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
	345206	A. BUILDING _____ B. WING _____	C 08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION	345 MANOR ROAD MARS HILL, NC 28754

(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 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. 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 guardian and staff interviews and record review, the facility failed to notify the legally responsible person of a change in	F 157	F157 483.10 NOTIFY OF CHANGES(INJURY, DECLINE,ROOM, ETC.) THE FACILITY WILL IMMEDIATELY INFORM THE RESIDENT; CONSULT WITH RESIDENT'S PHYSICIAN AND IF KNOWN, NOTIFY 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 PSYCHO-SOCIAL STATUS (A DETERIOATION IN HEALTH, MENTAL OR PSYCHOSOCIAL STATUS IN EITHER LIFE THREATENING CONDITIONS OR CLINICAL COMPLICATIONS); A NEED TO ALTER TREATMENT SIGNIFICANTLY (A NEED TO DISCONTINUE AN EXISTING FORM OF TREATMENT DUE TO ADVERSE CONSEQUENCES, OR TO COMMENCE A NEW FORM OF TREATME OR A DECISION TO TRANSFER OR DISCHARGE THE RESIDENT FROM THE FACILITY AS SPECIFIED. THE FACIITY WILL 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 OR A CHANGE IN RESIDENT RIGHTS UNDER FEDERAL OR STATE LAW OR REGULATIONS AS SPECIFICED IN PARAGRAPH B1 OF THIS SECTION	

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

Debra A. Breytanner, Administrator — Sept 16 2014

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.

Original Signature Date: Sept. 5, 2014

DHSR NHCS Black Mountain WRO Received SEP 17 2014 by: SKH

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F 157	Continued From page 1 condition for 1 of 4 residents (Resident #162). The findings included: Resident #162 was admitted to the facility on 11/19/13 with diagnoses which included kidney disease, vascular dementia with behavioral disturbance, and chronic pain. Resident #162's most recent quarterly Minimum Data Set (MDS) dated 01/15/14 assessed him as being cognitively intact. Review of Resident #162's medical record revealed a family member was listed as Resident #162's first emergency contact, and Resident #162's guardian was listed as Resident #162's second emergency contact. Review of Resident #162's care plan revealed an identified problem with onset of 09/26/13 of verbally aggressive behavior. Resident #162's care plan also contained a behavior plan that gave instructions regarding ways to respond to his foul language and verbal aggressiveness and ways to prevent his outbursts. In the approaches section of Resident #162's care plan, it was listed the facility would transfer Resident #162 to the emergency room at the hospital specified in the medical record if he became out of control with his verbal and physical aggression. Review of nursing notes from Resident #162's medical record revealed documentation of multiple occasions when Resident #162 was rude and verbally aggressive toward others. Review of nursing notes from Resident #162's medical record for the date of 01/13/14 revealed Resident #162 had become very upset and agitated about having a new roommate, and his behaviors had escalated during the evening from	F 157	THE FACILITY WILL RECORD AND PERIODICALLY UPDATE THE ADDRESS AND PHONE NUMBER OF THE RESIDENT'S LEGAL REPRESENTATIVE OR INTERESTED FAMILY MEMBER. THE NURSING 24 HOUR REPORT FORM WILL BE REVISED TO INCLUDE A SECTION WHERE NURSES ON ALL SHIFTS WILL BE REQUIRED TO IDENTIFY CHANGES IN CONDITION AND NOTIFICATION OF SAID EVENT TO A RESIDENT'S LEGAL REPRESENTATIVES OR INTERESTED FAMILY MEMBER. THE DIRECTOR OF NURSING WILL MONITOR THE 24 HOUR REPORT DAILY FOR 60 DAYS TO ENSURE NOTIFICATIONS HAVE BEEN MADE. THESE MONITORING RESULTS WILL BE INCLUDED IN THE QUALITY ASSURANCE MONTHLY MEETING. THE D.O.N. WILL SCHEDULE A MANDATORY INSERVICE FOR ALL NURSES TO REVIEW THE REVISED PROCEDURE FOR NOTIFICATION OF LEGAL REPRESENTATIVES AND INTERESTED FAMILY MEMBERS AND WILL INCLUDE SAID PROCEDURE IN NURSE JOB SPECIFIC ORIENTATION PROGRAM. THE OFFICE MANAGER WILL UPDATE ADDRESSES AND PHONE NUMBERS OF CURRENT RESIDENT LEGAL REPRESENTATIVES OR INTERESTED FAMILY MEMBERS AND WILL CONTINUE TO UPDATE SUCH INFORMATION ON A SCHEDULE THAT COORESPONDS TO THE RESIDENT CARE PLAN SCHEDULE.	

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F 157	Continued From page 2 verbal rudeness and aggression to verbal abuse toward the roommate and then threats of physical harm toward the roommate. The nursing note from 01/13/14 at 9:20 PM revealed Nurse #1 had called the Administrator and the decision had been made to send the resident to the emergency room at the hospital specified in the medical record. Interview with Nurse #1 on 08/13/14 at 8:05 AM revealed when a resident in the facility has an emergency or change in condition, or is being sent out to the hospital, the resident's physician and family are to be notified immediately. Nurse #1 stated she did not remember calling Resident #162's family or guardian once the decision had been made to call emergency medical services for transportation to the emergency room. Nurse #1 stated there was no documentation that she had called to notify Resident #162's guardian or family. Nurse #1 stated it had been a very stressful situation. When looking at Resident #162's face sheet, Nurse #1 stated if she had contacted someone, it would have been Resident #162's family member because that was who was listed as the first contact person on his face sheet, and not the guardian, who had been listed as contact #2. Interview with the Admissions Director (AD) on 08/13/14 at 3:57 PM revealed during all admissions, she assisted residents and families with completing the first, second, and third contact information sheet, which was used by all staff when notifying family members about changes in condition and when inviting families to care plan meetings. The AD stated whenever a resident with a legal guardian was admitted, the guardianship papers were reviewed, copied for	F 157	THE FACILITY QUALITY ASSURANCE PROGRAM WILL BE REVISED TO INCLUDE MONITORING - -EVERY WEEK FOR 4 WEEKS AND THEN MONTHLY- CONDITION NOTIFICATIONS AND OF THE DIRECTOR OF NURSING MONITORING OF SAID NOTIFICATIONS AS WELL AS THE ONGOING UPDATES OF THE RESI- DENT LEGAL REPRESENTATIVE OR INTERESTED FAMILY MEMBER INFORMATION ACCORDING TO THE CARE PLAN SCHEDULE. THE CORRECTIVE ACTIONS OF REVISING THE 24 HOUR NURSING REPORT FORM , INSERVICING THE NURSES ON THE DESCRIBED CHANGE IN PROCEDURE, MONITORING OF SAID NOTIFICATIONS BY THE DIRECTOR OF NURSING AND AN IMMEDIATE UPDATE OF CURRENT RESIDENT LEGAL REPRESENTA- TIVES OR INTERESTED FAMILY MEMBERS WILL RESOLVE THE DEFICIENT PRACTICE FOR THE RESIDENT FOUND TO BE AFFECTED AND THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED. THE SYSTEMIC CHANGE OF REVISING THE 24 HOUR NURSING FORM TO INCLUDE DOCUMENTATION OF AND MONITORING OF SIGNIFICANT CHANGES IN A RESIDENT'S PHYSICAL, MENTAL OR PSYCHOSOCIAL	

