

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

PRINTED: 06/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/09/2015
NAME OF PROVIDER OR SUPPLIER MOUNT OLIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365		
(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 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility did not honor the resident's right to privacy as evidenced by regularly searching personal belongings of 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122, and #172). Findings included:</p>	F 164	<p>¿ This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements,</p>	6/11/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/01/2015

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

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F 164	<p>Continued From page 1</p> <p>The undated "A CONDENSATION OF NORTH CAROLINA'S BILL OF RIGHTS FOR NURSING HOME RESIDENTS" that was included in the Admission packet for all residents noted that the resident had the right to enjoy privacy in his/her room. It was also noted that residents had the right to retain, to secure storage for, and to use personal clothing and possessions where reasonable.</p> <p>A copy of an undated bulletin was provided by the admissions office staff on 05/07/15 at 4:00 PM. This bulletin was entitled "IMPORTANT INFORMATION" and it noted that "due to regulatory restrictions and for the safety of all of our patients, the following items are not allowed in patient rooms." The list included, aerosol can products, baby powder, petroleum jelly, medicated ointments, medicated creams, eye drops, over the counter medications, alcohol, hydrogen peroxide, hand sanitizer, air fresheners and any product that was labeled "keep out of reach of children ". It also noted that "We reserve the right to remove and dispose of any products deemed potentially harmful (in accordance with NC and Federal regulations)."</p> <p>1.Resident #44 was re-admitted to the facility on 11/07/14. Cumulative diagnoses included congestive heart failure, hypertension, peripheral vascular disease and diabetes mellitus.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment of 04/24/15 noted he was cognitively intact and was independent with decision making. Resident #44 was included in a list provided by facility which included alert, oriented and reliable residents.</p> <p>On 05/05/15 at 10:26 AM, Resident #44 was interviewed. He stated a while back he had been given a list of items that he was not allowed to have in his room. He stated he couldn't</p>	F 164	<p>findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.¿</p> <p>F 164 E PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS Residents # 172, # 105, # 44, # 79, # 83, # 122 have had their personal items returned or replaced by Admission Coordinator on 5/12/15. These residents were interviewed on 5/28/15 by Department Managers to ensure that their personal items had been replaced and no further room searches have occurred.</p> <p>Other residents that may potentially be affected were identified by interviewing the residents or families of residents unable to be interviewed. The interviews were conducted by the Social Workers and Recreation Director on 5/28/15</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will</p>		

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F 164	Continued From page 2 remember all of the items on the list. Resident #44 stated activities staff #1 (AS #1) would come into his room on a daily basis and search through all of his personal belongings in all of his drawers and his closet. He reported that AS #1 would take Vaseline, baby powder, spray deodorant, shampoo and any item that was aerosol if he had it. He reported this to be most upsetting as he felt that it was an invasion of his right to privacy. Resident #44 reported this was his home and did not think it was right for anyone to come and search through his belongings. He also reported that at times he would refuse to allow them to go through his belongings because it made him so mad that they felt they could do this. He added that he paid monthly to live in this building and felt that taking his belongings was wrong. He also commented that he does not leave the room with any of those items and no one visits who would bring in anything unsafe. Resident #44 reported that a list of items that he was not allowed to have was given to him a while back but he didn't have it now. AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners,	F 164	be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video. Center staff was in-serviced on the revised bulletin that lists the items that the residents are requested not to have in their rooms and that the staff is not allowed to search the residents' rooms. The education was provided on 6/1/15 and 6/2/15 by Admission Director and Director of Nursing. During the Resident Council meeting of 5/12/14, the revised list was reviewed with the members by the Activity Director and Social Worker. The Administrator and Director of Nursing also attended the meeting to answer questions from the Council. The bulletin that listed the items that resident were not allowed to have in their rooms was revised to include aerosol cans and over the counter medications and ointments by the Administrator and Director of Nursing on 5/13/15. A mailing to the residents' responsible party, of the revised bulletin was completed on 5/28/15 by the Admission Director. A copy of the bulletin was posted on each resident bulletin board in their rooms by the Admission Director on 5/27/15. An interview will be completed on 14 alert/oriented residents weekly for 6 months, then monthly for 6 months to determine if room searches are being conducted and if personal items are being removed by staff. The interviews will be		

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F 164	Continued From page 3 alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident's privacy, she responded that it probably was but it was part of her responsibility. She stated it was part of the Partner rounds that all administrative staff performed. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not	F 164	completed by the Social Workers and Activity Staff. The results and any trends of the weekly interviews will be presented to the Quality Assurance Committee monthly for 12 months by the Social Worker and any need in change of plan will be adjusted.		

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F 164	<p>Continued From page 4 the items taken would be replaced.</p> <p>2. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident #79 was cognitively intact with independent decision making skills. Resident #79 was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated staff come into her room on a regular basis and search her personal belongings. Resident #79 stated it was upsetting that staff go through her belongings. She stated her family brought in baby wipes and the facility staff person told her she was not allowed to have them so they took them. She stated they took her mouth wash, her air freshener and baby powder. Resident #79 remarked that sometimes odors were overwhelming and she didn't want visitors to have to endure the odors. Resident #79 added that she didn't have much but what she had she wanted to keep. She stated she felt like she had no rights at all and was in prison.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any</p>	F 164			

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F 164	<p>Continued From page 5</p> <p>clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident's privacy, she responded that it probably was but it was part of her responsibility. She stated it was part of the Partner rounds that all administrative staff performed.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The</p>	F 164			

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F 164	<p>Continued From page 6</p> <p>Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>3. Resident #83 was admitted to the facility on 01/06/11. Cumulative diagnoses included congestive heart failure, hypertension and depression.</p> <p>The most recent Quarterly MDS of 04/24/15 noted the resident was cognitively intact. Resident #83 was included in a list provided by the facility for alert, oriented and reliable residents.</p> <p>During an interview with Resident #83, on 05/05/15 at 10:26 AM, she stated that staff come into her room on a daily basis and go through all of her belongings. She stated this was an invasion of her privacy and her home. She stated she did not like them going through her things but the staff had told her they had to do it so she would allow them to search. Resident #83 commented that the facility staff should not be allowed to go through all of her personal belongings looking for powders or spray deodorants. She commented that she didn't have much but it was hers and she didn't want people going through it. She stated she used those items when she lived at home before coming here.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal</p>	F 164			

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F 164	<p>Continued From page 7</p> <p>belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident's privacy, she responded that it probably was but it was part of her responsibility. She stated it was part of the Partner rounds that all administrative staff performed.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a</p>	F 164			

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F 164	<p>Continued From page 8</p> <p>monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>4. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly MDS of 02/21/15 noted Resident #105 was cognitively intact and independent with decision making. He was also identified by the facility to be alert, oriented and reliable. During an interview with Resident #105, on 05/06/15 at 10:30 AM, he stated staff come into his room regularly and search through all of his belongings. He stated it bothered him that they were allowed to do that since this was his home. He stated he was told by the staff that he couldn't do anything about it so he would just leave the room and let them go through whatever they wanted. Resident #105 stated they took his shaving cream and anything that sprayed as well as any type of powder. He commented that if he was living in a private home he could have those items and didn't understand why he couldn't have them here.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She</p>	F 164			

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F 164	<p>Continued From page 10</p> <p>they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>5. Resident #122 was admitted to the facility on 11/21/14. Cumulative diagnoses included hypertension, diabetes mellitus, chronic obstructive pulmonary disease and quadriplegia. The most recent Significant Change MDS of 04/12/15 indicated Resident #122 was cognitively intact and independent with decision making. Resident #122 was identified by the facility on a list of alert, oriented and reliable residents. Resident #122 was interviewed on 05/06/15 at 11:40 AM per request. He stated staff would come into his room regularly and search through his personal belongings and closet. He stated they search through all of his drawers and closet even if he isn't in the room. Resident #122 remarked "It ain't right" that they did this. He stated it made him mad and it was very upsetting that they thought it was okay to search his belongings. He stated he didn't have anything in his room that would be dangerous unless Vaseline was dangerous. He stated when he questioned staff about this, he was told it was their job to search his belongings. Resident #122 remarked he felt like he was in prison here and that he had no privacy at all. He also remarked that this was his home.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM.</p>	F 164			

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F 164	<p>Continued From page 11</p> <p>She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident's privacy, she responded that it probably was but it was part of her responsibility. She stated it was part of the Partner rounds that all administrative staff performed.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's</p>	F 164			

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F 164	<p>Continued From page 12</p> <p>belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>6. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change MDS of 04/01/15 noted Resident #172 was cognitively intact and independent in decision making. During an interview with Resident #172, on 05/06/15 at 2:40 PM, she stated she felt she was in a prison here and that she had no rights at all. She stated she did not appreciate staff coming into her room to search through all of her belongings. She stated this was her home and they had no right to take anything from her and it was an invasion of her privacy. Resident #172 stated when she questioned staff about searching her belongings she was told they needed to make sure no one had any aerosols because confused residents might get them. She stated no one came into her room and if she had aerosols she would keep them in a drawer. Resident #172 stated she had a bag of salt packets and staff took it. She commented that she was not on a</p>	F 164			

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F 164	Continued From page 13 salt restricted diet. AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident's privacy, she responded that it probably was but it was part of her responsibility. She stated it was part of the Partner rounds that all administrative staff performed. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items	F 164			

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F 164	Continued From page 14 on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.	F 164			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility did not follow-up on grievances expressed by 3 of 3 sampled residents (Resident #68, #105 and #172) regarding disruptive behaviors by another resident (Resident #168). Findings included: 1. Correspondence from the corporate law department of 04/10/15 which was provided by the facility noted that Social Worker #1 (SW #1)	F 166	F 166 E RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES Resident # 68 was discharged on 5/27/15. Resident # 168 was discharged on 5/21/15 Resident #68, # 105 and # 172 were	6/11/15	

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F 166	Continued From page 15 had contacted them in reference to Resident #168. The following recommendations were provided: <ul style="list-style-type: none"> . Reach out to the Ombudsman for assistance with alternative placement . Contact the local police to have them speak with him about his behaviors . Continue to search for alternative and appropriate placement A "GRIEVANCE/CONCERN FORM" of 04/13/15 written by Social Worker #1 (SW #1) from Resident #172, Resident #105 and Resident #68 noted that "Resident wrote up a long list of issues that they are having with the resident ___ (Resident #168)." Attached to the grievance completed by SW #1 was a handwritten grievance/concern form dated 04/10/15 from 4 residents (Resident #172, #105 and #68 and one that had been discharged). Resident #172 had written the concerns on paper and a copy was attached to both grievance/concern forms. The list included the following concerns: <ol style="list-style-type: none"> 1. Uses foul language (cursing, swearing and off color remarks) 2. He hollers loudly for staff rather than using call light 3. He enters residents' rooms at night and offers products for sale 4. Sits at nurses' carts while they are passing medications and tries to feel their bodies 5. Rides up and down hall in reckless manner 6. Plays television extremely loud even when not in the room 7. Sits in halls so people are unable to pass and calls them ugly names if residents ask to pass by 8. Smokes in yard at all hours unsupervised 9. Enters resident's rooms without knocking day and night 10. Aggravates the elderly residents until point of 	F 166	informed that resident # 168 was no longer a resident in this center by the Social Worker on 5/21/15. Other residents that may be affected by this practice were identified by resident and family interviews using a resident and family interview tool by the Social Workers and Activity Director on 5/20/15. Any negative responses were transferred to the center's Grievance/Concern form for investigation and resolution. Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video. Social Workers received education on the Grievance Process on 5/15/15 by the Corporate Social Service Specialist via Web Cast. Center staff, licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff and department heads received education regarding the grievance process by the Social Worker on 6/1/15 and 6/2/15. Resident interviews will be conducted for		

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F 166	<p>Continued From page 16</p> <p>tears and these residents are afraid of him</p> <p>11. Rides the halls with a cigarette in his mouth saying he can smoke and do as he pleases</p> <p>12. Calls residents extremely ugly names and threatens them</p> <p>13. Demands food in the lunch room</p> <p>14. Talks dirty to the young girls who help him</p> <p>15. Residents feel threatened by his talk and actions</p> <p>The investigation noted on this grievance indicated that the action taken to investigate grievance/concern was "Staff was aware of incidents and has been working on correcting behaviors with no positive changes." The recommended corrective action was that social services had telephoned the corporate attorney for guidance on the situation and social services was doing as advised by the attorney. It was noted in the resolution of grievance/concern section that the grievance was resolved on 04/13/15 due to social services was following the suggestions made by the attorney and would be contacting the local police department. There were no statements from any of the residents who brought the concern to the social services department nor were there any statements from staff regarding any of the issues mentioned in the handwritten grievance.</p> <p>Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus.</p> <p>The most recent Significant Change MDS of 04/01/15 noted Resident #172 was cognitively intact and independent in decision making. She was also identified as being alert, oriented and reliable by the facility.</p> <p>During an interview with Resident #172, on 05/07/15 at 2:40 PM, she stated there was one resident (Resident #168) in the facility who</p>	F 166	<p>14 residents weekly for 6 months then monthly for 6 months, questioning if they have any grievance/concerns and if they have expressed any has the staff returned with a resolution. Any grievance/concerns that are expressed will be reviewed in Morning Stand up meeting daily until the grievance/concern is resolved and closed.</p> <p>The results of the resident interviews resulting in a grievance/concern will be reviewed for any trends and presented to the Quality Assurance Committee monthly for 12 months by the Social Worker.</p>		

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F 166	Continued From page 17 constantly bothered and harassed the other residents. She stated Resident #168 kept everyone up all night using "awful" language, shouting and yelling down the halls. Resident #172 stated she had complained to numerous staff members about his behaviors but no one did anything about it. She commented she was tired of not getting any sleep because of Resident #168's yelling and cursing. Resident #172 stated about a month ago she and 2 other residents (Resident #105 and #68) sat down and wrote out several things in a grievance about Resident #168. She stated she hand delivered it to the social services department. She stated both social workers were in the room and told her they would speak with Resident #168. Resident #172 stated no one had followed-up with her about the grievance and the only thing that had been said was that they were talking to him. She stated when she complained about Resident #168 she was told that he had rights. She commented so did she and she felt that no one cared about her rights because nothing had changed. Resident #172 stated no one listened to her complaints and Resident #168 was allowed to do whatever he wanted. She stated staff didn't say anything to him when he was acting out. She reported that Resident #168 "bothered" and "tormented" other residents and was constantly calling them names. Resident #172 stated she and the other 2 residents felt that if they wrote down their concerns in a grievance something might be done. She stated they did the grievance because of the way he was treating the residents who couldn't defend themselves. She stated she shouldn't have to "be shut up in her room" because of him and his behaviors. Resident #172 commented she was tired and frustrated with not being allowed to get a good night's sleep because	F 166			

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F 166	<p>Continued From page 18 of Resident #168.</p> <p>Resident #172 reported on 05/08/15 at 11:45 AM that no one had followed up with her to see how things were going or to ask more questions since she filed the grievance last month. She stated there had been no change in Resident #168's behaviors.</p> <p>Resident #68 was admitted to the facility on 03/02/15. Cumulative diagnoses included thyroid disorder, depression and seizure disorder. The most recent Admission Minimum Data Set (MDS) assessment of 03/05/15 indicated Resident #68 was cognitively intact and independent in decision making. He was also identified as being alert, oriented and reliable by the facility.</p> <p>During an interview with Resident #68, on 05/07/15 at 9:50 AM, he stated he had been to the Administrator about 3 weeks ago concerning some issues he was having with another resident (Resident #168). Resident #68 stated he had complained to numerous staff on the hall and it was all "a big joke" with them. He stated when he would ask them to ask Resident #168 to turn the volume down on his television staff responded it wouldn't do any good because he would just turn it back up. He stated so nothing changed and he continued to play his television so loud that he couldn't hear his television.</p> <p>Resident #68 stated he went back to the Administrator again this week to complain about Resident #168 and was told his "hands were tied". He commented that he had also complained to the social services department on several occasions but was told Resident #168 had rights and there was nothing that they could do about his behaviors. He expressed anger with the situation and reported that he along with some of the other residents had written out 15 different concerns about Resident #168 and had</p>	F 166			

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F 166	<p>Continued From page 19</p> <p>given it to Social Worker #1 (SW #1). He reported no one had followed up with him or been back to gather more information and he felt the issue was not resolved. Resident #68 stated there had been no change in Resident #168's disruptive behaviors.</p> <p>A "GRIEVANCE/CONCERN FORM" dated 05/05/15 which was completed by the Administrator (provided on 05/09/15 at 10:00 AM) described a concern that Resident #68 had reported. The description A noted that Resident #68 "had asked to visit with me to discuss a previous grievance filed against Resident #168 on 04/13/15. He stated that _____'s behavior (Resident #168) during the early to late evening hours was keeping him from getting the rest he needed and enjoying his television programs." It was noted in the investigation section of the grievance/concern form that action taken to investigate included " Continuing to work toward locating an alternate placement for _____ (Resident #168). "</p> <p>Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent quarterly Minimum Data Set (MDS) assessment of 02/21/15 indicated Resident #105 was cognitively intact and independent in decision making.</p> <p>Resident #105 was interviewed on 05/06/15 at 10:30 AM. He stated he had complained to social worker #1 (SW #1) as well as other staff members in the past about some issues regarding another resident (Resident #168). He stated Resident #168 was disruptive and no one could sleep due to the extremely loud volume of his television. He stated he along with some of the other residents had taken their issues to SW #1. Resident #105 stated SW #1 told him that she was aware of the issues and there was</p>	F 166			

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F 166	<p>Continued From page 20</p> <p>nothing she could do about them. He commented SW #1 also stated Resident #168 had rights. Resident #105 stated he had reported an issue with Resident #168 demanding his snacks about 2-3 weeks ago to SW #1 but had heard nothing from her regarding the issue. He also stated no one had been in to follow-up with him or ask him any questions about the concerns they presented to SW #1 a few weeks back. Resident #105 remarked that he felt their grievance was unresolved because the issues had not changed and were on-going. He also remarked that obviously talking with Resident #168 was not working.</p> <p>During an interview with the social worker #1 (SW #1) on 05/07/15 at 11:20 AM, she stated she had spoken with Resident #168 about the residents and their rights. She stated talking with him was nonproductive and he continued with the unacceptable behaviors. SW #1 stated she had lots of incidents regarding Resident #168. She reported that she had spoken with him on almost a daily basis in regards to the huge list of unacceptable behaviors that he exhibited. SW #1 reported that she had contacted the Ombudsman for advice. When questioned about the safety of the residents in the facility she responded that the police had been out to the facility to speak with Resident #168 and gave him a verbal warning. She commented the behaviors were unchanged. SW #1 stated he had a signed behavior contract but there were no consequences if he broke the contract. She reported the only consequence was a 30 day notice for discharge but thus far she had not been able to find suitable placement for Resident #168. She commented that no one at the facility could do anything with him or his behaviors. SW #1 stated she could not provide a</p>	F 166			

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F 166	<p>Continued From page 21</p> <p>safe and orderly discharge so he would continue to be there until she found an appropriate placement. When questioned if she felt it was okay for him to continue with his unacceptable behaviors, she responded yes I guess so since the facility couldn't provide him with a safe and orderly discharge.</p> <p>A telephone interview was conducted with the Ombudsman on 05/07/15 at 3:03 PM. She stated the facility telephoned her about a month ago asking if she could come out and brainstorm with them on some issues at the facility. She stated they expressed no urgency with the request. The Ombudsman stated she came out last week and met with SW #1. She stated she advised them to telephone the police each time incidents occurred with Resident #168. She stated she was told by SW #1 that she had not been able to locate a suitable placement for Resident #168. The Ombudsman stated that the facility had not imposed any consequences for Resident #168 's inappropriate behaviors and he was doing whatever he wanted whenever he wanted and no one had done anything to stop him.</p> <p>The Administrator was interviewed about Resident #168 on 05/08/15 at 12:00 PM. He reported being aware of Resident #168's behaviors since February 2015. He stated social services had been dealing with the issues regarding Resident #168 and was actively seeking alternate placement for him. He stated the previous social worker had been dealing with the behavior issues but was not as pro-active as SW #1. He stated SW #1 was handling the issues with Resident #168 and was actively dealing with those issues. He reported that they were unable to control him or his behaviors because Resident #168 felt he was above the law</p>	F 166			

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F 166	<p>Continued From page 22</p> <p>so he did whatever he pleased. The Administrator also reported that Resident #168 was a master manipulator and knew exactly what he was doing. The Administrator reported they had telephoned the police to come to the facility and talk with Resident #168 about his behaviors. He stated the police told him he couldn't touch any of the residents here. He reported the corporate attorney had been consulted as well. He stated that he didn't remember any resident complaining to him until this week. The Administrator stated they investigated any resident to resident altercation that was brought to their attention and anyone could voice a grievance through the social services department as well as through the nursing department. He stated as soon as an alternate facility could be located Resident #168 would be discharged.</p> <p>On 05/09/15 at 10:00 AM, the Administrator stated that one on one supervision had been implemented yesterday evening for Resident #168. The Administrator stated he had completed a grievance and provided a copy. He also stated he spoke with Resident #68 and he reported it had been much quieter last evening since the one on one supervision started.</p> <p>During an interview with SW #1, on 05/09/15 at 4:45 PM, she stated she had been working in the facility for a few months and Resident #168 had been an issue. She did not know what the previous social worker had done to control his behaviors because the previous social worker didn't make a lot of notes in his record. She also stated that the nurses were not documenting any of his behaviors in his record. SW #1 added that staff were afraid of him and thought that was why</p>	F 166			

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F 166	Continued From page 23 they were not documenting anything about his behaviors. When questioned as to daily rounds and talking with the residents and following up on issues/concerns, she stated the residents knew they could come to her if they had concerns. SW #1 stated she felt the grievance that was brought to her by the 3 residents (Resident #172, #105 and #68) was resolved because she had spoken with Resident #168 and she was limited as to the information she could provide to them due to confidentiality concerns. SW #1 also stated she was aware of the issues before the grievance was brought to her and she was actively attempting to discharge him. She agreed that his behaviors were an on-going issue and tentative discharge was set for next week. She also reported that he had been placed on one on one supervision last evening.	F 166			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility did not post survey results from 8 of the 8 most recent surveys conducted in the facility in	F 167	F-167 C POSTING SURVEY RESULTS	6/11/15	

