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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHABILITATION AND CARE	POST OFFICE BOX 248 BURNSVILLE, NC 28714

(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=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to promote privacy during care for 1 of 2 residents observed during blood sugar checks and insulin injections. Nursing staff checked Resident #75's blood sugar level and injected her with insulin while in the	F 164	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. 1. Nurse #1 received written education upon notification of occurrence immediately. DON and ADON began immediate in-servicing for all licensed nurses to ensure compliance with policy of obtaining a blood glucose specimen and giving insulin in a resident room or private area were met. Mandatory in-service was held 7/15/15 for all staff. As of 7/21/15 all current licensed nurses have been provided with education on policy and procedures related to this deficiency. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All residents who require blood glucose monitoring were identified as having the potential to be affected.	8/7/15

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

Administrator 8-14-15

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	Continued From page 1 dining room at a table with 2 other residents during a meal. The findings included: Resident #75 was admitted to the facility on 04/11/11 with a diagnosis of Diabetes and Alzheimer's Disease. The significant change Minimum Data Set dated 05/01/15 coded her with long and short term memory impairment and moderately impaired decision making abilities. On 07/08/15 at 7:32 AM observations were made of the dining service in the secured unit. Nurse #1 entered with blood sugar glucometer and supplies and approached Resident #75 who was seated at a table with 2 other residents. Nurse #1 proceeded to try to check Resident #75's blood sugar via finger stick unsuccessfully. She then returned with more supplies and was successful in obtaining blood sugar readings. Nurse # 1 then stated she would return with insulin. While the nurse was gone, all 3 residents, at the table were served and began eating their breakfast trays. On 07/08/15 Nurse #1 reentered the dining room and proceeded to inject insulin in Resident #75's left stomach area as she ate her meal and with 2 other residents at the table. On 07/08/15 at 7:50 AM, Nurse #1 stated during interview that she always checked the blood sugar and gave insulin to Resident #75 in the dining room. She further stated that Resident #75 was hard to track down so she did these tasks as she found Resident #75 usually in the dining room. Nurse #1 stated that she was taught to move the resident to a private area for blood	F 164	3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: The DON/ ADON will conduct audit involving both nursing personnel and residents who receive glucose monitoring to ensure licensed nursing staff is following policy and procedure for proper technique for obtaining blood glucose specimen and administering insulin while providing privacy for the resident. Results of the audit will be taken to QA meeting to evaluate compliance. Audits will be conducted random audits for 1 persons involving both the nurse obtaining glucose specimen or giving insulin and the resident involved to ensure policy is followed and privacy is met, 3x week for 4 weeks, weekly x 4 weeks then monthly x 3 to ensure compliance is met. Each licensed nurse hired here after will be provided with signed education in regard to policy of obtaining blood glucose specimen and providing privacy to ensure compliance.	

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F 164	Continued From page 2 sugar checks and insulin injections. During interview with the Director of Nursing on 07/08/15 at 3:47 PM, she stated she expected the nurse to remove Resident #75 from the dining room to a private area to check her blood sugar and inject insulin.	F 164	4. The results of compliance will be reviewed every month x 3 months at the monthly QA meeting then quarterly at Quality Assurance Committee Meeting until resolved. The DON/ADON is responsible for overall compliance.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to check 2 of 5 sampled staff references per their abuse policy. (Nurse #5 and Nurse Aide #6). The findings included: The facility's abuse policy, revised 05/01/14, included under "Process" the area of screening. Under the area of screening, the policy stated: 1. Screening all potential employees for a history of abuse, neglect or mistreating residents during the hiring process will consist of but will not be limited to "c. Reference checks from previous and/or current employers" and 2. Include in the documentation the date, name and title of person contacted for reference, and the name of person obtaining the reference. File with other employee records.	F 226	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. F-226 1. Employees that had been identified as not having reference checks done will be completed by august 1st, 2015. No negative outcomes were identified. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: In-service provided to persons directly involved with the hiring process regarding reference check	8/7/15

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F 226	Continued From page 3 This policy was not followed as evidenced by: a. Review of the personnel file for Nurse Aide (NA) #6 revealed she gave 2 references with phone numbers on her application dated 02/05/15. The reference sheet in the application for staff to complete was totally blank. The personnel file did not have any evidence either of the references were checked prior to or since her date of hire on 03/10/15. b. Review of personnel file for Nurse #5 revealed she gave 2 references with phone numbers on her application dated 04/27/15. The reference sheet in the application for staff to complete was totally blank. The personnel file did not have any evidence either of the references were checked prior to or since her date of hire on 05/05/15. On 07/09/15 at 1:42 PM the Director of Nursing (DON) was interviewed. DON stated that references used to be checked by the Staff Development Coordinator who was no longer employed by the facility. DON stated the previous administrator abolished this position and responsibilities for checking references fell to the DON. DON stated that reference checks should be documented on the employees application. DON stated that some of the reference checks were not done and this responsibility just got dropped.	F 226	requirements. Newly hired employee reference checks and files audits will be conducted by Administrative Assistant to ensure that all employment references are completed by August 7th, 2015. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: all new hires will be checked for completion of references before the first day of employment by administrative assistant. 4. At the end of every month a complete audit of each months new hires will be reported to our monthly Quality Assurance committee meeting for review. This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 4 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain the dignity for 1 of 3 residents sampled for dignity by adequately supervising residents during dining. (Resident #96). The findings included: Resident #96 was admitted to the facility on 09/21/13. Her diagnoses included aphasia, cerebral vascular accident, and subarachnoid hemorrhage. Her most recent Minimum Data Set (MDS) dated 05/01/15 coded her with sometimes understanding and sometimes being understood, having no speech, having long and short term memory impairments and moderately impaired decision making skills, and requiring extensive assistance with eating. Resident #19 was admitted to the facility on 04/21/14 with diagnoses including Alzheimer's Disease, dementia with behaviors, and obsessive compulsive disorder. His most recent MDS, a quarterly dated 06/12/15 coded him with long and short term memory impairment, decision making problems in new situations only and requiring supervision and set up with eating. Resident #19 was ordered double portions of pureed meals. Resident #19 was observed removing food from Resident #96's trays as follows:	F 241	1. Corrective action for the residents found to have been affected by the alleged deficient practice. Resident # 19 was monitored during meal times to ensure that food was not being removed from the tray of other diners. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All fellow diners have potential to be affected. No negative outcomes were identified. All residents monitored and assessed for potential behaviors that could affect the dining process. Meal times have been audited with resident having not taken food from fellow diners' meal trays. 3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are: DON/ADON will in service dietary, nursing and C.N.A staff members on policy and procedures for dining room trends to include but no limited to hand hygiene, infection control cross contamination prevention. A	8/7/15

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F 241	Continued From page 5 a. On 07/06/15 at 5:28 PM, observations were made of the dining experience of residents in the secured unit. This dining room contained 2 tables and an overbed table at which residents sat for their meals. The first tray was served to Resident #19 at 5:38 PM. Resident #19 received a pureed tray with orange sherbet. Resident #96 was seating at the same table adjacent to Resident #19's right side and was the second resident to be served in the dining room. Resident #96 was served a regular mechanical soft diet including a sandwich and pie. Both residents were eating independently. On 07/06/15 at 5:43 PM, the surveyor noticed Resident #19 eating pie with his fingers and Resident #96 scraping her almost empty pie plate with her fork. Then the surveyor observed Resident #19 reach over and very quickly take the top slice of bread off of Residents #96's sandwich and start eating it. The surveyor brought this to the attention of staff whose backs were turned away from this table. NA #7 responded and removed the bread from Resident #19's hand. NA #7 stated at this time Resident #19 always received his tray first due to taking food off other's trays. Resident #19 left the dining room at 5:47 PM. Resident #96 continued to eat the remainder of her sandwich which was not removed by staff. Resident #96 left the dining room at 6:07 PM after eating 100 percent and never receiving any more pie or another sandwich. On 07/06/15 at 6:28 PM, NA #5 was interviewed. NA #7 stated she had to ask the kitchen to bring more sandwiches and more deserts. She further stated that since she was the only staff in the dining room, she was unable to obtain the extra	F 241	new system was implemented for dining room service for residents residing in the cottages. Residents are now offered dining services in the main dining room to be closely monitored and minimize reoccurrence of infection control issues during meals. Resident # 19 is seated at a table out of arms reach of other diners to minimize the potential to grab food from other residents meal trays. DON/ADON will conduct documented audits to monitor that staff are following policy for meal times through direct random observation. This will be monitored 3x week for 4 weeks, then weekly x 4 weeks then monthly till compliance is established. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed.	