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F 157	Continued From page 3 the chart, and the legal guardian was listed as the resident's first contact in the medical record so that they could be contacted first whenever there was an emergency or a change in condition. Interview with the legal guardian of Resident #162 on 08/13/14 at 4:14 PM revealed he had not been contacted by any staff at the facility regarding any change in Resident #162's condition or behaviors during the months of December, 2013 or January, 2014. The guardian of Resident #162 stated he had not been informed of any threat of harm Resident #162 had made toward any other resident at the facility. The guardian of Resident #162 stated he had been Resident #162's guardian during his entire stay at the facility and had provided the facility with the legal documentation of guardianship at the resident's admission to the facility. The guardian stated during the Resident #162's stay at the facility, the guardianship status had been changed from initial to permanent but no other changes had been made. The legal guardian of Resident #162 stated he had never been invited to a care plan meeting, had never participated in the development of a care plan, and was not aware of the facility's care plan which included instructions to transport Resident #162 to the emergency room if he exhibited verbal and physical aggression. Interview with Office Manager on 08/14/14 at 8:05 AM revealed facility had been given guardianship papers during Resident #162's admission. When asked why Resident #162's guardian was not listed as Resident #162's first emergency contact in his medical record, the office manager stated she had thought the guardianship had been revoked and so the emergency contact had been	F 157	STATUS , A NEED TO ALTER TREATMENT SIGNIFICANTLY OR A DECISION TO TRANSFER OR DISCHARGE FROM THE FACIITY,THE ONGOING MONITORING OF SAID FORM BY THE DIRECTOR OF NURSING EACH WEEK AND THE PROCEDURE CHANGE OF UPDATING THE ADDRESS AND PHONE NUMBER OF EACH LEGAL REPRESENTATIVE OR INTERESTED FAMILY MEMBER ACCORDING TO THE CARE PLAN SCHEDULE AND INCLUDING THE MONITORING OF THIS PROCEDURE IN THE MONTHLY FACILITY QUALITY ASSURANCE PROGRAM HAS CREATED THE MEASURE WHICH WILL ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. THE INCLUSION OF THE REVISED PROCEDURE FOR DOCUMENTATION OF SIGNIFICANT CHANGES ON THE 24 HOUR NURSING REPORT FORM BEING INCLUDED IN THE NURSE JOB SPECIFIC ORIENTATION PROGRAM, THE ONGOING MONITORING OF THE REVISED 24 HOUR NURSING REPORT BY THE DIRECTOR OF NURSING AND THE REVISION OF THE MONTHLY QUALITY ASSURANCE PROGRAM TO INCLUDE MONITORING OF UPDATING OF RESIDENT INFORMATION BASED ON THE CARE PLAN SCHEDULE WILL CREATE THE INTERNAL MONITORING TOOLS TO MAKE SURE THE SOLUTIONS TO THE DEFICIENT PRACTICES ARE SUSTAINED.	

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F 157	Continued From page 4 changed. The office manager stated she had no additional legal paperwork regarding any change in guardianship after Resident #162's admission.	F 157	F253 483.15 HOUSEKEEPING AND MAINTENANCE SERVICES THE FACILITY WILL PROVIDE HOUSEKEEPING AND MAINTENANCE SERVICES NECESSARY TO MAINTAIN A SANITARY, ORDERLY AND COMFORTABLE INTERIOR. THE MEDICAL SUPPLY COORDINATOR HAS CREATED A CURRENT LIST OF ALL RESIDENTS REQUIRING A BEDPAN OR URINAL. THE ADMISSION CARE PLAN HAS BEEN REVISED TO INCLUDE QUESTIONS ON URINAL AND BEDPAN NEEDS AND THE MEDICAL SUPPLY COORDINATOR OR IN HER ABSENCE HER DESIGNEE, HAS BEEN INSTRUCTED TO MAINTAIN A CURRENT BEDPAN AND URINAL LIST. THE JOB DESCRIPTION OF THE MED SUPPLY COORDINATOR HAS BEEN REVISED TO INCLUDE THE MAINTENANCE OF THE ONGOING LIST AND THE RESPONSIBILITY OF ISSUING THOSE ITEMS TO EACH RESIDENT WHO HAS THAT NEED ON A WEEKLY BASIS WITH APPROPRIATE LABELING OF NAME AND DATE OF ISSUANCE. THE PROCEDURES FOR PROVIDING URINALS AND BEDPANS WILL BE REVISED TO REQUIRE THAT THE	9/11/14
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label bedpans and urine collection devices with resident names for 5 resident bathrooms. The findings included: During an observation on 08/12/14 at 11:07 AM in the resident bathroom between rooms 110 and 112 there was a bedpan sitting on the back of the toilet. There was no resident name visible on the bedpan. During an observation on 08/12/14 at 11:13 AM in the resident bathroom between rooms 118 and 120 there was a urinal sitting on the shelf above the toilet. There was no resident name visible on the urinal. During an observation on 08/12/14 at 11:17 AM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf above the toilet. There was no resident name visible on the collection hat.	F 253		

