STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS IDR 3/30/15 resulted in deletion of F 241 and F 242. 4/8/15 CMS over rode IDR panel decision.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow their policy and request a criminal background review for 1 of 5 employees (Nursing Assistant # 6). Findings included: The facility's undated Abuse Prevention Program indicated resident's have the right to be free of abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Under Policy Interpretation and Implementation, Paragraph 2, the policy indicated the facility would not knowingly employ any individual who has been convicted of abusing, neglecting or mistreating individuals. Under Paragraph 3, the policy indicated the facility had established protocols for conducting employment background checks. Nursing Assistant (NA) #6 was hired on 12/30/14 and continues to work in the facility.	F 226	1. Nurse Assistant #6 back ground check was obtained by the Administrator on February 12, 2015 and placed in file in business office. 2. Any resident can be affected by this practice. Therefore, the business office manager on February 27, 2015 reviewed current personnel files to assure back ground checks are in place. 3. The Clinical Operations Nurse in-serviced the Administrator on March 2, 2015 on the requirement of a back ground check before employment is offered. A Requirement Employment Information Form was created by the Administrator and department managers were in-serviced on the use of the form and the requirements on March 2, 2015. 4. The Administrator will continue to put final signature on the Required Employment Information form after visual verification of the personnel file upon	3/5/15

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

Electronically Signed | 03/06/2015

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F 226	Continued From page 1 Review of NA #6's facility personnel record indicated the facility had not requested or sent information to their contract company for a criminal background check on NA #6. The Administrator was interviewed on 2/12/15 at 3:27 PM. She stated she was responsible for requesting and completing background checks with the Business Office Manager as her backup. The Administrator stated she had not requested the criminal background check on NA #6. She added as soon as she saw NA#6's name on the list of requested personnel files, she knew the file was going to be missing since she did not recognize the NA's name as a criminal background check that had been requested.. The Administrator added there was no current system in place to make sure criminal background checks were requested and not missed.	F 226	completion of orientation. 5. The Administrator will bring to the monthly Quality Assurance Process Improvement meeting the results of the new hire personnel file review for the next 3 months.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident, family member and staff interviews and record review, the facility failed to honor the request of 1 of 1 sampled resident (Resident # 102) to use his own underwear and not wear incontinent briefs. Findings included:	F 241	1. Resident #102 was interviewed by Social Worker on March 2, 2015 to assure provision of clothing/brief is at the resident's request. The Aide Care Card and Care Plan was updated on March 2, 2015 by the Minimum Data Set nurse. 2. Any resident requesting clothing/brief	3/5/15

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F 241	Continued From page 2 Resident # 102 was admitted on 1/15/15 with diagnoses that included a stroke, generalized muscle weakness, difficulty walking, congestive heart failure, diabetes, and lack of coordination. The Admission Minimum Data Set (MDS), dated 1/22/15, indicated Resident # 102 was cognitively intact with no behaviors or rejection of care identified. The MDS also indicated Resident # 102 required extensive assistance with hygiene and toileting. He was coded as frequently incontinent of bladder with no toileting program in place. An interview was held with Resident 102's family member on 2/10/15 at 2:00 PM. She stated the resident could propel the wheelchair and go into the bathroom alone. An interview was held with Nursing Assistant (NA) #1 on 2/11/15 at 11:05 AM. She stated the resident wanted to be independent. The NA added Resident # 102 was able to make his toileting needs known. NA #1 stated Resident # 102 became upset when staff placed incontinent briefs on him instead of his own underwear. On the morning of 2/10/15, when she arrived for her 7-3 shift, she stated she found the 11-7 NA, had placed an incontinent brief on the resident. The NA stated she spoke with NA #2 and told him the resident was able to use the urinal and was able to tell staff when he needed to void. NA #1 added NA #2 stated he placed the incontinent brief on Resident # 102 because he had wet the bed. The NA reported the urinal was out of the resident's reach when she went into his room. NA # 1 stated she reported the problem to MDS Nurse #1.	F 241	preferences can be affected by this process. Therefore, the Interdisciplinary Team will meet and review resident brief/clothing preferences on March 4, 2015 at Standards of Care Meeting based on the Guardian Angel rounds. The Standard of Care Meeting is a weekly meeting where the Adminsitrator, Director of Nursing, Staff Development Coordinator, Dietary Manager, Social Services, Activity Director and MDS nurses review in-house and high risk resident. The Guardian Angels are the center's management team that are assigned to residents to monitor care and services. Updates to the Aide Care Card and Care Plan will be done at this time. 3. Nurse aide #2 was in-serviced by the Staff Development Coordinator on February 13, 2015 on dignity and resident choice. An in-service was conducted for the nursing staff on February 13, 2015 by the Staff Development Coordinator regarding Resident Rights including dignity and resident choices. Staff will be provided the Resident Rights and a signed copy will be placed in their personnel folder. Staff education will be completed on March 4,2015. Directed In-service will be done by an RN working with Alliant Quality on Resident Rights including dignity and resident choices on March 4, 2015. Staff unable to attend the initial Directed Inservice, will not be scheduled to work until they have completed the Directed Inservice conducted by the Director of Nursing or Staff Development Coordinator. 4. The Guardian Angels assigned to	