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F 241	Continued From page 6 food herself and had to wait on the kitchen to bring the extra food. NA #7 further explained that Resident #19 was bad about taking food from other resident's plates but that since she was in the room alone, she was unable to see everything when she had her back turned when assisting another resident. She gave no reason for not removing Resident #96's contaminated sandwich. No additional deserts or sandwiches arrived by 6:32 PM. b. On 07/08/15 at 7:32 PM observations were made of the dining experience in the secured unit. At 7:38 AM, Resident #96 was served her tray of eggs and biscuits and gravy. She was seated at the same table, adjacent to Resident #19's left side. Resident #19 was already in the process of eating his pureed meal when Resident #96 was served. On 07/08/15 at 7:40 AM, Resident #19, finished with his meal, reached over and quickly grabbed a biscuit off of Resident #96's plate. The surveyor alerted staff who was able to remove the biscuit from Resident #19 after he consumed half of it. NA #6 removed the plate from Resident #96, requested another plate and Resident #19 left the dining room at 7:46 AM. On 07/08/15 at 11:29 AM, NA #8 was interviewed. She stated that Resident #19 ate very fast and was on a pureed diet so it was scary when he took regular textured food off other residents' trays. She stated she had alerted nurses to the fact that he eats off other's trays, which was why he was always served first. She further stated that there was only one nurse aide to watch residents in the secured hall's dining room. On 07/08/15 at 3:50 PM, the Director of Nursing (DON) stated during interview that she expected	F 241	4. Results of compliance will be reviewed monthly x3 at the QA meeting and then quarterly until compliance is established.	

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F 241	Continued From page 7 that when food was taken off a resident's plate by another resident, staff would intervene and replace the contaminated plate. She further stated that if a resident was known to exhibit this behavior, interventions could include staff adjusting a resident's seating placement, getting a tray earlier, making sure there was enough staff to supervise adequately and care planning the interventions. DON stated she was not aware that Resident #19 exhibited behaviors of taking food from another resident's plate but stated Resident #96 had been known to take food from other residents.	F 241	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review, resident interview and staff interview, the facility failed to allow 1 of 5 residents sampled for choices the option to smoke independently per his safe smoking assessment. (Resident #93). The finding included: The facility's Smoking Policy dated effective 02/07/14 included: *"All residents will be able to smoke at 6:30 AM,	F 242	F-242 1. Resident #93 was reassessed for safe smoking practices. All other residents who smoke were also reassessed for safe smoking practices and care plans updated accordingly. All residents were identified at risk and will be supervised by staff members at designated times. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All residents who smoke have the potential to be affected. All current residing residents signed compliance with current smoking policy. Audits have been implemented to ensure each	8/7/15

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F 242	Continued From page 8 10 AM, 1 PM, 4 PM, and 7 PM. No smoking will be permitted outside of these designated smoking times."; *"Each smoking session will last 20 minutes."; *"All smokers will wear a smoking apron."; *"Residents will be allowed to smoke two cigarettes during this time."; *"Staff members will be present with the smokers during this time."; and *"Staff members will light all cigarettes." Resident #93 was admitted to the facility on 07/22/14. His diagnoses included acute chronic respiratory failure, sepsis, cellulitis of the leg, venous insufficiency and lower extremity paralysis. The last 2 quarterly Minimum Data Sets dated 02/12/15 and 05/07/15 coded him as being cognitively intact, having no delirium, rejecting care, being independent with locomotion, and eating with set up only, and having no upper extremity impairments. A Smoking Safety Evaluation dated 05/07/15 noted Resident #93 had intact long and short term memory, was able to make decisions regarding tasks of daily living, was able to make himself understood, and was able to verbalize understanding of the smoking policy. The evaluation noted Resident #93 demonstrated the ability to hold a cigarette safely, light a cigarette safely, maintain control of a cigarette, use an ashtray appropriately, and to independently extinguish a cigarette. He was also noted to demonstrate no burns to self or clothing related to smoking. The evaluation further noted he was compliant with keeping smoking materials at the nurses' station, used oxygen, was able to	F 242	new admit will be aware of smoking policy at time of admission. Smoking assessments will be completed upon admission and evaluated by nursing administration to determine safety. 3. Audit for smoking assessments complete and updated. DON/ADON will audit new admissions x3 months to monitor compliance. 4. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and them quarterly in QA meeting. Changes will be made accordingly to meet and ensure compliance policies and care plans.	

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F 242	Continued From page 9 demonstrate and/or verbalize the need to remove oxygen prior to smoking and communicate and acknowledge the understood that distribution of smoking materials to any other resident was a violation of the facility's smoking policy and procedure. Although thee were no negatives noted relating to Resident #93's ability to smoke safely, he was marked needing supervision and requiring staff to light the cigarette and/or remain in attendance while the cigarette was burning. Interventions included a smoking apron, direct observation by staff and smoking materials maintained by staff. Resident #93 was observed smoking with a group of other residents under staff supervision on 07/07/15 at 1:12 PM and 07/08/15 at 9:57 AM. Resident #93 was observed in his wheelchair and wore a smoking apron while smoking. When he was finished smoking his cigarette, he was observed handing the butt to the staff on duty for disposal as the only ashtray was a tubular cigarette butt dispenser out of his reach. On 07/08/15 at 12:05 PM Nurse Aide #9 stated that all cigarettes were kept at the nursing station and everyone who smoked was required to wear an apron and be supervised. The Director of Nursing (DON) was interviewed on 07/08/15 at 3:04 PM regarding the smoking policy. She stated a smoking assessment was completed on admission by the nurse on hall. There were specific times designated for smoking and no resident was permitted to smoke at other times, without supervision or without an smoking apron. She explained that the facility was discussing going smoke free under the direction of the previous administrator but decided not to	F 242		

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F 242	Continued From page 10 go smoke free. DON further stated management subsequently decided it was safest to make sure no resident smoked alone, without an apron, or at other times than designated no matter what the results of the smoking assessment indicated. The policy dated 02/07/14 was then developed by the management team as the previous administrator had informed them it was a resident privilege not a resident necessity to smoke. On 07/08/15 at 3:36 PM, Resident #93 stated during interview that he was only permitted to smoke at designated smoking times and had to wear an apron. He further stated that if he was allowed, he would like to be able to smoke independently when he desired.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain guardianship for 1 of 1 resident sampled for social service needs. (Resident #38). The findings included: Resident #38 was admitted to the facility on 8/3/11 with diagnoses including stroke, cerebral degeneration, seizures, anxiety and	F 250	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	

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F 250	Continued From page 11 schizophrenia. Review of a letter from the primary care physician dated 11/14/11 indicated Resident #38 should have guardianship by (name of county) Department of Social Services (DSS) due to mental diagnosis, unable to complete a cognitive assessment and the date of incompetency was unknown. There were no social worker's notes for review regarding guardianship. The face sheet contact information listed Resident #38 as his own responsible party. There were no contact names or numbers for this resident. Social Services notes included 5/7/14 for Brief Interview for Mental Status with a score of 7. A score of 0 to 7 indicated severely impaired decision making skills. Physician note dated 5/29/15 indicated the resident was a long term resident of facility with schizophrenia, seizure disorder and resided in the locked unit. No changes in cognition were noted. "Past Medical History: Patient has a note in his chart saying that due to his schizophrenia and is unable to make basic self care decisions. A request was made to DSS to see part guardianship as there was no known family to take responsibility for his care ....Psychiatric: mood and affect are normal. Judgment/insight: Poor." Review of the "Nursing Evaluation" dated 6/10/15 indicated the resident was awake, alert, oriented to person. He was unable to cognitively participate in a vision assessment. Behaviors were listed as resists care and history of wandering. Cognitive/Communication was	F 250	F-250 1. Corrective action for the residents found to have been affected by the alleged deficient practice. Resident #38 will have guardianship applied for by August 1, 2015 and Social Service Director to follow up until obtained. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: Social Service director to audit all current residents to check if any doctor's orders have been missed regarding guardianship by August 7, 2015. 3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are: New admissions, will be audited by social services director in a timely manner. A resident who does not appear competent to the social worker upon initial meeting and does not have family, POA, or a guardian will have a petition for guardianship submitted to the clerk of court by the social	8/7/15