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F 253	Continued From page 5 During an observation on 08/12/14 at 11:18 AM in the resident bathroom between rooms 214 and 216 there was a bedpan on the shelf behind the toilet. There was no resident name visible on the bedpan. During an observation on 08/12/14 at 11:22 AM in the resident bathroom between rooms 222 and 224 there was a urinal on the shelf behind the toilet. There was no resident name visible on the urinal. During an observation on 08/12/14 at 4:55 PM in the resident bathroom between rooms 110 and 112 there was a bedpan sitting on the back of the toilet. There was no resident name visible on the bedpan. During an observation on 08/12/14 at 4:57 PM in the resident bathroom between rooms 118 and 120 there was a urinal on the shelf behind the toilet. There was no resident name visible on the urinal. During an observation on 08/12/14 at 4:58 PM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf behind the toilet. There was no resident name visible on the collection hat. During an observation on 08/12/14 at 5:00 PM in the resident bathroom between rooms 214 and 216 there was a bedpan on the shelf behind the toilet. There was no resident name visible on the bedpan. During an observation on 08/12/14 at 5:01 PM in the resident bathroom between rooms 222 and 224 there was a urinal on the shelf behind the	F 253	MEDICAL SUPPLY COORDINATOR OR DESIGNEE BE RESPONSIBLE FOR PROVIDING RESIDENTS WITH LABELED URINALS AND BEDPANS. THE D.O.N. WILL HOLD AN INSERVICE FOR NURSING AND HOUSEKEEPING STAFF TO INSTRUCT ON THE NEED FOR URINALS/BEDPANS TO BE LABELED WITH RESIDENT NAME/DATE ISSUED THIS INSERVICE WILL BE INCLUDED IN THE NURSES, C.N.A. AND HOUSEKEEPER JOB SPECIFIC ORIENTATION PROGRAM. RESIDENT BATHROOMS WILL BE CHECKED FOR LABELS/NAMES ON URINAL/BEDPANS WEEKLY BY THE MEDICAL SUPPLY COORDINATOR OR DESIGNEE AND 4 TIMES WEEK BY Q.A.COORDINATOR. THE MONTHLY Q.A PROGRAM WILL BE REVISED TO INCLUDE A 5 DAY PER WEEK BATHROOM MONITORING OF BEDPANS AND URINALS FOR 30 DAYS AND WEEKLY MONITORING THEREAFTER. THE CORRECTIVE ACTIONS OF CREATING A FACILITY LIST OF ALL RESIDENTS WHO NEED BEDPANS AND URINALS ,HAVING THE MEDICAL SUPPLY COORDINATOR /DESIGNEE BE RESPONSIBLE FOR PROVIDING LABELED UNITS, THE REVISION OF THE ADMISSION CARE PLAN TO	

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F 253	Continued From page 6 toilet. There was no resident name visible on the urinal. During an observation on 08/13/14 at 8:08 AM in the resident bathroom between rooms 110 and 112 there was a bedpan sitting on the back of the toilet. There was no resident name visible on the bedpan. During an observation on 08/13/14 at 4:57 PM in the resident bathroom between rooms 118 and 120 there was a urinal on the shelf above the toilet. There was no resident name visible on the urinal. During an observation on 08/13/14 at 8:10 AM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf behind the toilet. There was no resident name visible on the collection hat. During an observation on 08/13/14 at 8:12 AM in the resident bathroom between rooms 214 and 216 there was a bedpan on the shelf behind the toilet. There was no resident name visible on the bedpan. During an observation on 08/13/14 at 8:13 AM in the resident bathroom between rooms 222 and 224 there was a urinal on the shelf behind the toilet. There was no resident name visible on the urinal. During an observation on 08/13/14 at 3:28 PM in the resident bathroom between rooms 110 and 112 there was a bedpan sitting on the back of the toilet. There was no resident name visible on the bedpan.	F 253	INCLUDE BEDPAN AND URINAL NEEDS AND CHECKING OF RESIDENT BATHROOMS FOR CORRECTLY LABELED UNITS WILL RESOLVE THE DEFICIENT PRACTICE FOR THE RESIDENTS AFFECTED AND THOSE HAVING POTENTIAL TO BE AFFECTED. THE SYSTEMIC CHANGE OF REVISING THE JOB DESCRIPTIONS OF THE MEDICAL SUPPLY AND Q.A. COORDINATORS TO HAVE RESPONSIBILITY FOR PROVIDING, LABELING AND MONITORING BEDPANS/URINALS AND THE MONITORING OF RESIDENT BATHROOMS WILL CREATE THE MEASURES TO ENSURE THE DEFICIENT PRACTICE DOES NOT OCCUR.THE STAFF INSERVICING,REVISION OF THE MONTHLY FACILITY Q.A. PROGRAM TO INCLUDE MONITORING THE SYSTEM WHEREBY THE MEDICAL SUPPLY COORDINATOR ISSUES LABELED BEDPANS/URINALS AND ACTUAL BATHROOM MONITORING WILL DEVELOP THE INTERNAL PLAN TO ENSURE THE SOLUTIONS ARE SUSTAINED.	

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F 253	Continued From page 7 During an observation on 08/13/14 at 3:30 PM in the resident bathroom between rooms 118 and 120 there was a urinal on the shelf behind the toilet. There was no resident name visible on the urinal During an observation on 08/13/14 at 3:31 PM in the resident bathroom between rooms 213 and 215 there was a urine collection hat on the shelf above the toilet. There was no resident name visible on the collection hat. During an observation on 08/13/14 at 3:32 PM in the resident bathroom between rooms 214 and 216 there was a bedpan on the shelf behind the toilet. There was no resident name visible on the bedpan. During an observation on 08/13/14 at 3:33 PM in the resident bathroom between rooms 222 and 224 there was a urinal on the shelf above the toilet. There was no resident name visible on the urinal. During an interview on 08/13/14 at 3:48 PM with Nurse Aide (NA) #1 stated all personal care equipment for residents which included bedpans and urine collection devices that were stored in resident bathrooms were supposed to be clearly marked with the resident's name and have a plastic bag around them. NA #1 continued by stating the urinal in the bathroom between rooms 118 and 120 should have been visibly labeled. During an interview on 08/13/14 at 4:08 PM with NA #2 stated all personal care equipment for residents which included bedpans and urine collection devices that were stored in resident bathrooms were supposed to be clearly marked	F 253		

