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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 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 observations, record review, and staff interviews, the facility failed to dress resident in personal clothing instead of hospital gowns for 1 of 3 residents sampled for dignity (Resident #5). The findings included: Resident #5 was readmitted to the facility 04/05/12 with diagnoses which included Alzheimer's disease, paralysis, dysphagia, and respiratory failure. An annual Minimum Data Set (MDS) dated 02/12/15 coded Resident #5's cognition as severely impaired and required extensive assistance with bed mobility and was totally dependent on staff for transfers, toileting, personal hygiene, eating, and bathing, and always incontinent of bowel and bladder. Resident #5 was observed on 04/14/15 at 12:32 PM laying in her bed with her eyes closed, wearing a hospital gown, bed covers up to her waist area, and the door was opened. On 04/14/15 at 1:03 PM, nurse aide (NA) #3 was observed to enter Resident #5's room. She was observed to wake the resident, she spoke to the resident, and she pulled the bed covers up over the resident's arms, left the resident in a hospital gown, and left the room.	F 241		

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

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Resident #5 was observed on 04/15/15 at 9:22 AM in her bed, with the head of her bed at a 30 degree angle, NA #3 was feeding the resident, the resident's eyes was closed, and she was wearing a hospital gown.

Resident #5 was observed on 04/16/15 at 6:38 AM lying in her bed asleep, the head of the bed at a 30 degree angle, the overhead light was on over the resident's bed, the door to her room was opened, and she was wearing a hospital gown.

Resident #5 was observed on 04/16/15 at 9:47 AM, the door to her room was opened, and she was laying in her bed on her left side, wearing a hospital gown with her back and adult brief exposed, and was visualized from the hallway.

On 04/16/15 at 10:04 AM, NA #2 was observed to enter Resident #5's room. She was observed to pull the bed covers over the resident's backside, closed the curtain as to only see the resident's lower legs from the hallway, left the resident in a hospital gown, and left the room.

Resident #5 was observed on 04/16/15 at 2:12 PM, with the door to her room opened, lying in her bed with her eyes closed, and wearing a hospital gown. Further observation of Resident #5's closet revealed she had her own personal clothing.

An interview was conducted on 04/16/15 at 2:32 PM with Nurse #1. She stated she would have expected the NAs to have dressed the resident in her own clothes. She further stated Resident #5 was to be dressed in her own clothes every day as that was hers' and her family's preference.

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F 241	Continued From page 2 An interview was conducted on 04/16/15 at 2:47 PM with NA #3. She stated she was aware Resident #5 was supposed to be dressed in her own clothes every day and she had no answer as to why she was in a hospital gown except for the resident had refused in the past. She further stated she had not dressed the resident because she was too busy. An interview was conducted on 04/17/15 at 2:38 PM with NA #2. She stated she would always make an effort to get Resident #5 dressed every day but sometimes there was not enough hours in the day to get all of the residents activities of daily living/needs met and that she tried her best. An interview was conducted with the Director of Nursing (DON) on 04/17/15 at 5:55 PM. She stated she would have expected the NAs to have dressed Resident #5 in her own clothing every day. She further stated the facility was working to hire nursing aides and she was aware the NAs were busy but she expected the residents' needs to be met.	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		

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by:
Based on observations, record review and resident and staff interviews the facility failed to honor a resident's choice of when to get up in the morning for 1 of 1 resident sampled for choices (Resident # 123).

Findings included:

Resident #123 was re-admitted to the facility on 03/18/15 with diagnoses which included muscle weakness, difficulty walking, high blood pressure, chronic pain and anxiety. The 14 day admission Minimum Data Set (MDS) dated 04/01/15 indicated Resident #123 was cognitively intact for daily decision making. The MDS also indicated Resident #123 required extensive assistance with transfers and hygiene.

A review of monthly physician's order dated from 04/01/15 through 04/30/15 indicated Levothyroxine 25 micrograms (mcg) by mouth daily.

A review of the monthly Medication Administration Record dated 04/01/15 through 04/30/15 indicated Levothyroxine 25 mcg at 6:00 AM.

During an interview on 04/15/15 at 11:16 AM with Resident #123 he stated he preferred to sleep later but nursing staff came in before 6:00 AM and gave him medicine and there was so much noise in the hallway he didn't have much choice but to get up. He explained when staff woke him up he couldn't always go back to sleep and then he was tired the rest of the day. He stated he was at the facility for therapy and after his therapy sessions he needed to rest so he tried to take a nap during the day but it was difficult. He further

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stated if he was at home he would not get up early to take his medications but would wait until he woke up and then would take them.

During an observation on 04/16/15 at 6:00 AM all of the hallway lights were turned on bright and nursing staff were giving resident's medications.

During an interview on 04/16/15 at 6:25 AM with Nurse #1 she confirmed she routinely worked the night shift from 11:00 PM until 7:00 AM and gave Resident #123 medications. She explained housekeeping staff usually were out on the halls at 4:00 AM sweeping and laundry staff were usually on the halls by 5:00 AM. She explained some residents had medications scheduled at 5:00 AM and she usually started her medication pass at 4:00 AM or 4:30 AM in order to get finished by shift change. She stated nurses were expected to give report by 7:00 AM to the day shift so she had to start giving medications at 4:00 AM in order to be finished in time to give the report by 7:00 AM. She explained she usually gave Resident #123 his medication around 4:30 AM because she started her medication pass near his room and when she went in his room she had to call his name multiple times to wake him up.