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F 167	<p>Continued From page 24</p> <p>the Federal Survey notebook available to residents. Findings included:</p> <p>On 05/04/2015 at 3:00 PM, a review of the facility 's Survey Results notebook located in a wall pocket beside the reception desk revealed the most recent survey results available for review were from a complaint survey dated 05/12/2014.</p> <p>In an interview with the administrator on 05/06/2015 at 2:10 PM, he stated that he was the staff member responsible for maintaining the Survey Results notebook with up-to-date surveys. The administrator stated he agreed all complaint and follow up survey results, along with the previous recertification survey, should be available to residents for review. A review of the notebook with the administrator at the time of the interview revealed that the most recent survey results in the notebook were from a complaint follow-up survey dated 05/12/2014 in which the facility was deficiency-free. The complaint surveys which were not available were the following dates:</p> <p>Event ID # EZPE11 on 08/13/2014 Event ID # 93R011 on 08/27/2014 Event ID # ET0E11 on 10/02/2014 Event ID # ET0E12 on 10/22/2014 Event ID # 93R012 on 10/22/2014 Event ID # 93R013 on 10/22/2014 Event ID # QJDF11 on 01/30/2015 Event ID # QJDG12 on 03/05/2015</p> <p>During the same interview with the administrator on 05/06/2015 at 2:10 PM, he stated he did not realize there had been eight complaint and follow up surveys since 05/12/2014, and that he should</p>	F 167	<p>There were not any specific residents affected by this deficient practice.</p> <p>This deficient practice had the potential to affect all residents of the facility. The survey book has been brought up to date as evidenced by survey findings on 5/9/15. The Admission Director has the task of auditing the survey book for completeness on a weekly basis.</p> <p>The facility administrator will retain responsibility for maintaining the book containing the results of facility survey activity.</p> <p>a. Survey documentation is discussed at staff meetings and any new survey materials will be promptly filed when received from the State Agency.</p> <p>b. The Admission Director has been assigned the task to audit the survey book on a weekly basis to assure that required survey documents remain on file and have not been inadvertently removed.</p> <p>Results of the weekly audits will be discussed at the facility QAA meetings for the next three months (June & August).</p>		

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F 167	Continued From page 25 have posted them. The administrator stated he would review his files to locate the results from the eight most recent surveys and place them in the Survey Results notebook for residents to review.	F 167			
F 223 SS=G	A review of the Survey Results notebook on 05/09/2015 at 4:00 PM revealed the results of the eight most recent surveys were present in the notebook, and that the notebook was located in the wall pocket beside the reception desk. 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility allowed a resident (Resident #168) to verbally harass and torment 1 of 1 sampled residents (Resident #131). The facility also allowed Resident #168 to physically abuse 1 of 1 sampled residents (Resident #131). Findings included: Resident #131 was admitted to the facility on 09/06/11. Cumulative diagnoses included unspecified psychosis, depression, aphasia and vascular dementia. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/06/15 documented Resident #131 had poor	F 223	F 223 G FREE FROM ABUSE/INVOLUNTARY SECLUSION Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15. The responsible party of resident # 131 was notified on 5/27/15 by Social Worker that resident # 168 was no longer a resident in the center. The Social Worker informed residents # 105, # 43, # 79, and # 172 that resident # 168 no longer resided in the center on 5/27/15. Resident	6/11/15	

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F 223	Continued From page 26 decision making skills with moderately impaired cognition. A "GRIEVANCE/CONCERN FORM" dated 04/10/15 noted that Resident #131's family reported to SW #1 that she did not want Resident #168 anywhere around Resident #131. The family reported being worried about her safety and what Resident #168 was doing when she wasn't sitting with Resident #131. The family reported that Resident #168 had offered a stuffed animal to Resident #131 and the family told him not to give it to her but he gave it to her anyway. When Resident #131 started loving on the stuffed animal, Resident #168 remarked "Hey, I gave you that, why don't you give me some sugar like that?" and leaned into Resident #131. It was documented that the family told Resident #168 Resident #131 didn't give kisses to anyone. It was noted that Resident #131 was extremely demented and the family felt that Resident #168 disregarded the family's wishes. A note from SW #1 of 05/04/15 at 4:52 PM indicated that a grievance had been received from the call center regarding Resident #131. The grievance concerned resident on resident "tormenting" . SW #1 documented that she had been made aware of the issue weeks ago and had been in contact with law enforcement, the Ombudsman and the corporate attorney. She documented she had asked the family of Resident #131 to go to law enforcement themselves. SW #1 telephoned the family and suggested that they go to the Magistrate's office and talk to them about the concern. It was documented that the family stated they understood the restrictions the facility had but she feared for Resident #131's safety. SW #1 assured the family that she was doing the best she could to keep the two residents from	F 223	# 68 was discharged on 5/27/15. All residents in the center had the potential to be affected by this practice. Social Workers and Recreation Director conducted interviews with the interviewable residents and with family members using the family interview tool regarding possible abuse on 5/11/15 thru 5/20/15. No family member or resident related any concern regarding abuse that had occurred. Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video. Education was provided to Licensed Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE). Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Maintenance, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on what constitutes		

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F 223	<p>Continued From page 27</p> <p>interacting.</p> <p>Resident #105 was interviewed on 05/06/15 at 10:30 AM. He stated Resident #168 constantly harassed the female residents in the building including Resident #131.</p> <p>During an interview with Resident #43, on 05/06/15 at 10:50 AM, he stated Resident #168 "picked on" Resident #131 constantly. He stated he cursed and harassed her as well as other residents. He reported staff were very aware of his behaviors.</p> <p>During an interview with Resident #172, on 05/04/15 at 5:41 PM, she stated Resident #168 was disruptive and harassed Resident #131 constantly. She stated Resident #131 was "scared to death" of Resident #168. Resident #172 stated she had witnessed Resident #168 "tormenting" Resident #131 and calling her ugly names. She commented that staff allowed the behavior and said nothing to him.</p> <p>During an interview with social worker #1 (SW #1), on 05/07/15 at 11:20 AM, she stated she had received a grievance a few weeks ago from Resident #131's family in regards to Resident #168 harassing Resident #131 in front of the family. She commented the family was concerned about Resident #168 being inappropriate with Resident #131. SW #1 remarked the only consequence for Resident #168's behavior was a 30 day discharge but she had not been able to locate a suitable location thus far.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated Resident #168 "picked on" Resident #131 constantly and that Resident #168 talked very "ugly" to her. She stated Resident #131 couldn't defend herself. Resident #79 also stated that Resident #168 usually bothered the residents who weren't</p>	F 223	<p>abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Resident interviews will be conducted on 14 interviewable residents weekly for 6 months and then monthly for 6 months by the Social Services and Activities regarding if they feel if any abuse has occurred or been observed. A resident interview tool will be used.</p> <p>The results of the interviews, presented by the Social Worker, will be reviewed at the Quality Assurance Committee monthly for 12 months.</p>		

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F 223	Continued From page 28 capable of defending themselves. She commented that she had complained to various staff members in the past but nothing was ever done so she stopped complaining. The nurse staff scheduler was interviewed on 05/07/15 at 4:00 PM. She stated she had heard Resident #168 make inappropriate comments to Resident #131 and had reported it to social services. Resident #105 was interviewed again on 05/09/15 at 1:02PM. He stated he had witnessed Resident #168 spinning Resident #131's wheelchair around and around in a circle until she cried. He also stated Resident #168 was constantly abusing her. He stated he had reported it to social worker #1 (SW #1). Resident #68 was interviewed on 05/07/15 at 9:50 AM. He stated Resident #168 made fun of the "old folks", called them names and mocked them. He was not able to provide any residents names other than Resident #131 but he had witnessed these behaviors. Resident #68 stated Resident #168 constantly picked on Resident #131. He stated that Resident #168 would point at Resident #131 calling her ugly names. He stated he had complained about his behaviors to staff and administration but staff did nothing and the behaviors continued. Resident #68 reported that he had signed a grievance form that was compiled by some of the other residents concerning Resident #168's behaviors regarding some of the residents including Resident #131.	F 223			
F 226 SS=G	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	F 226		6/11/15	

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F 226	Continued From page 29 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility did not investigate allegations of abuse and did not protect 1 of 1 sampled residents (Resident #131) from on-going verbal and/or physical abuse by a cognitively intact resident (Resident #168). Findings included: The facility's Abuse prohibition policy, revised on 07/01/09, noted that abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and included verbal, sexual, physical, and mental abuse. It was noted that if suspected abuse was resident to resident, the resident who had in any way threatened another would be removed from the setting or situation. It was also noted that upon receiving information concerning a report of suspected or alleged abuse an immediate and thorough investigation was to be done. It was further noted that the facility would take whatever steps necessary to prevent further incidents. Resident #131 was admitted to the facility on 09/06/11. Cumulative diagnoses included unspecified psychosis, depression, aphasia and vascular dementia. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/06/15 documented Resident #131 had poor decision making skills with moderately impaired cognition. A "GRIEVANCE/CONCERN FORM" dated 04/10/15 noted that the family of Resident #131 reported to social worker #1 (SW #1) that she did	F 226	F 226 G Develop/Implement Abuse/Neglect, etc. Policies Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15. The responsible party of resident # 131 was notified on 5/27/15 by Social Worker that resident # 168 was no longer a resident in the center. The Social Worker informed residents # 105, # 43, # 79, and # 172 that resident # 168 no longer resided in the center on 5/27/15. Resident # 68 was discharged on 5/27/15. All residents in the center had the potential to be affected by this practice. Social Workers and Recreation Director conducted interviews with the interviewable residents and with family members using the family interview tool regarding possible abuse on 5/11/15 thru 5/20/15. No family member or resident related any concern regarding abuse that had occurred. Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on		

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F 226	<p>Continued From page 30</p> <p>not want Resident #168 anywhere around Resident #131. The family reported being worried about her safety and what Resident #168 was doing when she wasn't sitting with Resident #131. The family reported that Resident #168 had offered a stuffed animal to Resident #131 and the family told him not to give it to her but he gave it to her anyway. When Resident #131 started loving on the stuffed animal, Resident #168 remarked "Hey, I gave you that, why don't you give me some sugar like that?" and leaned into Resident #131. It was also noted that the family told Resident #168 that Resident #131 didn't give kisses to anyone. It was noted that Resident #131 was extremely demented and the family felt that Resident #168 disregarded the family's wishes.</p> <p>A note from social worker #1 (SW #1) of 05/04/15 at 4:52 PM indicated that a grievance had been received from the call center regarding Resident #131. The grievance concerned resident on resident "tormenting". SW #1 documented that she had been made aware of the issue weeks ago and had been in contact with law enforcement, the Ombudsman and the corporate attorney. She documented she had asked the family of Resident #131 to go to law enforcement themselves. SW #1 telephoned the family and suggested that they go to the Magistrate's office and talk to them about the concern. It was documented that the family stated they understood the restrictions the facility had but she feared for Resident #131's safety. SW #1 assured the family that she was doing the best she could to keep the two residents from interacting.</p> <p>Resident #105 was interviewed on 05/06/15 at 10:30 AM. He stated Resident #168 constantly harassed the female residents in the building</p>	F 226	<p>6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Education was provided to Licensed Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE).</p> <p>Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Maintenance, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on what constitutes abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Resident interviews will be conducted on 14 interviewable residents weekly for 6 months, then monthly for 6 months by the Social Services and Activities regarding if they feel if any abuse has occurred or been observed. A resident interview tool will be used.</p> <p>The results of the interviews, presented by the Social Worker, will be reviewed at the Quality Assurance Committee monthly for 12 months.</p>		

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F 226	<p>Continued From page 31 including Resident #131.</p> <p>During an interview with Resident #172, on 05/04/15 at 5:41 PM, she stated Resident #168 constantly harassed Resident #131. She stated Resident #131 was "scared to death" of Resident #168. Resident #172 stated she had witnessed Resident #168 "tormenting" Resident #131 and calling her "ugly" names.</p> <p>During an interview with SW #1, on 05/07/15 at 11:20 AM, she stated she had received a grievance a few weeks ago from Resident #131's family in regards to Resident #168 harassing Resident #131 in front of the family. She commented the family was concerned about Resident #168 being inappropriate with Resident #131.</p> <p>During another interview with Resident #172, on 05/07/15 at 2:40PM, she stated she along with 2 other residents had written a long list of concerns in a grievance that they had given to SW #1. She stated one of the reasons they prepared the grievance was because of the way Resident #168 was harassing and tormenting Resident #131 and the other residents. She also stated Resident #168 constantly called Resident #131 "ugly" names.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated Resident #168 "picked on" Resident #131 constantly and that Resident #168 talked very "ugly" to her. She stated Resident #131 couldn't defend herself. Resident #79 also stated that Resident #168 usually bothered the residents who weren't capable of defending themselves. She commented that she had complained to various staff members in the past but nothing was ever done so she stopped complaining.</p> <p>The nurse staff scheduler was interviewed on 05/07/15 at 4:00 PM. She stated she had heard</p>	F 226			

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F 226	<p>Continued From page 32</p> <p>Resident #168 make inappropriate comments to Resident #131 and had reported it to social services.</p> <p>Nurse #1 was interviewed on 05/07/15 at 5:15 PM. She stated Resident #168 was belligerent with the residents and harassed the residents who weren't capable of defending themselves. She stated she had reported issues to administration in the past but nothing was done so she stopped.</p> <p>Resident #105 was interviewed again on 05/09/15 at 1:02PM. He stated he had witnessed Resident #168 spinning Resident #131's wheelchair around and around in a circle until she cried. He also stated Resident #168 was constantly abusing her. He stated he had reported it to SW #1.</p> <p>Resident #68 was interviewed on 05/07/15 at 9:50 AM. He stated Resident #168 made fun of the "old folks", called them names and mocked them. He was not able to provide any residents names other than Resident #131 but he had witnessed these behaviors. Resident #68 stated Resident #168 constantly picked on Resident #131. He stated that Resident #168 would point at Resident #131 calling her ugly names. He stated he had complained about his behaviors to staff and administration but staff did nothing and the behaviors continued.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had been made aware of the incident regarding Resident #131 where Resident #168 had been seen spinning her around in her wheelchair. He stated SW #1 had been handling the issues regarding Resident #168 and Resident #131. He added that the facility investigated any resident to resident altercation that was brought to their attention.</p> <p>SW #1 was interviewed on 05/09/15 at 4:45 PM. She stated the issue regarding Resident #131's wheelchair was mentioned third party while</p>	F 226			

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F 226	Continued From page 33 talking with 2 other residents concerning a grievance they had brought to her concerning behaviors exhibited by Resident #168 toward the other residents. She stated the 2 residents gave no specific information other than Resident #168 had been observed twirling Resident #131 around in her wheelchair and that Resident #168 was harassing her. SW #1 stated she had spoken with some of the staff and no one was able to provide her with any information. She stated in order to investigate the issue she needed to know when it occurred and who witnessed it. When questioned about investigating the issues with Resident #131 as abuse, she responded that she felt it was a resident to resident confrontation and did not see it as an abuse situation. SW #1 reported she had been talking with Resident #168 about his behaviors toward Resident #131 as well as the other residents but the behaviors were unchanged. During an interview with the Director of Nurses (DON), on 05/09/15 at 5:00 PM, she denied awareness of the issue with Resident #131's wheelchair and Resident #168. She stated SW #1 was handling those issues.	F 226			
F 241 SS=H	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 record review, physician, resident and staff interviews, the facility allowed a resident	F 241	F 241 H DIGNITY AND RESPECT OF	6/11/15	

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F 241	<p>Continued From page 34</p> <p>(Resident #168) to disregard 13 of 13 sampled residents' right to be treated with dignity (Resident #39, #43, #68, #71, #78, #79, #81, #105, #129, #131, #143, #172, and #203) as evidenced by vulgar, offensive and disruptive behaviors. The facility also did not maintain dignity for 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122, and #172) who reported facility staff were searching their belongings routinely. Findings included:</p> <p>1.a. Resident #131 was admitted to the facility on 09/06/11. Cumulative diagnoses included unspecified psychosis, depression, aphasia, anxiety and vascular dementia. The most recent Quarterly Minimum Data Set (MDS) of 04/06/15 documented Resident #131 had poor decision making skills with moderately impaired cognition. A grievance/concern form dated 04/10/15 noted Resident #131 's family was very upset about an incident with Resident #168. The family reported to the social worker (SW #1) that she did not want Resident #168 anywhere around Resident #131. The family reported being worried about her safety and what Resident #168 was doing when she wasn't sitting with Resident #131. The family reported that Resident #168 had offered a stuffed animal to Resident #131 and the family told him not to give it to her but he gave it to her anyway. When Resident #131 started loving on the stuffed animal, Resident #168 remarked " Hey, I gave you that, why don't you give me some sugar like that? " and leaned into Resident #131. Resident #131 was extremely demented and the family felt that Resident #168 disregarded the family's wishes. A note from SW #1 of 05/04/15 at 4:52 PM noted that a grievance had been received from the call</p>	F 241	<p>INDIVIDUALITY</p> <p>Residents # 39, # 43, # 71, #78, # 79, #81, #105, # 129, # 131, # 143, and # 172 were informed that resident # 168 was no longer residing in the center. Resident # 68 was discharged on 5/27/15. Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15.</p> <p>Residents # 172, # 105, # 44, # 79, # 83, # 122 have had their personal items returned or replaced by the Social Services on 5/12/15 . These residents were interviewed on 5/28/15 by Department Managers to ensure that their personal items had been replaced and no further room searches have occurred.</p> <p>Other residents that may potentially be affected were identified by interviewing the residents or families of residents unable to be interviewed. The interviews were conducted by the Social Workers and Recreation Director on 5/11/15 thru 5/20/15.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees</p>		

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F 241	<p>Continued From page 35</p> <p>center regarding Resident #131. The grievance concerned resident on resident "tormenting" . According to the care line Resident #131's family was unhappy with the way the facility was handling the situation. SW #1 documented she had been made aware of the issue weeks ago and had been in contact with law enforcement, the Ombudsman and the corporate attorney. She documented she had asked the family of Resident #131 to go to law enforcement themselves. SW #1 telephoned the family and suggested that they go to the Magistrate's office and talk to them about the concern. It was documented that the family stated they understood the restrictions the facility had but she feared for Resident #131's safety. SW #1 also documented she assured the family that she was doing the best she could to keep the two residents from interacting.</p> <p>A late entry note from SW #1 indicated on 05/06/15 at 8:07 AM she had telephoned the magistrate's office. SW #1 was told someone from the facility would need to agree to testify for the resident (Resident #131). SW #1 documented that she could find no one who had witnessed any incidents or had firsthand experience.</p> <p>During an interview with Resident #81 on 05/07/15 at 3:45 PM, she stated about a month ago she had witnessed Resident #168 feeling the back of Resident #131's neck and flipping her hair. She stated Resident #131 was not capable of speaking for herself. She didn't report it to anyone.</p> <p>Resident #105 reported during an interview on 05/09/15 at 1:02 PM that he had witnessed Resident #168 twirling Resident #131's wheelchair around until she cried. He stated that Resident #168 was constantly harassing her.</p>	F 241	<p>that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Education was provided to Licensed Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE).</p> <p>Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on dignity and respect and what constitutes abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Residents will be interviewed to confirm that their dignity has been respected by staff and other residents in the facility. Resident interviews will be conducted on 14 inter-viewable residents weekly for 6 months, then monthly for 6 months by Social Services and Activities to see if they feel they are being treated with dignity and respect by staff and other residents. A resident interview tool will be used for the resident interviews.</p> <p>Center staff was in-serviced on Residents Rights, Dignity and Respect and staff responsibility to assure these rights are protected. In-service was provided by the Director of Admissions on 5/20, 5/21, and 5/22/15. Center staff was in-serviced on the revised bulletin that lists the items that the residents are requested not to have in their rooms and that the staff is not allowed to search the residents' rooms.</p>		

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F 241	<p>Continued From page 36</p> <p>During an interview with the social worker #1 (SW #1) on 05/07/15 at 11:20 AM, she stated she had received a grievance from Resident #131's family in regards to Resident #168 harassing Resident #131 in front of the family. She stated the family was concerned about Resident #168 being inappropriate with Resident #131.</p> <p>1.b. Resident #78 was admitted to the facility on 02/14/13. Cumulative diagnoses included depression, neuralgia and quadriplegia. The most recent Quarterly Minimum Data Set (MDS) assessment of 03/31/15 documented Resident #78 was cognitively intact and independent with decision making. This resident was also included in a list provided by the facility as being alert, oriented and reliable.</p> <p>A note from social worker #1 (SW #1) of 03/11/15 at 2:08 PM noted that the nurse staff scheduler had informed her that Resident #168 was speaking in an inappropriate vulgar manner to another female resident (Resident #78). It was noted that this time staff witnessed this behavior. SW #1 documented that Resident #168 was asking inappropriate sexual questions and the resident (Resident #78) felt uncomfortable and voiced she did not like him talking to her like that. Another note from SW #1 of 03/12/15 at 8:16 AM noted that SW #1 had spoken with Resident #168 about the incident of yesterday with a female resident where he was asking her sexual questions. He denied talking with the female (Resident #78).</p> <p>Resident #78 was interviewed about the incident with Resident #168 on 05/09/15 at 3:00 PM. She was visiting her male friend in his room. Resident #78 stated Resident #168 picked on her and harassed her constantly. She stated she had complained to several staff members including</p>	F 241	<p>The education was provided on 6/1/15 and 6/2/15 by the Admission Director. During the Resident Council meeting of 5/12/14, the revised list was reviewed with the members by the Activity Director and Social Worker. The Administrator and Director of Nursing also attended the meeting to answer questions from the Council.</p> <p>The bulletin that listed the items that resident were not allowed to have in their rooms was revised to include aerosol cans and over the counter medications and ointments by the Administrator and Director of Nursing on 5/13/15.</p> <p>A mailing to the residents, responsible party, of the revised bulletin was completed on 5/28/15 by the Admission Director. A copy of the bulletin was posted on each resident bulletin board in their rooms by the Admission Director on 5/27/15.</p> <p>An interview will be completed on 14 alert/oriented residents weekly for 6 months and monthly for 6 months if room searching are been conducted and if personal items are being removed b staff. The interviews will be completed by the Social Workers and Activities.</p> <p>The results of the resident interviews regarding Dignity & Respect, Abuse and Privacy will be presented to the Quality Assurance Committee by the Social Worker monthly for 12 months.</p>		