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F 253	Continued From page 8 with the resident's name. NA #2 further stated the urine collection hat in the bathroom between rooms 213 and 215 should have been visibly labeled. During an interview on 08/13/14 at 4:19 PM with NA #3 stated all personal care equipment for residents which included bedpans and urine collection devices that were stored in resident bathrooms were to be visibly labeled. NA #3 continued by stating the bedpan in the bathroom between rooms 110 and 112 should have been visibly labeled. During an interview on 08/13/14 at 4:37 PM with NA #4 stated all personal care equipment for residents which included bedpans and urine collection devices should be visibly labeled. NA #4 further stated the unlabeled urinal between rooms 222 and 224 and the unlabeled bedpan between rooms 214 and 216 should be visibly labeled with the resident's name. During an interview on 08/14/14 at 4:36 PM with the Director of Nursing (DON) stated it was her expectation that bedpans and urinals be clean and labeled with the resident's name. The DON further stated she had no explanation to how these personal care items were not labeled.	F 253		
F 280 SS=D	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.	F 280	F280 483.20 RIGHT TO PARTICIPATE PLANNING CARE REVISE CP 09/11/14 THE RESIDENT HAS THE RIGHT, UNLESS ADJUDGED INCOMPETENT OR OTHERWISE FOUND TO BE OTHERWISE FOUND TO BE INCAPACITATED UNDER	

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F 280	Continued From page 9 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 record reviews, and family and staff interviews, the facility failed to provide the right of responsible parties to participate in the development of care plans for 3 or 4 residents (Residents #49, #6, and #162). The findings included: 1. Resident #49 was admitted to the facility on 06/12/14 with diagnoses which included chronic heart failure, edema, and Alzheimer's Disease. Resident #49's most recent quarterly Minimum Data Set (MDS) dated 07/02/14 assessed him as severely cognitively impaired. Resident #49's family was listed as his responsible person in his medical record. Review of facility Interdisciplinary Care Plan Attendance Sign-in form for Resident #49, revealed date of meetings were 10/29/13, 01/17/14, and 04/21/14. Although a family	F 280	THE LAWS OF THE STATE, TO PARTICIPATE IN PLANNING CARE AND TREATMENT OR CHANGES IN IN CARE AND TREATMENT. THE FACILITY WILL DEVELOP A COMPREHENSIVE CARE PLAN 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. THE OFFICE MANAGER WILL PRINT OFF COMPUTER-IZED FACE SHEETS WITH RESPONSIBLE PARTIES LISTED AND CARE PLAN NOTICE RESPONSIBILITIES NOTED ON EACH RESIDENT IN THE FACILITY TO ENSURE THAT ALL RESPONSIBLE PARTY INFORMATION IS COMPLETE AND FACILITY FACE SHEET HAS THE CORRECT NAME OF	

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F 280	Continued From page 10 member was listed as invited on the form, no family member signatures were on any of the care plan attendance sign in sheets. An interview with the family of Resident #49 on 08/13/14 at 11:15 AM revealed the family had not been invited to a care plan meeting or to participate in the development of Resident #49's care plan in any way during the nine months Resident #49 had resided in the facility. Interview with facility social worker (SW) on 08/13/14 at 4:39 PM revealed the receptionist handled all responsibilities of inviting residents and responsible parties to care plan meetings. The SW stated the receptionist mailed out invitation post cards to the address listed in the first contact of the face sheet from the medical record. When asked about the family member listed as invited on the care plan meeting sign in sheet, the SW stated the care plan meeting sign in sheet was generated by the MDS Coordinator, who also listed the person named as first contact on the face sheet in the medical record on the sign in sheet. The SW stated the MDS Coordinator was not involved with the process of inviting the resident's contact person, but listed the contact person's name on the care plan meeting sign in sheet. Interview with facility receptionist on 08/14/14 at 10:23 AM revealed she was given a list of residents weekly who were scheduled for care plan meetings. When given the list, the receptionist stated she mailed a postcard to the resident's first contact from the face sheet in their medical record. The receptionist stated she tried to keep track of when she sent out the post cards. The receptionist stated there was no	F 280	THOSE IN THE FAMILY WHO WISH TO BE INVITED TO INTERDISCIPLINARY CARE PLAN MEEETINGS. THE JOB DESCRIPTION OF THE OFFICE MANAGER WILL BE REVISED TO INCLUDE THE RESPONSIBILITY OF UPDATING RESPONSIBLE PARTY INFORMATION AND CARE PLAN NOTICE RESPONSIBILITY IN THE COMPUTERIZED FACE SHEET AS CHANGES BECOME KNOWN. THE INTERDISCIPLINARY CARE PLAN PROCEDURE WILL BE REVISED TO REQUIRE THAT WITHIN 7 DAYS AFTER COMPLETION OF THE COMPREHENSIVE ASSESSMENT, THE FACILITY SOCIAL WORKER WILL CONTACT THE RESIDENT, RESIDENT'S FAMILY OR RESIDENT'S LEGAL REPRESENTATIVE BY LETTER AND FOLLOWUP TELEPHONE CALL WITH RESULTS DOCUMENTED IN SOCIAL SERVICE NOTES , TO A INTERDISCIPLINARY CARE PLAN MEETING TO ASSIST IN DEVELOPMENT OF THE COMPREHENSIVE CARE PLAN AND WILL SCHEDULE THE CARE PLAN MEETINGS ACCORDING TO THE COMPREHENSIVE ASSESSMENT DATES. THE SOCIAL WORKER JOB DESCRIPTION WILL BE REVISED TO REFLECT THIS RESPONSIBIITY. THE FACILITY QUALITY	