During an interview on 04/20/15 at 10:15 AM with Nurse #2 she verified Resident #123 had indicated during his admission assessment his preferences for when to get up in the morning was varied.

During an interview on 04/17/15 at 5:55 PM the Director of Nursing stated she had worked in the facility for about a month and was not aware of the 11:00 PM to 7:00 AM shift routine. She stated

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F 242	Continued From page 5 it was acceptable to give medications 1 hour before or 1 hour after they were scheduled to be given and it was her expectation for them to stay within that hour. She stated if staff couldn't stay within an hour before or after they needed to call the physician to get the order changed. She explained if a resident had a request regarding when to take medications in order to sleep later they should care plan it and give the medications later. She confirmed if a resident was at home they would not be awakened before 6:00 AM to take medications.	F 242		
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 repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift for providing maintenance and housekeeping services. The findings included: 1. Soiled privacy curtains in Resident room #'s 123 & 125. a. On 04/14/15 at 4:01 PM observed the privacy curtains between the Resident beds in rooms 123 &124 were soiled with brown stains. b. On 04/15/15 at 10:48 AM the privacy curtains remained the same.	F 253		

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c. On 04/16/15 at 9:19 AM the privacy curtains remained the same.
d. On 04/16/15 at 12:08 PM the privacy curtains remained the same.
e. On 04/16/15 at 4:02 PM the privacy curtains remained the same.

2. A hole in the wall of Resident room # 123 & a hole in the bathroom door of Resident Room # 124.
a. On 04/14/15 at 4:01 PM observed Resident room #123 with approximately 1-1/2" by 1/2" hole in the wall behind the entry door with a broken plastic door knob protector & a approximately 1" hole in the bathroom door of Resident Room # 124.
b. On 04/15/15 at 10:48 AM the holes remained unchanged.
c. On 04/16/15 at 9:19 AM the holes remained unchanged.
d. On 04/16/15 at 12:08 PM the holes remained unchanged.
e. On 04/16/15 at 4:02 PM the holes remained unchanged.

A review of the morning Administration room round assignment sheets for April 2015 indicated the wound care nurse was assigned to review rooms 122 through 127 using the administration check off list which listed the condition of resident's rooms for cleanliness and repairs needed and any Resident care concerns and equipment concerns. The check off lists were reviewed for 04/14/15, 04/15/15 and 04/16/15 and no concerns were written on these sheets for the hole in the wall of room 123, the hole in the bathroom door of room 124, and the soiled privacy curtains in Resident room #'s 123 & 125.

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An interview and tour of rooms 123,124 &125 was conducted on 04/16/15 at 3:40 PM with the Wound Care Nurse (WCN). The WCN verified the hole in the wall of room 123, the hole in the bathroom door of room 124, and the soiled privacy curtains in Resident room #'s 123 & 125. The WCN confirmed that she had failed to notice these room concerns. The WCN further confirmed that if she had seen them, she would have checked them on the room assignment checklist for holes that required repairs and soiled privacy curtains. The WCN stated she had been assigned to check the rooms 122 through 127 for the month of April. The WCN further stated that the assistant Director of Nursing (ADON) checked those rooms for her on Wednesday because she was with the wound care doctor that morning.

An interview and tour of rooms 123,124 &125 was conducted on 04/16/15 at 3:54 PM with the Maintenance /housekeeping supervisor (MHS). The MHS verified the hole in the wall of room 123, the hole in the bathroom door of room 124 needed repairs and the soiled privacy curtains in Resident room #'s 123 & 125 needed to be cleaned. The MHS stated he received the completed checklists from administrative staff after the morning room rounds were completed. The MHS further stated that anything on the checklists that needed to be addressed would then be placed in the computer system for repairs. The MHS further stated the computer system was checked several times daily for repairs that needed addressing immediately. The MHS indicated the privacy curtain in room 123 required changing frequently due to soiling. The MHS further indicated housekeeping staff cleaned resident rooms daily and as needed, and

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were expected to check the privacy curtains for cleanliness. The MHS revealed that all staff was expected to report any needed repairs or soiled items. The MHS further revealed no one had reported and he was not aware of the holes in room 123 &124 or the soiled privacy curtains in rooms 123 & 125.

An interview was conducted on 04/16/15 at 4:02 PM with the Assistant Director of Nursing (ADON). The ADON verified the hole in the wall of room 123, the hole in the bathroom door of room 124, and the soiled privacy curtains in Resident room #'s 123 & 125. The ADON further verified she had completed the morning room rounds check for the WCN on the morning of 04/15/15. The ADON confirmed that she had failed to notice these room concerns. The ADON further confirmed that if she had seen them she would have checked them on the room assignment checklist for holes that required repairs and soiled privacy curtains.