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F 250	Continued From page 12 assessed as "Moderate/severe Decision Making and Comprehension/Communication problems." Review of the Minimum Data Set (MDS) dated 6/15/15 indicated Resident #38 was assessed under communication he rarely/never was able to understand. The MDS nurse was unable to do interview for cognition and memory. The MDS indicated he had long/short term memory impairment and severe impairment for decision making abilities. The MDS indicated no moods or behaviors were exhibited during this assessment time frame. The care plan dated 6/24/15 for problems of cognition/communication included he had both long and short term memory problems. He could not verbalize his needs consistently and his needs had to be anticipated by staff. He was able to verbally communicate but not consistently and when he did it was very short one word answers. Approaches included he would have needs met daily and staff were to repeat instructions as needed and allow him time to process what has been said, offer simple choices, provide cues, redirection and reminders as needed. Staff were to monitor body language and facial expressions for needs. The onset of this problem was 8/17/11. On 07/08/2015 at 3:39 PM an interview was conducted with the interim administrator. During the interview it was explained a request for guardianship had been made 4 years ago and he was not aware of the request as an interim. The normal process to obtain guardianship by DSS would include the social worker contacting DSS and begin the paperwork necessary. The administrator explained he was not here and	F 250	worker. During the quarterly assessment of all resident assessments will be checked for need of guardianship by MDS department. If needed; social services director will be responsible for obtaining guardianship. 4. During the monthly QA meeting, Social Service Director will report all guardianships they have obtained during the previous month. This audit will be in place x 3 months.	

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F 250	Continued From page 13 could not attest to what might have happened in this situation. Interview with the social worker on 07/08/2015 at 8:47 AM revealed the facility was aware the guardianship was needed for Resident #38. The social worker explained he had known since he started work at the facility in 2013. Further interview revealed Resident #38 has had a decline and he did not know why DSS had not obtained guardianship. The social worker explained it was probably something he should have followed up on. The social worker would initiate the guardianship, with some kind of form to be filled out. Interview on 07/08/2015 at 8:53 AM with Nurse #1 revealed the face sheet would inform her of a contact or responsible party for Resident #38. Nurse #1 checked the face sheet and stated the resident was his own responsible party. If there was a change in condition or orders she would not call anyone.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to make repairs to walls and baseboards, repair constant dripping water faucet, replace a burnt out light bulb and clean a soiled privacy curtain on 3 of 4 halls. (Long hall,	F 253	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	

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F 253	Continued From page 14 Short hall and Annex hall) The findings included: The following observations were made on 07/06/15 and 07/07/15 during day 1 and day 2 of the survey: a. Room 401 - hot water constantly dripping from water faucet. b. Room 408 - hot water constantly dripping from water faucet. c. Room 420 - sheet rock peeling on corner wall at the right side of the bathroom door with a 3 foot strip loose from the wall. d. Room 422 - the corner of the wall on the left side of the bathroom door has a 14 inch strip of paint and sheet rock loose from the wall and the corner baseboard has a 3 inch x 3 inch piece missing. A section on the bathroom wall beside the toilet has sheet rock and paint missing approximately 4 inch x 4 inch in size. e. Room 437 - caulking around toilet missing and tile around toilet stained dark yellow. Toilet is loose and slightly moves from the floor. f. Room 441 - soap dispenser off the wall and on the sink in the bathroom exposing 6 screw holes in the wall where the soap dispenser was. g. Room 445 - the light fixture over the bed A was very dim and noted to have a burnt out light bulb. h. Room 445 - privacy curtain by bed B was soiled with a brown substance. An interview with Nurse #3 on 07/09/15 at 1:50 PM revealed that clip boards are located at each nurse's station with maintenance request forms and any time that repairs are needed by the maintenance department available for any staff to fill out the form. The maintenance staff check the boards each morning and several times through the day. If it needs quick attention the	F 253	F- 253 1. Corrective action for the residents found to have been affected by the alleged deficient practice. All issues identified in rooms 401, 408, 420, 422, 437, 441, and 445 were repaired by in house maintenance staff on or before July 30, 2015. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: Maintenance staff will do an audit for similar items that might need repairing or replaced by August 7, 2015. All noted items will be repaired, replaced or ordered for replacement by August 7, 2015. 3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are: Maintenance department will conduct weekly room audits and document any items identified to have need for repair or replacement and make repairs as needed on a continuous weekly basis.	8/7/15

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F 253	Continued From page 15 maintenance staff are paged and if it is after hours and can't wait until the next morning then maintenance staff is notified by phone. During an interview with Nurse Aide #10 on 07/09/15 at 3:50 PM indicated that if any equipment needs repaired or there was any concern with a resident room, a maintenance requisition form was filled out. The forms were kept at the nurse's station. If it was urgent then maintenance staff was called. During a second observation with the Maintenance Director on 07/10/15 at 8:30 AM revealed the following: a. Room 401 - maintenance was not aware of the dripping water faucet and indicated that it would be fixed today. He ordered 4 faucets per month and tries to replace the old faucets. b. Room 408 - maintenance was not aware of the dripping water faucet and indicated that it would be fixed today. He ordered 4 faucets per month and tries to replace the old faucets. c. Room 420 - the 3 foot strip of wall paper loose from the corner wall was observed to be repaired and covered with joint compound, but not painted. d. Room 422 - the 14 inch strip of paint on the left side of the bathroom door was noted to be repaired and covered with joint compound, but not painted. The corner baseboard was missing as was the sheet rock and paint in the bathroom beside the toilet. e. Room 437 - the caulking around the toilet was missing and tile around the toilet stained. The Maintenance Director indicated that he was aware and planned to add new caulking and Clorox around the toilet. f. Room 441 - a new soap dispenser was	F 253		

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F 253	Continued From page 16 observed to be placed on the wall. The maintenance director indicated that a new dispenser was placed on the wall 2 days ago. The screw holes remained on the wall. g. Room 445 - a light fixture above the bed A was confirmed by the maintenance director to have a burnt out light bulb and he indicated that he was not aware the bulb was burnt out and will replace it today h. Room 445 - the privacy curtain by bed B was observed to be soiled with a brown substance, the maintenance director indicated that he was not aware of the soiled privacy curtain and will have it cleaned today. An interview with the Maintenance Director on 07/10/15 at 8:50 AM revealed that he did not have a process to do room checks for repairs. He depended on the staff to communicate by the maintenance requisition forms. He further indicated that he tried to check rooms at least once a week to identify needed repairs. He checked maintenance request forms each morning and several time during the day.	F 253	4. All weekly room audits will be forwarded to the monthly QA meeting. This audit will be in place x 3 months. And then quarterly thereafter to ensure repairs are being conducted.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	

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F 280	Continued From page 17 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan for the use of a splint for 1 of 1 sampled resident with a splinting device. (Resident #22). The findings included: Resident #22 was admitted to the facility on 4/26/10 with diagnosis including Alzheimer's disease and Paralysis Agitans. The Occupational Therapy (OT) discharge summary dated 07/23/14 revealed "the splint would be administered and monitored by Restorative Nursing and to be worn up to 5 hours. Education provided on splint use, wearing schedule, skin inspection and effective monitoring of pain/discomfort in preparation for discharge from skilled services. Recommendations were for splint/orthotic recommendations: 5 hours a day/gradual increase up to 8 hours if patient can tolerate; continued gentle stretch with warm water baths as needed (Depending on stiffness) prior to splint use. " The annual Minimum Data Set (MDS) dated	F 280	1. The physician orders and care plan were reviewed for Resident #22 and updated to ensure the care plan matches the current physician orders. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All residents with splinting devices have the potential to be affected. No negative outcomes were identified. Physician orders and care plans have been audited for those with a splinting device to ensure accuracy. Licensed and unlicensed staff has been educated on physician's orders and following the care plans and Kardex to ensure all nursing staff are following physician orders. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: All staff was educated 7/15/15 to provide splinting and following physician orders as indicated. DON/ADON will monitor physician orders against care plans and Kardex weekly x 4 weeks and monthly thereafter until compliance is met. Results will be reviewed in QA. DON/ADON will audit splint placement 3x week for 4 weeks then weekly x4 weeks, then monthly till	8/7/15