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F 280	Continued From page 11 documentation kept regarding family response to the cards and no follow up was done to ensure the family members had received the post card. The receptionist provided one of the cards that was sent out to family members/contacts. The front of the card has the address of the facility and space to write the name and address of the resident's contact/family. The back of the card stated the family members care plan had been reviewed and to please call the Receptionist to arrange a conference time or the care plan could be mailed to the family. The bottom of the card had the name of the facility and the phone numbers to contact the facility. During a subsequent interview on 08/14/14 the receptionist provided a list of residents, which included the name of Resident #49, for whom she had sent cards out on 05/02/14. The receptionist stated she did not know if the family of Resident #49 received the card and she had no documentation of any response from them. When shown the facility Interdisciplinary Care Plan attendance sign in form for Resident #49, which stated the date of meeting was 04/21/14, and asked why she had mailed out the card on 05/02/14 and not before the meeting, the receptionist stated she was given a list of residents to send cards out for once their care plan meeting was completed to invite them to have the plan reviewed with them or have it mailed to them. Interview with the MDS Coordinator on 08/14/14 at 2:58 PM revealed she generated the interdisciplinary care plan attendance sheet for each resident whenever a care plan revision was needed: quarterly, when there was a significant change, or any other time an assessment was	F 280	ASSURANCE PROGRAM WILL BE REVISED TO INCLUDE MONTHLY MONITORING OF CARE PLAN SCHEDULE, WITH CHECKS OF DATES LETTERS WERE SENT, DATES CALLS WERE MADE, DATES OF ACTUAL MEETINGS AND CHECKS OF ATTENDANTS AT CARE PLAN MEETINGS. A CHECK WILL ALSO BE MAD E TO ENSURE FACE SHEET RESPONSIBLE PARTY/ INTERESTED FAMILY UPDATES WERE COMPLETED WITH THE CARE PLAN SCHEDULE. THE CORRECTIVE ACTIONS OF REVIEWING ALL CURRENT RESIDENT FACE SHEETS FOR UPDATED RESPONSIBILITY PARTY/FAMILY INFORMATION AND CORRECT COMPUTERIZED SECTION WHICH DESIGNATES THOSE TO CONTACT FOR CARE PLAN MEETINGS, REVISING THE JOB DESCRIPTION OF THE SOCIAL WORKER TO BE RESPONSIBLE FOR NOTIFI-CATION OF RESIDENTS AND RESPONSIBLE PARTIES / INTERESTED FAMILY MEMBERS AND DOCUMENTA-TION OF NOTIFICATION RESULTS AS WELL AS THE SCHEDULING THE CARE PLAN MEETINGS BASED ON THE COMPREHENSIVE ASSESSMENT SCHEDULE WILL CORRECT THE DEFICIENT PRACTICE FOR THOSE	

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F 280	Continued From page 12 done. The MDS Coordinator stated the family member name written on the "invited" line of the sign in sheet is generated directly from the first emergency contact name from the resident's face sheet in the medical record. The MDS Coordinator stated she verified the name on the sign in sheet matched the resident's emergency contact person, but had no involvement in the process of inviting families or guardians to the meetings. The MDS Coordinator stated the receptionist did all of that once she was given a list of all residents who had a care plan revision. The MDS coordinator stated once the updated care plan resident list went to the receptionist to send the postcard out, the care plan had already been developed by the interdisciplinary team. The MDS coordinator stated the purpose of sending the post card to families or guardians was to give them a chance to express their desire to review the revised care plan with someone. The MDS coordinator stated if a family called to do this, the Administrator would appoint a nurse or another staff person to meet with the family member or guardian to review the care plan. The MDS Coordinator stated this had been the facility's procedure for the 3 years she had been working there. 2. Resident #6 was admitted to the facility on 08/13/09 with diagnoses which included Parkinson's disease, seizures, and gallstones. Resident #6's most recent quarterly Minimum Data Set (MDS) dated 06/24/14 assessed her as being moderately cognitively impaired. Resident #6's family was listed as her responsible person in her medical record. Review of facility Interdisciplinary Care Plan Attendance Sign-in form for Resident #6,	F 280	AFFECTED BY THE DEFICIENT PRACTICE AS WELL AS THOSE HAVING THE POTENTIAL TO BE AFFECTED. THE SYSTEMIC CHANGE OF ASSIGNING THE SOCIAL WORKER THE RESPONSIBILITY OF RESIDENT AND FAMILY NOTIFICATION, REQUIRING DOCUMENTATION OF NOTIFICATION RESULTS AND SCHEDULING OF THE INTERDISCIPLINARY CARE MEETINGS BASED ON THE 7 DAYS FOLLOWING THE COMPLETION OF THE COMPREHENSIVE ASSESSMENT AS WELL AS REQUIRING THE OFFICE MANAGER TO UPDATE THE FACILITY COMPUTERIZED FACE SHEET AS CHANGES BECOME KNOWN IN RESPONSIBLE PARTIES AND INTERESTED FAMILY AND THOSE WHO WANT INVOLVEMENT IN THE PROCESS HAS CREATED THE MEASURE WHICH PUTS INTO PLACE THE CHANGE WHICH WILL PREVENT THE DEFICIENT PRACTICE FROM OCCURRING. THE REVISION IN THE FACILITY QUALITY ASSURANCE PROGRAM WILL CREATE INTERNALMONITORING DATES OF CARE PLAN NOTIFICATIONS , OF ACTUAL MEETINGS AND REVISIONS TO FACE SHEET INFORMATION WILL CREATE THE INTERNAL MONITORING TOOL TO MAKE SURE THE SOLUTIONS ARE SUSTAINED.	

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F 280	Continued From page 13	F 280		

revealed date of meetings were 10/23/13, 01/20/14, 04/14/14, and 07/08/14. No family member signatures were on any of the care plan attendance sign in sheets.

Interview with family member of Resident #6 on 08/11/14 at 3:25 PM revealed she had never been invited to a care planning meeting or to participate in the care plan development process during the 5 years Resident #6 had been at the facility.

Interview with facility social worker (SW) on 08/13/14 at 4:39 PM revealed the receptionist handled all responsibilities of inviting residents and responsible parties to care plan meetings. The SW stated the receptionist mailed out invitation post cards to the address listed in the first contact of the face sheet from the medical record. When asked about the family member listed as invited on the care plan meeting sign in sheet, the SW stated the care plan meeting sign in sheet was generated by the MDS Coordinator, who also listed the person named as first contact on the face sheet in the medical record on the sign in sheet. The SW stated the MDS Coordinator was not involved with the process of inviting the resident's contact person, but listed the contact person's name on the care plan meeting sign in sheet.

Interview with facility receptionist on 08/14/14 at 10:23 AM revealed she was given a list of residents weekly who were scheduled for care plan meetings. When given the list, the receptionist stated she mailed a postcard to the resident's first contact from the face sheet in their medical record. The receptionist stated she tried to keep track of when she sent out the post

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cards. The receptionist stated there was no documentation kept regarding family response to the cards and no follow up was done to ensure the family members had received the post card. The receptionist provided one of the cards that was sent out to family members/contacts. The front of the card had the address of the facility and space to write the name and address of the resident's contact/family. The back of the card stated the family members care plan had been reviewed and to please call the Receptionist to arrange a conference time or the care plan could be mailed to the family. The bottom of the card had the name of the facility and the phone numbers to contact the facility.