An interview was conducted on 04/17/15 at 2:23 PM with the Administrator. The Administrator stated he was not aware of the hole in the wall of room 123, the hole in the bathroom door of room 124, and the soiled privacy curtains in rooms 123 & 125 until yesterday. The Administrator revealed it was his expectation that all staff was expected to report any needed repairs or soiled items. The Administrator further revealed administration staff should observe areas that need repairs or cleaning, complete the morning rounds checklist with any concerns and report them to the MHS. The administrator indicated due to the buildings age it remained to be a challenge but he expected the MHS to repair or clean anything broken, stained, and/or un-presentable in resident

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rooms or in the facility.
3. Observations on 04/14/15 at 12:44 PM revealed a sit to stand lift in the hallway next to resident room 113 with brown debris spilled on the brace that attached the padded knee pads to the lift.

Observations on 04/16/15 at 6:50 AM revealed a sit to stand lift in the hallway next to resident room 117 with brown debris spilled on the brace support that attached the padded knee pads to the lift.

Observations on 04/17/17 at 4:09 PM revealed a sit to stand lift in the hallway next to resident room 137 revealed brown debris spilled on the brace support that attached the padded knee pads to the lift.

During an interview on 04/17/15 at 4:10 PM the Director of Facility Services who was also in charge of maintenance and housekeeping verified he had a monthly schedule for cleaning sit to stand lifts but if something was spilled on the lift or it needed cleaning before the next scheduled cleaning day it should be cleaned. The Director of Facility Services confirmed the sit to stand lift next to resident room 137 was dirty and it looked like brown debris had been spilled or splattered on the brace that attached the padded knee pads to the lift. He stated he should have caught it and cleaned it but usually the Nurse Aides told him when they saw lifts were dirty and needed to be cleaned. He further stated he expected for the lifts to be wiped down between the monthly cleaning when debris was spilled on them.

During an interview on 04/20/15 at 2:00 PM the

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F 253	Continued From page 10 Administrator stated the Director of Facility Services had told him the sit to stand lift needed to be cleaned and it was his expectation for staff to clean or report when lifts needed to be cleaned.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews the facility failed to shower residents who required assistance with activities of daily living for 2 of 4 sampled residents (Resident #149 and #5). The findings included: 1) Resident #149 was admitted to the facility on 11/05/14 with diagnoses which included musculoskeletal disorders, muscle weakness, and diabetes mellitus with long term use of insulin. A review of a quarterly Minimum Data Set (MDS) dated 02/10/15 coded Resident #149 as cognitively intact and capable of making his needs known. The MDS indicated Resident #149 required extensive assistance for activities of daily living (ADLs) which included hygiene but was totally dependent on staff for showers.	F 312		

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Further review of the MDS indicated Resident #149's preferences for showers was very important with no documented behaviors or refusal of care.

A review of a care plan dated 02/11/15 revealed a problem statement that Resident #149 required staff assistance for all activities of daily living and the goal indicated he would be able to participate in part of ADLs through the next review. The approaches were listed in part to provide 1 staff to assist resident with bathing and/or showering daily as necessary/requested.

A review of shower and bath schedules indicated Resident #149 was to receive a shower on Tuesday and Saturday of each week.

A review of a Facility Documentation/Tracking Report dated for March 2015 and April 2015 was reviewed. The report contained showers that were to be provided to Resident #149. The dates of Tuesday 03/03/15, Tuesday 03/10/15, Saturday 03/14/15, Tuesday 03/17/15, Tuesday 03/24/15, Saturday 03/28/15, and Tuesday 03/31/15 were initialed and indicated completion of the task. The date of Friday 04/10/15 was initialed and indicated completion of the task.

During an observation on 04/14/15 at 3:37 PM Resident #149 was lying in bed in his room with stubbles of facial hair, fingernails were long and uneven, and his hair was greasy looking.

During an interview on 04/15/15 at 9:07 AM Resident #149 stated he had received a shower on Friday 04/10/15 but that was the only shower he had received in April. He indicated he was supposed to have a shower 2 times a week but

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was lucky to get a shower once a week. He further stated the nurse aides (NAs) and the nurses would tell him there was not enough staff.

During an observation on 04/16/15 at 10:32 AM Resident #149 was setting in his wheelchair in his room with unshaved facial hair, greasy looking hair, and fingernails that were long and uneven.

During an interview on 04/16/15 at 10:38 AM NA #3 stated her assignment was to give the residents their showers. She indicated Resident #149's name was on the shower sheet to have a shower on Tuesday and Saturday. She stated showers was supposed to be done on 1st shift but the shower person would have to stop showers to pass ice, help feed the residents, and/or to assist with ADLS for the residents because the facility was short staffed. She further stated when a shower was provided the NAs were expected to initial the shower sheet that hangs in the shower rooms. A review of the shower sheet for April 2015 revealed Resident #149 had a shower on 04/10/15.

During an observation on 04/16/15 at 2:37 PM and at 4:14 PM Resident #149 was lying in his bed in his room, his fingernails was observed to be long and uneven, his hair appeared greasy looking, and he had unshaved facial hair.

During an interview on 04/17/15 at 9:06 AM Nurse #2 stated there was not enough staff and there were times when resident showers were not being given. She further stated when there was one NA scheduled to do resident showers that NA was usually asked to stop the showers and assist the other NAs on the hall with residents ADL care, assist to feed the residents, or to pass ice/water,

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and the resident showers would not be given.