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F 241	Continued From page 3 On 2/11/15 at 2:10 PM, Nurse #1 was interviewed. She stated she worked with Resident # 102 Monday through Friday on the 7-3 shift. Nurse # 1 stated Resident # 102 was alert, oriented and reliable. She added the resident was capable of letting the staff know when he needed to void. Resident # 102 was interviewed on 2/11/15 at 2:33 PM. The resident stated he had problems with NA # 2 that worked the 11-7 shift. He stated NA # 2 made him wear an incontinent brief instead of his own underwear, although he had told NA #2 he did not want to wear the incontinent brief. Resident # 102 stated wearing the incontinent brief made him feel like a child. He added he was capable of using the urinal, if the urinal was in reach. Resident # 102 stated he was capable of using the call bell to call for assistance as needed. He stated on the occasions he had worn his own underwear and wet the bed, it was because NA #2 had placed the urinal out of his reach. The resident confirmed he had told NA # 1 about NA #2 making him wear the incontinent brief. An interview was held with the Certified Occupational Therapy Assistant (COTA) on 2/11/15 at 2:43 PM. She stated she worked with Resident # 102 on an almost daily basis. The COTA stated Resident # 102 was alert, oriented and reliable. She added he was able to make his needs known and was able to use the urinal. . MDS Nurse #1 was interviewed on 2/11/15 at 3:50 PM. She stated she had received information from NA #1 that the night shift NA made Resident # 102 wear an incontinent brief	F 241	residents will interview each resident weekly regarding staff responsiveness to resident choices as well as maintenance of dignity. Any concerns expressed in the interviews will be brought to the Stand Up Meeting and will be placed into the formal grievance process. 5. The Administrator will review the results of the interviews to assist with identification of future staff training. The results will be brought to the monthly Quality Assurance Process Improvement meeting by the Administrator for committee review for 4 months.	

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F 241	Continued From page 4	F 241		

and the resident did not want to wear the incontinent brief. She stated she had called the NA several times, but he had not returned her calls.

A telephone interview was held with NA#2 on 2/12/15 at 5:30 AM. NA #2 confirmed he worked with Resident # 102 on the 11 to 7 shift at least 5 days a week. He stated he was trained on resident's rights during orientation. The NA stated he was aware a resident had the right to refuse anything. NA #2 acknowledged he had used incontinent briefs on Resident # 102 because the resident wet the bed at night. He stated the urinal was kept within the resident's reach. The NA stated he was currently working with Resident # 102 during this 11 to 7 shift. The NA stated he had not placed an incontinent brief on the resident at any time during the night.

An interview was held with NA #1 on 2/12/15 at 9:30 AM. The NA stated when she arrived for work at 7:00 AM she checked on Resident #102. The NA added she found Resident # 102 wearing an incontinent brief placed by NA #2 who had cared for the resident on the 11-7 shift. The NA added Resident #102's briefs were laying in the chair next to the bed. NA # 1 stated she removed the incontinent brief and placed Resident # 102 in his own clothing.

Resident # 102 was interviewed on 2/12/15 at 9:40 AM. He stated NA # 2 placed an incontinent brief on him during the 11-7 shift. The resident stated he did not refuse last night, adding he had refused so many times before and it had done no good. Resident # 102 stated, "I guess I just have to accept it."