During a subsequent interview on 08/14/14 the receptionist provided a list of residents, which included the name of Resident #6, for whom she had sent cards out on 05/02/14. The receptionist stated she did not know if the family of Resident #6 received the card and she had no documentation of any response from them. When shown the facility Interdisciplinary Care Plan attendance sign in form for Resident #6, which stated the date of meeting was 04/14/14, and asked why she had mailed out the card on 05/02/14 and not before the meeting, the receptionist stated she was given a list of residents to send cards out for once their care plan meeting was completed to invite them to have the plan reviewed with them or have it mailed to them.

Interview with the MDS Coordinator on 08/14/14 at 2:58 PM revealed she generated the interdisciplinary care plan attendance sheet for each resident whenever a care plan revision was needed: quarterly, when there was a significant

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F 280	Continued From page 15 change, or any other time an assessment was done. The MDS Coordinator stated the family member name written on the "invited" line of the sign in sheet is generated directly from the first emergency contact name from the resident's face sheet in the medical record. The MDS Coordinator stated she verified the name on the sign in sheet matched the resident's emergency contact person, but had no involvement in the process of inviting families or guardians to the meetings. The MDS Coordinator stated the receptionist did all of that once she was given a list of all residents who had a care plan revision. The MDS coordinator stated once the updated care plan resident list went to the receptionist to send the postcard out, the care plan had already been developed by the interdisciplinary team. The MDS coordinator stated the purpose of sending the post card to families or guardians was to give them a chance to express their desire to review the revised care plan with someone. The MDS coordinator stated if a family called to do this, the Administrator would appoint a nurse or another staff person to meet with the family member or guardian to review the care plan. The MDS Coordinator stated this had been the facility's procedure for the 3 years she had been working there. 3. Resident #162 was admitted to the facility on 11/19/13 with diagnoses which included kidney disease, vascular dementia, and chronic pain. Resident #162's most recent quarterly Minimum Data Set (MDS) dated 01/15/14 assessed him as being cognitively intact. Review of Resident #162's medical record revealed family member was listed as Resident #162's first emergency contact, and Resident #162's guardian was listed as Resident #162's second emergency contact.	F 280		

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F 280	Continued From page 16 Review of facility Interdisciplinary Care Plan Attendance Sign-in form for Resident #162, revealed date of meetings were 10/13/13 and 01/07/14. No family member or guardian signatures were on any of the care plan attendance sign in sheets. Interview with the Admissions Director (AD) on 08/13/14 at 3:57 PM revealed during all admissions, she assisted residents and families with completing the first, second, and third contact information sheet, which was used by all staff when notifying family members about changes in condition and when inviting families to care plan meetings. The AD stated whenever a resident with a legal guardian was admitted, the guardianship papers were reviewed, copied for the chart, and the legal guardian was listed as the resident's first contact in the medical record. Interview with the legal guardian of Resident #162 on 08/13/14 at 4:14 PM revealed he had never been invited to attend a care plan meeting or participate in the care plan development process since Resident #162's admission to the facility. The guardian of Resident #162 stated he had been Resident #162's guardian during his entire stay at the facility and had provided the facility with the legal documentation of guardianship at the time of Resident #162's admission to the facility. The guardian further stated that during Resident #162's stay at the facility, the guardianship status had changed from interim to permanent, but no other changes had been made. Interview with facility social worker (SW) on 08/13/14 at 4:39 PM revealed the receptionist	F 280		

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F 280	Continued From page 17 handled all responsibilities of inviting residents and responsible parties to care plan meetings. The SW stated the receptionist mailed out invitation post cards to the address listed in the first contact of the face sheet from the medical record. When asked about the family member listed as invited on the care plan meeting sign in sheet, the SW stated the care plan meeting sign in sheet was generated by the MDS Coordinator, who also listed the person named as first contact on the face sheet in the medical record on the sign in sheet. The SW stated the MDS Coordinator was not involved with the process of inviting the resident's contact person, but listed the contact person's name on the care plan meeting sign in sheet. Interview with Office Manager on 08/14/14 at 8:05 AM revealed facility had been given guardianship papers during Resident #162's admission. When asked why the guardian of Resident #162 had not been listed as the first contact on Resident #162's face sheet, the office manager stated she had thought that the guardianship of Resident #162 had been revoked at some point during his stay. The office manager stated she had no additional legal paperwork regarding any change in guardianship after Resident #162's admission. Interview with facility receptionist on 08/14/14 at 10:23 AM revealed she was given a list of residents weekly who were scheduled for care plan meetings. When given the list, the receptionist stated she mailed a postcard to the resident's first contact from the face sheet in their medical record. The receptionist stated she tried to keep track of when she sent out the post cards. The receptionist stated there was no documentation kept regarding family response to	F 280		

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F 280	Continued From page 18 the cards and no follow up was done to ensure the family members had received the post card. The receptionist provided one of the cards that was sent out to family members/contacts. The front of the card has the address of the facility and space to write the name and address of the resident's contact/family. The back of the card stated the family members care plan had been reviewed and to please call the Receptionist to arrange a conference time or the care plan could be mailed to the family. The bottom of the card had the name of the facility and the phone numbers to contact the facility. During a subsequent interview on 08/14/14 the receptionist provided a list of residents, which included the name of Resident #162, for whom she had sent cards out on 01/06/14. The receptionist stated the card had been sent to Resident #162's family member who was listed on his face sheet as first emergency contact and not to his guardian. When asked why she had not mailed the card to the resident's guardian, the receptionist stated she had been told to only mail the card out to the name listed in the first emergency contact of the face sheet. The receptionist stated she did not know if the family of Resident #162 received the card and she had no documentation of any response from them. When shown the facility Interdisciplinary Care Plan attendance sign in form for Resident #162, which stated the date of meeting was 01/07/14, and asked why she had mailed out the card on 01/06/14 and not in enough time before the meeting for the family to attend, the receptionist stated she was given a list of residents to send cards out for once their care plan was completed to invite them to have the plan reviewed with them or just have it mailed to them.	F 280		