During an observation on 04/17/15 at 11:17 AM Resident #149 was lying in his bed in his room, his fingernails was observed to be long and uneven, greasy looking hair, and unshaved facial hair.

During an interview on 04/17/15 at 2:11 PM NA #6 confirmed she shaved and gave Resident #149 a shower on 04/10/15. She stated Resident #149 liked to cut his own fingernails. She indicated she had assisted him with a bed bath on 04/14/15 but not a shower. She stated the NAs were expected to shower the residents on 1st shift 2 times per week. She further stated the NAs tried to assist the residents with a shower at least once a week and occasionally a resident would be given a shower 2 times a week but the NAs were too busy and it was not possible to complete 2 times a week for each resident.

During an interview on 04/17/15 at 5:55 PM the Director of Nursing (DON) stated it was her expectation for NAs to shower the residents on their assigned shower days. She further stated she expected for NAs to report to the nurse if a resident refused and/or had not been given a shower. She further stated the facility was working to hire nurse aides and she was aware the NAs were busy but she expected the residents' needs to be met.

2) Resident #5 was readmitted to the facility 04/05/12 with diagnoses which included Alzheimer's disease, paralysis, dysphagia, and respiratory failure.

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An annual Minimum Data Set (MDS) dated 02/12/15 coded Resident #5's cognition as severely impaired and required extensive assistance with bed mobility and was totally dependent on staff for transfers, toileting, personal hygiene, eating, and showers/bathing, and was always incontinent of bowel and bladder.

A review of a care plan with the latest revision date of 03/03/15 revealed a problem statement that Resident #5 required staff assistance for all activities of daily living and the goal indicated she would maintain the highest level of function possible through the next review date of 06/15/15. The approaches were listed in part for 1 staff to provide total assistance to resident with a bath and/or shower daily and as necessary.

A review of shower and bath schedules indicated Resident #5 was to receive a shower on Wednesday and Saturday of each week.

A review of a Facility Documentation/Tracking Report dated for March 2015 and April 2015 was reviewed. The report contained showers were to be provided to Resident #5. The dates of Wednesday 03/18/15, Wednesday 03/25/15, Wednesday 04/01/15, Saturday 04/04/15, Wednesday 04/08/15, and Wednesday 04/15/15 were initialed and indicated completion of the shower task.

Resident #5 was observed on 04/14/15 at 12:32 PM laying in her bed wearing a hospital gown, long uneven fingernails, brown substance was observed underneath her index, middle, and ring fingers of the right hand, and the left hand was not observed as it was underneath the bed covers.

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On 04/14/15 at 1:03 PM, nurse aide (NA) #2 was observed to enter Resident #5's room. She was observed as to speak to the resident, placed the resident's right hand underneath the bed covers, and pulled the covers up to the resident's neck, and left the room.

Resident #5 was observed on 04/15/15 at 9:22 AM in her bed, with the head of her bed at a 30 degree angle, NA #2 was feeding the resident, the resident's fingernails were observed to be long, uneven with brown substance underneath the index, middle, and ring fingers of the right hand.

An interview was conducted on 04/16/15 at 2:32 PM with Nurse #1. She stated she would have expected the NAs to have given Resident #5 a shower or at least cleaned the brown substance from underneath her fingernails. She confirmed Resident #5 was supposed to have a shower 2 times a week on Wednesday and Saturday. Nurse #1 indicated there was not enough staff and there were times when resident showers were not being given. She further indicated when one NA was scheduled to do resident showers that NA was usually asked to stop the showers and assist the other NAs on the hall with residents ADL care, assist to feed the residents, or to pass ice/water, and the resident showers would not be given.

During an interview on 04/16/15 at 10:38 AM NA #2 stated her assignment was to give the residents their showers. She indicated Resident #5's name was on the shower sheet to have a shower on Wednesday and Saturday. She stated showers was supposed to be done on 1st shift

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F 312	Continued From page 16 but the shower person would have to stop showers to pass ice, help feed the residents, and/or to assist with ADLS for the residents because the facility was short staffed. She further stated when a shower was provided the NAs were expected to initial the shower sheet that hangs in the shower rooms. A review of the shower sheet for April 2015 confirmed NA #2 had completed Resident #5's showers on 04/01/15, 04/04/15, 04/08/15, and 04/15/15. NA #2 indicated Resident #5 had went from 04/08/15 to 04/15/15 with no shower. She confirmed she had worked on Saturday 04/11/15 and stated she had not given Resident #5 a shower on 04/11/15 because she and the other NAs were too busy on this day to have given any resident showers. During an interview on 04/17/15 at 5:55 PM the Director of Nursing (DON) stated it was her expectation for NAs to shower the residents on their assigned shower days. She further stated she expected for NAs to report to the nurse if a resident refused and/or had not been given a shower. She further stated the facility was working to hire nurse aides and she was aware the NAs were busy but she expected the residents' needs to be met.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, the facility failed to apply splints to prevent/decrease contractures for 1 of 3 residents reviewed for contractures (Resident #5).