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F 241	Continued From page 5 An interview was held with the Director of Nursing (DON) on 2/12/15 at 10:115 AM. The DON stated staff was taught about resident's rights during orientation and yearly. Included in the resident's rights presentation is the right to refuse treatments and medications. The DON stated if a resident refused to wear an incontinent brief she expected staff to honor the right to refuse and not place the incontinent brief. The DON added if the brief was applied after the resident refused, it was "just wrong." The Staff Development Coordinator (SDC) was interviewed on 2/12/15 at 2:21 PM. She stated resident's rights were reviewed during orientation, yearly and as issues arose. The SDC added staff are taught that residents have the right to refuse treatments, medications and anything else that may occur. She stated she taught staff if the resident refused to wear an incontinent brief, then you leave the brief off. The SDC stated NA # 2 had been hired on 8/12/14. He had signed receipt of the employee handbook, but had not signed the paper that spoke specifically about resident's rights.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced	F 242		3/5/15

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F 242	Continued From page 6 by: Based on resident, family member and staff interviews and record review, the facility failed to honor the request of 1 of 1 sampled resident (Resident # 102) to use his own underwear and not wear incontinent briefs. Findings included: Resident # 102 was admitted on 1/15/15 with diagnoses that included a stroke, generalized muscle weakness, difficulty walking, congestive heart failure, diabetes, and lack of coordination. The Admission Minimum Data Set (MDS), dated 1/22/15, indicated Resident # 102 was cognitively intact with no behaviors or rejection of care identified. The MDS also indicated Resident # 102 required extensive assistance with hygiene and toileting. He was coded as frequently incontinent of bladder with no toileting program in place. An interview was held with Resident 102's family member on 2/10/15 at 2:00 PM. She stated the resident could propel the wheelchair and go into the bathroom alone. An interview was held with Nursing Assistant (NA) #1 on 2/11/15 at 11:05 AM. She stated the resident wanted to be independent. The NA added Resident # 102 was able to make his toileting needs known. NA #1 stated Resident # 102 became upset when staff placed incontinent briefs on him instead of his own underwear. On the morning of 2/10/15, when she arrived for her 7-3 shift, she stated she found the 11-7 NA, had placed an incontinent brief on the resident. The NA stated she spoke with NA #2 and told him the	F 242	1. Resident #102 was interviewed by Social Worker on March 2, 2015 to assure provision of clothing/brief is at resident's request. The Aide Care Card and Care Plan was updated on March 2, 2015 by Minimunm Data Set nurse. 2. Any resident requesting clothing/brief preferences can be affected by this process. Therefore, the Interdisciplinary Team will meet and review residents brief/clothing preferences on March 4, 2015 at Standards of Care meeting based on the Guardian Angel rounds. The Standards of Care meeting is a weekly meeting where the Administrator, Director of Nursing, Staff Development Coordinator, Dietary Manager, Social Services, Activity Director and Minimum Data Set nurses review in-house and high risk residents. The Guardian Angels are the center's management team that are assigned to residents to monitor care and services. Updates to the Aide Care Card and Care Plan will be done at this time. 3. Nurse Aide #2 was in-serviced by the Staff Development Coordinator on February 13, 2015 on dignity and resident choice. An In-service was conducted for nursing staff of February 13, 2015 by the Staff Development Coordinator regarding the Residetns Rights including dignity and resident choices. Staff will be provided the Resident Rights and a signed copy will be placed in their personnnel folder. Staff education will be completed on March 4, 2015. Directed In-servicing will be done by an RN working with Alliant Quality on Residnet Rights including dignity and	