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F 241	Continued From page 37 the social workers but no one had done anything because he was still doing it. Resident #78 could not provide any of the staff member's names other than social worker #1 (SW #1). Resident #78 stated Resident #168 would park himself in her doorway and stare at her from the hallway which made her very uncomfortable. She stated she felt that he was invading her rights when he made those horrible sexual comments in front of the other residents. Resident #78 reported there had been one incident with him a few months back where she was so upset she cried from embarrassment about the disrespectful way he treated her. She stated he was making awful vulgar sexual comments that she couldn't repeat about sexual things he thought she and her male friend were doing. Resident #78 stated he yelled it out (the B--- J---) in the hallway in front of the other residents. Her male friend reported that Resident #168 was constantly harassing Resident #78 and staff allowed him to do so. He stated he was present in the hallway that day and he told Resident #168 to stop talking to her like that. He also stated he told Resident #168 if he didn't leave her alone he was calling the police himself since the facility didn't appear to be doing anything to resolve the issue. Resident #78 stated no one had come back to her to ask her any questions about the incident or offer any resolution to the problem she was having with Resident #168. (The male friend did not want to be included in the list of residents but gave permission to share the interview.) 1c. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/21/15 indicated he was cognitively intact and independent with decision making. He was also	F 241			

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F 241	Continued From page 38 identified by the facility to be alert, oriented and reliable. Resident #105 was interviewed on 05/06/15 at 10:30 AM. He stated Resident #168 constantly yelled, cursed and would go into other resident's rooms uninvited. He stated he harassed the female residents in the building and had witnessed him going into other residents' rooms to curse them. He commented that this type of behavior had been going on for over a year now. He stated Resident #168 came into his room about 3 weeks ago and demanded a bag of pork skins that he had seen on top of his refrigerator. Resident #105 stated he told Resident #168 that he couldn't have the bag of skins. He stated that Resident #168 responded that if he wanted it he would take it and he couldn't stop him. As he was talking, tears were coming out of both eyes. Resident #105 stated Resident #168 told him there was nothing he could do about it because he was "stuck" in the bed and couldn't get up to stop him. He reported that he had reported that incident and others concerning Resident #168 to SW #1 on many occasions. When questioned about resolution, he stated SW #1 told him Resident #168 had rights and she couldn't do anything about it. He also stated she told him he didn't have any rights. Resident #105 stated Resident #168 had told him and the other residents as well as staff that he could do whatever he wanted. Resident #105 stated no one would say anything to him. He commented that Resident #168's behaviors were very upsetting for him. He also commented that he couldn't continue to "live like this" going without sleep every single night because of Resident #168's yelling, cursing and playing his television full volume. During another interview with Resident #105, on	F 241			

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F 241	<p>Continued From page 39</p> <p>05/08/15 at 11:28 AM, he stated he didn't feel that the facility was doing anything to change the way Resident #168 behaved. He stated he had been up every night this week yelling, cursing and playing his television at full volume. He appeared to be angry and frustrated based on his tone stating something had to be done. Resident #105 reported he had complained to SW #1 several times and she always responded that she had spoken with Resident #168 about the issue. Resident #105 commented it was obvious that talking with Resident #168 was not doing anything. He also stated he knew first hand that Resident #168 had been warned by staff to behave when visitors were in the building. He also stated if he capable of behaving when visitors were in the building why couldn't he behave all of the time.</p> <p>1.d. Resident #203 was admitted to the facility on 04/30/15. Cumulative diagnoses included hypertension, gastroesophageal reflux disease (GERD) and cerebrovascular accident (CVA). There was no minimum data set (MDS) assessment available for this resident. Resident #203 was identified by the facility as being alert, oriented and reliable.</p> <p>A nurse's note of 05/05/15 at 11:11 AM indicated Resident #203 was alert and oriented x 4. During an interview with Resident #203, on 05/06/15 at 6:00 PM, he stated this was his second admission to the facility. He reported during his last admission there were problems with Resident #168 talking ugly to the other residents in the facility and it was still happening. Resident #203 stated Resident #168 disturbed the residents at night preventing them from sleeping. He reported this past Sunday his family was visiting him. He stated his grandchildren</p>	F 241			

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F 241	<p>Continued From page 40</p> <p>were here and Resident #168 was using M----- F----- along with other "awful" words in front of them. He stated he did not like that type of language to begin with but it was even worse when it was in front of his grandchildren. Resident #203 stated he didn't like that type of language in front of the other residents either. He reported it to be disgusting. When questioned if he had reported it, he responded he had not and that was why he was complaining in hopes someone could do something since the administration at the facility had not.</p> <p>1.e. Resident #39 was admitted to the facility on 11/27/12. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA) and abnormality of gait. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/07/15 noted Resident #39 to be independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #39, on 05/09/15 at 11:45 AM, she stated one night recently she was going to the bathroom and Resident #168 was in the hallway. She stated he started yelling at her from the hallway calling her "d--- f-a-- ". Resident #39 stated she told him to stop calling her names. She stated he continued to roll down the hallway yelling out "d--- f-a- ". She stated she had not reported it to anyone but if he continued to talk to her in that manner or came into her room she would hit him with her reacher. Resident #39 commented that she felt his language was offensive.</p> <p>1.f. Resident #43 was admitted to the facility 04/30/13. Cumulative diagnoses included neurogenic bladder and hypertension. The most</p>	F 241			

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F 241	<p>Continued From page 41</p> <p>recent Quarterly Minimum Data Set (MDS) assessment of 04/02/15 documented Resident #43 as independent with decision making and cognitively intact. He was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #43, on 05/06/15 at 10:50 AM, he stated Resident #168 would go into other resident's rooms uninvited and would take sodas. He stated the management of the facility was well aware of his behaviors. He reported that Resident #168 constantly "picked on" one of the female residents. Resident #43 stated SW #1 had reported to him that the facility was actively seeking placement elsewhere. He stated staff and other residents had complained to him about Resident #168 being loud and disruptive.</p> <p>1.g. Resident #68 was admitted to the facility on 03/02/15. Cumulative diagnoses included thyroid disorder, depression and seizure disorder. The most recent Admission Minimum Data Set (MDS) assessment of 03/05/15 documented that Resident #68 was cognitively intact with independent decision making skills. He was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #68, on 05/07/15 at 9:50 AM, he stated that Resident #168 was the rudest and most disrespectful person he had ever encountered. He stated Resident #168 terrorized the other residents and treated the elderly badly. Resident #68 stated he sits behind the residents and mocks them and makes fun of them. He stated he talked ugly to them calling them names. Resident #68 stated Resident #168 was up all night every night disturbing all of the residents with his television</p>	F 241			

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F 241	Continued From page 42 on full volume preventing anyone from getting any sleep. He stated Resident #168 was constantly yelling and cursing and disturbing everyone. Resident #68 stated he had asked the staff to ask Resident #168 to please turn his television down and they responded that it wouldn't do any good to ask him to turn it down because he turned it back up after they left the room. He stated the whole issue with Resident #168 had become a "big joke" with the staff. He was expressing anger with the issue and stated he was fed up. Resident #68 stated he complained to social worker #1 (SW #1) about Resident #168 and was told Resident #168 had rights and was told there was nothing they could do. He commented "what about my rights?" and stated he had rights just as well as Resident #168 did. He reported complaining to the Administrator about 3 weeks ago concerning issues with Resident #168. He stated he had complained again this past Monday about Resident #168 and was told by the Administrator that his "hands were tied." Resident #68 reported that he had complained to the nurses and they did nothing either. He stated that a few weeks ago he had been involved in a grievance with 3 other residents about Resident #168. He stated they wrote down about 15 different issues concerning Resident #168 and took them to SW #1. Resident #68 reported nothing had changed and expressed that it was not "right" that Resident #168 would be allowed to mistreat the other residents and act like he was. He added that the "old folks" in this facility should not have to put up with Resident #168 constantly abusing then and staff doing nothing to stop it. 1.h. Resident #71 was admitted to the facility on 10/28/09. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA)	F 241			

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F 241	<p>Continued From page 43</p> <p>and osteoarthritis. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/06/15 documented Resident #71 to be independent with decision making and was cognitively intact. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #71, on 05/07/15 at 9:35 AM, she stated Resident #168 was loud. She stated his room was at the other end of the hall and she could hear him in her room. She stated he felt that his constant cursing was offensive. She stated she was afraid of him because of his anger management problems. She had not reported her feelings to anyone.</p> <p>1.i. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident #79 was cognitively intact with independent decision making skills. Resident #79 was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #79, 05/07/15 at 2:30 PM, she stated Resident #168 "picked on" one of the female residents constantly and she couldn't defend herself. She also stated that he talked very "ugly" to her. She also commented that Resident #168 usually bothered the residents who weren't capable of defending themselves. She stated she had complained to various staff members in the past about Resident #168's behaviors but nothing was ever done so she stopped complaining.</p> <p>1.j. Resident #81 was admitted to the facility on 03/13/14. Cumulative diagnoses included hypertension, diabetes mellitus and anemia. The</p>	F 241			

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F 241	<p>Continued From page 44</p> <p>most recent quarterly Minimum Data Set (MDS) assessment of 04/23/15 documented Resident #81 has being independent with decision making. There were no behaviors noted in this assessment. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #81, on 05/07/15 at 3:45 PM, she stated that Resident #168 would come into her room uninvited when she was wearing her night gown. She stated that it bothered her and felt he was mistreating her. She stated she had witnessed Resident #168 bothering a female resident about a month ago. She commented that about a month ago she and some of the other residents had complained to SW #1 about him and SW #1 told her that the facility couldn't do anything about Resident #168. Resident #81 stated if Resident #168 continued to come into her room uninvited she would use her walking stick on him. She also commented she did not like being mistreated.</p> <p>1.k. Resident #129 was admitted to the facility on 11/11/11. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA) with hemiplegia and difficulty walking. The most recent Quarterly Minimum Data Set (MDS) assessment of 03/11/15 documented Resident #129 as being independent with decision making and cognitively intact. She was also identified as being alert, oriented and reliable by the facility. During an interview with Resident #129, on 05/07/15 at 9:35 AM, she stated Resident #168 played his television so loud at night that it kept her awake and she couldn't sleep. She stated she had reported the issue to 2 different nurses but couldn't remember who. She stated Resident #168 would get so angry over things and she was afraid of him. Resident #129 also stated " he</p>	F 241			

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F 241	<p>Continued From page 45 cares" her.</p> <p>1.I. Resident #143 was admitted to the facility on 11/18/13. Cumulative diagnoses included cerebral palsy, anxiety and difficulty walking. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/15/15 documented Resident #143 as being independent with decision making and cognitively intact. He was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #143, on 05/07/15 at 10:55 AM, he stated because of cerebral palsy he ambulated with 2 hand held walking canes and was very slow. He stated Resident #168 had a habit of "riding" on his heels with his wheelchair. Resident #143 stated about a couple of months ago he was walking in the hall with his canes and Resident #168 came up behind him. He stated Resident #168 used very loud foul language and threatened to "run him over." Resident #143 reported that he was afraid that Resident #168 was going to hurt him. He commented that he had completed a grievance and gave it to the social services department.</p> <p>During another interview with Resident #143, on 05/09/15 at 3:15 PM, he stated there was an on-going problem with Resident #168 telling him he was going to "run him over." He stated that he had been to the social worker to report the issue.</p> <p>During another interview with SW #1, on 05/09/15 at 5:00 PM, she stated as of last evening Resident #168 had been placed on one on one supervision in an attempt to control his behaviors. She was not aware of any issue regarding Resident #143 and denied ever receiving any grievance or complaint from Resident #143. She stated no one had reported anything about</p>	F 241			

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F 241	<p>Continued From page 46</p> <p>Resident #168 trying to "run over" Resident #143.</p> <p>1.m. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/01/15 documented Resident #172 was independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable.</p> <p>During an initial interview with Resident #172, on 05/04/15 at 5:41 PM, she stated staff were nice to her but there was one resident (Resident #168) who was disruptive and harassed some of the other residents constantly. She stated one of the female residents was "scared to death" of him. She reported Resident #168 being up at night yelling and cursing in the halls. Resident #172 stated he had his volume too high on his television making it difficult for her to sleep. She also stated a lot of the residents would not go to activities programs because Resident #168 was so disruptive.</p> <p>During the follow-up interview with Resident #172, on 05/07/15 at 2:40 PM, she stated Resident #168 constantly bothered and harassed the other residents. She stated Resident #168 kept everyone up all night using "awful" language, shouting and yelling down the halls. Resident #172 stated she had complained to numerous staff members about his behaviors but no one did anything about it. She commented she was tired of not getting any sleep because of Resident #168's yelling and cursing. Resident #172 stated she and 2 of the other residents had gone to SW #1 to report concerns regarding Resident #168 ' s behaviors and the way he</p>	F 241			

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F 241	<p>Continued From page 47</p> <p>treated the other residents. She stated SW #1 told her she would speak with Resident #168. She stated SW #1 told her Resident #168 had his rights. She commented so did she and she felt that no one cared about her rights because nothing had changed. Resident #172 stated no one listened to her complaints and Resident #168 was allowed to do whatever he wanted. She stated staff didn't say anything to him when he was acting out. She reported that Resident #168 "bothered" and "tormented" one of the confused female residents and was constantly calling her names. She stated she shouldn't have to "be shut up in her room" because of him and his behaviors. Resident #172 commented she was tired and frustrated with not being allowed to get a good night's sleep because of Resident #168.</p> <p>Resident #168 was admitted to the facility on 05/22/14 and re-admitted on 10/13/14. Cumulative diagnoses included hypertension, quadriplegia and delusional disorder. A "contract to enhance POSITIVE behaviors", signed by Resident #168 on 12/17/14, noted that the goal was that Resident #168 would treat all residents and staff members with kindness. The objective for this goal was that Resident #168 would use nice words when speaking to residents. Another goal indicated that Resident #168 was to stay in his room and his space. The objective for this goal was that Resident #168 would learn to respect the privacy of the other residents by not going into their rooms. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/16/15 noted Resident #168 to be cognitively intact with independent decision making skills. He had verbal behavior symptoms exhibited 1 to 3 days during the</p>	F 241			

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F 241	<p>Continued From page 48 assessment period.</p> <p>Resident #168's care plan of 02/23/15 identified problems with:</p> <ul style="list-style-type: none"> . Exhibits behaviors of verbal aggression as evidenced by calling residents names. Interventions included approach him in a calm friendly manner, develop a behavior plan if needed. Another intervention was to identify triggers and reduce exposure to them. Maintain a consistent routine as possible was also included as an intervention. . Exhibits disruptive/demanding behaviors as evidenced by cursing at staff and picking arguments with his roommate. Interventions included to approach in a calm friendly manner, document interventions and responses, identify behavior triggers and reduce exposure to them, maintain consistent routine and work with resident to develop a behavior contract if necessary. <p>Information provided by the facility of 04/10/15 indicated that the corporate Regulatory Affairs Specialist had provided recommendations for dealing with Resident #168. The recommendations included:</p> <ul style="list-style-type: none"> .Reach out to the ombudsman for assistance with placement .Contact local police to have them talk with Resident #168 regarding behaviors .Continue search for alterative placement .If able to locate safe discharge to let the specialist know <p>A note from SW #1 of 04/14/15 at 4:00 PM noted that a meeting had been held with Resident #168, 2 police officers and the social worker. It was documented that the police spoke with Resident #168 about his behaviors and how his behaviors were unacceptable. The police officers also told</p>	F 241			

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F 241	<p>Continued From page 49</p> <p>Resident #168 that these behaviors could be punishable by law if anyone felt the need to press charges. The police officers also explained to Resident #168</p> <p>The physician's orders for May of 2015 indicated Resident #168 was receiving Ambien 2.5 milligrams (a sleep aid) at bedtime as needed, Celexa 30 milligrams daily (an antidepressant), Depakote 250 milligrams at bedtime (a mood stabilizer) and Valium 5 mg every 8 hours as needed (an antianxiety medication).</p> <p>An interview was conducted with Nurse #6 on 05/07/15 at 9:30 AM. She stated she worked on Resident #168's hall and was familiar with him and his behaviors. She stated he was angry, aggressive and disrespectful to the other residents. Nurse #6 stated she had been in his room on several occasions and asked him to turn his television volume down and he would get very angry with her but he would turn it down. She stated but as soon as she left out of the room he would turn it back up. Nurse #6 stated she had told him to not go into other resident's rooms and to respect their privacy as well as respect them as individuals. She stated some of the residents had complained to her about Resident #168 and she advised them to talk with the social workers. Resident #168 was interviewed on 05/07/15 at 10:45 AM. Resident #168 reported that some of the residents had complained about the volume of his television and he would turn it down. Resident #168 stated the staff employed at the facility was too young to work with elderly residents including himself. He stated he was - years old and wasn't going to have any young staff member telling him what to do with his television because the television was his. He denied being disruptive and disrespectful to the other residents in the facility. It was apparent that</p>	F 241			

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F 241	Continued From page 50 he was beginning to get agitated as he was taking his gloves off and putting them back on during the interview and was not maintaining eye contact. He was also becoming argumentative. Resident #168 also stated no one was going to tell him what to do. He denied going into other resident's rooms uninvited. He reported that at times he wasn't able to sleep at night and would go to the break room for a while but he would go back to his room. When questioned about being loud and keeping the other residents awake, he responded "you could hear a pin drop" on night shift. Resident #168 reported the facility staff had telephoned the police about him and they came out to the facility. He reported that he was not afraid of the police officers. Resident #168 stated that routinely when he was self-propelling his wheelchair down the hallways there were several residents who parked their wheelchairs in the hallways. He reported that he expected them to move out of his way because they could see him coming and he shouldn't have to say anything to pass through. When questioned about being considerate of others when he needed to pass them, he responded "why should I have to say excuse me?" Resident #168 stated he did not know what his rights were here at the facility and ended the conversation saying it was time for a smoke break. A follow-up interview was not conducted due to the apparent agitation and defensiveness displayed during this interview. During an interview with the social worker #1 (SW #1) on 05/07/15 at 11:20 AM, she stated she had spoken with Resident #168 on multiple occasions about the rights of the residents. She stated talking with him was nonproductive and he continued with the unacceptable behaviors. SW #1 stated she had lots of incidents too numerous to go over individually regarding Resident #168.	F 241			

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F 241	<p>Continued From page 51</p> <p>She reported that she had spoken with him on almost a daily basis in regards to the huge list of unacceptable behaviors that he exhibited. SW #1 reported that she had contacted the Ombudsman for advice. When questioned about the safety of the residents in the facility she responded that the police had been out to the facility to speak with Resident #168 and gave him a verbal warning. She commented the behaviors were unchanged. SW #1 stated he had a signed behavior contract but there were no consequences if he broke the contract. She reported the only consequence was a 30 day notice for discharge but thus far she had not been able to find suitable placement for Resident #168. She commented that no one at the facility could do anything with him or his behaviors. SW #1 stated she could not provide a safe and orderly discharge so he would continue to be there until she found an appropriate placement.</p> <p>A telephone interview was conducted with the Ombudsman on 05/07/15 at 3:03 PM. She stated the facility telephoned her about a month ago asking if she could come out and brainstorm with them on some issues at the facility. She stated they expressed no urgency with the request. The Ombudsman stated she came out last week and met with SW #1. She stated she advised them to call the police each time incidents occurred. She stated SW #1 told her she had not been able to find a suitable place for him to be discharged to. The Ombudsman commented that the facility had not imposed any consequences for his unacceptable behaviors and he was doing whatever he wanted whenever he wanted and no one had done anything to stop him.</p> <p>During an interview with the nurse staff scheduler, on 05/07/15 at 4:00 PM, she stated Resident #168 had been a problem for the facility</p>	F 241			

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F 241	Continued From page 52 for a while. She stated he was constantly making inappropriate comments to the other residents. She stated she had witnessed incidents and had reported them to the social services department. During an interview with Nurse #4, on 05/07/15 at 4:40 PM, she stated she worked third shift and there was one resident who disrupted the entire hall. She stated Resident #168 made inappropriate verbal sexual comments to the residents. She stated she had overheard some of the other residents talking about his behaviors and constant verbal abusive manners. When questioned if she reported it or talked with them about it, she responded she had not. She did state she passed it on to the oncoming nurses. Nurse #4 stated she had spoken with him numerous times about his inappropriate behaviors toward the other residents but he paid no attention to what she was saying and continued doing the same things. She commented that when she spoke with him about his behaviors he told her no one could kick him out of the building. Nurse #1 was interviewed on 05/07/15 at 5:15 PM. She was identified as working third shift on Resident #168's hall. Nurse #1 reported that she was very familiar with Resident #168 and his behaviors. She reported that he frequently told staff that he could do whatever he wanted and no one could stop him. Nurse #1 stated it didn't do any good to say anything to him because there were no consequences for his unacceptable behaviors. She stated there was chaos wherever he would go in the building. Nurse #1 reported him as being belligerent with the other residents and harassed the residents who weren't capable of defending themselves. She commented that just the other day she overheard Resident #168 call a very confused female resident an awful	F 241			

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F 241	<p>Continued From page 53</p> <p>name (f---- b----). She stated she intervened and told him how inappropriate that it was to talk like that and he needed to stop. Nurse #1 reported it was fruitless to complain to management about his behaviors because it "falls on deaf ears" so staff had stopped complaining. She reported that Resident #168 had been acting this way since the day he was admitted and he was fully aware of what he was doing. Nurse #1 added that because there were no consequences for his unacceptable behaviors he did whatever he wanted.</p> <p>A telephone interview was conducted with a third shift nurse (Nurse #5) who had been identified as working regularly with Resident #168 on 05/07/15 at 11:16 PM. He stated he was very familiar with Resident #168. When questioned about Resident #168's behaviors, Nurse #5 laughed and responded Resident #168 was usually up all night and would go to bed about 4:00 AM. He reported that some of the residents on his hall did complain about not being able to sleep because of him playing his television loudly. Nurse #5 stated he would go into Resident #168's room and ask him to turn the volume down on his television. He stated he would turn it down but as soon as he left the room Resident #168 would turn it back up. Nurse #5 stated Resident #168 had been "acting out" for a long time and thought the rules at the facility did not apply to him. Nurse #5 stated he had documented his behaviors and passed it on to the oncoming shift. Nurse #5 reported that Resident #168 was fully aware of what he was doing.</p> <p>During a telephone interview with a third shift nurse aide (NA #1) on 05/07/15 at 11:30 PM, NA#1 stated Resident #168 was disrespectful of everyone including staff and residents. She stated he cursed "something awful" at the</p>	F 241			