The findings included:

Resident #5 was readmitted to the facility 04/05/12 with diagnoses which included Alzheimer's disease, paralysis, dysphagia, and respiratory failure. An annual Minimum Data Set (MDS) dated 02/12/15 indicated the resident's cognition was severely impaired. The MDS specified Resident #5 required extensive assistance with bed mobility and was totally dependent on staff for transfers, toileting, personal hygiene, and bathing. The MDS indicated the resident did not ambulate during the assessment period. The MDS further specified the resident had range of motion impairment in the upper extremities on one side.

A review was conducted of an updated Nurse Tech Information Kardex. Under the heading Adaptive Devices was written "Elbow/Wrist splint RUE (right upper extremity) 4 hrs (hours) daily."

A review was conducted of an Occupational Therapy Treatment Encounter Note dated 07/16/13. The document specified education was provided to the restorative aide regarding how to stretch the resident's right upper extremity and how to apply a splint to the right elbow/wrist. Further review revealed the resident was being discharged from therapy and referred to

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restorative to prevent further contracture in the resident's right elbow/wrist. The document further specified teaching range of motion techniques and application of the splint to the restorative aide was completed with return demonstrations. The document was signed by the Certified Occupational Therapy Aide (COTA).

A review of a Facility Documentation/Tracking Report dated for March 2015 and April 2015 was reviewed. The report contained range of motion and splinting that was to be provided to Resident #5. The dates of March 3rd, 12th, 29th, and 30th were initialed and indicated completion of the task. The dates of April 2nd, 5th, 11th, and 15th were initialed and indicated completion of the task. No other dates for the months of March and April were initialed on the form.

An observation on 04/14/15 at 12:32 PM revealed Resident #5 was lying in bed on her back and her right arm was observed to be lying flaccid on her chest. There was no splint on her right arm.

An additional observation on 04/14/15 at 2:23 PM revealed Resident #5 was lying in bed on her left side and her right arm was observed to be hanging flaccid off the side of the bed. There was no splint on her right arm.

An observation on 04/16/15 at 9:47 AM revealed Resident #5 was lying in bed again on her left side and her right arm was observed to be lying flaccid on the mattress next to her chest. There was no splint on her right arm.

An additional observation on 04/16/15 at 1:12 PM revealed Resident #5 was lying in bed on her back and her right arm was observed to be

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F 318	Continued From page 19 hanging flaccid over the side of the bed. There was no splint on her right arm. An interview was conducted on 04/17/15 @ 2:28 PM with Nurse Aides (NA) #2 and #3. The NAs confirmed they were usually assigned to Resident #5's hall. Both the NAs stated they did not apply splints or do range of motion to Resident #5's right arm. NA #2 stated the restorative aide does those things. An interview was conducted with the Assistant Director of Nursing (ADON) on 04/17/15 at 3:46 PM. The ADON stated after a resident was assessed by therapy, the therapist gave nursing staff recommendations and instructions for splint application. She further stated her expectation was for the splint to have been applied for 4 hours every day. An interview was conducted with the Director of Therapy Services on 04/17/15 at 5:47 PM. She stated Resident #5 was in therapy to prevent contractures of her right arm and wrist. She indicated after therapy, she was turned over to the facility's restorative aide that was trained to do stretching of the right arm joints and application of the elbow/wrist splint. The Therapy Director stated the splint should be worn 4 hours every day to prevent any more deterioration and/or further contracting of the elbow/wrist. An interview was conducted with the Director of Nursing (DON) on 04/17/15 at 5:55 PM. She stated if the therapist recommended splint use, the nurses should be responsible for seeing splints were correctly applied as recommended.	F 318		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to provide the required assistance to transfer a resident and the resident fell for 1 of 3 sampled residents (Resident #60).

The findings included:

Resident #60 was admitted to the facility on 11/25/09 and readmitted on 03/20/15 with diagnoses that included femur fracture, dementia, hypertension and others. The most recent Minimum Data Set (MDS) dated 03/27/15 specified the resident had moderately impaired cognition, required extensive 2 person assistance with transfers and the resident had not fallen.

A fall risk assessment dated 03/20/15 specified Resident #60 was high risk for falls.

Review of the Care Area Assessment (CAA) Worksheet dated 04/07/15 for falls specified Resident #60 required "dependant-extensive" assistance with transfers and toileting and that the resident was non-ambulatory.

Resident #60's care plan updated on 04/13/15

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identified the resident had impaired self care deficit and required "dependant-extensive" assistance with transfers.

Review of Resident #60's medical record revealed a nurse's entry dated 04/12/15 that resident #60 fell when nurse aide #1 attempted to transfer the resident off the commode but the resident was not injured.

On 04/17/15 at 3:15 PM nurse aide (NA) #1 was interviewed and reported that on 04/12/15 she was assigned to care for Resident #60. She added that it was her second time ever caring for the resident and that during the first time she was assigned to care for Resident #60 the resident was not transferred. She explained that on 04/12/15 she observed Resident #60 propelling herself into the bathroom. NA #1 stated that at the time she was not sure how the resident transferred but attempted to assist the resident to the bathroom by herself. NA #1 stated that while her back was turned to the resident, the resident attempted to stand and the nurse aide assisted the resident to the floor. Once on the floor, the nurse aide reported that she left the resident to get help from the nurse. NA#1 stated that she did not ask for help to transfer the resident and offered no explanation. She stated she generally relied on other staff to tell her how much assistance a resident required for transfers.