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F 242	Continued From page 7 resident was able to use the urinal and was able to tell staff when he needed to void. NA #1 added NA #2 stated he placed the incontinent brief on Resident # 102 because he had wet the bed. The NA reported the urinal was out of the resident ' s reach when she went into his room. NA # 1 stated she reported the problem to MDS Nurse #1. On 2/11/15 at 2:10 PM, Nurse #1 was interviewed. She stated she worked with Resident # 102 Monday through Friday on the 7-3 shift. Nurse # 1 stated Resident # 102 was alert, oriented and reliable. She added the resident was capable of letting the staff know when he needed to void. Resident # 102 was interviewed on 2/11/15 at 2:33 PM. The resident stated he had problems with NA # 2 that worked the 11-7 shift. He stated NA # 2 made him wear an incontinent brief instead of his own underwear, although he had told NA #2 he did not want to wear the incontinent brief. Resident # 102 stated wearing the incontinent brief made him feel like a child. He added he was capable of using the urinal, if the urinal was in reach. Resident # 102 stated he was capable of using the call bell to call for assistance as needed. He stated on the occasions he had worn his own underwear and wet the bed, it was because NA #2 had placed the urinal out of his reach. The resident confirmed he had told NA # 1 about NA #2 making him wear the incontinent brief. An interview was held with the Certified Occupational Therapy Assistant (COTA) on 2/11/15 at 2:43 PM. She stated she worked with Resident # 102 on an almost daily basis. The	F 242	resident choices on March 4, 2015. Staff unable to attend the initial Directed In-service will not be scheduled to work until completion of Directed In-service conducted by the Director of Nursing or Staff Development Coordinator. 4. The Guardian Angels assigned to residents will interview each resident weekly regarding staff responsiveness to resident choices as well as maintenance of dignity. Any concerns expressed in the interviews will be brought to the Stand Up Meeting and will be placed into the formal grievance process. These interviews will be reviewed by the Administrator weekly for 4 months. 5. The Administrator will review the results of the interviews to assist with identification of future staff training. The results will be brought to the monthly Quality Assurance Process Improvement meeting by the Administrator for committee review for 4 months.	

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F 242	Continued From page 8 COTA stated Resident # 102 was alert, oriented and reliable. She added he was able to make his needs known and was able to use the urinal. . MDS Nurse #1 was interviewed on 2/11/15 at 3:50 PM. She stated she had received information from NA #1 that the night shift NA made Resident # 102 wear an incontinent brief and the resident did not want to wear the incontinent brief. She stated she had called the NA several times, but he had not returned her calls. A telephone interview was held with NA#2 on 2/12/15 at 5:30 AM. NA #2 confirmed he worked with Resident # 102 on the 11 to 7 shift at least 5 days a week. He stated he was trained on resident's rights during orientation. The NA stated he was aware a resident had the right to refuse anything. NA #2 acknowledged he had used incontinent briefs on Resident # 102 because the resident wet the bed at night. He stated the urinal was kept within the resident ' s reach. The NA stated he was currently working with Resident # 102 during this 11 to 7 shift. The NA stated he had not placed an incontinent brief on the resident at any time during the night. An interview was held with NA #1 on 2/12/15 at 9:30 AM. The NA stated when she arrived for work at 7:00 AM she checked on Resident #102. The NA added she found Resident # 102 wearing an incontinent brief placed by NA #2 who had cared for the resident on the 11-7 shift. The NA added Resident #102 ' s briefs were laying in the chair next to the bed. NA # 1 stated she removed the incontinent brief and placed Resident # 102 in his own clothing.	F 242		

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F 242	Continued From page 9 Resident # 102 was interviewed on 2/12/15 at 9:40 AM. He stated NA # 2 placed an incontinent brief on him during the 11-7 shift. The resident stated he did not refuse last night, adding he had refused so many times before and it had done no good. Resident # 102 stated, "I guess I just have to accept it." An interview was held with the Director of Nursing (DON) on 2/12/15 at 10:115 AM. The DON stated staff was taught about resident's rights during orientation and yearly. Included in the resident's rights presentation is the right to refuse treatments and medications. The DON stated if a resident refused to wear an incontinent brief she expected staff to honor the right to refuse and not place the incontinent brief. The DON added if the brief was applied after the resident refused, it was "just wrong." The Staff Development Coordinator (SDC) was interviewed on 2/12/15 at 2:21 PM. She stated resident's rights were reviewed during orientation, yearly and as issues arose. The SDC added staff are taught that residents have the right to refuse treatments, medications and anything else that may occur. She stated she taught staff if the resident refused to wear an incontinent brief, then you leave the brief off. The SDC stated NA # 2 had been hired on 8/12/14. He had signed receipt of the employee handbook, but had not signed the paper that spoke specifically about resident's rights.	F 242		
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		3/5/15