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F 241	Continued From page 54 residents. NA #1 stated she was a Christian and couldn't repeat the words he used. She stated residents on the hall where he resided complained about him being disrespectful to them and about the loud volume of his television. She stated it did no good to try to correct his behaviors because he did what he wanted. NA #1 also stated he was taking pictures of some of the female residents with his cellular phone and she told him he couldn't do that. She reported Resident #168 did not respect the other resident's rights. NA #1 stated staff were very aware of his behaviors and she had reported it. During an interview with Resident #168's physician, on 05/08/15 at 10:00 AM, he stated he was new at this facility and had been Medical Director for about a month. He reported he had not been able to review all of the resident's charts as yet. He stated no one had specifically made him aware of any issues with Resident #168. The physician stated staff communicated with him through a communication book. He stated he was looking through it last week to see what issues were there that he needed to address. He stated he ran across an entry about Resident #168 but couldn't remember what the issue was or who had written it in the book. He stated when he inquired he was told by staff that Resident #168's behaviors were inappropriate. He remarked that his first reaction was "Why is he still here?" The physician stated there was no medication that he could prescribe that would change or correct his behaviors without over medicating him which he couldn't do. He stated Resident #168 was completely aware of his behaviors and was a "mean" individual who enjoyed bullying others. He commented that he had spoken with staff and was told that they were not able to provide a safe discharge but were	F 241			

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F 241	<p>Continued From page 55</p> <p>working on it. The physician stated that if his behaviors were threatening to the other residents or to the staff he needed to be discharged.</p> <p>The Administrator was interviewed about Resident #168 on 05/08/15 at 12:00 PM. He reported being aware of Resident #168's behaviors since February 2015. He stated social services had been dealing with the issues regarding Resident #168 and was actively seeking alternate placement for him. He stated the previous social worker had been dealing with the behavior issues but was not as pro-active as SW #1. He stated SW # was actively dealing with the issues associated with Resident #168. He reported that they were unable to control him or his behaviors because Resident #168 felt he was above the law so he did whatever he pleased. The Administrator also reported that Resident #168 was a master manipulator and knew exactly what he was doing. The Administrator reported they had telephoned the police to come to the facility and talk with Resident #168 about his behaviors. He stated the police told him he couldn't touch any of the residents here. He reported the corporate attorney had been consulted as well. The Administrator stated they investigated any resident to resident altercation that was brought to their attention. He stated as soon as an alternate facility could be located Resident #168 would be discharged.</p> <p>The Director of Nurses (DON) was interviewed on 05/08/15 at 4:45 PM. She stated SW #1 was the person responsible for dealing with all of the behaviors exhibited by Resident #168 on a regular basis. She stated Resident #168 had been an issue for the facility for a while and SW</p>	F 241			

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F 241	<p>Continued From page 56</p> <p>#1 was actively seeking alternative placement for him. The DON also stated thus far SW #1 had not been successful.</p> <p>On 05/09/15 at 10:00 AM, the Administrator stated that one on one supervision had been implemented yesterday evening for Resident #168.</p> <p>During another interview with SW #1, on 05/09/15 at 5:00 PM, she stated as of last evening Resident #168 had been placed on one on one supervision in an effort to control his behaviors. She stated his behaviors were discussed every morning during their morning meetings. She stated she had been actively seeking placement and had a tentative placement set for next week. SW #1 stated that she did not know what the previous social worker had done to control his behaviors because the previous social worker didn ' t make a lot of notes in his record. She also stated that the nurses were apparently afraid of him and were not documenting any of his behaviors in his record.</p> <p>2. The undated "A CONDENSATION OF NORTH CAROLINA'S BILL OF RIGHTS FOR NURSING HOME RESIDENTS" that was included in the admission packet for all residents noted that the resident had the right to be treated with consideration, respect and full recognition of personal dignity and individuality. Information provided by the facility included an undated bulletin entitled "IMPORTANT INFORMATION" which noted that "due to regulatory restrictions and for the safety of all of our patients, the following items are not allowed in patient rooms." The list included aerosol can products, baby powder, petroleum jelly, medicated ointments, medicated creams, eye</p>	F 241			

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F 241	<p>Continued From page 57</p> <p>drops, over the counter medications, alcohol, hydrogen peroxide, hand sanitizer, air fresheners and any product that was labeled "keep out of reach of children." It also indicated that "We reserve the right to remove and dispose of any products deemed potentially harmful (in accordance with NC and Federal regulations)." The facility's policy regarding Patient's Bill of Rights and Responsibilities, with an effective date of 06/01/96 and revision date of 08/04/14, noted that residents have the "fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social and spiritual values." It further noted that the purpose was to assure that the personal dignity, well-being and self- determination was maintained and to make sure the residents were knowledgeable of their responsibilities in this regard. It noted that the "Patient's Bill of Rights and Responsibilities" would be posted throughout the center at all times.</p> <p>2a. Resident #44 was re-admitted to the facility on 11/07/14. Cumulative diagnoses included congestive heart failure, hypertension, peripheral vascular disease and diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) assessment of 04/24/15 noted he was cognitively intact and was independent with decision making. Resident #44 was included in a list provided by facility of alert, oriented and reliable residents.</p> <p>On 05/05/15 at 10:26 AM, Resident #44 was interviewed. He stated a while back he had been given a list of items that he was not allowed to have in his room. He stated he couldn ' t remember all of the items on the list. He reported not having the list. Resident #44 stated activities staff #1 (AS #1) would come into his room on a</p>	F 241			

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F 241	<p>Continued From page 58</p> <p>daily basis and search through all of his personal belongings in all of his drawers and his closet. He reported that AS #1 would take Vaseline, baby powder, spray deodorant, shampoo and any item that was aerosol if he had it. He reported this to be most upsetting as he felt that it was an invasion of his right to privacy. Resident #44 reported this was his home and did not think it was right for anyone to come and search through his belongings. He also reported that at times he would refuse to allow them to go through his belongings because it made him so mad that they felt they could do this. He added that he paid monthly to live in this building and felt that taking his belongings was wrong. He also commented that he does not leave the room with any of those items and no one visits who would bring in anything unsafe.</p> <p>2b. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident #79 was cognitively intact and independent in decision making. Resident #79 was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated staff come into her room on a regular basis and search her personal belongings. When questioned which staff members, she responded that it depended upon who worked. Resident #79 stated it was upsetting that staff go through her belongings. She stated her family brought in baby wipes and the facility staff person told her she was not allowed to have them so they took them. She stated they took her mouth wash, her air</p>	F 241			

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F 241	<p>Continued From page 59</p> <p>freshener and baby powder. Resident #79 remarked that sometimes odors were overwhelming and she didn't want visitors to have to endure the odors. Resident #79 added that she didn't have much but what she had she wanted to keep. She stated she felt like she had no rights at all and was in prison.</p> <p>2c. Resident #83 was admitted to the facility on 01/06/11. Cumulative diagnoses included congestive heart failure, hypertension and depression. The most recent Quarterly MDS of 04/24/15 noted the resident was cognitively intact. Resident #83 was included in a list provided by the facility of alert, oriented and reliable residents. During an interview with Resident #83, on 05/05/15 at 10:26 AM, she stated that staff (AS #1) would come into her room on a daily basis and go through all of her belongings. She stated this was an invasion of her privacy and her home. She stated she did not like them going through her things but the staff had told her they had to do it so she would allow them to search. Resident #83 commented that the facility staff should not be allowed to go through all of her personal belongings looking for powders or spray deodorants. She commented that she didn't have much but it was hers and she didn't want people going through it. She stated she used those items when she lived at home before coming here.</p> <p>2d. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/21/15 indicated he was cognitively intact and independent in decision making. Resident #105</p>	F 241			

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F 241	<p>Continued From page 60</p> <p>was also identified as being alert, oriented and reliable by the facility.</p> <p>During an interview with Resident #105, on 05/06/15 at 10:30 AM, he stated staff routinely search through all of his belongings. He stated it bothered him that they were allowed to do that since this was his home. He stated he was told by staff that he couldn't do anything about it so he would just leave his room and let them go through whatever they wanted. Resident #105 stated they took his shaving cream. He also stated they would take anything that was aerosol as well as any type of powder. Resident #105 stated if he was living in a private home he could have those items and didn't understand why he couldn't have them here.</p> <p>2e. Resident #122 was admitted to the facility on 11/21/14. Cumulative diagnoses included hypertension, diabetes mellitus and quadriplegia. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/12/15 documented Resident #122 to be independent with decision making and cognitively intact. He was identified by the facility as being alert, oriented and reliable.</p> <p>An interview was conducted with Resident #122 on 05/06/15 at 11:40 AM per request. He stated staff would come into his room regularly and search through his personal belongings and his closet. He stated they search through all of his drawers and closet even if he wasn't in his room. Resident #122 stated activities staff #1 had been in and gone through his belongings. He commented "it ain't right" that facility staff did this. Resident #122 stated it made him mad and it was very upsetting that they thought it was okay to search his belongings. He stated when he questioned staff about the issue, he was told it</p>	F 241			

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F 241	<p>Continued From page 61</p> <p>was their job. Resident #122 commented that he felt like he was in prison here and had no privacy at all. He also commented that this was his home. He remarked staff would take his Vaseline. Resident #122 stated he didn't have anything dangerous unless Vaseline was.</p> <p>2f. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/01/15 documented Resident #172 was independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #172, on 05/07/15 at 2:40 PM, she stated she felt she was in a prison here and that she had no rights at all. She stated she did not appreciate staff coming into her room to search through all of her belongings. She could not say which staff members. She stated this was her home and they had no right to take anything from her and it was an invasion of her privacy. Resident #172 stated when she questioned staff about searching her belongings she was told they needed to make sure no one had any aerosols because confused residents might get them. She stated no one came into her room and if she had aerosols she would keep them in a drawer. Resident #172 stated she had a bag of salt packets and staff took it. She commented that she was not on a salt restricted diet.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. AS #1 stated each staff person was assigned a certain set of rooms for Partner Rounds. She stated when she went into the resident's room she was looking for</p>	F 241			

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F 241	Continued From page 62 several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items taken from the rooms were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list (undated bulletin "IMPORTANT INFORMATION) to all of the families advising them of items the residents were not allowed to have in this building but was not sure of when it was sent. She was unable to name all of the items on that list. When questioned if she felt that this was an invasion of the resident 's privacy, she responded that it probably was but it was part of her responsibility during rounds to take items that were not allowed. She stated it was part of the Partner rounds that all administrative staff performed. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items (the undated bulletin entitled "IMPORTANT INFORMATION") yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use	F 241			

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F 241	Continued From page 63 items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.	F 241			
F 242 SS=E	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 by: Based on record review, resident and staff interviews, the facility did not honor the choices of 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122 and #172) by not allowing them to have certain items to include but not limited to Vaseline, baby powder, spray deodorant or any aerosol spray product, shaving cream or baby	F 242	F 242 E Self-determination & right to make choices Residents # 172, # 105, # 44, # 79, # 83, # 122 have had their personal items returned or replaced by Social Services on 5/12/15. These residents were	6/11/15	

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F 242	<p>Continued From page 64</p> <p>wipes in their rooms. The facility also did not allow 1 of 1 sampled residents (Resident #168) who had voiced a desire to be an independent smoker to be given a trial to demonstrate safe smoking behaviors. Findings included:</p> <p>1.The undated "A CONDENSATION OF NORTH CAROLINA'S BILL OF RIGHTS FOR NURSING HOME RESIDENTS" that was included in the Admission packet for all residents noted that the residents had the right to retain, to secure storage for, and to use personal clothing and possessions where reasonable.</p> <p>There was an undated bulletin provided by the facility that was mailed on an unknown date to resident's family members at the request of the admissions office in regards to items the facility did not allow residents to possess. This bulletin was also provided to the current residents residing in the facility with date of distribution unknown. This bulletin was entitled "IMPORTANT INFORMATION" and it noted that "due to regulatory restrictions and for the safety of all of our patients, the following items are not allowed in patient rooms." The list included, aerosol can products, baby powder, petroleum jelly, medicated ointments, medicated creams, eye drops, over the counter medications, alcohol, hydrogen peroxide, hand sanitizer, air fresheners and any product that was labeled "keep out of reach of children" . It also noted that "We reserve the right to remove and dispose of any products deemed potentially harmful (in accordance with NC and Federal regulations)."</p> <p>1. Resident #44 was re-admitted to the facility on 11/07/14. Cumulative diagnoses included congestive heart failure, hypertension, peripheral vascular disease and diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) assessment of 04/24/15 noted he was</p>	F 242	<p>interviewed on 5/28/15 by Department Managers to ensure that their personal items had been replaced and no further room searches have occurred.</p> <p>Other residents that may potentially be affected were identified by interviewing the residents or families of residents unable to be interviewed. The interviews were conducted by the Social Workers and Recreation Director on 5/28/15.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Center staff was in-serviced on the revised bulletin that lists the items that the residents are requested not to have in their rooms and that the staff is not allowed to search the resident's rooms. The education was provided on 6/1/15 and 6/2/15 by the Admission Director and Director of Nursing. During the Resident Council meeting of 5/12/14, the revised list was reviewed with the members by the Activity Director and Social Worker. The</p>		

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F 242	Continued From page 65 cognitively intact and was independent with decision making. Resident #44 was included in a list provided by facility which included alert, oriented and reliable residents. On 05/05/15 at 10:26 AM, Resident #44 was interviewed. He stated a while back he had been given a list of items that he was not allowed to have in his room. He stated he couldn't remember all of the items on the list. He reported that the activities staff (AS #1) would take Vaseline, baby powder, spray deodorant, shampoo and any item that was aerosol if he had it. Resident #44 reported this was his home. He also reported that at times he would refuse to allow them to go through his belongings because it made him so mad that they felt they could do this. He added that he paid monthly to live in this building and felt that taking his belongings was wrong. He also commented that he does not leave the room with any of those items and no one visits who would bring in anything unsafe. He stated he didn't think he still had the list. AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items, any ants and for any clutter on top of the closets. She stated she looked to see if there were any pests in the room and would complete a work order if she found any. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that	F 242	Administrator and Director of Nursing also attended the meeting to answer questions from the Council. The bulletin that listed the items that resident were not allowed to have in their rooms was revised to include aerosol cans and over the counter medications and ointments by the Administrator and Director of Nursing on 5/13/15. A mailing to the residents, responsible party, of the revised bulletin was completed on 5/28/15 by the Admission Director. A copy of the bulletin was posted on each resident bulletin board in their rooms by the Admission Director on 5/27/15. An interview will be completed on 14 alert/oriented residents weekly for 6months, then monthly for 6 months if room searching are been conducted and if personal items are being removed by staff. The interviews will be completed by the Social Workers and Activities. Resident #168 was discharged on 5/21/15. Residents that prefer to smoke have the potential to be affected by this practice. Unit managers identified the residents that wished to smoke by interviewing the residents on 5/18/15 thru 5/21/15. Licensed nursing staff was reeducated on the completion of the smoking evaluation on 6/1/15 and 6/2/15 by Nurse Practice Educator (NPE). Identified smokers were reevaluated by the Unit Managers on 5/18/15 thru 5/21/15, the Director of		

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F 242	<p>Continued From page 66</p> <p>was all that she could think of at the moment. She stated the items that were taken from the residents were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated staff should not be searching their belongings. He stated if the items that had been removed were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>2. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident</p>	F 242	<p>Nursing reviewed the evaluation on 5/22/15. 17 that smoke were reevaluated and 11 were identified as being able to smoke unsupervised. Resident will be re-evaluated quarterly, annually and with change in condition that could make them safe or unsafe smokers. The Unit Managers will observe the residents that smoke weekly for 6 months to determine if there is any change that would constitute the need for a reevaluation. Unsupervised smoking times were reviewed and changes made to include unsupervised smoking times on the 11-7 shift. The residents that smoke were informed of the changes on 6/2/15 and by the Director of Nursing.</p> <p>The results and any trends of the weekly interviews and the observation of the residents that smoke will be presented to the Quality Assurance Committee monthly for 6 months by the Social Worker and any need in change of plan will be adjusted.</p>		

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F 242	<p>Continued From page 67</p> <p>#79 was cognitively intact with independent decision making skills. Resident #79 was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated facility staff come into her room on a regular basis and search her personal belongings. Resident #79 stated it was upsetting that staff go through her belongings. She stated her family brought in baby wipes and the facility staff person told her she was not allowed to have them so they took them. She stated they took her mouth wash, her air freshener and baby powder. Resident #79 remarked that sometimes odors were overwhelming and she didn't want visitors to have to endure the odors. Resident #79 added that she didn't have much but what she had she wanted to keep. She stated she felt like she had no rights at all and was in prison.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment.</p>	F 242			

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F 242	<p>Continued From page 68</p> <p>She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident 's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items that were taken were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>3. Resident #83 was admitted to the facility on 01/06/11. Cumulative diagnoses included congestive heart failure, hypertension and depression. The most recent Quarterly MDS of 04/24/15 noted the resident was cognitively intact. Resident #83 was included in a list provided by the facility for alert, oriented and reliable</p>	F 242			

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F 242	Continued From page 69 residents. During an interview with Resident #83, on 05/05/15 at 10:26 AM, she stated that staff come into her room on a daily basis and go through all of her belongings. She stated this was an invasion of her privacy and her home. She stated she did not like them going through her things but the staff had told her they had to do it so she would allow them to search. Resident #83 commented that the facility staff should not be allowed to go through all of her personal belongings looking for powders or spray deodorants. She commented that she didn't have much but it was hers and she didn't want people going through it. She stated she used those items when she lived at home before coming here. AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this	F 242			

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F 242	<p>Continued From page 70</p> <p>and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items that were taken were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>4. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly MDS of 02/21/15 noted Resident #105 was cognitively intact and independent with decision making. He was also identified by the facility to be alert, oriented and reliable. During an interview with Resident #105, on 05/06/15 at 10:30 AM, he stated staff come into his room regularly and search through all of his</p>	F 242			

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F 242	Continued From page 71 <p>belongings. He stated it bothered him that they were allowed to do that since this was his home. He stated he was told by the staff that he couldn't do anything about it so he would just leave the room and let them go through whatever they wanted. Resident #105 stated they took his shaving cream and anything that sprayed as well as any type of powder. He commented that if he was living in a private home he could have those items and didn't understand why he couldn't have them here.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. The Administrator was interviewed on 05/08/15 at</p>	F 242			

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F 242	<p>Continued From page 72</p> <p>12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items that were taken were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>5. Resident #122 was admitted to the facility on 11/21/14. Cumulative diagnoses included hypertension, diabetes mellitus, chronic obstructive pulmonary disease and quadriplegia. The most recent Significant Change MDS of 04/12/15 indicated Resident #122 was cognitively intact and independent with decision making. Resident #122 was interviewed on 05/06/15 at 11:40 AM per request. He stated different facility staff would come into his room regularly and search through his personal belongings and closet. He stated they search through all of his drawers and closet even if he isn't in the room. Resident #122 remarked "It ain't right" that they did this. He stated it made him mad and it was very upsetting that they thought it was okay to search his belongings. He stated he didn't have</p>	F 242			

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F 242	<p>Continued From page 73</p> <p>anything in his room that would be dangerous unless Vaseline was dangerous. He stated when he questioned staff about this, he was told it was their job to search his belongings. Resident #122 remarked he felt like he was in prison here and that he had no privacy at all. He also remarked that this was his home.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He</p>	F 242			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/09/2015
NAME OF PROVIDER OR SUPPLIER MOUNT OLIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365		
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F 242	<p>Continued From page 74</p> <p>stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items that were taken were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>6. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change MDS of 04/01/15 noted Resident #172 was cognitively intact and independent in decision making. During an interview with Resident #172, on 05/06/15 at 2:40 PM, she stated she felt she was in a prison here and that she had no rights at all. She stated she did not appreciate staff coming into her room to search through all of her belongings. She stated this was her home. Resident #72 stated she had been given a long list of items she was not allowed to have a while back but couldn't remember who gave it to her. She stated if she had any of those items staff took them. Resident #172 stated when she questioned staff about searching her belongings she was told they needed to make sure no one had any aerosols because confused residents might get them. She stated no other residents</p>	F 242			

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F 242	<p>Continued From page 75</p> <p>came into her room and if she had aerosols she would keep them in a drawer. Resident #172 stated she had a bag of salt packets and staff took it. She commented that she was not on a salt restricted diet.</p> <p>AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list to all of the families advising them of items the residents were not allowed to have in this building.</p> <p>The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that</p>	F 242			

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F 242	<p>Continued From page 76</p> <p>administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items that were taken were still in the facility they would be given back to the residents and if not the items taken would be replaced.</p> <p>7. The facility's smoking policy with an effective date of 06/01/96 noted that "Patients will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely and, if necessary, will be supervised." A copy of the facility's smoking policy of June 2013 that was included in the admission paperwork noted that each resident would be evaluated upon admission and quarterly for safe smoking status and needs. It was noted that residents who were deemed as safe smokers would be able to smoke without supervision at any time. Residents deemed as unsafe smokers would require supervision and follow the smoke break schedule. It was noted at the bottom of this policy that the supervised smoking schedule was 7:30 AM, 10:30 AM, 1:30 PM, 4:30 PM, 7:30 PM and 9:30 PM. Resident #168 was admitted to the facility on 05/22/14 and re-admitted on 10/13/14. Cumulative diagnoses included depression and delusional disorder. A smoking evaluation of 08/22/14 noted that</p>	F 242			