On 04/17/15 at 4:00 PM the Assistant Director of Nursing (ADON) was interviewed and reported that she investigated falls to determine root cause and ensure that interventions were implemented to prevent reoccurrences. The ADON explained that nurse aides should ask a nurse, a therapist or reference the "kardex" (a written detailed

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F 323	Continued From page 22 explanation of resident needs) before transferring a resident for the first time. The ADON stated she thought NA#1 was walking by and observed the resident in bathroom and attempted to assist the resident. The ADON reported that NA #1 should have called for help before assisting the resident ad should not have left the resident alone in the bathroom to get help.	F 323		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to ensure adequate	F 353		

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staffing to meet residents' shower needs for 2 of 4 sampled residents (Resident #149 and #5).

The findings included:

1) Resident #149 was admitted to the facility on 11/05/14 with diagnoses which included musculoskeletal disorders, muscle weakness, and diabetes mellitus. Review of a quarterly Minimum Data Set (MDS) dated 02/10/15 coded Resident #149 as cognitively intact and capable of making his needs known. The MDS indicated Resident #149 required extensive assistance for activities of daily living (ADLs) which included hygiene but was totally dependent on staff for showers.

A review of care plans dated 02/11/15 revealed a problem statement that Resident #149 had an ADL self-care performance deficit related to fatigue, activity intolerance, and self-care impairment with approaches for staff to assist with ADLs.

During an interview on 04/15/15 at 9:07 AM Resident #149 stated he had received a shower on Friday 04/10/15 but that was the only shower he had received in April. He indicated he was supposed to have a shower 2 times a week but was lucky to get a shower once a week. He further stated the nurse aides (NAs) and the nurses would tell him there was not enough staff.

A review of the staffing assignments from 03/01/15 through 04/14/15 revealed 15 out of 45 days on 1st shift there were 2 NAs on each hall to provide ADL care to as many as 30 residents.

A review of the Resident Council Meeting minutes

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dated 03/04/14 through 04/07/15 revealed concerns for needing more NA staff, especially on the weekends, because their needs were not being met. The action taken was the Nursing Administration was actively recruiting for nurse aides.

During an interview on 04/16/15 at 6:31 AM Nurse #7 stated residents showers were not done every week, oral care was rarely done for residents, and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed.

During an interview on 04/16/15 at 6:42 AM Nurse #5 stated the NAs worked very hard and there were times when residents ADL needs were not always met and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. Nurse #5 further stated some residents had to stay in bed longer in the mornings because the NAs would be too busy to assist/transfer the residents out of bed.

During an interview on 04/16/15 at 10:30 AM NA #7 stated the NAs worked short staffed most days. NA #7 indicated with 2 NAs the work could be done but it was impossible to complete all care such as shaving, oral care, showers, toileting, and changing residents briefs every 2 hours, and/or more often with some residents, plus making and changing beds. NA #7 further indicated there were times when the residents were not changed and/or had other ADLs that was not met.

During an interview on 04/16/15 at 10:41 AM NA #4 stated the NAs worked short staffed most days with an assignment load of 16 residents for

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each NA. NA #4 indicated there were times when resident showers were not done every week especially when the NAs had to assist with ADLs and/or to feed the residents.

During an interview on 04/16/15 at 3:56 PM The Regional Director of Clinical Services stated she was aware of the staffing concerns and had identified problems with staffing and they were in the process of recruiting nurse aides and nurses and was actively working to maintain staff stability. She further stated they had utilized a staffing agency to assist with the staffing shortage.

During an interview on 04/17/15 at 9:06 AM Nurse #4 stated there was not enough staff to do resident showers 2 times a week and that it was particular challenging on the weekends because the NA assigned to do showers would have to stop giving showers and would have to assist to feed the residents, pass ice, and/or assist with other ADLs. Nurse #4 further stated when there was not a shower person working then the showers definitely were not done because the NAs would be too busy. Nurse #4 indicated should the facility have a call in and be further short staffed then the nurses which were responsible for taking call would have to come in and work as a nurse aide due to there not being enough staff.

During an interview on 04/17/15 at 2:11 PM NA #6 stated the NAs were expected to shower the residents on 1st shift 2 times per week and the NAs tried to assist the residents with a shower at least once a week and occasionally a resident would be given a shower 2 times a week but the NAs were too busy and it was not possible to give

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a shower 2 times a week to each resident.

During an interview on 04/17/15 at 2:38 PM NA #2 stated there were times when the residents were not changed in a timely manner and/or every 2 hours because there was not enough time to meet the ADLs of all of the residents on the hall because the NAs were so busy it was impossible to complete all care such as showers and oral care.

During an interview on 04/17/15 at 3:28 PM the Unit Manager stated there were times when incontinent care was not met in a timely manner and residents would have to wait 2 or more hours to be changed, and showers were not done weekly, and residents have complained about not getting put to bed at the time they had requested to go to bed.