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F 280	Continued From page 18 05/12/15 indicated Resident #22 required total care with activities of daily living (ADLs), had functional limitation in range of motion to bilateral upper and lower extremities. The MDS assessed Resident #22 with severe impairment of cognition and memory. The care plan originally dated 07/14/14 included the following problems: ADLs/mobility, required total assistance of 2 staff for ADLs and bilateral upper and lower contractures. Resident #22 was at risk for contractures worsening. The stated goal was for contractures to not worsen. The approaches included for Dynamic splint to be applied to the right hand 3 hours per day. Remove the splint if any pain noted with use. An update to the care plan with a date of 09/4/14 indicated the splint would be applied in the AM and off in the PM. The most recent update was on 05/26/15 to "const POC" (continue Plan of Care). Review of the monthly physician's orders for June 2015 indicated Resident #22 was to wear the dynamic splint to the right hand 5 hours a day. Take the splint off if any signs/symptoms of pain. The initial order date was 07/14/14. Interview conducted on 07/08/2015 at 9:17 AM with restorative aide #1 revealed she provided range of motion to the upper extremities. A splint was applied to the left hand and worn about 5 hours. Further interview revealed the restorative aides worked 7 days a week for 8 hours. Interview with the MDS nurse on 07/09/2015 at 10:05 AM revealed the Care Area Assessment dated 5/12/15 included impairment of both sides for ROM limitation upper and lower extremity.	F 280	compliance is met. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and then quarterly in QA meeting till compliance is established. Changes will be made accordingly to meet and ensure compliance with physician orders and care plans.	

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F 280	Continued From page 19 These were completed for contractures and a decision made to proceed to care plan with restorative to provide care and services. The orders were reviewed with the MDS nurse for wear time of the splint and compared to the care plan. The MDS nurse explained the restorative nurse updated the care plan for the splint wear time of "on in AM and off in PM." Further interview revealed the physician's order was for 5 hours wear time and progress to 8 hours as tolerated. On 07/10/2015 at 8:19 AM an interview was conducted with the restorative nurse supervisor. During the interview she explained plan from OT was for the splint to be worn 5 hours, and could go to 8 hours. The restorative aide or the evening aide/nurse would remove the splint. The restorative nurse supervisor did not have documentation for the time the splint was applied and removed. She was not able to verify if the splint was increased to 8 hours wearing time. Further interview revealed the care plan was not according to the plan from OT with the amount of time the splint should be worn. Interview on 07/10/2015 at 8:40 AM an interview was conducted with restorative aide #1. During the interview she explained she would apply Resident #22's splint usually after breakfast. Further interview revealed she did not have a set time to apply the splint and did not document the time. The splint was to be progressive from 5 hours to 8 hours if the resident could tolerate it. She did not know how long Resident #22 was wearing the splint this week.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 20 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the care plan interventions to prevent choking for 1 of 1 resident sampled for the need for adaptive eating equipment. (Resident #96). The findings included: Resident #96 was admitted to the facility on 09/21/13. Her diagnoses included aphasia, cerebral vascular accident, and subarachnoid hemorrhage. Resident #96's annual Minimum Data Set dated 08/26/14 coded her as having long and short term memory impairments, severely impaired decision making skills, requiring set up and supervision for eating and having no swallowing problems. ST evaluated Resident #96 on 11/19/14 for dysphagia and began treatment. One of the short term goals was for the resident to participate in a feeding modification program to increase the use of compensatory strategies via physical cues (small/single boluses, double swallows, alternate consistencies) to eliminate overfilling of oral cavity and clear oral residue. A diet order and communication sheet dated 12/02/14 signed the ST revealed the need for	F 282	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. Resident # 96 was monitored during meal times to ensure that bowls were present for meal times and that staff were following the care plan and placing food in bowls for consumption to reduce risk of aspiration and or adverse events. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All residents receiving adaptive/assistive dining utensils have the potential to be affected. NO negative outcomes were identified. Meal times have been audited. Bowls were noted to be present and staff utilizing them appropriately. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: Dietary and nursing staff has been re- educated to provide bowls with meals and	8/7/15

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F 282	Continued From page 21 adaptive equipment of placing an extra empty bowl and empty cup on the tray. A care plan was developed on 12/03/14 to address the problem of packing food in her mouth during meals to the point of vomiting and placing her at risk for aspiration. The goal was to have no signs or symptoms of aspiration. Interventions included: *during meals supervise her and cue her to take small bite; *give fluid after she swallows a bite; *during meals put one large bite in an bowl and give it to her and allow her to eat. take the bowl back and add another bite to bowl and continue this process until she completes the meal or is finished eating. ST discharged Resident #96 on 01/14/15 with recommendation for a mechanical soft/chopped meats, mechanical soft/ground textures, thin liquids by cup and by straw, sitting in upright position, small single boluses, presented one at a time in separate bowl/cup, double swallows, until buccal cavity and oral residue are cleared, and to alternate consistencies as needed to clear residue. Close supervision was also recommended. The quarterly Minimum Data Sets, dated 02/09/15 and 05/01/15, coded Resident #96 with having no speech, sometimes being understood and sometimes understanding, having long and short term memory impairments, having moderately impaired decision making skills, and requiring extensive assistance of one person for eating. The care plan related to aspiration risk was last	F 282	ensure staff are using them accordingly. DON/ADON will audit for placement of bowls and appropriate usage 3x a week for 4 weeks, then weekly x4 weeks and then monthly until compliance is met. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4. Audits will be reviewed by QA committee members monthly x 3 months and then quarterly till compliance is established. Changes will be made accordingly to meet and ensure compliance with providing and using bowls for meal times.	

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F 282	Continued From page 22 reviewed 05/15/15 and the interventions listed above which included small boluses in a separate bowl/cup remained in effect. Review of the Activities of Daily Living Care book, maintained for easy review of resident care by the nurse aides, revealed a separate undated hand written note which stated "Attention" with the instructions for staff that during meals put one large bite in an empty bowl, hand the bowl to the resident and let her eat the bite, take the bowl back and add another bite to bowl and continue this until she completes the meal or no longer wants to eat. Resident #96 was observed during the evening meal on 07/06/15. She was served at 5:38 PM. Her tray included a plate included a whole sandwich, cauliflower and a separate plate of pie. The tray card indicated an extra bowl and cup was to accompany the plate. There were no extra bowls or cups observed and food was served all at once. Resident #96 was observed feeding herself slowly at this meal. Nurse Aide #7 did encourage Resident #96 to chew her food a couple of times during the meal. Staff did not follow the plan of care to put bites of food in a bowl and serve individually. During interview with NA #7 on 07/09/15 at 5:00 PM, NA #7 stated that an extra bowl came on the resident's trays but she will only use it when she sees Resident #96 put too much food in her mouth. If it was observed toward the end of the meal, then she will cue her to slow down and chew. NA #7 stated that the resident will become anxious when the tray is removed once she starts eating and putting food in bowls after the tray has been placed in front of her became more of a hazard.	F 282		