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F 242	<p>Continued From page 77</p> <p>Resident #168 was to be a supervised smoker due to several staff members had witnessed him sleeping with a lit cigarette in his hand. A smoking evaluation of 12/03/14 completed for Resident #168 noted that supervised smoking was required based on having a history of unsafe smoking habits. It was noted in the observation section that he was able to safely hold a cigarette. It was noted that he had the ability to light a cigarette. It was noted that he properly disposed of the ashes/butts. It was also noted that Resident #168 could smoke safely without the use of a smoking apron.</p> <p>Another smoking evaluation of 01/03/15 for Resident #168 noted that he was to be a supervised smoker based on a history of unsafe smoking habits. It was noted in the observation section of this evaluation that he was able to safely hold a cigarette. It was noted that he had the ability to light a cigarette. It was noted that he properly disposed of the ashes/butts. It was also noted that Resident #168 could smoke safely without the use of a smoking apron.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 02/16/15 documented that Resident #168 was cognitively intact and independent with decision making. This resident was included on the list provided by the facility to be alert, oriented and reliable.</p> <p>Resident #168's care plan of 02/23/15 identified several issues including may smoke with supervision per the smoking assessment. Interventions included providing a smoking apron as needed, providing education/material regarding smoking cessation and staff were to keep the cigarettes and the lighter.</p> <p>Resident #168 was observed sitting in the smoking court along with several other residents and staff members on 05/06/15 at 2:15 PM. He</p>	F 242			

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F 242	Continued From page 78 was not wearing a smoking apron and appeared to be able to hold his cigarette without dropping it. He was alert and talking with the other residents. No unsafe smoking behavior was observed. During an interview with Resident #168, on 05/07/15 at 10:45 AM, he stated that he had asked to be an independent smoker but the facility refused to allow him to smoke unsupervised. He stated at one time he was independent but that had been changed. When questioned about sleeping with a lit cigarette, he stated that he had been on medication that made him sleepy but was no longer on that medication. He stated he didn't understand why he could not be independent because he could do all of the things required to be a safe smoker. During an interview with the Director of Nurses (DON), on 05/08/15 at 4:45 PM, she stated that residents who desired to smoke were assessed upon admission and quarterly. She stated if the resident had a history of unsafe smoking behaviors the resident was deemed to be supervised even if they demonstrated safe smoking. The DON stated once a resident had those behaviors they were always supervised. She commented it was their policy that if a resident had unsafe smoking behaviors they were not safe smokers and had to be supervised. She stated the safe smokers or the independent smokers could smoke whenever they wanted but the supervised smokers had to adhere to the designated smoking times. When questioned about Resident #168's unsafe smoking behaviors, she responded that he was constantly smoking unsupervised. She stated there were 2 incidents that made him unsafe. She stated once he went to sleep with a lit cigarette and the second time staff caught him smoking unsupervised and he tried to hide the cigarette by	F 242			

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F 242	Continued From page 79 placing it underneath his leg. The DON stated no trial period had been established to allow Resident #168 to demonstrate that he was a safe smoker.	F 242			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review the facility failed to resolve grievances expressed during resident council meetings concerning incompatibility between resident food preferences and corporate menus and inconsistencies in the quality of the food being served. Findings included: Review of 12/16/14 resident council minutes revealed the only meal and dining concerns expressed by attendees regarded meal trays not coming out in order and the kitchen running out of food. Review of 01/20/15 resident council minutes documented, "no old business discussed". The single meal and dining issue regarded meals coming at different times (inconsistent delivery). Review of 02/17/15 resident council minutes documented, "no old business discussed". The	F 244	F 244 E LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATIONS Resident # 43, # 105, # 172, # 143 and # 103 were informed on 5/28/15 that the Administrator and District Food Service Manager would attend a Resident Council meeting at the president's invitation to discuss the menus. Residents were interviewed by the disinterested third party Social Worker using the resident interview tool to identify residents that may be affected by the same practice on 6/2/15 and 6/3/15. Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff,	6/11/15	

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F 244	<p>Continued From page 80</p> <p>single meal and dining issue regarded seeking the continuation of resident choice meals (one meal monthly).</p> <p>Review of 03/17/15 resident council minutes documented, "no old business discussed". Meal and dining concerns were, "trays not out on time.....concerns discussed about meals."</p> <p>Review of 04/21/15 resident council minutes documented, "no old business discussed". No meal and dining issues were documented.</p> <p>In an interview with the activity director and social work assistant at 11:40 AM on 05/08/15 they stated grievances expressed during resident council meetings were looked into and interventions were developed to solve issues. They reported concerns were considered resolved unless they were brought back up at the next resident council meeting. Food concerns they recalled being brought up by residents during resident council meetings since December 2014 included meal trays not coming out on time, small portion sizes, cold food, tough chicken, menus not "Southern" enough, potatoes not cooked enough, food tasteless, and running out of ice cream.</p> <p>At 12:45 PM on 05/08/15 Resident #43, the resident council president, stated since December 2014 attendees in resident council meetings discussed their dislike of the foods incorporated into the menus, the lack of taste and flavor of the foods, and the inconsistency of the cooking. He explained the residents in the building were basically good country people who liked plain Southern cooking, and frequently foods were either undercooked or overcooked.</p>	F 244	<p>housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>With the agreement of the President of resident council, the meeting is being held weekly starting on 5/12/15 to discuss grievance/concerns and resolution of such. The Social Worker and Recreation Director are in attendance as invited by the members. The Administrator and District Food Manager will met the members on 6/4/15 and discuss the residents' dislikes and what changes can be made in the menus. The Social Workers and Recreation Director will conduct an interview with 14 residents weekly regarding food quality weekly for the next 6 months, then monthly for 6 months.</p> <p>The Recreation Director will review the weekly/monthly minutes and the resident interviews regarding food quality for any trends and report monthly for 12 months to the Quality Assurance Committee.</p>		

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F 244	<p>Continued From page 81</p> <p>He reported the resident council grievances were not being addressed because the canned response was always that the facility had to go by corporate menus, and the facility was in the process of trying to find a new dietary manager so until then there might be some inconsistency with the quality of the food. According to Resident #43, the district food service manager did attend a resident council meeting about three months ago, but she again brought up the need to follow corporate menus. He commented the district manager talked some about what she was doing in some of her other buildings to improve food satisfaction, but offered no interventions about what was going to be done in this facility. (Resident #43's 04/02/15 quarterly minimum data set (MDS) documented his cognition was intact, and he was on a list of interviewable residents presented by the facility staff).</p> <p>At 2:43 PM on 05/08/15 the administrator stated he was not invited to attend resident council meetings, but he reviewed the minutes. He commented from reading the minutes he did not realize the menus and food quality inconsistency were such issues for the residents. However, he reported most of his nursing home residents were country folks and farmers who liked basic foods, nothing too fancy. According to the administrator, the fact that the facility was without a dietary manager for most of 2015 probably contributed to some of the food quality concerns. He also he reported he might need to think about hiring a couple more cooks with good regional cooking skills.</p> <p>At 2:50 PM on 05/08/15, during a telephone interview, the district food service manager stated since December 2014 she could think of two</p>	F 244			

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F 244	<p>Continued From page 82</p> <p>changes she had made in the menus to adapt them to the facility population. She reported the cooks were now preparing chicken pastry instead of chicken and dumplings, and one time the cook was asked to prepare black-eye peas instead of another dried bean on the menu.</p> <p>At 10:53 AM on 05/09/15 the facility's registered dietitian (RD) reported she did not attend resident council meetings. However, she reported some residents complained to her that dishes such as shrimp scampi, sweet and sour shrimp, and pasta primavera were too fancy for them. She commented these residents wanted more Southern food items on the menus. When residents complained about the menus, the RD stated she told residents that the facility had corporate menus it had to follow, but to ask for alternates such as soups and sandwiches. According to the RD, residents sometimes shared concerns about food quality such as foods being mushy, tough, raw, or overcooked, but it was usually after the fact, so again she encouraged them to ask for alternate menu selections and snacks.</p> <p>At 11:30 AM on 05/09/15 Resident #143, identified by staff as a resident who frequently attended resident council meetings, stated on a regular basis the group discussed their desire for the facility to serve home cooked, Southern foods. He also recalled residents mentioning some meats such as chicken and liver being cooked too hard and meats frequently being tasteless. He reported the facility frequently ran out of the alternate/substitute foods because so many residents requested them over the strange foods on the main menu. The resident commented management did not share what they</p>	F 244			

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F 244	<p>Continued From page 83</p> <p>were going to do to make the food/meals better, and he saw no improvement in food quality. According to Resident #143, residents were frequently told by the facility that their hands were tied because they had to follow menus which were corporately prepared. (Resident #143's 02/15/15 quarterly MDS documented his cognition was intact, and he was on a list of interviewable residents presented by the facility staff).</p> <p>At 12:50 PM on 05/09/15 Resident #105, identified by staff as a resident who frequently attended resident council meetings, stated Southern food items were not on the facility menus, and this was brought up over and over again in resident council. He reported there was no real resolution because the facility did not try to adapt the menus, stating they were corporately prepared. He commented it was so frustrating that he had not been to the last couple of resident council meetings. The resident stated it had gotten to the place that at lunch and supper he just requested sandwiches because of all the strange foods on the menus. According to the resident broccoli, Brussel sprouts, and carrots appeared on the corporate menus a lot when the residents would prefer collards, turnip greens, green beans, slaw, cooked cabbage, and sweet potatoes. Resident #105 commented there were problems getting what you preferred even during the last couple resident choice meals. He explained the facility requested chocolate pie and had to settle for another dessert, and the vendor for ribs was changed so now the ribs were longer, fattier, and greasier. (Resident #105's 02/21/15 quarterly MDS documented his cognition was intact, and he was on a list of interviewable residents presented by the facility staff).</p>	F 244			

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F 244	Continued From page 84 At 12:55 PM on 05/09/15 Resident #172 identified herself as someone who attended resident council periodically. She reported expressing food concerns in the meetings proved to be a waste of time. She explained attendees were continually told that the facility had to follow corporate menus. She commented so many residents disliked the corporate menu items that the facility was all the time running out of alternate food items and snacks. The resident stated it was brought up during council meetings that the kitchen was frequently out of items such as certain types of fruit juice and ice cream, but the situation did not improve. According to Resident #172, by the time the weekends rolled around the kitchen was out of so many food items that they never served what was posted on the menu boards. She reported council attendees were regularly promised that food inventory levels would be better once a new dietary manager was in place. (Resident #172's 04/01/15 significant change MDS documented her cognition was intact, and she was on a list of interviewable residents presented by the facility staff). At 3:47 PM on 05/09/15 Resident #103, identified by staff as a resident who frequently attended resident council meetings, stated some residents got really worked up in the meetings because they did not like the types of food the facility was serving. He reported these residents felt like they were being "put off" because they were repeatedly told the facility had to follow corporate menus. He stated meeting attendees also complained about the way things were cooked with some foods being overcooked and some being undercooked. The resident commented the council was repeatedly promised things would	F 244			

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F 244	Continued From page 85 get better when they hired another dietary manager and there was more consistency and guidance. According to Resident #103, he had seen very little improvement in the food quality and menu selections. (Resident #103's 03/31/15 quarterly MDS documented her cognition was intact, and she was on a list of interviewable residents presented by the facility staff).	F 244			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: 1. Based on nurse practitioner (NP) interview, staff interview, and record review the facility delayed the development and consideration of treatment options for 1 of 3 sampled residents (Resident #17) with physician orders to draw an urinalysis (UA) by not obtaining final lab/culture and sensitivity (C & S) results. 2. Based on observations, record review, staff, and resident interviews, the facility also delayed a follow-up appointment on 05/07/2015, for evaluation of indwelling catheter removal for one of two residents, Resident #122, reviewed for indwelling catheter care. Findings included:	F 315	F 315 D No catheter, prevent UTI, restore bladder Resident # 122's Foley Catheter was removed on 5/10/15 and was seen for follow up urology appointment on 5/11/15. Residents that have appointments scheduled outside the center have the potential to be affected by this practice. Medical record review was completed by Nurse Consultant on 6/1/15 and 6/2/15 reviewing consultant reports and	6/11/15	

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F 315	<p>Continued From page 86</p> <p>1. Resident #17 was admitted to the facility on 07/26/13. His documented diagnoses included diabetes, hypertension, and peripheral vascular disease.</p> <p>In a 02/06/15 physician progress note nurse practitioner NP #1 documented Resident #17 was having off and on confusion which was not typical for him. The NP noted no evidence of resident confusion in her assessment, but she ordered lab work including an urinalysis.</p> <p>02/09/15 lab results documented the resident had an elevated white blood cell (WBC) count of 12.3 K/uL (thousands per microliter), with the normal range being 4 - 10.5 K/uL.</p> <p>In a 02/27/15 physician progress note NP #1 documented Resident #17 had an elevated WBC, and preliminary analysis of the resident's urine drawn on 02/10/15 was "positive for trace bacteria...awaiting C & S."</p> <p>In a 03/09/15 physician progress note NP #2 documented, "Contacted hospital for final UA results from 02/12/15--significant for greater than 100,000 CFU (colony forming units) of bacteria (Serratia Marcescens)." NP #2 ordered Cipro (antibiotic) 250 milligrams (mg) twice daily (BID) x 10 days "as guided by sensitivity report." She also ordered a repeat UA/C & S in two weeks.</p> <p>Review of Resident #17's medical record revealed the copy of the final UA/C & S requested by NP #2 on 03/09/15. The lab sample was collected on 02/10/15 and the final UA/C & S was available on 02/12/15.</p>	F 315	<p>physician orders for any appointment and ensuring the appointments were schedule. No missed appointments were found.</p> <p>The licensed nurses were reeducated on a new process for scheduling appointments and transportation on 6/1/15 and 6/2/15 by the Director of Nursing. New process consists of one person to schedule appointments and arrange transportation for residents. Appointment calendar will be posted at each nurse's station for the next day appointments with any special instructions by the scheduler. Physician orders and consultant sheets will be reviewed twice a week for 4 weeks by the unit managers for appointments, then weekly for 6 months.</p> <p>Resident # 17's final U/A C&S results were negative with no growth on 5/08/15 and was addressed by the physician with no new orders and filed in the resident's medical record by the Medical Record Clerk.</p> <p>Residents that have ordered labs have the potential to be affected by this practice. Lab audit of residents' orders and lab results to ensure that results were in the medical record by Unit Managers on 5/11/15.</p> <p>The Licensed nurses were reeducated on use the lab tracking book on 5/14/15 and 5/15/15 by the Director of Nursing. Unit Managers will review lab orders compared</p>		

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F 315	<p>Continued From page 87</p> <p>A follow-up lab documented on 03/09/15 Resident #17's WBC was at 7.9 K/uL, which was within the normal range of 4 - 10.5 K/uL.</p> <p>A 03/25/15 preliminary lab result in Resident #17's medical record documented the presence of 2+ bacteria. A staff member documented the primary physician's office was to be notified when the final sensitivity report was received.</p> <p>Record review revealed there was no final UA/C & S report in Resident #17's medical record related to the 03/25/15 urine collection.</p> <p>The resident's 04/17/15 annual minimum data set (MDS) documented his cognition was intact, he required extensive assist by a staff member for toileting, and he was always continent of bladder and occasionally incontinent of bowel.</p> <p>On 04/28/15 "Resident exhibits or is at risk for complications of infection related to UTI (urinary tract infection)" was identified as a problem in Resident #17's care plan. Interventions for this problem included the administration of medication as ordered, and drawing labs as ordered.</p> <p>At 12:15 PM on 05/06/15 NP #1 stated when she ordered a UA/C & S she expected the facility to obtain the final lab report and C & S data even if the preliminary lab report was not definitive for a UTI. She reported the final lab report and C & S were what she based her decision about possible antibiotic treatment on. The NP commented what might have caused the problem with the facility not obtaining the final lab reports and C & S information for Resident #17 was that his urine specimens were sent to the hospital lab for analysis, and unlike the facility's usual laboratory,</p>	F 315	<p>to lab tracking book 5 days a week at the clinical stand up meeting to ensure that the labs orders request have been placed in the lab tracking book on the appropriate date. Unit Managers will review labs that were drawn on the previous day to ensure that the lab results are back and the physician has been notified of the results. The unit managers will complete a weekly audit on the lab tracking book and audit the medical record to ensure that the lab orders and labs have been drawn, results have returned, the physicians have been notified and lab results have been placed in the medical record weekly for 6 months.</p> <p>The results of the audit for appointments and for labs will be presented to the Quality Assurance Committee monthly for 6 months.</p>		

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F 315	<p>Continued From page 88</p> <p>the hospital had to be called for non-critical lab results. She stated usually the hospital lab generated a final lab report within two to three days after receiving the urine sample, and if the facility had not received results shortly after that, she expected a staff member to call for the information. According to NP #1, waiting almost a month after urine collection was too long to wait to consider treatment options such as the initiation of antibiotic treatment. She explained her physician group usually utilized an antibiotic when the CFUs were greater than 100,000.</p> <p>At 2:35 PM on 05/06/15 the director of nursing (DON) stated unit managers were responsible for checking to make sure labs were drawn and final lab results were available for review by the physicians.</p> <p>At 3:02 PM on 05/06/15 Unit Manager (UM) #1 stated floor nurses in conjunction with supervisors monitored to make sure final lab results were obtained. She explained a lot of times the labs the NPs requested were STAT (at once), and in that case specimens were taken to the hospital for analysis. The UM stated her expectation was for the floor nurse to call the next day after hospital receipt to see if final results were available, and if not, then hospital knew that results were being sought, and would usually fax final results to the facility when available. However, she commented sometimes the hall nurses still had to call the hospital for final lab reports.</p> <p>At 3:30 PM on 05/06/15 the DON called the hospital to obtain the final lab result and C & S from the urine collected and submitted to its lab on 03/25/15. This report documented final lab</p>	F 315			

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F 315	<p>Continued From page 89 and C & S results were available on 03/27/15, and Resident #17 had greater than 100,000 CFUs of bacteria present (Providencia Stuartii). NP #1 was contacted and ordered urine to be recollected for a UA/C & S.</p> <p>At 3:40 PM on 05/06/15 Resident #17 stated he did not remember for sure whether he exhibited symptoms of a UTI back in the February - March 2015 time period. He commented he thought maybe he was going to the bathroom a little more, but did not recall any pain or burning upon urination. He stated within the last month he had not noticed any symptoms that might indicate the presence of a UTI.</p> <p>At 10:11 AM on 05/08/15 the DON provided a copy of the final UA/C & S results obtained for the 05/06/15 urine sample. The final lab reported no growth of bacteria.</p> <p>2. A review of the Minimum Data Set admission assessment dated 01/12/2015 revealed Resident #122 was admitted to the facility on 12/31/2014, was cognitively intact, and had partial list of diagnoses including post-surgical care for a laminectomy performed prior to admission.</p> <p>A review of Resident #122's nursing care plan initiated on 05/28/14 and last updated on 4/15/15</p>	F 315			

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F 315	<p>Continued From page 90</p> <p>revealed he had measureable goals with related interventions to address the use of an indwelling catheter and the risk for complications of a urinary tract infection. One of the interventions included in the care plan was to provide catheter care as ordered and as needed.</p> <p>A Physician's Order dated 04/08/2015 indicated an indwelling catheter was in place because the resident had a history of decreased urinary output. The medical doctor was to be notified if there was an occlusion or if there was leaking from the catheter.</p> <p>The resident ' s medical record included a urology consult dated 04/13/2015. Review of the consult report revealed the resident was seen on 04/13/2015 to address his diagnoses of benign prostatic hypertrophy, neurogenic bladder, and his indwelling catheter. The consult also indicated the existing indwelling catheter was not secured with a leg strap, and that the reasons for his urinary retention issues were multifactorial, such as his recent surgery and the use of medications that could negatively impact his ability to void. The consult report read as follows: "We can see him back in two weeks and have him remove the catheter the day before to see how well he is emptying, but this may be something that is long term [indwelling catheter] versus intermittent catheterization, which we did a little here today."</p> <p>Review of a nurse ' s progress note dated 04/13/2015 revealed the resident had returned from an appointment with the urologist on 04/13/2015 and that a follow up appointment was scheduled with the urologist on 04/30/2015. Another nurse ' s progress note dated 04/14/2015</p>	F 315			

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F 315	<p>Continued From page 91</p> <p>indicated the resident complained of burning at the indwelling catheter insertion site and that the on-call physician was notified. The same progress note also indicated that the following orders were received at that time: 1. Secure indwelling catheter, 2. Notify urology to move up appointment, 3. Obtain urine for a culture and sensitivity. In addition, the same progress note dated 04/14/2015 indicated that the resident had just seen the urologist the day before and that the follow-up appointment was already scheduled for 04/30/2015. Another progress note dated 04/27/2015 indicated that the resident was concerned about a long clot noted in the tubing of the indwelling catheter and that the medical doctor was notified about the resident ' s concern about the clot. The same 04/27/2015 progress note indicated that the resident was being followed by a urologist, and that he had a urology appointment on 04/30/2015.</p> <p>Further review of the progress notes revealed a nurse's note dated 4/28/15 at 5:03 PM in which the nurse was called to the resident ' s room to look at his indwelling catheter and that the resident ' s penis was swollen and that the resident complained of tenderness at the catheter insertion site. The same nurse ' s progress note revealed there was no bleeding noted, that the resident was taking an antibiotic for a urinary tract infection, and that the resident received a pain medication (Percocet) at that time.</p> <p>An additional "Late Entry" progress note dated 04/28/2015 indicated the resident came in to the social services office complaining about his private area being in pain and having pus. The same note indicated the writer got a nurse to address his concern, and that the nurse</p>	F 315			

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F 315	<p>Continued From page 92</p> <p>acknowledged there was a clot in the catheter bag. The note indicated the nurse told the resident and his family that she was aware of his concern and that a follow up appointment had been made with the urologist for 04/30/2015.</p> <p>In an interview with Resident #122 on 05/07/2015 at 11:45 AM, he stated he was supposed to go to the urologist's office that day (05/07/2015) at 9:20 AM for a follow-up appointment with the urologist about removing his indwelling catheter, but the appointment was canceled. Resident #122 stated he was upset the appointment was canceled because he really wanted to have the catheter removed. He explained that the catheter was causing him pain and that he had some blood clots and visible blood in his urine tubing and collection bag recently. Resident #122 also stated he asked the appointment scheduler at 10:00 AM that day about his 9:20 AM urology appointment, and the scheduler told him it was too late to get him to the appointment and that it would have to be have to be rescheduled.</p> <p>An observation of the resident's catheter tubing and the urine collection bag during the interview with him on 05/07/2015 at 11:45 AM revealed there were no blood clots or visible blood present; however, a small amount of brown sediment was present in the bag.</p> <p>During an interview with the facility's appointment Scheduler #1 on 05/07/2015 at 12:10 PM, she explained that original follow-up urology appointment for Resident #122 was supposed to be 04/30/2015, but the urologist ' s office had called the facility to re-schedule it for 05/07/2015 at 9:20 AM due to a conflict in the urologist ' s schedule. Scheduler #1 stated she did not write</p>	F 315			