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F 280	Continued From page 19 Interview with the MDS Coordinator on 08/14/14 at 2:58 PM revealed she generated the interdisciplinary care plan attendance sheet for each resident whenever a care plan revision was needed: quarterly, when there was a significant change, or any other time an assessment was done. The MDS Coordinator stated the family member name written on the "invited" line of the sign in sheet was generated directly by the first emergency contact name from the resident's face sheet in the medical record. The MDS Coordinator stated she verified the name on the sign in sheet matched the resident's emergency contact person, but had no involvement in the process of inviting families or guardians to the meetings. The MDS Coordinator stated the receptionist did all of that once she was given a list of all residents having a care plan revision. The MDS coordinator stated once the updated care plan resident went goes to the receptionist to send the postcard out, the care plan had already been developed by the interdisciplinary team. The MDS coordinator stated the purpose of sending the post card to families or guardians was to give them a chance to express their desire to review the revised care plan with someone. The MDS coordinator stated if a family called to do this, the Administrator would appoint a nurse or another staff person to meet with the family member or guardian to review the care plan. The MDS Coordinator stated this had been the facility's procedure for the 3 years she had been working there.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	F312 483;25 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS THE FACILITY WILL PROVIDE THE NECESSARY SERVICES 09/11/14 TO MAINTAIN GOOD NUTRITION, GROOMING AND PERSONAL AND ORAL HYGIENE FOR RESIDENTS UNABLE.	

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	345206	A. BUILDING _____ B. WING _____	C 08/14/2014

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F 312	Continued From page 20 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and family interviews the facility failed to provide nail care to 1 of 5 sampled residents reviewed for activities of daily living (Resident #115). The findings included: Resident #115 was admitted on 02/27/14 with diagnosis which included dementia, muscle weakness and lack of coordination. The most recent quarterly Minimum Data Set (MDS) dated 05/12/14 revealed Resident #115 was severely cognitively impaired and had unclear speech but was usually understood. The MDS further revealed Resident #115 required extensive assistance from staff for transfer, dressing, and personal hygiene. Resident #115 was coded as not being resistive to care. A care plan dated 03/19/14 indicated Resident #115 required extensive 2 person assistance with all activities of daily (ADL) care. The goal stated Resident #115 would be able to participate in part of ADL care through next review date of 08/19/14. The ADL care plan included approaches to assist Resident #115 by breaking tasks up into smaller steps, allowing rest breaks between tasks, talking with resident while proving care to build rapport and trust along with giving verbal cues to help prompt.	F 312	TO CARRY OUT ACTIVITIES OF DAILY LIVING. THE ONE NAIL IN QUESTION DURING EXIT CONFERENCE OF RESIDENT #115 WAS CUT ON 08/13/14. THE RESIDENT NAIL CARE PROCEDURE WILL BE REVISED. THE SHOWER TEAM C.N.A.'S ARE RESPONSIBLE FOR DAILY NAIL CARE BUT NOW PERFORM NAIL CARE ON ALL RESIDENTS NOTED ON DAILY SHOWER LIST AFTER THE SHOWERS ARE COMPLETED FOR THE SHIFT. THIS CHANGE IN NAIL CARE PROCEDURE WILL REDUCE THE NUMBER OF ADL FUNCTIONS THAT MUST BE PROVIDED DURING THE SHOWER-BATHING EXPERIENCE AND WILL ALLOW MORE INDIVIDUALIZED NAIL CARE. THE SHOWER TEAM DAILY ASSIGNMENT SHEET WILL BE REVISED TO INCLUDE COMMENTS ON RESIDENT NAIL CONDITION. THE DIRECTOR OF NURSING WILL REVIEW THE CHANGES IN SHOWER TEAM RESPONSIBILITIES AND NAIL PROCEDURES IN A MANDATORY C.N.A. AND NURSE INSERVICE. THE JOB DESCRIPTION OF THE NURSE MANAGERS WILL BE REVISED TO INCLUDE THE RESPONSIBILITY OF DAILY MONITORING OF NAIL CARE AND DAILY SHOWER	

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F 312	Continued From page 21 A review of a nurse aide assignment sheet dated 08/11/14 through 08/15/14 identified Resident #115 received her showers on Wednesdays and Fridays. During an observation on 08/11/14 at 11:04 AM revealed Resident #115 had 10 fingernails with dark colored debris under her nails. During an observation on 08/12/14 at 11:51 AM revealed Resident #115 had 10 fingernails with dark colored debris under her nails. During an observation on 08/12/14 at 3:45 PM revealed Resident #115 had 10 fingernails with dark colored debris under her nails. During an observation on 08/13/14 at 10:00 AM revealed Resident #115 returned to her room following her shower with Nurse Aide (NA) #5 and had 10 fingernails with dark colored debris under her nails. During an interview on 08/12/14 at 11:46 AM with Resident #115's family revealed they would like for her nails to be cleaned because they felt this would be more sanitary. During an interview on 08/13/14 at 10:16 AM with NA #5 who was familiar with Resident #115 and had assisted with her shower described their system for showers. NA #5 stated she looked at the assignment sheet each day and made note of the residents who would be getting showers that day. NA #5 continued by stating nails would get clipped and filed along with cleaning the fingernails if they had debris under them. NA #5 confirmed Resident #115 was complete with her shower when she brought her back to her room.	F 312	TEAM DOCUMENTATION FORM WILL BE REVISED TO MORE CLEARLY DENOTE THOSE RESIDENT'S PROVIDED NAIL CARE AS WELL AS A COMMENT SECTION ON NAIL CONDITION. THE FACILITY QUALITY ASSURANCE PROGRAM WILL BE REVISED TO INCLUDE MONITORING OF THE SHOWER TEAM DOCUMENTATION- -FOR 4 WEEKS AND THEN MONTHLY--- ON NAIL CARE AND THE MONITORING OF THE NURSE MANAGER'S MONITORING OF THE DAILY NAIL CARE. THE CORRECTION ACTION OF CUTTING RESIDENT #115'S FINGERNAIL AND THE CORRECTIVE ACTIONS INVOLVED IN REVISING THE NAIL CARE PROCEDURES, REVISING THE SHOWER TEAM NAIL CARE DOCUMENTATION FORM AND ASSIGNING THE NURSE MANAGERS THE RESPONSIBILITY OF MONITORING DAILY NAIL CARE WILL RESOLVE THE DEFICIENT PRACTICE FOR THE RESIDENT AFFECTED AND THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED. THE SYSTEMIC CHANGE OF PROVIDING NAIL CARE SEPARATE FROM THE SHOWER-BATHING EXPERIENCE AND	