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F 282	Continued From page 23 Resident #96 was served her breakfast in the dining room on 07/08/15 at 7:38 AM. She was served a plate containing biscuits and gravy and eggs. No extra bowls or cups were observed in use. Resident #96 was served a second replacement tray at 8:07 AM after another resident grabbed a biscuit off her plate. No additional bowls or cups were served with this second plate and the plate was placed whole in front of her. Resident #96 began eating the eggs immediately and took large spoonful after spoonful of eggs quickly, not finishing what was in her mouth before taking another bite. Resident #96 was not cued to slow down or drink between bites. After she finished all the eggs, she began to eat the biscuits and gravy. Again she took large bites and after eating one third of the biscuit, she got up and left the room without any cueing to slow down or drink after bites of food. She drank no liquids off this second tray and staff did not follow the plan of care to put bites of food in a bowl and serve individually. Nurse Aide (NA) #9 was in the room assisting the residents during this meal. On 07/08/15 at 11:53 Nurse Aide (NA) #9 was interviewed. She stated that she knew how to care for residents via word of mouth from the nurses, the medication administration records, the resident's chart or the care sheets. When asked about the tray card which included the need to place an extra bowl and cup on the tray, NA #9 stated she was not sure but staff used to put small amounts of her food in bowls in order to slow her eating down. She stated it had been about a month since she worked with the resident and she was not sure if the need to put food in bowls had changed. She stated at breakfast this date, an extra bowl did not come on the tray so she did not use the bowl that came on the noon tray.	F 282		

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F 282	Continued From page 24 On 07/08/15 at 11:37 PM, Resident #96 was served a plate of food including ground meat and gravy, potato wedges, greens and a roll. Peaches were placed in front of her at the same time in a separate bowl. An extra bowl was observed to the side of the plate, but was not used by staff or Resident #96. Staff did not separate the food in bowls per the plan of care. Resident #96 left at 11:42 AM after eating only the potatoes. Nurse Aide (NA) # 9 was in the room assisting the residents during this meal. On 07/08/15 at 11:53 Nurse Aide (NA) #9, who was serving in the dining room was interviewed. She stated that she knew how to care for residents via word of mouth from the nurses, the medication administration records, the resident's chart or the care sheets. When asked about the tray card which included the need to place an extra bowl and cup on the tray, NA #9 stated she was not sure but staff used to put small amounts of her food in bowls in order to slow her eating down. She stated it had been about a month since she worked with the resident and she was not sure if the need to put food in bowls had changed. NA #8 was interviewed on 07/08/15 at 12:27 PM. She stated the Resident #96 used to eat very fast and staff were afraid the resident would choke. NA #8 stated therapy came up with the ideas to put a scoop of food in a bowl to slow her down. NA #8 further stated that now the kitchen still sent an extra bowl but staff only serve food in the bowl if the resident is observed eating too fast. ST who worked with Resident #96 was interviewed on 07/09/15 at 4:43 PM. ST stated Resident #96 packed her mouth so full of food to	F 282		

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F 282	Continued From page 25 the point she gagged, choked and vomited. It seemed to be more behavioral than a risk for aspiration. ST stated that the resident would eat slow, take one bite at a time as long as staff sat with her and watched her, but the minute staff turned away or was not right there with the resident, Resident #96 would stuff her mouth full of food. She would not eat pureed food so the facility went back to mechanical soft foods and developed a behavior modification plan to put 1 to 2 spoons of food in a bowl and let her eat that while assisting other residents. ST further stated that the care plan was still to be in effect and staff were to use bowls and cups individually to slow the resident's eating down. She further stated she was in the dining room about a month ago and she saw staff utilizing the bowls for Resident #96. MDS Nurse stated on 07/10/15 at 9:56 AM that the care plan to place spoons of food in bowls and serve it individually to Resident #96 was still a current intervention to be followed by direct care staff consistently.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	

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F 318	Continued From page 26 Based on observations, staff interviews and record review the facility failed to apply a splint and carrot device for contracture management according to the physician orders and therapy recommendations for 1 of 1 sampled resident with contractures. (Resident #22). The findings included: Resident #22 was admitted to the facility on 4/26/10 with diagnoses including Alzheimer's disease and Paralysis Agitans. The Occupation Therapy (OT) discharge summary dated 07/23/14 revealed the splint would be administered and monitored by Restorative Nursing and would be worn up to 5 hours. Education provided on splint use, wearing schedule, skin inspection and effective monitoring of pain/discomfort in preparation for discharge from skilled services. Recommendations were for splint/orthotic recommendations: " 5 hours a day/gradual increase up to 8 hours if patient can tolerate; continued gentle stretch with warm water baths as needed (Depending on stiffness) prior to splint use. " The Minimum Data Set (MDS) dated 05/12/15 indicated Resident #22 was total care with activities of daily living (ADLs), had functional limitation in range of motion to bilateral upper and lower extremities. The MDS assessed Resident #22 with severe impairment of cognition and memory. The initial care plan dated 07/14/14 included the following problems: ADLs/mobility, required total assistance of 2 staff for ADLs and bilateral upper and lower contractures. Resident #22 was at risk	F 318	1. Resident #22 was re- assessed and changes made accordingly to best meet the needs of the resident. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All resident who use splinting devices were audited for placement of splints and contracture preventing devices. Devices are in facility and are available to be meet resident needs 3. .Measures/ systems put into place to ensure the alleged deficient practice does not re occur: All nursing staff were educated on splinting types, application and removal by licensed OT personnel 7/15/15. Staffs were educated on applying, removing and adjusting according to the physician order, care plan, TAR and Kardex. All staff is aware of requirements for accurate documentation in the resident's medical records. Clarification provided to all staff of responsibility of application and removal of devices. DON/ADON will audit for device placement and	8/7/15

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F 318	Continued From page 27 for contractures worsening. The stated goal included contractures to not worsen. The approaches included a Dynamic splint to be applied to the right hand 3 hours per day. Remove the splint if any pain noted with use. An update to the care plan with a date of 09/04/14 indicated the splint would be applied in the AM and off in the PM. The most recent update was on 05/26/15 to "cont POC" (continue Plan of Care). A carrot (hand positioning device) was to be used when the splint was removed. Review of the monthly physician's orders for June 2015 indicated Resident #22 was to wear the dynamic splint to the right hand 5 hours a day. Take the splint off if any signs/symptoms of pain. A carrot splint was to be used when the dynamic splint was off and monitor every shift for placement. Review of the Medication Administration Record (MAR) for July 2015 revealed both the splint and carrot were initialed as being in use on 7-3 shift. The carrot was initialed as being in use for 3-11 shift and 11-7 shift. Observations on 07/06/2015 at 5:44 PM revealed Resident #22 did not have a splint or the carrot in his right hand. Observations on 07/07/2015 at 8:38 AM revealed Resident #22 did not have a carrot splint in his hand while seated in a gerichair at breakfast. Observations on 07/07/2015 at 10:30 AM revealed the splint was on Resident #22's right hand. Observations on 07/07/2015 at 5:00 PM revealed Resident #22 had the splint on his right hand. The wearing time for the splint would have	F 318	documentation 3x week for 4 weeks, then weekly x 4, then monthly will compliance is met. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4. Audits will be reviewed by the QA committee members for 3 months and then quarterly till compliance is met. Changes will be made accordingly to meet and ensure compliance with splints/contracture prevention devices are in place and used properly.	

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F 318	Continued From page 28 been about six and a half hours. Observations on 07/07/2015 at 12:20 PM revealed the splint was on the right hand with the pointer finger on top of the strap that goes over the knuckles of the hand and the middle finger was contracted and curled under resting on the splint. Observations on 07/08/2015 at 6:46 AM revealed Resident #22 was dressed and in a gerichair. The carrot device was not observed in his right hand. Resident #22's right hand was observed to be in a closed fist. Interview on 07/08/2015 at 9:17 AM with restorative aide #1 revealed Resident #22 received range of motion to the upper extremities. A splint was to be applied to the left hand. The splint was to be worn about five hours. The resident did not refuse to allow application of the splint. Observations on 07/08/2015 at 10:43 AM of Resident #22 revealed all of his fingers on the right hand were not under the strap to keep them straightened while wearing the splint. The thumb was secured in a separate strap. The four fingers were curled back into his hand and resting on the top of the splint. Interview with Nurse Aide (NA) # 1 on 07/08/2015 4:07 PM revealed she had not seen the resident with a splint on his right hand before. NA #1 had provided care to Resident #22 on previous dates. Continued interview revealed she was not aware if she would be responsible to remove the splint. Interview on 07/08/2015 4:09 PM with the Nurse	F 318		