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F 315	<p>Continued From page 93</p> <p>the appointment date and time in the transportation book, which is the place where nursing staff check for scheduled appointments. Scheduler #1 explained that Resident #122 came to the scheduler's office to ask about his appointment that morning, but by the time he asked about it, it was too late to transport him to the appointment. Scheduler #1 added that he could not have gone to the appointment anyway because the nurse was supposed to carry out a nursing task for him prior to the appointment, and the nursing staff had not completed the task.</p> <p>Scheduler #2 stated in same interview on 05/07/2015 at 12:10 PM, that she was the one who received the call from the urologist 's office to reschedule the 04/30/2015 appointment to 05/07/2015 and that she sent a copy of the new appointment time to the Director of Nursing (DON), the assistant director of nursing (ADON) and to Scheduler #1.</p> <p>An interview was conducted on 05/07/2015 at 4:20 PM with the nurse (Nurse #2) who was assigned to Resident #122 that day. Nurse #2 stated that whenever a resident returned to the facility from an outside office appointment, the nurse on duty would receive notes from the office visit and review them for any orders to initiate. Nurse #2 stated that she did not know that the resident had an appointment with the urologist on 05/07/2015 because there was no note in the transportation book for an appointment for Resident #122. Nurse #2 stated that whenever a resident had an appointment to go to an appointment, the scheduler would make a note in the transportation book so that nurses would know to prepare residents to go out for the appointment.</p>	F 315			

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F 315	<p>Continued From page 94</p> <p>In an interview with Nurse #3 on 05/07/2015 at 4:26 PM, she stated she was the nurse assigned to Resident #122 when he returned from his urology appointment on 04/13/2015. Nurse #3 explained Resident #122 returned to the facility with papers which included an order to return to the urologist on 04/30/2015. Nurse #3 explained that she processed the order for the return appointment, but the appointment was eventually rescheduled by the facility ' s scheduler because the urologist had a conflict on the return appointment date. Nurse #3 stated that when the resident returned from the urologist appointment on 04/13/2015, the consult report was not yet completed by the urologist ' s office and was not yet available for review. Nurse #3 added that the urology consult was faxed to the facility on 04/15/2015 per the date of the faxed copy, and that she was not the nurse who received the faxed urology consult to review it for orders. Nurse #3 stated the order to remove the resident ' s catheter the day before the follow up appointment was on the faxed consult report.</p> <p>During the same interview with Nurse #3 on 05/07/2015 at 4:26 PM, she explained that when faxes came in to facility, someone (not certain who) would take the faxed report or consult, hand it to the assigned nurse, and then the nurse would review it for orders. Nurse #3 stated after the nurse reviewed the report, he/she would process any orders noted on the consult report, then place the report in the physician ' s box for review/sign off. She added that after the physician reviewed it, he/she would place the consult report in a separate box for the medical record department to file in the chart.</p>	F 315			

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F 315	<p>Continued From page 95</p> <p>In an interview with the assistant director of nursing (ADON) on 5/8/15 at 11:00 AM, the ADON stated that the fax machine was checked a couple of times per shift by a supervisor, if possible, or by nurse on duty. The ADON explained that whoever took the fax off the fax machine would then give it to the nurse assigned to the resident, who would then review the report and process any orders if necessary. She stated that if the information in the report needed to be reviewed the physician, the nurse would either make a note to the physician in the physician ' s notebook, or contact the physician immediately if the information was urgent.</p> <p>A review of the physician's orders revealed there was no order present to remove Resident #122's indwelling catheter on 05/06/2015.</p> <p>The director of nursing (DON) stated in an interview on 05/08/2015 that the nursing department did not know Resident #122 had an appointment with the urologist on 05/07/2015 because the appointment was not noted in the transportation book by the scheduler. She explained the nursing staff knew the resident ' s catheter needed to be removed the day before the follow-up appointment with the urologist as noted in the consult report dated 04/13/2015, and that this had been discussed in daily stand up meetings. The DON stated that the order was not processed because the nursing staff would have needed to know the date for the urology appointment in order to remove the catheter 24 hours in advance.</p> <p>A review of the physician's orders on 05/09/2015 revealed an order was in place to see the urologist on 05/11/2015 and for the indwelling</p>	F 315			

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F 315	Continued From page 96	F 315			
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff and resident interviews, the facility delayed the administration of a nutritional supplement for one of two residents, Resident #149, was reviewed for significant weight loss. Findings included:</p> <p>A review of the Quarterly Minimum Data Set assessment dated 02/09/2015 revealed Resident #149 was cognitively intact, was independent of all activities of daily living, and had a partial list of diagnoses including anemia, diabetes mellitus, end stage renal disease, gastroparesis, and esophageal reflux. The same assessment indicated the resident was on a physician prescribed weight-gain regimen.</p> <p>A review of Resident #149's nursing care plan initiated on 04/11/2014 and last updated on 05/05/2015 revealed there were measureable</p>	F 325	<p>F 325 D Maintain Nutrition Status unless unavoidable</p> <p>Resident # 149's supplement order for Nepro, 237 ml. with 1 tablespoon Strawberry Nequik was placed on Medication Administration Record (MAR) and was administered one time on 5/08/15 by medication nurse and documented on MAR.</p> <p>Residents that have an order for supplements have the potential to be affected. To identify residents with supplement orders, physician orders were reviewed by the Director of Nursing on 5/21/15. Dietary recommendations were reviewed beginning 5/18/15 by the</p>	6/11/15	

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F 325	<p>Continued From page 97</p> <p>goals with related interventions in place to address the resident ' s nutritional risk related to dialysis treatment and significant weight loss. Some of the interventions included a registered dietician evaluation and to provide one can of Nepro (a liquid nutritional supplement) mixed with 1 tablespoon of Strawberry Nesquik.</p> <p>A review of the weights recorded by the facility for Resident #149 revealed that on 04/02/2015, the resident weighed 113.5 pounds, and on 05/01/2015 the resident weighed 106.2 pounds. This represented a significant weight loss of 7.3 pounds, or a 6.4% weight loss in 30 days.</p> <p>A review of the Physician's Orders revealed an order dated 05/05/2015 for Nepro/Carb Steady Liquid (Nutritional Supplement), give 237 milliliters po (by mouth) one time a day for a supplement. The order also included instructions to mix one tablespoon of strawberry flavored Nesquik with the can of Nepro. A note with the order stated, "To Be Ordered."</p> <p>In an interview with Resident #149 on 05/06/2015 at 4:22 PM, he stated he did not care much for the food provided in the facility, and that the only item he really enjoyed were strawberry milkshakes (Nepro supplement with strawberry flavoring), but that he had not received one in several months.</p> <p>On 05/06/2015 at 4:30 PM, a review of the resident's Medication Administration Record (MAR) for May 2015 revealed there was no entry on the MAR to reflect the order for Nepro mixed with 1 tablespoon of strawberry flavored Nesquik.</p> <p>In an interview with Nurse #1 on 05/07/2015 at</p>	F 325	<p>Director of Nursing to ensure that recommendations for supplements have been approved, order written and placed on the MAR.</p> <p>Unit Managers were reeducated on review physician orders and transcription to the MAR as appropriate on 5/18/15 by the Director of Nursing. The Director of Nursing will complete weekly audit times 3 months of the Dietary recommendation to ensure all recommendation are completed.</p> <p>The Director of Nursing will review the weekly audit for trends and present to the Quality Assurance Committee for 3 months</p>	

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F 325	<p>Continued From page 98</p> <p>5:41 PM, she stated that typically when a new order was written for a resident, the nurse would go ahead and implement the order as soon as possible by printing it onto the MAR for the prescribed month and date so that the medication or supplement could begin. Nurse #1 also stated that the order summary would then be placed in the physician ' s book for the physician to sign off on it, usually the next day. Nurse #1 further stated the medication or supplement would be administered as soon as possible and before the order had been signed by the physician.</p> <p>In a review on the May 2015 MAR on 05/08/2015 at 11:15 AM, there was no entry for the Nepro supplement which was ordered on 05/05/2015.</p> <p>In an interview with Resident #149 on 05/08/2015 at 2:00 PM, he stated he still had not received a strawberry flavored supplement.</p> <p>An interview with the facility's registered dietician (RD) was conducted on 05/08/2015 at 2:52 PM. During the interview, the RD stated that she wrote the order for the Nepro, 237 milliliters by mouth once daily on 05/05/2015 to help prevent weight further weight loss for the resident. The RD explained that Resident #149 had received Nepro during an earlier admission at the facility, and that she wanted to re-start the Nepro supplement due to his recent weight loss. The RD also stated she could not remember exactly when the last time was he received the supplement. The RD further stated that she wrote the recommendation as an order in the electronic chart system and also provided a copy of the order to the Director of Nursing at the end of the day on 05/05/2015. The RD stated she was not sure who was responsible for processing the order after it was written.</p>	F 325			

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F 325	Continued From page 99 In an interview with Nurse #1 at 3:00 pm on 5/8/15, she stated that the resident used to have an order for a strawberry Nepro nutritional supplement when he had been in the facility previously, but that the order had not been restarted for his current admission. Nurse #1 stated he was receiving the supplement before he was sent to the hospital "two times ago," and that she did not know the specific dates when he had been sent to the hospital. An interview was conducted with the facility's Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 05/08/2015 at 4:09 PM. During the interview, the DON stated that milkshakes were typically provided as a supplement by the dietary department. The DON reviewed the order for Nepro, 237 milliliters by mouth with 1 tablespoon Strawberry Nesquik dated 05/05/2015 and then stated Central Supply was responsible for providing the Nepro supplement. The DON explained the nursing staff was responsible for notifying Central Supply the Nepro supplement should be ordered and that she did not know why the order had not been processed. The ADON stated she was responsible for following through on the Nepro order, and that she had forgotten to do so. The RD stated in an interview on 05/09/2015 at 10:50 AM that Nepro was a supplement, and that it was not provided by the dietary department. The RD stated the Nursing Department was responsible for this supplement orders.	F 325			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		6/11/15	

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F 356	<p>Continued From page 100</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility did not post daily the total number or actual number of hours worked by licensed and unlicensed nursing staff on the Daily Nurse Staffing Form for 5 of 6 days of review. Findings included:</p>	F 356	<p>F-356 C Posting Staffing Hours</p> <p>There were not any specific residents affected by this deficient practice.</p>		

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F 356	<p>Continued From page 101</p> <p>A review of the Daily Nurse Staffing Form in the lobby area of the facility on 05/04/2015 at 12:00 PM revealed there was no total number of hours posted for the licensed and unlicensed nursing staff. The posting revealed there 10.90 nursing assistants (NAs), 5.90 licensed practical nurses (LPNs), and 1.80 registered nurses (RNs) working the day shift (7:00 AM to the 3:00 PM), that there were 11 NAs and 4 LPNs working the evening shift (3:00 PM to 11:00 PM), and that there were 10.80 NAs and 3 LPNs working the night shift (11:00 PM to 7:00 AM) for a census of 131 residents. In addition, there was no total number of hours worked by the nursing staff on the posting.</p> <p>A review of the Daily Nurse Staffing Forms dated 05/05/2015, 05/06/2015, 05/07/2015, and 05/08/2015 revealed that there was no number of hours listed for each day, evening, or night shifts for any category of the nursing staff. The same posting listed only the number of individual NAs, LPNs, and RNs working each shift for a census of 131 residents.</p> <p>In an interview with the administrator on 05/09/2015 at 3:30 PM, he stated he had not seen the Daily Nurse Staffing Form and he would notify the scheduler that the number of hours for each type of nursing staff should be posted on the Daily Nurse Staffing Form instead of the number of individual nurses and certified nursing assistants for each shift.</p> <p>In an interview with Scheduler #3 on 05/09/2015 at 4:35 PM, she stated that the Daily Nurse Staffing Form was a template provided by the owner of the facility and was set up to show the</p>	F 356	<p>This deficient practice had the potential to affect all residents of the facility. The staffing hours are being manually calculated daily by shift and posted as required. The Admission Director has the task of auditing the staff hours for completeness on a daily basis.</p> <p>The facility Staffing Coordinator will continue to post the daily shift hours for nursing personnel and will extend hours worked manually until such time as the system is changed to produce electronic results.</p> <p>¿ Nursing Staff Hours posted by the Staffing Coordinator are verified daily by the Admission Coordinator.</p> <p>Results of the daily audits will be discussed at the facility QAA meetings for the next three months (June ¿ August).</p>		

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F 356	Continued From page 102 number of nursing staff by category (CNAs, LPNs, RNs) rather than the total number or actual number of hours worked by the nursing staff. The scheduler stated she would update the form to provide the total number and actual number of hours worked by the nursing staff. A review of the updated Daily Nurse Staffing Form dated 05/09/2015 at 4:50 PM revealed the staffing information had been corrected to reveal the actual and total number of hours worked by CNAs, LPNs, and RNs for each shift for the census of 131 residents.	F 356			
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: Based on observation and staff interview the facility failed to clean the face of a wall fan blowing into the dish machine area where sanitized kitchenware was unloaded, failed to air dry and remove food particles from kitchenware before stacking it in storage, failed to monitor wash/rinse gauges during the operation of the dish machine, failed to clean walls/corners/floors in the kitchen, and failed to label and date opened	F 371	F-371 E FOOD PROCURE. STORE/PREPARE/SERVE There we were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents.	6/16/15	

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F 371	<p>Continued From page 103 food items. Findings included:</p> <p>1. During initial tour of the kitchen on 05/04/15, beginning at 10:00 AM, the face of a wall fan, which was blowing into the area where sanitized kitchenware was being unloaded from the dish machine, was coated with a film of dust. There were also several strands of dust hanging from the fan face.</p> <p>At 2:28 PM on 05/07/15 the district food service manager stated all fans used to ventilate the kitchen should be kept free of dust and dirt to prevent contamination of food items and sanitized kitchenware. She reported she thought the maintenance department was responsible for keeping the fans clean.</p> <p>At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a dietary manager, stated the maintenance department was supposed to clean the wall fans in the kitchen every three months and as needed. She reported she could not remember the last time they were cleaned. The cook commented maintenance dismantled the fans and sprayed/washed them down outside.</p> <p>2. During a kitchenware inspection on 05/07/15, beginning at 11:18 AM, 25% of the ready-to-use kitchenware examined was compromised by moisture, abrasion, or the presence of dried food particles. 1 of 28 plates in the plate warmer had dried food particles on it, 5 of 7 sectional plates had food particles on them, 2 of 24 side dishes (china bowls) were stacked with moisture inside, 9 of 24 side dishes (china bowls) had dried food particles on them, 7 of 24 side plates (china dessert plates) had food particles on them, 2 of</p>	F 371	<p>Maintenance cleaned the face of the wall fan blowing into the dish machine area and has placed it on a schedule for monthly cleaning.</p> <p>Dietary Staff received in-service training on the importance of properly air drying kitchenware and assuring that the washing process has removed all food particles and kitchenware/utensils are thoroughly dry before being stacked/stored.</p> <p>The booster heater for the dish machine has been adjusted to provide a constant supply of water at the proper temperature for the wash and rinse cycles.</p> <p>Maintenance and Dietary Staff have cleaned the walls, ceilings, corners and floors in the kitchen.</p> <p>Staff have labeled and dated all open food items.</p> <p>The stated deficient practices had the potential to affect all residents of the facility.</p> <p>In-service training was provided by the NHA on 5/11/15, 5/13/15,5/18/15 and 5/19/15 for Dietary Staff covering the requirements of F-371 and the importance of thoroughly executing the posted DailyCleaning Schedule for the kitchen. Staff was provided copies of those documents to assure familiarity with content and</p>		

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F 371	<p>Continued From page 104</p> <p>18 soup/cereal bowls were abraded inside and rough to the touch, 4 of 10 tray pans stacked on top of one another had moisture trapped inside of them, 2 of 10 tray pans had dried particles on them, and 3 of 5 large baking pans had dried food particles on them. At this time a dietary employee stated she was unsure whether the tray pans and china bowls were stacked wet the night before or after running breakfast kitchenware through the three-compartment sink that morning.</p> <p>At 2:28 PM on 05/07/15 the district food service manager stated it was not good practice to stack kitchenware wet because trapped moisture could lead to bacterial growth. She reported the preferred method was to air dry kitchenware prior to stacking it in storage. According to the district manager, kitchenware was also supposed to be clean before placement into storage.</p> <p>At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a dietary manager, stated all dietary staff were trained to wait until kitchenware was completely dry and free of food particles before stacking it in storage. She reported the dietary employee retrieving sanitized kitchenware out of the dish machine was supposed to run any kitchenware with food particles back through the dish machine until it was completely free of food debris. She commented only then could the kitchenware be stacked dry in storage.</p> <p>3. During dish machine observation on 05/06/15, beginning at 9:40 AM, the two employees involved in the operation were not watching the wash and rinse gauges to make sure they registered the 150 degrees and 180 degrees respectively as recommended by dish machine</p>	F 371	<p>requirements.</p> <p>In-service training was provided to Dietary Staff by the Regional Director of Dining Services on 6/5/15 and 6/10/15 covering the importance of maintaining a clean work area, following cleaning schedules and properly labeling and dating open food items.</p> <p>The NHA and RD each have a Kitchen Sanitation audit that will be completed according to the schedule listed below to assure continued compliance with proper Kitchen Sanitation Procedures.</p> <p>The following procedures have been put into place to assure that proper sanitation standards are maintained in the kitchen:</p> <p>The Administrator and Registered Dietician each have specific dietary sanitation audits that Will be performed as follows:</p> <p>Weekly by NHA for 12 months (June 2015 to May 2016) Weekly by the RD for 12 weeks (June to August), then twice a month for the next 8 weeks (September & October) and then monthly as a matter of routine practice. Frequency is subject to revision for more frequent audits if results indicate the need but audits will be completed at least monthly.</p> <p>Housekeeping staff will perform a deep cleaning of the kitchen floor at least monthly to be inspected by the NHA to</p>		

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F 371	<p>Continued From page 105</p> <p>manufacturer. From 10:08 AM until 10:18 AM on 05/06/15 nine racks of kitchenware were run through the dish machine and the wash gauge registered 135 to 148 degrees Fahrenheit. After surveyor intervention, the dietary employee feeding dirty kitchenware into the dish machine reported the wash temperature was supposed to register at least 150 degrees Fahrenheit. This employee drained and refilled the dish machine. At 10:30 AM on 05/06/15 six more racks of kitchenware were run through the dish machine, and the wash gauge registered between 140 and 142 degrees Fahrenheit.</p> <p>At 3:25 PM on 05/06/15 the service representative reported the dish machine was running fine when he inspected it in the last 30 minutes, and the gauges were registering at least 150 degrees Fahrenheit during the wash cycle and at least 180 degrees Fahrenheit during the final rinse cycle. However, he reported he thought the wash gauge may not have been calibrated correctly so he adjusted it. According to the representative, keeping the wash temperature at 150 degrees helped to cut grease and promote quicker drying of the kitchenware.</p> <p>At 2:28 PM on 05/07/15 the district food service manager stated the dish machine wash and rinse temperature was recorded on a log after running about three racks of kitchenware through the dish machine after each meal. However, she reported the staff operating the dish machine were supposed to continue to monitor the gauges throughout the dish machine operation.</p> <p>At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a dietary manager, stated it was important to watch</p>	F 371	<p>following day if not to standards, service to be repeated within 48-hours.</p> <p>Staff has been provided with a comprehensive Daily Cleaning Schedule that details the areas of cleaning responsibility for staff on each shift by shift assignment.</p> <p>For F-371, the Directed Plan of Correction (DPOC) imposed by CMS has been incorporated into this POC with a correction date of 6/16/15</p> <p>Administrator will take appropriate action with and dietary employees who fail to follow the cleaning schedule to include additional training, disciplinary action and termination if warranted.</p> <p>Sanitation Checklists and the completed Staff Cleaning Assignments Checklist will be reviewed by the facility QAPI Committee monthly for 6 months and the review period may be extended based on results and progress with sanitation improvement and maintenance of acceptable levels of sanitation and the PIP plan will be updated as necessary to address any continuing systemic problems.</p>		

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F 371	<p>Continued From page 106</p> <p>the gauges of the dish machine continuously so if the wash and rinse were not hot enough maintenance or the dietary manager could be alerted. When dish machine temperatures were below manufacturer's recommendations, she commented it could affect the ability of the dish machine to sanitize kitchenware.</p> <p>4. During initial tour of the kitchen on 05/04/15, beginning at 10:00 AM, the wall behind the hand sink and the ice machine, the wall behind the beverage preparation table, and the wall by a blowing fan had patches of dust on them and dried food and dirt on them. The plate warmer with dishes in it had dried food on the top, there was dried/spilled food between the wells of the steam table, and a storage unit containing bowls and saucers had dried food crumbs in it. There was a border of greasy food build-up and dirt around the walls of the kitchen. There were food crumbs, dirt, and a dead roach in the corner behind the beverage preparation table. The wall by the preparation counter housing the robot coupe also had patches of dust on it, and dried food splatters on it. There were dried food on the tops of the storage containers of flour, sugar, and cornmeal. There was a spill of dried food down in the cornmeal. The wall behind the tray pan storage unit was dirty and the plaster was gouged out in places. The corners of the wall behind this storage unit were caked with grease and dirt, and there was a dead roach in one of the corners. The tray pans stacked in the storage unit were covered in a film of grease. In the dry storage area there were food crumbs and decorative sprinkles in the storage container of pie fillings and crystals of fruit punch in the beverage mix container.</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 371	<p>Continued From page 107</p> <p>At 9:42 AM on 05/06/15 the same dried food, originally observed on 05/04/15, was still present on the plate warmer. There were still dried food crumbs in the storage unit where bowls and saucers were stacked. Dried egg and food spills covered the steam table unit.</p> <p>At 11:18 AM on 05/06/15 there were still dried food spills on the plate warmer and on the steam table, and the food crumbs had not been cleaned out of the storage unit housing bowls and saucers.</p> <p>At 4:05 PM on 05/08/15 there were food crumbs, dirt, and a dead roach behind the beverage preparation table. Food debris was observed under the preparation table adjacent to the steam table, under the wire rack next to the microwave, under the unit housing the toaster, under the stove, and under the long food preparation unit housing a two-compartment sink. There was grease on the floor around the deep fryer. The baseboard had come loose from the wall, and was on the floor under the long storage rack to the right when entering the dry storage room.</p> <p>Review of the daily cleaning schedule for May 2015 revealed through 05/07/15 18 assignments had not been initialed off as being completed.</p> <p>At 2:28 PM on 05/07/15 the district food service manager stated she thought the dietary employees were keeping up with the daily cleaning tasks, but there might be problems with more routine cleaning tasks such as the cleaning of walls, ovens, and baseboards.</p> <p>At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a</p>	F 371			