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F 279	Continued From page 10 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a care plan with measureable goals for 1 of 5 residents (Resident #65) reviewed for unnecessary medications who was receiving an antipsychotic medication and failed to care plan for target behaviors for 2 of 5 residents (Residents #65 and # 80) receiving antipsychotic medications. The findings included: 1. Resident #65 was readmitted to the facility on 2/13/12. Her diagnoses included Alzheimer's disease, depressive disorder, cognitive deficits related to cerebrovascular disease, anxiety state and other persistent mental disorder. Her medications included Aricept for dementia, Lasix for fluid retention, Zoloft for depression and Risperdal for psychosis.	F 279	1. Resident #65 and #80 had their care plans updated on February 14, 2015 by the Minimum Data Set nurse and Staff Development Coordinator to reflect the targeted behaviors and medical necessity of physician ordered medications. 2. Any resident receiving psychotropic medications would be affected by this practice. Therefore, the Interdisciplinary Team will meet on March 4, 2015 and review residents on these medications for medical necessity and targeted behaviors as well as these behaviors are present on the behavior monitoring sheets. 3. The Regional MDS Consultant conducted an in-service on February 20,2015 for MDS nurses, Director of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 The annual Minimum Data Set (MDS) for Resident #65 dated 12/22/14 revealed her cognitive skills were severely impaired and she had received antipsychotics, antidepressants, and diuretics for the last 7 days. The Care Area Assessment Summary (CAA) was triggered for behavioral symptoms and psychotropic drug use. Both areas were also triggered for address in care plan. The Care Plan revealed a problem of "uses antidepressant medications related to depression" was initiated on 1/15/13 and a "potential for dehydration related to diuretic use" was initiated on 1/15/13. In addition the Care Plan revealed a problem of "Resident yells out at times related to depression/dementia." There was no Care Plan for the use of psychotropic drugs. Attached to the care plan was a care plan conference attendee's sheet which revealed the annual care plan review was completed on 1/6/15 and was signed by MDS Nurse #1. A medical record review revealed the January monthly progress note from the psychiatric services which indicated Resident #65 was seen for medication review. The note revealed Resident #65 "still had some paranoia and delusions per staff but no increase in psychosis reported since reduction of Risperdal in November." During an interview with MDS Nurse #1 on 2/12/15 at 12:18 PM she stated Resident #65 did not have anything in her care plan about her psychosis. MDS Nurse #1 stated she had missed putting it on her care plan. She stated the Resident had received Risperdal since 11/26/14.	F 279	Nursing and Social Service regarding identification and documentation of target behaviors versus diagnosis. The Director of Nursing in-seviced the nursing staff on February 27, 2015 on targeted behaviors and behavior documentation with emphasis on nurse aide reporting targeted or any new behaviors. 4. The MDS nurse will audit physician orders for any new orders or changes in the psychotropic medications. For any new medications, the MDS nurse will assure accuracy of the targeted behaviors related to the new medications and update the care plan as needed. This audit wil be done 5 days a week for 3 months. The Director of Nursing will review the audit tool weekly to assure compliance with targeted behaviors. 5. The Director of Nursing will bring the results of this audit to the monthly Quality Assurance Process Improvement committee for review for 4 months.	

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	345356	A. BUILDING _____ B. WING _____	02/12/2015

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MDS Nurse #1 added that the target behaviors were not on the care plan since the Risperdal (antipsychotic medication) was not there.

Resident #80 was admitted on 12/11/13 with diagnoses that included unspecified psychosis, anxiety, depression and Parkinson's disease.

Social work (SW) progress notes, dated 11/12/14 indicated Resident #80 was alert, oriented and able to make needs known. The SW documented the resident was very religious. No moods or behaviors were identified.

The 11/15/14 Quarterly Minimum Data Set (MDS), indicated the resident was cognitively intact and had no behaviors. Active diagnoses included depression and a psychotic condition other than schizophrenia.

The resident's care plan, last reviewed on 11/25/14, did not identify target behaviors for the antipsychotic medications, did not include goals and had no interventions directed toward anti-psychotic use.

A Behavioral Health consult, dated 1/16/15, indicated the resident denied hallucinations, but did state the "lord speaks to me." The consult also indicated staff reported the resident locked himself in the room or the bathroom at times and seemed preoccupied with religion. Seroquel (an antipsychotic medication) 12.5 mg (milligrams) was restarted.