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F 318	Continued From page 29 #2 responsible for Resident #22's care revealed she was working on the 3-11 shift. Further interview revealed she would have to check the treatment record for information about his splint. At the time of the interview, she was not sure who would remove the splint. She stated she would check on the splint this evening. Observations on 07/08/15 at 5:07 PM revealed Resident #22 had the splint removed and a carrot was not observed in his right hand. His hand was in a closed fist position. Observations on 07/09/2015 8:00 AM of Resident #22 revealed he was seated in a gerichair. A splint was not in use for the right hand at this observation. A carrot was not observed in the resident's right hand. Interview with NA #5 revealed the 11-7 shift got Resident #22 up in the morning. NA #5 explained Resident #22 had a splint for the right hand. Further interview revealed NA #5 was not aware of a carrot being used for the right hand for contractures. Interview on 7/9/15 at 8:15 AM with the Director of Nursing (DON), treatment nurse and Nurse #2 revealed Resident #22 did have a carrot for use in the right hand. The DON explained the restorative aide puts the splint on during the day. The aides (floor) take the splint off in the evening. Review of the physician orders with these three nurses revealed the splint was to be worn for 5 hours. It was on yesterday longer than the 5 hours. The DON responded it should be on for 5 hours. The restorative plan of care had the splint would be applied in am and off in pm. She explained that would be clarified/corrected. The	F 318		

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F 318	Continued From page 30 surveyor informed her it was documented as being done each shift as being applied. Further explanation was provided by Nurse #2 that the resident had the carrot last evening when she worked. Nurse #2 did not know if the carrot was in Resident #22's hand this morning. Further explanation provided by the DON included she would expect the orders to be carried out for the resident and the carrot applied to the hand when the splint was removed. On 07/10/2015 at 8:19 AM an interview was conducted with the Restorative Nurse Supervisor regarding the plan of care for contracture management for Resident #22. The plan from OT was for the splint to be worn 5 hours, and could go to 8 hours. The restorative aide or the evening aide/nurse would remove the splint. This nurse did not have the time the splint was applied and removed. The amount of wearing time was not known. The staff were supposed to place a carrot in his hand. Further interview revealed Resident #22's fingers were supposed to be straight (outstretched) on the splint and she was aware his (fingers) did not always stay flat on the splint. Interview on 07/10/2015 at 8:40 AM with restorative aide #1 revealed she would apply the splint usually after breakfast. The time the splint was applied and removed was not recorded. She had to work with passive range of motion for about 5 minutes to get the fingers outstretched to fit into the splint. She had found the splint applied incorrectly when it was applied by the floor staff (on 07/08/15). The splint was to be progressive from 5 hours to 8 hours wearing time if the resident could tolerate it. The splint was not applied on Monday due to restorative had to	F 318		

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F 318	Continued From page 31 obtain the monthly weights. It took both restorative aides to do the weights and there was no restorative care provided on 07/06/15. That was the reason Resident #22 was not wearing the splint on Monday (0706/15). Further interview revealed she had not seen a carrot for this resident and was not aware a carrot was to be used until this week.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to adequately supervise 1 of 2 residents sampled for smoking safety (Resident #71) and failed to identify and remove electrical hazards in 2 of 34 sampled resident rooms. (rooms 423 and 448) The findings included: 1. Resident #71 was most recently admitted to the facility on 12/12/13. Her diagnoses included acute and chronic respiratory failure, schizophrenia and dementia. Resident #71's most recent Minimum Data Set, a quarterly dated 05/20/15, coded her as having	F 323	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. All residents who smoke were re-assessed for safety abilities and care plans up dated accordingly. All oxygen tanks and accessories are now removed prior to smoking. Resident #121s room has been assessed for any dangerous electrical hazards in the room. Any issues found will be corrected by August 7th, 2015.	8/7/15

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F 323	Continued From page 32 intact cognition (scoring a 12 out of 15 on the brief interview for mental status), having no behaviors, and receiving oxygen therapy. A Smoking Safety Evaluation dated 05/20/15 indicated she had long and short term memory impairments, visual impairments, did not demonstrate the ability to light a cigarette safely, and required supervision of staff to light the cigarette and/or remain in attendance while the cigarette was burning. A care plan was last updated on 06/03/15 stating she was at risk for injury related to smoking with interventions including she may smoke under staff supervision outside in designated area at designated times and to ensure she wore a smoking apron while smoking. Intervention of continuous oxygen at 2 liters per minute. The resident's July 2015 physician orders included that oxygen may be titrated at 1 to 5 liters per minute to maintain saturation levels of 90%. On 07/08/15 at 9:57 AM Resident #71 was observed waiting in the dining room at the door to the outside smoking area, wearing oxygen via a nasal cannula. Nurse Aide (NA) #9 disconnected the oxygen tubing from the oxygen tank and then took the oxygen tank from the back of the wheelchair and placed it in the holder inside the dining room. Resident #71 then proceeded to go outside to the designated smoking area wearing the nasal cannula and tubing in her nares, as staff did not remove the tubing. Once outside, NA #9 proceeded to light the cigarette in Resident #71's mouth while the resident was still wearing the oxygen tubing in her nares. Resident #71	F 323	2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All resident who wear oxygen and smoke have the potential to be affected. All resident rooms were checked for any unsafe electrical issues, any issues found will be corrected by 8/7/2015. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: DON/ADON re-educated all staff effective date 7/21/15 if the smoking policy and expectation of removal of oxygen tanks and accessories prior to smoking. Written signature of compliance received from all staff. New employees will be educated upon hire of smoking policy and expectation to remove oxygen tanks and accessories before smoking to eliminate risk for injury. To ensure staff are removing oxygen sources prior to smoking, an audit will be implemented to ensure compliance. DON/ADON will audit smoking times to ensure proper removal and oxygen accessories 3xweek for 4	

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F 323	Continued From page 33 smoked one cigarette, while wearing the oxygen tubing, then handed the butt to staff, removed her apron and proceeded back inside the facility. On 07/08/15 at 12:05 PM NA #9 was interviewed. She stated that she often floated on the halls and that the staff that floated or completed showers generally were assigned smoking duties with the residents. She stated that she was expected to remove all oxygen tanks from residents before they went to smoke. She further stated that as far as she knew, the oxygen tubing was permitted to stay on the resident while smoking as long as the tank was removed. On 07/08/15 at 12:56 a phone interview was conducted with staff from the oxygen supply company used by the facility. The company representative stated there was "absolutely" oxygen residual in the oxygen tubing once the tank was removed and therefore the tubing should be removed from the resident's nares prior to lighting a cigarette. On 07/08/15 at 3:04 PM an interview with the Director of Nursing DON) revealed all residents had to wear aprons and be supervised during smoking. DON further stated that oxygen tanks were not permitted in the smoking area during smoking times. When asked about the removal of nasal cannulas and tubing, DON stated the tubing was to be removed from the resident's face as the tubing may still contain oxygen but that the tubing may remain in the resident's wheelchair. She further stated that she expected all sources of oxygen to be removed during smoking times and that NA #9 did not regularly take residents to smoke.	F 323	weeks, then weekly x4 weeks, then monthly until compliance is met. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. Resident rooms will be checked weekly continuously and any issues will be noted on weekly round sheets and corrected as needed. 4. Audits will be reviewed monthly for 3 months by QA committee members and then quarterly to review that all staff are compliant with removal of oxygen tanks and accessories during smoking. Weekly room round sheets will be reviewed monthly by QA committee members X 3 months and then quarterly continuously.	

