said she did not know that the Resident Council could file grievances. She said the facility staff person who is responsible for acting on the grievance doesn't come to the Resident Council Meetings to tell them what they are doing about the issue, so they don't know if the grievance was addressed or not. Record review of Resident Council Minutes from 2016 to , , 2017 revealed new concerns were discussed in every meeting, but the response and rationale was not documented. Review of the grievance log from last survey to present time did not reveal any grievances from Resident Council. In an interview with the Director of Nursing on at 2:24 PM, she said she speaks individually to residents about their concerns/grievances discussed in the resident council meetings or will tell the Activity Director what to say to the Resident Council, but nothing is documented or sent directly back to the Resident Council to let them know their grievances were heard and that the facility is working to resolve them. She confirmed the facility has a process for resolving grievances from individuals, but that process was not followed for grievances from resident council meetings.	F 244	1. How Corrective action will be accomplished for those found to have been affected. On Administrator or Designee informed the Resident Council President the manner in which the Resident Council may file grievances and, upon invitation from the Resident Council, the staff person (Social Services Director) responsible for acting on the grievances will attend Resident Council Meetings. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. On Resident Council Meeting was conducted and the Administrator or designee informed the Resident Council and Resident Council President the manner in which the Resident Council may file grievances and, upon invitation from Resident Council, the staff person (Social Services Director) responsible for acting on the grievances will attend Resident Council Meetings. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. On the Regional Nurse educated Social Services Director regarding attending Resident Council Meetings upon invitation from Resident Council, logging Resident Council Concerns/Grievances on the Facility Grievance Log, informing Resident Council of the Facility s efforts to respond to grievances, as well as, the status of the Grievance resolution.	

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F 244	Continued From page 12	F 244	4. How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator or Designee will conduct random weekly audits of the Grievance Log and random monthly audits of Resident Council minutes for 3 Months to ensure that Resident Council Grievances are logged on the Facility Grievance Log and that Social Services Director or Designee attends Resident Council when invited and informs Resident Council of the Facility s efforts to respond to grievances, as well as, the status of the Grievance resolution.. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		

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F 371	Continued From page 13 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the refrigerators on 2 of 2 halls in a manner to prevent food bourne illness. Findings: 1. On at 4:17 PM, the North Wing nourishment contained 1 carton of chocolate fat free milk dated and 1 opened individual cup of applesauce with the opened cover pushed down onto the applesauce on the 2nd shelf of the door. On at 4:25 PM, the Dietary Supervisor and the Certified Dietary Manager (CDM A) verified the findings. 2. On at 4:33 PM, the South Wing nourishment had 1 vanilla snack pack pudding opened with the lid pushed into the top of the pudding on the top shelf of door. This finding was confirmed by at 4:33 PM by the Dietary Supervisor and CDM A. On at 4:26 PM, CDM A and the Dietary Supervisor reported that dietary staff are to check the nourishment every morning around 7 AM for outdated food or open, non-labeled food items.	F 371	Tag F371 Food Procure, Store/Prepare/Serve Sanitary 1. How Corrective action will be accomplished for those found to have been affected. On upon discovery of need the chocolate fat free milk and the opened individual cup of applesauce in the nourishment refrigerator on North Wing, as well as, the opened vanilla snack pudding in the nourishment refrigerator on South were discarded. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. North and South Nursing Units only have the nourishment refrigerators referenced above. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. On Dietary Manager or Designee re-educated dietary staff regarding the facility s policies and practice guideline for maintaining safe and sanitary food storage, handling, and food consumption.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106027	A. BUILDING ______ B. WING ______	05/18/2017

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F 371	Continued From page 14	F 371	4. How the facility plans to monitor its performance to make sure that solutions are sustained. Dietary Manager or Designee will conduct random weekly audits of the North and South Unit Nourishment refrigerators for 3 Months to ensure that food items are properly labeled, dated and stored. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) CONTROL, PREVENT SPREAD, LINENS (a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or	F 441		