On 1/19/15, a psychiatric consult note indicated in house psychiatric services started. The note indicated prior to 1/16/15, the staff reported the resident was spending increased time in the

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F 279	Continued From page 13	F 279		

bathroom saying there was evil in the hall and accusing others of trying to trick him. The note indicated the resident's thinking continued to be religious focused and mildly grandiose. The note indicated Resident #80 mentioned he was "led by the spirit." The note also documented Resident #80 reported intermittent anxiety and said he liked for things to be in order.

Review of the January 2015 Medication Administration Record (MAR) revealed the 1/16/15 order for Seroquel had been transcribed. The resident was identified as receiving Lorazepam 0.5 mg as needed for anxiety/agitation on 1/20, 21, 22, 23, 27, 30 and 31.

Review of the February 2015 MAR indicated Resident #80 received Celexa 10 mg daily for depression, Seroquel 25 1/2 tab (12.5 mg) twice daily for dementia with behavioral disturbances and Lorazepam 0.5 mg twice daily as needed anxiety/agitation.

A telephone order dated 1/19/15 indicated the psychiatric services would sign off care at the request of the resident.

An interview was held Nursing Assistant (NA) #1 on 2/11/15 at 10:58 AM. She stated at times the noise on the hall upset Resident #80. He would then go into the bathroom to calm down. The NA stated the resident fasted on certain days, but some staff did not understand Resident#80 refused food for religious reasons. The NA added the resident came from a religious family and he was practicing his beliefs. NA #1 stated it was a common idea in the area among religious people that the Lord spoke to them. She added if

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F 279	Continued From page 14 Resident #80 did not get his medicine, he became confused to the point of not recognizing staff. The SW was interviewed on 2/11/15 at 12:28 PM. She stated the resident and his family were religious. He had identified the bathroom as a "safe haven". The SW stated at times Resident #80 refused to eat because he was fasting for religious reasons. The SW added although the resident was religious, he needed the antipsychotic medication because of paranoia and talking to people not present. The SW stated she was responsible for care planning behaviors and the use of antipsychotic medication. She added she did not consider Resident #80's religious practice a behavior, but rather a choice in lifestyle and religious expression. The SW stated she had not been educated on identification of target behaviors, care planning for target behaviors or even care planning the behavior for which the antipsychotic was needed. An interview was held with Nurse #1 on 2/11/15 at 2:01 PM. She worked with Resident #80 on the 7-3 shift Monday through Friday. Nurse #1 stated Resident #80 sat in the bathroom at times to meditate. She added he got behind the door to the room and peeped out of the door; adding he did not want people "running in on him." The nurse stated he was a bit paranoid and also got nervous at times, but she was not aware of hallucinations or delusions. The nurse stated the resident went to church weekly. He read his Bible a lot and quoted scripture a lot. Nurse #1 stated she did not see Resident #80's religious practices as a preoccupation with religion, but more of a lifestyle. The nurse added Resident #80 received the Seroquel for paranoia.	F 279		

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F 279	Continued From page 15 An interview was held with the Director of Nursing (DON) on 2/12/15 at 10:53 AM. She stated religion was part of Resident #80's life and not a preoccupation. The DON stated she was aware Resident #80 refused meals to fast. She added she did not consider fasting an abnormal behavior because fasting was a part of the resident's religious expression. The DON stated she was aware the resident sat in the bathroom to meditate and added she did not think it was abnormal for the resident to want a quiet place for meditation. The DON stated she was also aware Resident #80 had hallucinations about seeing snakes. The DON stated specific target behaviors should be documented on each resident ' s behavior sheet. She added behaviors should be care planned with specific behaviors, goals and interventions included. NA #3 was interviewed on 2/12/15 at 2:55 PM. NA #3 stated he worked at least 5 days per week with Resident #80 on the 7 to 3 shift. He stated he knew what to do for residents from information listed on the Kardex (a card that gives specific information to staff). NA #3 stated Resident #80's behaviors included thinking people were ganging up on him, talking about dying a lot and saying he was scared to die. He stated this happened on an almost daily basis. The NA stated he tried to reassure Resident #80 that no one was going to hurt him and he tried to let the nurse know if the behaviors started. The NA reviewed the Kardex for Resident #80 and acknowledged the resident's behaviors were not listed on the Kardex. NA #3 added it would be helpful to have the information on the Kardex along with ways to help the resident.	F 279		