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F 323	Continued From page 34 2. During an interview with Resident #121 who resided in room 423, the resident indicated on 07/07/15 at 11:46 AM that he was concerned with the electrical outlet under his TV being overloaded and on several occasions his roommate (Resident #118) had bumped the electrical cords and disconnected his TV. An observation on 07/07/15 at 11:50 AM revealed an electrical outlet under the TV in room 423 to have a multi-plug adapter plugged into the outlet holding the cords to the TV, cable box and cable adapter. All 3 devices were taped together with masking tape and held to the wall with masking tape and sticking out from the wall 4 inches. The outlet was on the right side of the closet causing Resident #118 to bump it when she would go to her closet. During an interview with both residents residing in room 423 indicated that the outlet has been that way since December of 2014 and it was reported to the Maintenance Director. An observation on 07/10/15 at 8:45 AM in room 448 revealed an electrical outlet under the TV to have a multi plug adapter plugged into the outlet holding the cords to the TV, cable box and cable adapter. All 3 devices were taped together with masking tape and held to the wall with masking tape and held to the wall with masking tape. A review of the maintenance request form dated 05/18/15 indicated that room 448 had a cable box that kept falling off the wall, maintenance indicated on the maintenance requisition form that the work done on 05/19/15 was the cable box was taped back on the wall. During an interview with the Maintenance Director on 07/10/15 at 9:00 AM revealed that the cable company was changed in December and they left him in a mess. After several attempts to get the cable company to come to the facility he has	F 323		

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F 323	Continued From page 35 started moving the cable box and cable adapters his self to the corner of the rooms and covering the cables and was starting in the empty rooms. 2. During an interview with Resident #121 that resides in room 423-A indicated on 7/7/15 at 11:46 AM that he was concerned with the electrical outlet under his TV being overloaded and on several occasions his roommate (Resident #118) had bumped the electrical cords and disconnected his TV. An observation on 7/7/15 at 11:50 AM revealed an electrical outlet under the TV in room 423 to have a multi-plug adapter plugged into the outlet holding the cords to the TV, cable box and cable adapter. All 3 devices were taped together with masking tape and held to the wall with masking tape and was sticking out from the wall 4 inches. The outlet was on the right side of the closet causing Resident #118 to bump it when she would go to her closet. During an interview on 7/7/15 at 11:55 AM with Resident #118 and Resident #121 residing in room 423-A and 423-B indicated that the outlet had been that way since December of 2014 and it was reported to the Maintenance Director In December 2014. An observation on 7/10/15 at 8:45 AM in room 448 revealed an electrical outlet under the TV to have a multi-plug adapter plugged into the outlet holding the cords to the TV, cable box and cable adapter. All 3 devices were taped together with masking tape and held to the wall with masking tape and held to the wall with masking tape. A review of the maintenance request form dated 5/18/15 indicated that room 448 had a cable box	F 323		

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F 323	Continued From page 36 that keeps falling off the wall and maintenance indicated on the maintenance requisition form that the work done on 5/19/15 was that the cable box was taped back on the wall. During an interview with the Maintenance Director on 7/10/15 at 9:00 AM revealed that the cable company was changed in December and they left him in a mess. After several attempts to get the cable company to come to the facility he had started moving the cable box and cable adapters to the corner of the rooms and covering the cables.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. BMP lab was obtained for Resident #16 and MD notified for further recommendations. All licensed nurses were educated on receiving, transcribing and follow through for physician orders by the DON/ADON prior to survey exit. No negative outcomes were identified.	8/7/15

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F 329	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to obtain lab values for Basic Metabolic Panel (BMP) as ordered by the physician for 1 of 5 residents reviewed for unnecessary drugs. (Resident #16). The findings were: Resident #16 was admitted to the facility on 6/25/15 with diagnosis of congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus and bipolar disorder. The most recent Minimum Data Set (MDS) assessment with assessment reference date of 04/17/15 indicated that Resident #16 required extensive assistance with activity of daily living (ADL's) and was severely cognitively impaired. The care plan initiated on 04/20/15 identified a problem that Resident #16 can become short of breath upon exertion related to congestive heart failure and chronic obstructive pulmonary disease. A physician order dated 07/02/15 indicated to do a venous doppler of left lower extremity to rule out deep vein thrombosis, give Lasix (diuretic) 40 milligrams (mg) by mouth twice a day for edema, chlorthalidone (diuretic) 50 mg by mouth every day for edema and BMP on 07/03/15 and 07/07/15. A second physician order dated 07/07/15 indicated to obtain a BMP on 07/09/15. A record review on 07/09/15 revealed that lab results for BMP on 07/03/15 and 07/07/15 could not be located. An interview with Nurse #1 on 07/09/15 at 10:00 AM revealed that the physician's order dated	F 329	2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: Residents receiving orders for lab work have the potential to be affected by the same alleged deficient practice. Lab orders have been audited for accuracy by nursing administration for compliance. No other residents had noted negative outcomes. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: DON/ADON educated all licensed nursing staff effective date 7/21/15 on policy for taking orders from physicians, transcribing, documenting and follow through for specified orders. Nurses aware of proper laboratory requirements associated with proper placement of labs on lab book to be obtained and a co-worker double checking process to eliminate potential error. DON/ADON will monitor physician orders and lab book 3x week for 4	

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F 329	Continued From page 38 07/02/15 was carried out except for the BMP. Nurse #1 indicated that after the order was signed by the nurse the lab order was placed on the medication administration record (MAR) and the lab book so that 3rd shift can obtain the lab. Nurse #1 confirmed that the lab order for the BMP was not placed on the MAR or the lab book and therefore the BMP was not obtained on 07/03/15 and 07/07/15. Nurse #1 indicated that the BMP was obtained this morning and should have results today (07/09/15). During an interview with the physician on 07/09/15 at 2:15 PM confirmed that the BMP's were not obtained on 07/03/15 and 07/07/15 and he ordered the BMP again. An interview with the Director of Nursing on 07/09/15 at 5:00 PM revealed that it was her expectation that the lab orders were double checked by another nurse to confirm that the lab was placed on the MAR and lab book so that labs were obtained as ordered. An interview with Nurse #4 on 07/10/15 at 10:20 AM revealed that she signed off the physicians order dated 07/02/15 and must have gotten busy and did not put the BMP order on the lab book or the MAR and the lab was not done.	F 329	weeks, then weekly x 4 weeks, then monthly till compliance is established. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4. Audits will be reviewed by QA committee members for 3 months then quarterly to review if current plan of action is effective till compliance is established. Revisions will be made by the QA committee team to the current plan of action to ensure compliance.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: 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: - Registered nurses.	F 356		

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F 356	Continued From page 39 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the required nurse staffing data for 4 of 5 days of the annual recertification survey. The findings included: During the initial tour of the facility on 07/06/15 the "Daily Nursing Staff Form" was observed to be posted at the front entrance to include the facility name, current date, total number of nursing staff and the census. The "Daily Nursing Staff Form" did not include the actual hours and it was posted for all 3 shifts.	F 356	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. Posting of nursing staff information and hours form revised and posted in new location. All residents, staff and visitors have access to this form located at the south nurse's station. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All persons have the potential to be affected. No negative outcomes identified. 3. Measures/ systems put into place to ensure the alleged deficient practice does not re occur: DON/ADON and ward clerk will audit 3x week for 4 weeks, then weekly x 4 then monthly for 3 months to ensure that form is posted and all numbers and hours are correct and are	8/7/15

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F 356	Continued From page 40 An observation for 4 consecutive days 07/06/15, 07/07/15, 07/08/15 and 07/09/15 at 10:00 AM revealed a posting each morning to include all 3 shifts and did not include the actual hours worked for licensed and unlicensed nursing staff and was not revised when staff changes occurred. During an interview with the unit secretary on 07/09/15 at 1:00 PM who was responsible for posting the "Daily Nursing Staff Form" indicated that each morning she posted the "Daily Nursing Staff Form" and made sure it included the date, census, number of licensed and unlicensed nursing staff and provided the data for all 3 shifts. She further indicated that she was not aware that the data needed to include the total number of hours worked, that it needed to be posted at the beginning of each shift or that the data needed to be revised when staff changes occurred. An interview with the Director of Nursing on 07/09/15 at 3:30 PM confirmed that the nurse staffing data was posted each morning for all 3 shifts, did not include the total number of hours worked for licensed and unlicensed nursing staff and it was not revised when staff changes occurred. She further indicated that the form had been used for a long time and it will be changed today to indicate the required nurse staffing data.	F 356	updated as changes with staffing and census occur. All nursing staff was educated on the new format and documentation of hours worked requirement. The charge nurse is responsible for updating the form each shift if any changes occur. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4. Results of compliance will be reviewed monthly x3 at the QA meeting and then quarterly until resolved.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		