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F 441	Continued From page 15 before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable .... or .... should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ....; ( ) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the .... agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable .... or .... skin ..... from direct contact with residents or their food, if direct contact will transmit the ....; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . . . (f) Annual review. The facility will conduct an	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 441	Continued From page 16 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an control program that included sufficient tracking, trending, and reporting of organisms, including multi-drug resistant organisms (MDROs). Findings: The facility's prevention and control surveillance data was reviewed on from 11:30 AM -12:30 PM with the facility's control coordinator and former control coordinator. They indicated that there had been three different control coordinators over the past year. They provided only 6 months of data for review, 2016 - , 2017, instead the full year's review. The control coordinators stated that the facility's control surveillance data was collected, reviewed and logged at the end of each month. They validated that the information was not collected, reviewed, and logged as an ongoing process during each month increasing the risk of failure to timely identify trends or clusters. Review of the facility's process for surveillance included a monthly line listing of resident , a monthly facility map tracking and trending tool, and a monthly surveillance report. The facility map tool included a color coding to identify the anatomical location of the resident such as upper , , tract, lower , /, , and other/skin/eye. It also included color coding to identify the locations	F 441	Tag F441 Control, Prevent Spread, Linens 1. How Corrective action will be accomplished for those found to have been affected. By Facility' s current monthly mapping tools and surveillance reports submitted to QAA Committee will address in-house organisms including MDROs. 2. How corrective action will be accomplished for those having potential to be affected by the same practice. On DON or Designee conducted an audit of the Control Binder to ensure the appropriate Control forms were being completed. No issues were identified. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Control Coordinator and Unit Managers were reeducated on by DON or Designee regarding completion of the control tracking and mapping forms, as well as, surveillance reports. Emphasis was placed upon addressing in-house organisms including MDROs. 4. How the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 441	Continued From page 17 of and , but it did not include the tracking of any other organism types or MDROs for trending purposes. A comparison review of the monthly facility map tracking and trending tool and the monthly resident line listing tools was done for the months of 2016 through , 2017. The review validated that all of known resident organisms documented on each monthly resident line listing tool were not acknowledged and placed on the facility map tool in order to trend and report potentially micro-organism clusters within the facility. The control coordinators validated this finding on at about 12:15 PM. The following in-house organisms, including multi-drug resistant organisms (MDROs), were not tracked and trended on the facility's monthly mapping tools from 2016 through , 2017: 2016 - Providencia Stuartii, , Extended Spectrum Lactamase (ESBL)(MDRO), Morganella Morganii, and 2016 - ESBL (MDRO), Enterobacter Aerogenes, Citrobacter Koseri, Klebsiella (MDRO), Serratia Marcescens, Providencia Stuartii, , and 2017 - , ESBL (MDRO), Citrobacter Koseri, Providencia Stuartii, and Resistant (VRE)(MDRO). 2017 - ESBL (MDRO).	F 441	DON or designee will conduct random weekly audits of the control tracking and mapping forms, as well as, surveillance reports for 3 Months to ensure that organisms including MDROs are addressed. Audit results will be reviewed with the QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.	

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F 441	Continued From page 18 2017 - Klebsiella (MDRO), Urinae, and , 2017 - , ESBL (MDRO), Acinetobacter Baumanni (MDRO), and Morganella Morganii. Continued review of the facility's surveillance data revealed that there were not any micro-organisms, including MDROs, documented on the facility's monthly surveillance reports submitted to the facility's quality assurance committee. This was validated by the control coordinator on at about 12:15 PM. "Multi-Drug resistant organisms (MDROs) refers to microorganisms, predominantly , that are resistant to one or more classes of agents. Although the names of certain MDROs describe resistance to only one agent, these , are frequently resistant to most available agents." - Center for Medicare and Medicaid Services.	F 441		