During an interview on 04/17/15 at 3:46 PM the Assistant Director of Nursing (ADON) stated she would like to have more staff on all shifts and they had identified problems with staffing and that staff was asked to work over or come in early if there were call outs. She further stated she was aware the NAs were busy but she expected the needs of the residents to be met. The interview further revealed they were supposed to have 8 to 10 NAs on 1st shift (7:00 AM to 3:00 PM), at least 8 NAs on 2nd shift (3:00 PM to 11:00 PM) and at least 6 on 3rd shift (11:00 PM to 7:00 AM).

During an interview on 04/17/15 at 5:55 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident as quickly as possible but at least every 2 hours and if certain areas were missed they should be reported for the next shift to do. She

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further stated she had identified problems with staffing and the facility was working to hire nursing aides and she was aware the NAs were busy but she expected the residents' needs to be met.

2) Resident #5 was readmitted to the facility 04/05/12 with diagnoses which included Alzheimer's disease, paralysis, dysphagia, and respiratory failure. An annual Minimum Data Set (MDS) dated 02/12/15 coded Resident #5's cognition as severely impaired and required extensive assistance with bed mobility and was totally dependent on staff for transfers, toileting, personal hygiene, eating, and showers/bathing, and always incontinent of bowel and bladder.

A review of a care plan with a revision date of 03/03/15 revealed a problem statement that Resident #5 had an ADL self-care performance deficit related to dementia and Alzheimer's disease with approaches for staff to assist with all ADLs.

Resident #5 was observed on 04/14/15 at 12:32 PM laying in her bed wearing a hospital gown, long uneven fingernails, brown substance was observed underneath her index, middle, and ring fingers of the right hand, and the left hand was not observed as it was underneath the bed covers.

Resident #5 was observed on 04/15/15 at 9:22 AM in her bed, with the head of her bed at a 30 degree angle, NA #2 was feeding the resident, the resident's fingernails were observed to be long, uneven with brown substance underneath the index, middle, and ring fingers of the right

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hand.

A review of the staffing assignments from 03/01/15 through 04/14/15 revealed 15 out of 45 days on 1st shift there were 2 NAs on each hall to provide ADL care to as many as 30 residents.

A review of the Resident Council Meeting minutes dated 03/04/14 through 04/07/15 revealed concerns for needing more NA staff, especially on the weekends, because their needs were not being met. The action taken was the Nursing Administration was actively recruiting for NAs.

During an interview on 04/16/15 at 10:30 AM NA #7 stated the NAs worked short staffed most days. NA #7 indicated with 2 NAs the work could be done but it was impossible to complete all care such as shaving, oral care, showers, toileting, and changing residents briefs every 2 hours, and/or more often with some residents, plus making and changing beds. NA #7 further indicated there were times when the residents were not changed and/or had other ADLs that was not met.

During an interview on 04/16/15 at 10:41 AM NA #4 stated the NAs worked short staffed most days with an assignment load of 16 residents for each NA. NA #4 indicated there was times when resident showers were not done every week especially when the NAs had to assist with ADLs and/or to feed the residents.

During an interview on 04/16/15 at 2:32 PM Nurse #1 stated she would have expected the NAs to have given Resident #5 a shower or at least cleaned the brown substance from underneath her fingernails. She confirmed

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Resident #5 was supposed to have a shower 2 times a week on Wednesday and Saturday. Nurse #1 indicated there was not enough staff and there were times when resident showers were not being given. She further indicated when one NA was scheduled to do resident showers that NA was usually asked to stop the showers and assist the other NAs on the hall with residents ADL care, assist to feed the residents, or to pass ice/water, and the resident showers would not be given.

During an interview on 04/16/15 at 3:56 PM The Regional Director of Clinical Services stated she was aware of the staffing concerns and had identified problems with staffing and they were in the process of recruiting nurse aides and nurses and was actively working to maintain staff stability. She further stated they had utilized a staffing agency to assist with the staffing shortage.

During an interview on 04/17/15 at 3:28 PM the Unit Manager stated there were times when incontinent care was not met in a timely manner and residents would have to wait 2 or more hours to be changed, and showers were not done weekly, and residents have complained about not getting put to bed at the time they had requested to go to bed.

During an interview on 04/17/15 at 3:46 PM the Assistant Director of Nursing (ADON) stated she would like to have more staff on all shifts and they had identified problems with staffing and that staff was asked to work over or come in early if there were call outs. She further stated she was aware the NAs were busy but she expected the needs of the residents to be met. The interview further

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F 353	Continued From page 30 revealed they were supposed to have 8 to 10 NAs on 1st shift (7:00 AM to 3:00 PM), at least 8 NAs on 2nd shift (3:00 PM to 11:00 PM) and at least 6 on 3rd shift (11:00 PM to 7:00 AM). During an interview on 04/17/15 at 5:55 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident as quickly as possible but at least every 2 hours and if certain areas were missed they should be reported for the next shift to do. She further stated she had identified problems with staffing and the facility was working to hire nursing aides and she was aware the NAs were busy but she expected the residents' needs to be met.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and tasting of foods served on a requested test tray the facility failed to serve hot breakfast foods at proper temperature and failed to ensure food was served to residents at an acceptable temperature for 2 of 2 sampled residents (Resident #s 97 and 54). The findings included:	F 364		

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1. Resident #97 was admitted to the facility on 01/14/14. The most recent Minimum Data Set (MDS) dated 02/23/15 specified the resident's cognition was intact.