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F 371	<p>Continued From page 108</p> <p>dietary manager, stated dietary and maintenance shared tasks such as the cleaning of the walls and floors. She explained that dietary washed down the walls that were lower, and they mopped the main kitchen floor which was uncluttered with equipment and preparation tables. However, the cook reported maintenance was responsible for cleaning the walls that had to be reached via ladder, and cleaning along the edges of the floors/baseboards where equipment and tables had to be moved to gain access to hard-to-reach areas prone to gathering dust, dirt, and grease/food particle build-up.</p> <p>5. During initial tour of the kitchen on 05/04/15, beginning at 10:00 AM, 35-ounce bags of cornflakes and sugar frosted flakes cereal, found in the dry storage room, were opened but without labels and dates. Also in the dry storage room a 24-ounce package of orange gelatin mix and a 160-ounce bag of elbow macaroni were opened without labeling and dating. In the walk-in refrigerator there was no label and date on an onion which had been peeled and halved, and there were no labels or dates on partially used and re-wrapped corned beef and beef brisket stored in the walk-in freezer.</p> <p>During a follow-up inspection of storage areas on 05/06/15, beginning at 10:25 AM, food items which had been opened were still found without labels and dates including a 160-ounce bag of elbow macaroni, a 35-ounce bag of cornflakes cereal, and a bag of vanilla wafers in the dry storage room. In addition, a gallon container of creamy Caesar dressing in the walk-in refrigerator was opened but without labeling and dating.</p>	F 371			

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F 371	Continued From page 109 At 2:28 PM on 05/07/15 the district food service manager stated in the absence of a dietary manager the responsibility for monitoring storage areas for labeling and dating would fall on the lead cook. She reported storage areas were to be inspected at least every couple of days to make sure they were clean and opened food items were sealed and labeled/dated. At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a dietary manager, stated it was the responsibility of all dietary employees to monitor the storage areas. She explained anytime an employee opened a food item and resealed or repackaged it, that person was responsible for placing a label and date on it. She commented that all food items which were opened/resealed, food items which were removed from original packaging and repackaged, and leftovers were to have labels and dates on them in order to use up the older food first.	F 371			
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, and record review the facility failed to eradicate and contain common household pests in resident care areas, and failed to maintain cleanliness in the kitchen which was	F 469	F-469 PEST CONTROL PROGRAM Residents #69, #86, #179, #49, #168, #106, and #27 were identified to have	6/11/15	

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F 469	<p>Continued From page 110 identified as the possible cause of a bug infestation. Findings included:</p> <p>Review of pest control service records revealed the facility received monthly service on 11/20/14 when it was documented roaches were found throughout the kitchen and in food storage areas, on 12/26/14 when it was documented roaches were found in three resident rooms and the hair salon with food debris found on floors and behind room refrigerators, and on 01/28/15 when roaches were again found in a resident room.</p> <p>02/02/15 communication between the pest control company and the facility concerning a plan of action to control roach infestation in the kitchen documented, "1. Sanitation (This is first and foremost on the list. Any successful pest program must start here."</p> <p>A 02/18/15 progress report from the maintenance manager to the administrator documented, "Educated kitchen staff on a proper cleaning procedure in every area of the kitchen. Putting together a daily cleaning schedule for the kitchen and making sure everyone is adhering to it."</p> <p>An outline for a 02/19/15 dietary in-service documented, "Brief description of presentation: specific areas of kitchen, storage rooms to be cleaned and proper techniques for storage and sanitation. Improved communication between dietary staff and maintenance using work orders, which will be used to inform maintenance of any concerns or any repairs needed."</p> <p>Monthly service was also provided to the facility on 03/03/15 by a new pest control company.</p>	F 469	<p>been affected by the deficient practice:</p> <p>Resident #168 has been discharged from the facility effective 5/21/5.</p> <p>Resident #49 - residents room was deep cleaned and family agreed to remove a wardrobe containing VCR tapes and cardboard boxes which was found to be infested with roaches. Resident #49s room is on a list to be checked daily to assure the pest problem is being controlled.</p> <p>Resident #69 - cleaned room and treated by Arrest-A-Pest - room is on the list to be monitored</p> <p>Resident #86 - cleaned room (behind wardrobe) and treated by Arrest-A-Pest - room is on the list to be monitored</p> <p>Resident #179 - cleaned room (behind wardrobe) and treated by Arrest-A-Pest - room is on the list to be monitored</p> <p>Resident #106 - cleaned room and treated by Arrest-A-Pest - room is on the list to be monitored</p> <p>Resident #27 - cleaned room and treated by Arrest-A-Pest - room is on the list to be monitored</p> <p>All residents have the potential to be affected by the deficient practice. Maintenance Staff and Housekeeping Staff have been addressing the pest control program on several levels:</p>		

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F 469	<p>Continued From page 111</p> <p>The weekly kitchen audit for the week of 04/13/15 through 04/17/15 documented, "noticed a little more insect activity."</p> <p>04/21/15 Resident Council minutes documented, "bugs being spotted in facility."</p> <p>The facility received its montly pest control service on 04/22/15.</p> <p>During initial tour of the kitchen on 05/04/15, beginning at 10:00 AM, the wall behind the hand sink and the ice machine, the wall behind the beverage preparation table, and the wall by a blowing fan had patches of dust on them and dried food and dirt on them. The plate warmer with dishes in it had dried food on the top, there was dried/spilled food between the wells of the steam table, and a storage unit containing bowls and saucers had dried food crumbs in it. There was a border of greasy food build-up and dirt around the walls of the kitchen. There were food crumbs, dirt, and a dead roach in the corner behind the beverage preparation table. The wall by the preparation counter housing the robot coupe also had patches of dust on it, and dried food splatters on it. There were dried food on the tops of the storage containers of flour, sugar, and cornmeal. There was a spill of dried food down in the cornmeal. The wall behind the tray pan storage unit was dirty and the plaster was gouged out in places. The corners of the wall behind this storage unit were caked with grease and dirt, and there was a dead roach in one of the corners. The tray pans stacked in the storage unit were covered in a film of grease. In the dry storage area there were food crumbs and decorative sprinkles in the storage container of pie fillings and crystals of fruit punch in the beverage mix</p>	F 469	<p>Facility utilizes a work order system that encourages any staff member to report an issue with pest activity - the reports are logged by administration and promptly delivered to maintenance and or housekeeping for corrective action;</p> <p>Maintenance and Social Services have developed a list of problematic rooms and have been making contact with family members to remove any unnecessary items that are stored directly on the floor or prohibit free movement of housekeeping staff in patient care areas;</p> <p>Maintenance is working with the new pest control company, Arrest-A-Pest, to assure problem areas are treated as often as necessary and to assure we are provided with a written status report following their visit to assist with our follow up activities.</p> <p>Kitchen sanitation is key to overall facility pest control and the following measures have been implemented to achieve acceptable levels of sanitation in the kitchen work and storage areas:</p> <ul style="list-style-type: none"> o The Administrator and Registered Dietician each have specific dietary sanitation audits that will be performed as follows: <ul style="list-style-type: none"> o Weekly by NHA for 12 months (June 2015 to May 2016) o Weekly by the RD for 12 weeks (June thru August), then twice a month for the next 8 weeks (September & October) and then monthly as a matter of routine 		

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F 469	<p>Continued From page 112 container.</p> <p>At 9:28 AM on 05/05/15 Resident #69 stated she was still seeing roaches in her bathroom. At 9:31 AM on 05/05/15 a medium-sized brown bug (roach) was observed on the wall of the bathroom, below the resident's sink. (Resident #69's 03/17/15 quarterly minimum data set (MDS) documented her cognition was intact, and she appeared on a list of interviewable residents provided by facility staff).</p> <p>At 9:33 AM on 05/05/15 during an interview with Resident #86 a medium-sized brown bug (roach) was observed calling across the resident's floor.</p> <p>At 9:55 AM on 05/05/15 during an interview with a family member who did not wish to be identified, the family member stated this past weekend "many, many" roaches were observed in the resident's room, mainly under furniture where the floor needed to be cleaned.</p> <p>At 11:00 AM on 05/05/15 a medium-sized brown bug (roach) was observed in Resident #179's bathroom, and he stated he had seen a couple of roaches in the bathroom himself over the last couple of weeks. (Resident #179's 02/25/15 quarterly MDS documented his cognition was intact, and he appeared on a list of interviewable residents provided by facility staff).</p> <p>At 9:42 AM on 05/06/15 dried food was still present on the plate warmer in the kitchen. There were still dried food crumbs in the storage unit where bowls and saucers were stacked. Dried egg and food spills covered the steam table unit.</p>	F 469	<p>practice. Frequency is subject to revision for more frequent audits if results indicate the need but audits will be completed at least monthly.</p> <p>Housekeeping staff will perform a deep cleaning of the kitchen floor at least monthly to be inspected by the NHA the following day and if not to standards, service to be repeated within 48-hours.</p> <p>Staff has been provided with a comprehensive Daily Cleaning Schedule that details the areas of cleaning responsibility for staff on each shift by shift assignment.</p> <p>Administrator will take appropriate action with and dietary employees who fail to follow the cleaning schedule to include additional training, disciplinary action and termination if warranted.</p> <p>Staff is encouraged to report pest activity so maintenance and housekeeping personnel can address and correct the concern. The Maintenance Director will verify effectiveness of the Dietary Cleaning Schedule weekly for 6 months.</p> <p>The Company's Property Manager visited the facility on June 1 & 2 to thoroughly review areas in the kitchen and other areas in the center for unsealed penetrations and any other areas that might be an avenue for pest access to the building.</p>		

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F 469	<p>Continued From page 113</p> <p>At 11:18 AM on 05/06/15 there were still dried food spills on the plate warmer and on the steam table in the kitchen, and the food crumbs had not been cleaned out of the storage unit housing bowls and saucers.</p> <p>At 9:38 AM on 05/07/15 a glue trap was found under Resident #49's chest of drawers. There were four dead medium-sized bugs (roaches) stuck in the trap. There was food particles, dirt, and dust under the chest of drawers.</p> <p>At 10:45 AM on 05/07/15 during an interview with Resident #168, a medium-sized bug (roach) crawled across the resident's floor, and the resident stated "That's nothing...We have bugs two to three times that size running around here every day." (Resident #168's 02/16/15 quarterly MDS documented his cognition was intact, and he appeared on a list of interviewable residents provided by facility staff).</p> <p>At 2:22 PM on 05/08/15 the maintenance assistant stated the facility switched pest control companies in March 2015 because the new company was using different types of chemicals which the facility hoped would be more effective in killing bugs. He reported the facility only received monthly pest control service, and the new company sprayed the hallways and placed bait in the kitchen and problem rooms. According to the assistant, the facility was trying to focus on eliminating pests in the kitchen so weekly rounds were being completed by maintenance regarding kitchen sanitation and pest activity in the kitchen. He commented the facility was also focusing on cluttered rooms where pest activity could be increased. He explained letters were sent to family members about reducing the clutter, and</p>	F 469	<p>Maintenance will be conducting a series of audits to monitor pest control activity in the Dietary Department and the general facility through the remainder of 2015. Initial audits will be daily x 5 days/week for 8 weeks; Three times a week (Mon-Wed-Fri) for 8 weeks; and then weekly for 12 weeks. Findings are discussed daily at the morning staff meeting. Any evidence of increased pest activity will result in reverting back to the previous level of audits.</p> <p>Maintenance staff is rounding in the facility after hours (10 PM and Later) Monday - Friday to identify any areas with pest activity. The after- hours visits will continue for 60 days (through July 31) with an option for extension if observations warrant.</p> <p>The Arrest-A-Pest staff will be making visits to the facility 2 times a month for the next 2 months (through July 31) to treat specific areas identified by audit activity.</p> <p>Facility Administrator in conjunction with Maintenance Director and Housekeeping Supervisor and Dietary staff will design a PIP to assure the elements of the POC at F-371 and F-469 are incorporated into a program that establishes accountability and responsibility for executing an effective Pest Control Program. Maintenance Director will report findings and recommendations to the facility QAPI committee for a minimum of 4 months.</p>		

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F 469	<p>Continued From page 114</p> <p>environmental services was checking on the rooms frequently.</p> <p>At 2:35 PM on 05/08/15 there were four dead roaches and one live roach caught in the glue trap under Resident #49's chest of drawers. The maintenance assistant stated this resident's room was on the cluttered list, and he placed roach bait behind the furniture and in the corners of the resident's section of the room. He was not sure why the facility was still finding roaches in the glue trap.</p> <p>At 4:05 PM on 05/08/15 there were food crumbs, dirt, and a dead roach behind the beverage preparation table in the kitchen. Food debris was observed under the preparation table adjacent to the steam table, under the wire rack next to the microwave, under the unit housing the toaster, under the stove, and under the long food preparation unit housing a two-compartment sink. There was grease on the floor around the deep fryer. The baseboard had come loose from the wall, and was on the floor under the long storage rack to the right when entering the dry storage room.</p> <p>Review of the daily kitchen cleaning schedule for May 2015 revealed through 05/07/15 18 assignments had not been initialed off as being completed.</p> <p>At 3:00 PM on 05/09/15 Resident #106 stated there were a lot of roaches in the building, and she stepped on three baby roaches in her bathroom last week. (Resident #106's 04/13/15 quarterly MDS documented her cognition was intact, and she appeared on a list of interviewable residents provided by facility staff).</p>	F 469			

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F 469	Continued From page 115	F 469			
F 490 SS=H	<p>At 4:00 PM on 05/09/15 a small brown bug (roach) was seen on the floor of Resident #27's room.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, resident and staff interviews, the facility administration did not follow through on verbal and written concerns of 1 resident (Resident #168) who exhibited disrespectful, bullying behavior for 13 of 13 residents (Resident #39, #43, #68, #71, #78, #79, #81, #105, #129, #131, #143, #172, and #203) and the bullying behavior continued. The facility's administration also did not maintain a respectful/dignified environment for 6 of 6 sampled residents (Resident #) who reported staff searching their belongings regularly. Findings included:</p> <p>This tag is cross referenced to F166. Based on record review, resident and staff interviews, the facility did not follow-up on grievances expressed by 3 of 3 sampled residents (Resident #68, #105 and #172) regarding disruptive behaviors by another resident (Resident #168).</p> <p>This tag is cross referenced to F223. Based on</p>	F 490	<p>F-490 ADMINISTRATION - RESIDENT WELL-BEING</p> <p>To the extent that this tag is a cross reference to deficiencies F-166, F-223, and F-241 listed earlier in this 2567, those responses are listed below to address the citation at F-490.</p> <p>F 166 E RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>Resident # 68 was discharged on 5/27/15. Resident # 168 was discharged on 5/21/15</p> <p>Resident #68, # 105 and # 172 were informed that resident # 168 was no longer a resident in this center by the Social Worker on 5/21/15.</p>	6/11/15	

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F 490	<p>Continued From page 116</p> <p>record review, resident and staff interviews, the facility allowed a resident (Resident #168) to verbally harass and torment 1 of 1 sampled residents (Resident #131). The facility also allowed Resident #168 to physically abuse 1 of 1 sampled residents (Resident #131).</p> <p>This tag is cross referenced to F241. Based on record review, physician, resident and staff interviews, the facility allowed a resident (Resident #168) to disregard 13 of 13 sampled residents' right to be treated with dignity (Resident #39, #43, #68, #71, #78, #79, #81, #105, #129, #131, #143, #172, and #203) as evidenced by vulgar, offensive and disruptive behaviors. The facility also did not maintain dignity for 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122, and #172) who reported facility staff were searching their belongings routinely.</p>	F 490	<p>Other residents that may be affected by this practice were identified by resident and family interviews using a resident and family interview tool by the Social Workers and Activity Director on 5/20/15. Any negative responses were transferred to the center's Grievance/Concern form for investigation and resolution.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Social Workers received education on the Grievance Process on 5/15/15 by the Corporate Social Service Specialist via Web Cast. Center staff, licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff and department heads received education regarding the grievance process by the Social Worker on 6/1/15 and 6/2/15. Resident interviews will be conducted for 14 residents weekly for 6 months then monthly for 6 months, questioning if they have any grievance/concerns and if they</p>		

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F 490	Continued From page 117	F 490	<p>have expressed any has the staff returned with a resolution. Any grievance/concerns that are expressed will be reviewed in Morning Stand up meeting daily until the grievance/concern is resolved and closed.</p> <p>The results of the resident interviews resulting in a grievance/concern will be reviewed for any trends and presented to the Quality Assurance Committee monthly for 12 months by the Social Worker.</p> <p>F 223 G</p> <p>Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15. The responsible party of resident # 131 was notified on 5/27/15 by Social Worker that resident # 168 was no longer a resident in the center. The Social Worker informed residents # 105, # 43, # 79, and # 172 that resident # 168 no longer resided in the center on 5/27/15. Resident # 68 was discharged on 5/27/15.</p> <p>All residents in the center had the potential to be affected by this practice. Social Workers and Recreation Director conducted interviews with the interviewable residents and with family members using the family interview tool regarding possible abuse on 5/11/15 thru 5/20/15. No family member or resident related any concern regarding abuse that had occurred.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants,</p>		

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F 490	Continued From page 118	F 490	<p>dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Education was provided to Licensed Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE).</p> <p>Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Maintenance, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on what constitutes abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Resident interviews will be conducted on 14 interviewable residents weekly for 6 months and then monthly for 6 months by the Social Services and Activities regarding if they feel if any abuse has occurred or been observed. A resident interview tool will be used.</p> <p>The results of the interviews, presented by the Social Worker, will be reviewed at the Quality Assurance Committee monthly for 12 months.</p> <p>F 241 H</p>		

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F 490	Continued From page 119	F 490	<p>DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>Residents # 39, # 43, # 71, #78, # 79, #81, #105, # 129, # 131, # 143, and # 172 were informed that resident # 168 was no longer residing in the center. Resident # 68 was discharged on 5/27/15. Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15.</p> <p>Residents # 172, # 105, # 44, # 79, # 83, # 122 have had their personal items returned or replaced by the Social Services on 5/12/15 . These residents were interviewed on 5/28/15 by Department Managers to ensure that their personal items had been replaced and no further room searches have occurred.</p> <p>Other residents that may potentially be affected were identified by interviewing the residents or families of residents unable to be interviewed. The interviews were conducted by the Social Workers and Recreation Director on 5/11/15 thru 5/20/15.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to</p>		

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F 490	Continued From page 120	F 490	<p>newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Education was provided to Licensed Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE).</p> <p>Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on what constitutes abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Resident interviews will be conducted on 14 interviewable residents weekly for 6 months, then monthly for 6 months by the Social Services and Activities regarding if they feel if any abuse has occurred or been observed. A resident interview tool will be used for the resident interviews.</p> <p>Center staff was in-serviced on the revised bulletin that lists the items that the residents are requested not to have in their rooms and that the staff is not allowed to search the residents rooms. The education was provided on 6/1/15 and 6/2/15 by the Admission Director. During the Resident Council meeting of 5/12/14, the revised list was reviewed with the members by the Activity Director and Social Worker. The Administrator and Director of Nursing also attended the meeting to answer questions from the Council.</p>		

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F 490	Continued From page 121	F 490	<p>The bulletin that listed the items that resident were not allowed to have in their rooms was revised to include aerosol cans and over the counter medications and ointments by the Administrator and Director of Nursing on 5/13/15. A mailing to the residents responsible party, of the revised bulletin was completed on 5/28/15 by the Admission Director. A copy of the bulletin was posted on each resident bulletin board in their rooms by the Admission Director on 5/27/15. An interview will be completed on 14 alert/oriented residents weekly for 6 months and monthly for 6 months if room searching are been conducted and if personal items are being removed b staff. The interviews will be completed by the Social Workers and Activities.</p> <p>The results of the resident interviews regarding abuse and privacy will be presented to the Quality Assurance Committee by the Social Worker monthly for 12 months.</p>		
F 507 SS=D	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS</p> <p>The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>This REQUIREMENT is not met as evidenced by: Based on nurse practitioner (NP) interview, staff</p>	F 507	F 507 D	6/11/15	