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F 312	Continued From page 22 NA #5 concluded she had noticed the debris under Resident #115 nails and was not able to get it cleaned out. During an interview on 08/13/14 at 10:53 AM with Nurse #1 stated she was familiar with the care of Resident #115. Nurse #1 stated it was her expectation that resident's nails were clean and this was part of the shower routine. Nurse #1 confirmed that Resident #115's nails did need to be cleaned and she would get a nurse aide to clean them. During a follow-up interview on 08/13/14 at 11:18 AM with Nurse #1 she stated Resident #115's nails were clean and Resident #115 had allowed them to clean her nails. During an interview on 08/14/14 at 4:33 PM with the Director of Nursing (DON) she explained nail care should be provided during the shower. The DON further stated they had some staff on light duty who worked on nail care every day. The DON concluded by stating it was her expectation that debris under nails be cleaned because it should not be there.	F 312	REVISING THE SHOWER TEAM DOCUMENTATION FORM TO INCLUDE MORE INFORMATION ON NAIL CARE CONDITIONS WILL CREATE THE CHANGE THAT WILL ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR. THE DAILY MONITORING OF RESIDENT NAIL CARE BY THE NURSE MANAGERS AND THE REVISION OF THE FACILITY QUALITY ASSURANCE PROGRAM TO MONITOR THESE SYSTEM CHANGES WILL CREATE THE INTERNAL MONITORING PLAN WHICH WILL ENSURE THE SOLUTIONS ARE SUSTAINED	
F 371 SS=E	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	F 371	F371 483:35 FOOD PROCEDURE=STORE/PREPARE/ SERVE SANITARY 09/11/14 THE FACILIITY WILL PROCURE FOOD FROM SOURCES APPROVED AND CONSIDERED SATISFACTORY BY FEDERAL, STATE OF LOCAL AUTHORITIES AND STORE PREPARE, DISTRIBUTE AND SERVE FOOD UNDER	

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F 371	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain cleanliness in 1 of 2 pantry refrigerators. The findings included: A review of an undated Job Description for Night Shift Nurses was conducted. Included in duties of the night shift nurses was the nurses were to be sure the nurse aides cleaned the large refrigerator in the pantry rooms every Monday night. 1a. An observation on 08/11/14 at 9:33 AM revealed the freezer in the south pantry room refrigerator contained a raised ping pong ball size yellowish substance on the floor of the freezer. The interior of the refrigerator contained a reddish spill across the right half of the top of the shelf over the vegetable bin. The substance was sticky when touched. The spill extended from the front edge to approximately mid way across the bin. A brownish colored splatter was observed in front of the right front of the vegetable bin and extended under the bin approximately half of the depth of the bin. The refrigerator contained juices and nutritional supplements for residents. 1b. An additional observation on 08/12/14 at 11:22 AM revealed a tray of sandwiches, juices, and nutritional supplements labeled for resident use was placed over the sticky splatter on the shelf over the vegetable bin. The other spills were unchanged in appearance.	F 371	SANITARY CONDITIONS. THE PROCEDURE FOR CLEANING THE PANTRY REFRIGERATORS WILL BE REVISED. THE JOB DESCRIPTION OF THE DIETARY AIDE WILL BE REVISED TO INCLUDE THE DAILY CLEANING OF ALL PANTRY REFRIGERATORS BEFORE THE 2:PM SNACKS ARE TAKEN TO THE NURSING UNIT. ALL DIETARY STAFF WILL BE INSERVICED ON THIS CLEANING PROCEDURE BY THE FSM. THE INSERVICE WILL BE INCLUDED IN THE DIETARY JOB SPECIFIC ORIENTATION THE JOB DESCRIPTION OF THE FOOD SERVICE MANAGER WILL BE REVISED TO INCLUDE THE RESPONSIBILITY OF MONITORING THE CLEANLINESS OF THE PANTRY REFRIGERATORS. THE Q.A. PROGRAM WILL BE REVISED TO INCLUDE DAILY MONITORING OF PANTRY CLEANLINESS FOR 2 WEEKS AND THEN WEEKLY MONITORING FOR 4 WEEKS. MONTHLY CHECKS BY THE Q.A. COORDINATOR IN THE FACILITY Q.A. PROGRAM THEREAFTER. THE PANTRY REFRIGERATOR WAS CLEANED 8/13/14	

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F 371	Continued From page 24 1c. Continued observations on 08/13/14 at 7:50 AM and 3:15 PM revealed the soiled areas in the south pantry refrigerator were unchanged. Unit Manager (UM) #1 participated in the observation of the south pantry refrigerator on 08/13/14 at 3:15 PM. UM #1 acknowledged the refrigerator should be cleaned. She stated she thought it was the responsibility of the night shift nurse aide to clean the refrigerator. UM #1 was unsure who monitored the nurse aides to see this was done. An interview with the Director of Nursing (DON) on 08/14/14 at 4:46 PM revealed the night nurse aides were supposed to clean the pantry refrigerators on Monday nights. The DON stated it was her expectation this task would be completed so the refrigerator remained clean.	F 371	THIS CORRECTIVE ACTION AND THE CORRECTIVE ACTIONS INVOLVED IN REVISION OF THE JOB DESCRIPTION OF THE DIETARY AIDE TO INCLUDE DAILY CLEANING OF PANTRY REFRIGERATORS AND THE INSERVICING OF DIETARY STAFF IN THIS NEW RESPONSIBILITY NOTED ON THE DAILY CLEANING ASSIGNMENT AND THE FSM'S RESPONSIBILITY IN CHECKING WILL RESOLVE THE DEFICIENT PRACTICE FOR THE RESIDENT AFFECTED AND THOSE HAVING THE POTENTIAL TO BE AFFECTED AS WELL AS CREATE THE SYSTEMIC CHANGE WHICH WILL ENSURE THE DEFICIENT PRACTICE DOES NOT OCCUR. THE REVISION OF THE FACILITY QUALITY ASSURANCE PROGRAM TO MONITOR THE CLEANLINESS OF PANTRY REFRIGERATORS DAILY, WEEKLY AND THEN MONTHLY WILL CREATE THE INTERNAL MONITORING PLAN TO MAKE SURE THE SOLUTIONS ARE SUSTAINED.	