A document titled "Resident Council Meeting" dated 04/07/15 was reviewed with permission by the Resident Council President. The document revealed that Resident #97 expressed concern that her food was consistently cold for all meals.

On 04/17/15 at 8:34 AM the hot foods served on a requested breakfast test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's scrambled eggs, oatmeal and sausage gravy revealed these foods were barely warm. Interview with the facility's DM during the tasting of the foods served on the test tray, revealed the DM felt the foods were acceptable. The facility's DM measured the internal temperature of the hot foods with a digital thermometer. The sausage gravy was 120 degrees Fahrenheit, the scrambled eggs were 123 degrees Fahrenheit and the oatmeal was 141 degrees Fahrenheit.

Resident #97 was not in the facility during the breakfast meal served on 04/17/15. Resident #97 was interviewed in her room on 04/17/15 at 4:45 PM. Resident #97 explained that she ate most her meals in her room and the food was cold almost all of the meals. She stated that she had reported the problems "on several occasions" but there had been no improvement.

2. Resident #54 was admitted to the facility on 12/27/14. The most recent Minimum Data Set (MDS) dated 01/03/15 specified the resident's cognition was intact.

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F 364	Continued From page 32 On 04/15/15 at 9:25 AM Resident #54 was interviewed and reported that her food was not served at the proper temperature. On 04/17/15 at 8:34 AM the hot foods served on a requested breakfast test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's scrambled eggs, oatmeal and sausage gravy revealed these foods were barely warm. Interview with the facility's DM during the tasting of the foods served on the test tray, revealed the DM felt the foods were acceptable. The facility's DM measured the internal temperature of the hot foods with a digital thermometer. The sausage gravy was 120 degrees Fahrenheit, the scrambled eggs were 123 degrees Fahrenheit and the oatmeal was 141 degrees Fahrenheit. On 04/17/15 at 8:42 AM Resident #54 was eating her breakfast in her room. She was interviewed and reported that the breakfast was not hot enough but she did not want to complain.	F 364		
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 This REQUIREMENT is not met as evidenced by:	F 371		

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Based on observations, staff interviews and record review the facility failed to keep the beverage station floor clean and the walk-in freezer and walk-in cooler free from food in the floor.

The findings included:

An initial tour was made of the facility's kitchen with the Dietary Manager (DM) on 04/14/15 at 10:35 AM. The floor around the beverage station was noted to have dried spills that covered approximately 4 tiles measuring 5 inches x 5 inche. The DM observed the dried spills around the beverage station and reported that the area was unclean. He explained that the floor was cleaned at the end of every shift. The DM added that a cleaning schedule was in place and explained that each employee had a cleaning assignment and was expected to document in the cleaning log when they had completed a task. The DM referenced the cleaning schedule log that revealed the floors were not documented as having been cleaned for 2 weeks. The DM was interviewed and reported that he was not aware the cleaning log was not being followed because he had been out of work.

On 04/14/15 at 10:42 AM during the initial tour, observations were made of the walk-in freezer and walk-in cooler with the Dietary Manager. Inside the walk-in freezer there were individual cartons of ice cream lying in the floor. Inside the walk-in cooler, the floor was littered with small butter containers and food particles and debris. The DM was interviewed and reported that he the freezer and cooler floors were cleaned twice weekly. He confirmed that the floors were last cleaned on 04/07/15 and stated he would have

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F 371	Continued From page 34 expected them to be cleaned again.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December of 2013. This was for two recited	F 520		

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deficiencies which were originally cited in December of 2013 on a recertification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of housekeeping and maintenance services, and to procure, store, prepare, serve and provide sanitary food services. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referred to:

1 a. F 253: Housekeeping and Maintenance Services: Based on observations and staff interviews the facility failed to repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift for providing maintenance and housekeeping services.
The facility was recited for F 253 for failing to repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift. F 253 Housekeeping and Maintenance Services was originally cited during the 12/05/13 recertification survey for failing to maintain wheelchairs and tube feeding poles in a clean, sanitary, and orderly manner for 6 residents residing on 2 of 4 halls (Resident# 4, #15, #28, #38, #65, and #129).

b. F 371: Based on observations, staff interviews and record review the facility failed to keep the beverage station floor clean and the walk-in freezer and walk-in cooler free from food in the floor.

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F 520	Continued From page 36 During the recertification survey of 12/05/13 the facility was cited for failure to store an ice scoop in a clean container and failed to ensure dented cans were not stored ready for use. On the current recertification survey F 371 was again recited for failing to keep the beverage station floor clean and the walk-in freezer and walk-in cooler free from food in the floor. During an interview on 04/20/15 at 2:05 PM the facility administrator explained there had been improvements in the areas of housekeeping/maintenance and dietary but interventions were missed for these instances. He stated the maintenance/housekeeping director had worked hard to make changes but there was still work to do. He explained the facility had a new manager in the kitchen but needed to take what improvements he had made and expand it to prevent deficiencies. He stated prior to the new kitchen manager they had rotating managers but progress was not being made so changes had to be made. He further stated there needed to be fine tuning and refinement to prevent future deficiencies.	F 520		