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F 507	<p>Continued From page 122</p> <p>interview, and record review the facility failed to provide final urinalysis (UA)/culture and sensitivity (C & S) reports and valproic acid levels to the physician group which were important in making treatment decisions for 3 of 8 sampled residents (Resident #17, #49, and #163) whose medications and labs were reviewed. Findings included:</p> <p>1. Resident #17 was admitted to the facility on 07/26/13. His documented diagnoses included diabetes, hypertension, and peripheral vascular disease with an above-the-knee amputation.</p> <p>In a 02/27/15 physician progress note NP #1 documented Resident #17 had an elevated white blood cell count, and preliminary analysis of the resident's urine drawn on 02/10/15 was "positive for trace bacteria...awaiting C & S."</p> <p>In a 03/09/15 physician progress note NP #2 documented, "Contacted hospital for final UA results from 02/12/15--significant for greater than 100,000 CFU (colony forming units) of bacteria (Serratia Marcescens)." NP #2 ordered Cipro (antibiotic) 250 milligrams (mg) twice daily (BID) x 10 days "as guided by sensitivity report." She also ordered a repeat UA/C & S in two weeks.</p> <p>Review of Resident #17's medical record revealed the copy of the final UA/C & S requested by NP #2 on 03/09/15. The lab sample was collected on 02/10/15, and the final UA/C & S was available on 02/12/15.</p> <p>A 03/25/15 preliminary lab result in Resident #17's medical record documented the presence of 2+ bacteria. A staff member documented the primary physician's office was to be notified when</p>	F 507	<p>Lab reports in record</p> <p>Resident # 17's final U/A C&S results were negative with no growth on 5/08/15 and was addressed by the physician with no new orders and filed in the resident's medical record by the Medical Record Clerk.</p> <p>Resident # 49's Valproic Acid lab results on 01/15/15 was within normal limits, the results were reviewed by the physician with no new orders and lab slip was placed in the medical record by the Medical Record Clerk.</p> <p>Resident # 163 final U/A C&S of 5/01/15 results were negative with no growth and were addressed by physician with no new orders and results placed in the medical record by the Medical Record Clerk.</p> <p>Residents that have ordered labs have the potential to be affected by this practice. Lab audit of residents' orders and lab results to ensure that results were in the medical record by Nurse Consultant on 5/19/15 thru 5/27/15.</p> <p>The Licensed nurses were reeducated on use the lab tracking book on 5/14/15 and 5/15/15 by the Director of Nursing. Unit Managers will review lab orders compared to lab tracking book 5 days a week at the clinical stand up meeting to ensure that the labs orders request have been placed in the lab tracking book on the appropriate date. Unit Managers will review labs that were drawn on the previous day to ensure</p>		

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F 507	<p>Continued From page 123 the final sensitivity report was received.</p> <p>Record review revealed there was no final UA/C & S report in Resident #17's medical record related to the 03/25/15 urine collection.</p> <p>At 3:30 PM on 05/06/15 the director of nursing (DON) called the hospital to obtain the final lab result and C & S from the urine collected and submitted to its lab on 03/25/15. This report documented final lab and C & S results were available on 03/27/15, and Resident #17 had greater than 100,000 CFUs of bacteria present (Providencia Stuaritii). NP #1 was contacted, and ordered urine to be recollected for a UA/C & S.</p> <p>At 10:11 AM on 05/08/15 the DON provided a copy of the final UA/C & S results obtained for the 05/06/15 urine sample. The final lab reported no growth of bacteria.</p> <p>At 12:15 PM on 05/06/15 NP #1 stated when she ordered a UA/C & S she expected the facility to obtain the final lab report and C & S data even if the preliminary lab report was not definitive for a urinary tract infection (UTI). She reported the final lab report and C & S were what she based her decision about possible antibiotic treatment on. The NP commented what might have caused the problem with the facility not obtaining the final lab reports and C & S information for Resident #17 was that his urine specimens were sent to the hospital lab for analysis, and unlike the facility's usual laboratory, the hospital had to be called for non-critical lab results. She stated usually the hospital lab generated a final lab report within two to three days after receiving the urine sample, and if the facility had not received results shortly after that, she expected a staff</p>	F 507	<p>that the lab results are back and the physician has been notified of the results. The unit managers will complete a weekly audit on the lab tracking book and audit the medical record to ensure that the lab orders and labs have been drawn, results have returned, the physicians have been notified and lab results have been placed in the medical record weekly for 3 months.</p> <p>The results of the weekly audit will be presented to the Quality Assurance Committee monthly for 3 months.</p>		

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F 507	<p>Continued From page 124</p> <p>member to call for the information. According to NP #1, waiting almost a month after urine collection was too long to wait to consider treatment options such as the initiation of antibiotic treatment. She explained her physician group usually utilized an antibiotic when the CFUs were greater than 100,000.</p> <p>At 2:35 PM on 05/06/15 the director of nursing (DON) stated unit managers were responsible for checking to make sure labs were drawn and final lab results were available for review by the physicians.</p> <p>At 3:02 PM on 05/06/15 Unit Manager (UM) #1 stated floor nurses in conjunction with supervisors monitored to make sure final lab results were obtained. She explained a lot of times the labs the NPs requested were STAT (at once), and in that case specimens were taken to the hospital for analysis. The UM stated her expectation was for the floor nurse to call the next day after hospital receipt to see if final results were available, and if not, then hospital knew that results were being sought, and would usually fax final results to the facility when available. However, she commented sometimes the hall nurses still had to call the hospital for final lab reports.</p> <p>2. Resident #49 was admitted to the facility on 06/27/05 and readmitted on 03/04/13. The resident's diagnoses included epilepsy/convulsions/seizure disorder.</p> <p>A 01/23/14 physician order placed Resident #49 on dilantin 200 milligrams (mg) twice daily (BID).</p> <p>A 04/24/14 physician order placed Resident #49</p>	F 507			

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F 507	<p>Continued From page 125 on depakote (valproic acid) extended release 1,000 mg three times daily (TID).</p> <p>A 01/14/15 physician progress note documented the nurse practitioner wanted the facility to check Resident #49's ammonia and valproic acid levels as well as obtain a liver function panel due to the emergence of lethargy and abnormal behaviors.</p> <p>Record review revealed there were no lab results documenting valproic acid levels in Resident #49's medical record.</p> <p>A 02/16/15 physician progress note documented Resident #49 experienced seizure activity over the weekend, and the resident's dilantin administration was changed to 200 mg every morning and 250 mg every evening.</p> <p>At 10:28 AM on 05/08/15 the director of nursing (DON) contacted the facility's contracted lab service, and obtained a copy of a lab result which documented a specimen was drawn on 01/14/15 with the valproic acid result available on 01/15/15. Resident #49's valproic acid level was within normal limits at 82.1 ug/mL (normal range being 50 - 100 ug/mL).</p> <p>At 11:00 AM on 05/08/15 the assistant director of nursing (ADON) stated supervisors or hall nurses were supposed to check the fax machines a couple times a shift for things such as lab results. Once retrieved, the ADON explained the lab results were taken to the appropriate nursing station. If a nurse was not present, she commented the lab results were left in the "to be reviewed by nurse" box on the wall. The ADON remarked once a nurse reviewed the faxed labs, and if they were within normal limits or there were</p>	F 507			

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F 507	<p>Continued From page 126</p> <p>no concerns, the results were placed in the "file in medical records" box on the wall. If labs were not within normal levels or there were other concerns, the ADON stated the physician was notified immediately or the labs and concerns were placed in the physician book for the physician, NP, or physician assistant (PA) to review on their next visit.</p> <p>At 2:32 PM on 05/08/15 nurse practitioner (NP) #1 stated it was important to have the levels of all monitored anti-seizure medications present when making decisions about adjusting dosages due to symptoms of over or under medication and due to current seizure activity. She reported her expectation was for the staff to pull lab results off the fax and make them available for the physician team to review. She commented if the facility did not receive results via fax, they were supposed to call the entity performing the analysis and obtain copies of the results.</p> <p>3. Resident #163 was admitted on 03/24/14. Her documented diagnoses included diabetes and hypertension.</p> <p>A 03/08/15 progress note documented Resident #163 was experiencing increased confusion and hallucinations and refusing her evening medications.</p> <p>A 03/23/15 physician order started the resident on Seroquel (antipsychotic) 12.5 milligrams nightly.</p> <p>On 04/22/15 a urine sample was collected from Resident #163 to determine if a urinary tract infection (UTI) was contributing to the resident's escalation of behaviors.</p>	F 507			

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F 507	<p>Continued From page 127</p> <p>A 04/23/15 final lab report documented "multiple bacteria species present, consistent with a contaminated specimen."</p> <p>A 04/29/15 progress note documented a nurse practitioner (NP) saw Resident #163 on rounds and provided the facility with an order to redraw a UA/C & S.</p> <p>Record review revealed a 05/01/15 preliminary lab result in the resident's medical record documenting no bacteria was found in the urine sample, but abnormal levels of glucose and protein were present.</p> <p>There was no final UA/C & S lab report in the resident's medical record.</p> <p>At 12:15 PM on 05/06/15 NP #1 stated when she ordered a UA/C & S she expected the facility to obtain the final lab report and C & S data even if the preliminary lab report was not definitive for a UTI.</p> <p>At 3:18 PM on 05/07/15 the director of nursing (DON) contacted the facility's contracted lab service, and obtained a copy of a lab result which documented on 05/01/15 at 5:50 PM a final lab report was available which documented there was no bacterial growth in the urine sample collected for Resident #136.</p> <p>At 11:00 AM on 05/08/15 the assistant director of nursing (ADON) stated supervisors or hall nurses were supposed to check the fax machines a couple times a shift for things such as lab results. Once retrieved, the ADON explained the lab results were taken to the appropriate nursing station. If a nurse was not present, she</p>	F 507			

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F 507	Continued From page 128 commented the lab results were left in the "to be reviewed by nurse" box on the wall. The ADON remarked once a nurse reviewed the faxed labs, and if they were within normal limits or there were no concerns, the results were placed in the "file in medical records" box on the wall. If labs were not within normal levels or there were other concerns, the ADON stated the physician was notified immediately or the labs and concerns were placed in the physician book for the physician, NP, or physician assistant (PA) to review on their next visit. At 2:32 PM on 05/08/15 NP #1 stated when new behaviors began emerging for residents she liked to draw a UA/C & S to make sure a UTI was not causing or contributing to the behavior changes. She reported she liked to base her decision to initiate, reduce, increase, or discontinue psychotropic medications based on the final UA lab report.	F 507			
F 520 SS=H	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.	F 520		6/11/15	

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F 520	<p>Continued From page 129</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to 1) utilize its quality assurance (QA) process to resolve kitchen sanitation/cleanliness issues which were cited as deficient practice in multiple surveys and which were addressed in the facility's current QA action plan to correct problems with pest control in the facility. The facility was previously required to develop plans of correction for kitchen sanitation citations received during the 2012, 2013, and 2014 annual recertification surveys and during a 2014 complaint investigation. The facility developed a plan of correction for a pest control citation received during a 2015 complaint investigation. 2) utilize its QA process to resolve dignity issues which were cited as deficient practice during January 2015 and March 2015 complaint surveys. Findings included:</p> <p>1. This tag is cross referenced to:</p> <p>F371: Based on observation and staff interview the facility failed to clean the face of a wall fan blowing into the dish machine area where</p>	F 520	<p>F-520 QAA COMMITTEE/MEMBERSHIP</p> <p>It is the intent of the facility to fully utilize the expertise of the members of the QAA Committee to provide oversight and feedback concerning the efforts of the Maintenance, Housekeeping and Dietary staff to effect corrective actions on these citations and change daily practices to assure compliance, once achieved, is maintained.</p> <p>The audits and checklists developed to investigate and track progress with correction action at F-371 and F-469 will continue to be checked daily during routine staff meetings and other managers will be asked for input about their opinions related to progress and overall success.</p> <p>Progress with PIPs developed to bring about and assure continued compliance in the areas of F-371 and F-469 will be</p>		

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F 520	<p>Continued From page 130</p> <p>sanitized kitchenware was unloaded, failed to air dry and remove food particles from kitchenware before stacking it in storage, failed to monitor wash/rinse gauges during the operation of the dish machine, failed to clean walls/corners/floors in the kitchen, and failed to label and date opened food items.</p> <p>F469: Based on observation, resident interview, family interview, staff interview, and record review the facility failed to eradicate and contain common household pests in resident care areas, and failed to maintain cleanliness in the kitchen which was identified as the possible cause of a bug infestation.</p> <p>At 2:28 PM on 05/07/15 the district food service manager stated the facility had been without a dietary manager for approximately four months so she tried to assist the facility one or two days a week. She reported she did not conduct kitchen sanitation audits since she was in the building on a limited basis. She commented she thought the dietary employees were keeping up with the daily cleaning tasks, but there might be problems with more routine cleaning tasks such as the cleaning of walls, ovens, and baseboards.</p> <p>Review of the kitchen's daily cleaning schedule for May 2015 revealed through 05/07/15 18 assignments had not been initialed off as being completed.</p> <p>At 2:35 PM on 05/07/15 the lead cook, helping to supervise the dietary staff in the absence of a dietary manager, stated she was not told that conducting sanitation audits was a part of her job responsibilities.</p>	F 520	<p>reviewed weekly and modified as necessary to assure appropriate corrective procedures have been implemented and are being followed. Audit tools and PIPs will be reviewed daily/weekly and by the facility QA Committee monthly for at least 6 months. Additional review time will be added if audits, PIPs and validation inspections warrant.</p> <p>To the extent that this tag is a cross reference to deficiencies F-371 and F-469 listed earlier in this 2567, those responses are listed below to address the citation at F-520.</p> <p>F-371 E There were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents.</p> <p>¿ Maintenance cleaned the face of the wall fan blowing into the dish machine area and has placed it on a schedule for monthly cleaning.</p> <p>¿ Dietary Staff received in-service training on the importance of properly air drying kitchenware and assuring that the washing process has removed all food particles and kitchenware/utensils are thoroughly dry before being stacked/stored.</p> <p>¿ The booster heater for the dish machine has been adjusted to provide a constant supply of water at the proper temperature for</p>		

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F 520	<p>Continued From page 131</p> <p>At 2:43 PM on 05/08/15 the administrator stated the purpose of a QA program was to identify areas of resident care that the facility needed to improve upon, develop interventions to facilitate the improvement, utilize an audit process to evaluate the effectiveness of the interventions, and revise the proposed interventions or incorporate the successful interventions into system changes to prevent the problems from reoccurring. According to the administrator, there was not a current QA action plan in place for F371, but kitchen sanitation was the key intervention in a current QA action plan for pest control. He explained he thought kitchen sanitation issues were resolved after each survey through development and implementation of a plan of correction. The administrator commented on-going routine kitchen sanitation inspections were necessary to make sure kitchen sanitation issues remained resolved. He reported he had not done any kitchen sanitation audits himself since the summer of 2014. He stated, however, maintenance was supposed to be completing weekly pest control audits in the kitchen since this was the area of the building identified as the main source of roach infestation during a 2015 complaint investigation.</p> <p>Review of weekly pest control audits, completed by the maintenance department in the kitchen, revealed generally less live roaches were being found, but during the week of 04/13/15 through 04/17/15 audits documented, "noticed a little more insect activity." The audits documented a couple of issues in the kitchen over the past month which may have contributed to the return of roaches in the kitchen such as boxes on the floors for prolonged periods of time and dirty, sticky kitchen floors.</p>	F 520	<p>the wash and rinse cycles.</p> <ul style="list-style-type: none"> ¿ Maintenance and Dietary Staff have cleaned the walls, ceilings, corners and floors in the kitchen. ¿ Staff have labeled and dated all open food items. <p>The stated deficient practices had the potential to affect all residents of the facility.</p> <ul style="list-style-type: none"> ¿ In-service training was provided by the NHA on 5/11/15, 5/13/15, 5/18/15 and 5/19/15 for Dietary Staff covering the requirements of F-371 and the importance of thoroughly Executing the posted Daily Cleaning Schedule for the kitchen. Staff was provided copies of those documents to assure familiarity with content and requirements. ¿ In-service training was provided to Dietary Staff by the Regional Director of Dining Services on 6/5/15 and 6/10/15 covering the importance of maintaining a clean work area, following cleaning schedules and properly labeling and dating open food items. ¿ The NHA and RD each have a Kitchen Sanitation audit that will be completed according to the schedule listed below to assure continued compliance with proper Kitchen Sanitation Procedures. <p>The following procedures have been put into place to assure that proper sanitation standards are maintained in the kitchen:</p> <ul style="list-style-type: none"> ¿ The Administrator and Registered 	

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F 520	Continued From page 132 At 10:53 AM on 05/09/15 the facility's registered dietitian stated that completing kitchen sanitation audits were not part of her job responsibilities. 2. This tag is cross referenced to: F241: Based on record review, physician, resident and staff interviews, the facility allowed a resident (Resident #168) to disregard 13 of 13 sampled residents' right to be treated with dignity (Resident #39, #43, #68, #71, #78, #79, #81, #105, #129, #131, #143, #172, and #203) as evidenced by vulgar, offensive, and disruptive behaviors. The facility also did not maintain dignity for 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122, and #172) who reported facility staff were searching their belongings routinely. At 2:43 PM on 05/08/15 the administrator stated the purpose of a QA program was to identify areas of resident care that the facility needed to improve upon, develop interventions to facilitate the improvement, utilize an audit process to evaluate the effectiveness of the interventions, and revise the proposed interventions or incorporate the successful interventions into system changes to prevent the problems from reoccurring.	F 520	Dietician each have specific dietary sanitation audits that Will be performed as follows: 1.Weekly by NHA for 12 months (June 2015 ¿ May 2016) 2.Weekly by the RD for 12 weeks (June ¿ August), then twice a month for the next 8 weeks (September & October) and then monthly as a matter of routine practice. Frequency is subject to revision for more frequent audits if results indicate the need but audits will be completed at least monthly. ¿ Housekeeping staff will perform a deep cleaning of the kitchen floor at least monthly to be inspected by the NHA to following day ¿ if not to standards, service to be repeated within 48-hours. ¿ Staff has been provided with a comprehensive Daily Cleaning Schedule that details the areas of cleaning responsibility for staff on each shift by shift assignment. ¿ Administration will take appropriate action with and dietary employees who fail to follow the cleaning schedule to include additional training, disciplinary action and termination if warranted. Sanitation Checklists and the completed Staff Cleaning Assignments Checklist will be reviewed by the facility QAPI Committee monthly for 6 months and the review period may be extended based on		

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F 520	Continued From page 133	F 520	<p>results and progress with sanitation improvement and maintenance of acceptable levels of sanitation and the PIP plan will be updated as necessary to address any continuing systemic problems.</p> <p>Date √ 6/11/15</p> <p>F-469 PEST CONTROL PROGRAM</p> <p>Residents #69, #86, #179, #49, #168, #106, and #27 were identified to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> √ Resident #168 has been discharged from the facility effective 5/21/15. √ Resident #49 - resident's room was deep cleaned and family agreed to remove a wardrobe containing VCR tapes and cardboard boxes which was found to be infested with roaches. Resident #49's room is on a list to be checked daily to assure the pest problem is being controlled. √ Resident #69 √ cleaned room and treated by Arrest-A-Pest √ room is on the list to be monitored √ Resident #86 √ cleaned room (behind wardrobe) and treated by Arrest-A-Pest √ room is on the list to be monitored √ Resident #179 √ cleaned room (behind wardrobe) and treated by Arrest-A-Pest √ room is on the list to be monitored √ Resident #106 √ cleaned room and treated by Arrest-A-Pest √ room is on the list to be monitored √ Resident #27 √ cleaned room and treated by Arrest-A-Pest √ room is on the 		

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F 520	Continued From page 134	F 520	<p>list to be monitored</p> <p>All residents have the potential to be affected by the deficient practice. Maintenance Staff and Housekeeping Staff have been addressing the pest control program on several levels:</p> <ul style="list-style-type: none"> ¿ Facility utilizes a work order system that encourages any staff member to report an issue with pest activity ¿ the reports are logged by administration and promptly delivered to maintenance and or housekeeping for corrective action; ¿ Maintenance and Social Services have developed a list of problematic rooms and have been making contact with family members to remove any un-necessary items that are stored directly on the floor or prohibit free movement of housekeeping staff in patient care areas; ¿ Maintenance is working with the new pest control company, Arrest-A-Pest, to assure problem areas are treated as often as necessary and to assure we are provided with a written status report following their visit to assist with our follow up activities. ¿ Kitchen sanitation is key to overall facility pest control and the following measures have been implemented to achieve acceptable levels of sanitation in the kitchen work and storage areas: 		

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F 520	Continued From page 135	F 520	<p>1.The Administrator and Registered Dietician each have specific dietary sanitation audits that will be performed as follows:</p> <p>2.Weekly by NHA for 12 months (June 2015 ¿ May 2016)</p> <p>3.Weekly by the RD for 12 weeks (June ¿ August), then twice a month for the next 8 weeks (September & October) and then monthly as a matter of routine practice. Frequency is subject to revision for more frequent audits if results indicate the need but audits will be completed at least monthly.</p> <p>¿ Housekeeping staff will perform a deep cleaning of the kitchen floor at least monthly to be inspected by the NHA to following day ¿ if not to standards, service to be repeated within 48-hours.</p> <p>¿ Staff has been provided with a comprehensive Daily Cleaning Schedule that details the areas of cleaning responsibility for staff on each shift by shift assignment.</p> <p>¿ Administration will take appropriate action with and dietary employees who fail to follow the cleaning schedule to include additional training, disciplinary action and termination if warranted.</p> <p>Staff is encouraged to report pest activity so maintenance and housekeeping personnel can address and correct the concern. The Maintenance Director will</p>		

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F 520	Continued From page 136	F 520	<p>verify effectiveness of the Dietary Cleaning Schedule weekly for 6 months.</p> <p>¿ The Company¿s Property Manager visited the facility on June 1 & 2 to thoroughly review areas in the kitchen and other areas in the center for unsealed penetrations and any other areas that might be an avenue for pest access to the building.</p> <p>¿ Maintenance will be conducting a series of audits to monitor pest control activity in the Dietary Department and the general facility through the remainder of 2015. Initial audits will be daily x 5 days/week for 8 weeks; Three times a week (Mon-Wed-Fri) for 8 weeks; and then weekly for 12 weeks. Findings are discussed daily at the morning staff meeting. Any evidence of increased pest activity will result in reverting back to the previous level of audits.</p> <p>¿ Maintenance staff is rounding in the facility after hours (10 PM and Later) Monday ¿ Friday to identify any areas with pest activity. The after- hours visits will continue for 60 days (through July 31) with an option for extension if observations warrant.</p> <p>¿ The Arrest-A-Pest staff will be making visits to the facility 2 times a month for the next 2 months (through July 31) to treat specific areas identified by audit</p>		

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F 520	Continued From page 137	F 520	activity. Facility Administrator in conjunction with Maintenance Director and Housekeeping Supervisor and Dietary staff will design a PIP to assure the elements of the POC at F-371 and F-469 are incorporated into a program that establishes accountability and responsibility for executing an effective Pest Control Program. Maintenance Director will report findings and recommendations to the facility QAPI committee for a minimum of 4 months.		