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F 371	Continued From page 16	F 371		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a barrier between ready to eat food and bare hands for 2 of 6 staff members, (Nursing Assistant #3 & Certified Occupational Therapy Assistant #1) who picked up bread with their bare hands during 3 of 3 observed meals. The findings included: 1. On 2/9/2015 at 12:21 PM, during an observation in the main dining room, the nursing assistant (NA #3), took bread out of the wrapper with his bare hand, then folded the bread and placed it on the resident's plate. On 2/10/2015 at 12:39 PM, NA #3 took bread out of the wrapper with his bare hands and placed the bread on the resident's plate. An interview was conducted with NA #3 on 2/10/2015 at 13:49 PM. NA #3 stated he was given dining instruction during an orientation when he started at the facility, and also attended in-service training for dining instruction. NA #3 stated that he did use his bare hand to place the bread on the resident's tray each day, because the resident was blind. He stated he wanted the	F 371	1. Nurse Aide #3 was educated by the Staff Development Coordinator on February 13, 2015 regarding provision of a barrier between resident food and food handler. The Certified Occupational Therapy Assistant #1 was educated by the Director of Nursing on March 3, 2015 regarding the provision of a barrier between the resident food and the food handler. 2. Any resident requiring assistance with food set up can be affected by this practice. 3. Therefore, the Staff Development Coordinator on February 13, 2015 in-serviced the nursing staff on provision of a barrier between resident food and the food handler. On February 24, 2015 the Staff Development Cordinator in-serviced the Nurse Aide II students on provision of a barrier between the resident food and the food handler. On February 27, 2015 the Director of Nursing in-serviced the	3/5/15

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F 371	Continued From page 17 resident to know where the bread was located. He stated he folded the bread for another resident, because she would eat it better if it was like a sandwich. On 2/11/2015 at 4:34 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she conducted the orientation and in-service training for dining instruction. She instructed staff it was not acceptable to touch resident's food with bare hands. The SDC produced a copy of the last dining in-service and NA #3's name was not on the list of attendees. The SDC stated attendance is not mandatory at the in-service. On 2/12/2015 at 11:02 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the NA's should not use bare hands to touch food. She stated the dining instruction information was given to NA's during their orientation. 2. During a dining observation on 2/9/15 at 12:59 PM the Certified Occupational Therapy Assistant (COTA) was assisting Resident #5 with her meal. The COTA was observed to remove a slice of bread from the bag using her bare hands. She then tore the slice of bread into 2 pieces and gave one piece to Resident #5. An interview was conducted with the COTA on 2/9/15 at 1:00 PM. The COTA stated she was not aware she could not touch the piece of bread with her bare hands. An interview was conducted with the Staff Development Coordinator (SDC) on 2/11/15 at 4:34 PM. The SDC stated she conducted educational training for food handling which included that staff should not touch resident's	F 371	nursing staff on provision of a barrier between resident food and the food handler. The Dietary Manager in-serviced the dietary staff on February 28, 2015 on the provision of a barrier between the resident food and the food handler. The Director of Nursing in-serviced the therapy staff on March 3, 2015 on the provision of a barrier between the resident food and the food handler. 4. Observations will be made by the Charge Nurse assigned to the dining room doing a Food Service Monitoring audit every meal 5 times a week for 4 months for staff compliance in providing a barrier between the resident food and the food handler. Observation will be made by the Charge Nurse assigned to the hall doing a Food Service Monitoring Audit every meal 5 times a week for 4 months. If staff are found not in compliance, re-education will be done at that time. 5. The Director of Nursing will select one week per month of dining room observation using the audit tool to monitor on- going compliance. A summary report of the results of these audits will be brought by the Director of Nursing to the monthly Quality Assurance Process Improvement committee for review for 4 months.	

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F 371	Continued From page 18 food. An interview was conducted with the Director of Nursing (DON) on 2/12/15 at 11:02 AM. She stated the staff should not touch bread with their bare hands. She added that the NAs received dining instruction information during their orientation.	F 371		