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F 364	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on review of Resident Council minutes, 4 resident interviews (Residents #54, #72, #39 and 16), an observation of the dinner meal tray line, a test tray, staff interviews and review of facility records, the facility failed to store foods on the steam table no more than 30 minutes before the start of the tray line and provide residents with palatable foods based on resident preference for food temperature and taste. The findings included: 1a. During a February 2015 Resident Council meeting, Resident #39 complained that the food was lukewarm and that the nurse aides would not reheat his food. During an April 2015 Resident Council meeting, multiple residents complained that they did not like the food that was offered and that it was often cold. The certified dietary manager (CDM) conducted a staff in-service on 04/24/15. After the in-service, the CDM followed up with residents and they expressed that their food was warmer. During a May 2015 Resident Council meeting, residents complained that their food was not warm enough and that they did not like the food. Residents requested to have the CDM attend the next Resident Council meeting. During a June 2015 Resident Council meeting, the CDM attended and residents who ate meals in their rooms expressed that they still received cold foods, but some residents received staff	F 364	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. Corrective action for the residents found to have been affected by the alleged deficient practice. CDM to ensure that each resident receives food prepared in a manner that preserves nutritive value, flavor and appearance. Also, to prepare food that is palatable, attractive and at proper temperature. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: Heated plate lowerators will be ordered on 7/24/2015 with anticipated delivery in 2-4 weeks. Plates will be heated per manufacturer's directions and used for service for all steam tables in facility.	8/7/15

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F 364	Continued From page 42 assistance with reheating their foods. During an interview on 07/08/2015 at 3:37 PM, the social worker (SW) stated that for the past 2 ½ years, residents who ate foods in their rooms complained that they often received foods that were cold. The SW stated that when he received a complaint about cold foods, he passed the grievance on to the CDM and encouraged the resident to ask staff to reheat their foods or to eat their meals in the dining room rather then in their rooms. The SW stated that he followed up with residents after the April 2015 Resident Council meeting and the residents expressed that their food had improved, however, the SW stated that resident complaints about cold foods was an ongoing issue. During an interview with the CDM on 07/09/15 at 4:53 PM, she revealed that she attended the June 2015 Resident Council meeting and some residents expressed that they still received cold foods. Additionally, some residents also stated that they received staff assistance with reheating their foods. The CDM stated she encouraged the residents who attended the June 2015 Resident Council meeting to eat their meals in the dining room in order to receive foods that were hot, but these residents preferred to eat meals in their room. The CDM stated that in an effort to serve residents hot foods, dietary staff put plates in a heated well in the steam table for the breakfast meal to keep the plates hot, but there was not enough time between meals to heat plates for the lunch/supper meals after the plates were washed. The CDM also stated that she encouraged the nursing staff to distribute meals more timely to residents who ate in their rooms.	F 364	Cooks in serviced on 7-15-2015 to complete preparation of hot food as close to meal service time as possible, held in cooking equipment until 30 minutes prior to meal services, any hot food temp measured at less than 165 degrees is reheated to >165 degrees for 15 seconds before service on to heated plates. Nursing staff in serviced on reheating plates of food at resident request or if upon presentation of meal to resident lack of adequate heat is apparent. 3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are: CDM/RD consultant monitors meal service on halls tracking temp and taste of food on test tray each week and interview 2 residents on rotating halls for one month after heated lowerators installed. When no complaints are received then monitoring will be decreased to monthly on rotating halls on a continual basis.	

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F 364	Continued From page 43 b. An observation in the kitchen of the steam table occurred on 07/06/2015 at 4:39 PM. The dial for each steam table well was set to its highest setting. The following foods were observed stored on the steam table for the dinner meal service: · Stuffed pepper casserole · Mixed greens · Pinto beans · Mashed potatoes · Cauliflower · Vegetable soup · chicken noodle soup · Tomato soup · Pureed zucchini · Pureed tomato soup · Puree pinto beans · Pureed greens · Puree pepper casserole Dietary staff #1 stated during an interview on 07/06/15 at 4:40 PM that she prepared foods for the dinner meal that day and placed the foods on the steam table about an hour ago, which was her usual practice. Dietary staff #1 stated the foods would remain on the steam table until the dinner meal tray line started around 5:15 PM. An interview with the CDM on 07/09/2015 at 4:53 PM revealed that dietary staff routinely placed hot foods on the steam table whenever the staff completed cooking, but no more than 2 hours before the meal. The CDM stated the steam table was used to keep the hot foods hot until the tray line began. The CDM further stated that she was not aware that hot foods should not be placed on the steam table more than 30 minutes prior to a meal service to ensure residents received	F 364	4. CDM will attend resident council meeting to receive menu/food comments and present request to RD consultant for menu adjustments as needed during month following first new menu cycle rotation. Results of audits will be forwarded to monthly QA meeting for 3 months then quarterly thereafter. . CDM/RD will monitor on monthly basis continuously.	

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F 364	Continued From page 44 palatable foods. c. Review of a quarterly minimum data set dated 04/20/15 assessed Resident #54 with intact cognition and independent with eating, requiring set up help only. On 07/07/15 at 8:54 AM, Resident #54 stated during interview she would like her food hotter. She stated she ate in her room and he breakfast was always cold. She further explained that the trays are delivered to the hall but delivery is slow. A follow up interview with Resident #54 on 07/09/15 at 8:19 AM revealed her breakfast was warm but she would prefer it hotter. She further stated most days the food is not hot enough and she would like her coffee much hotter. d. Review of a quarterly MDS dated 04/21/15 assessed Resident #72 with intact cognition and independent with eating, requiring set up help only. During an interview on 07/07/15 at 9:03 AM Resident #72 stated that the food was cheap and not good, but that the food used to be good. Resident #72 stated that sometimes the food was hot and sometimes it was cold, for example, he stated that last night (07/06/15) his food was real cold, especially the French fries. e. Review of a quarterly MDS dated 05/11/15 assessed Resident #39 with intact cognition and independent with eating, requiring set up help only. During an interview on 07/07/15 at 10:18 AM, Resident #39 stated that he ate meals in his room	F 364		

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F 364	Continued From page 45 and sometimes the food was not good, usually "warmish", but if the meal cart sat on the hall too long, the food was cold. f. Review of an admission MDS dated 04/17/15 assessed Resident #16 with impaired cognition and independent with eating, requiring set up help only. During an interview on 07/07/15 at 3:37 PM, Resident #16 stated that the food at the facility had no taste or seasoning, was greasy and was served cold, especially the lunch and dinner meals. g. On 07/08/2015 a lunch meal test tray for a regular diet was requested at 11:50 AM. The meal was plated in an insulated dome lid and bottom and taken to the 400 hall in an insulated cart. The meal included milk, tea, water, peaches, spinach, potatoes, chicken and a roll. The CDM was present and tasted the meal at 12:25 PM. Butter was observed added to the potatoes, spinach and roll, but did not completely melt in the potatoes or on the roll. The CDM stated after tasting the meal that the chicken was good, "but not really hot", the spinach and potatoes were good but "not what you would call hot", the peaches and beverages were cool. The CDM further stated that she would prefer to have the hot foods for this meal reheated. The CDM stated that she felt that if more residents ate their meals in the dining room and if the dietary department had a plate warmer these things would help to ensure the foods were served to residents hot.	F 364		
F 369	483.35(g) ASSISTIVE DEVICES - EATING	F 369		

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F 369 SS=D	Continued From page 46 EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide and utilize the adaptive eating equipment for 1 of 1 resident sampled for the need to have adaptive eating equipment. (Resident #96). The findings included: Resident #96 was admitted to the facility on 09/21/13. Her diagnoses included aphasia, cerebral vascular accident, and subarachnoid hemorrhage. Resident #96's annual Minimum Data Set dated 08/26/14 coded her as having long and short term memory impairments, severely impaired decision making skills, requiring set up and supervision for eating and having no swallowing problems. ST evaluated Resident #96 on 11/19/14 for dysphagia. The assessment summary stated the Resident #96 exhibited moderate to severe orphanage dysphagia by overfilling oral cavity with multiple boluses without attempts to chew/swallow, rapid rate of self-feeding, coughing/gagging when oral cavity is overfilled, vomiting after meals due to rapid intake/gagging, expectoration of bolus due to inability to masticate/swallow large amounts in oral cavity, decreased oral sensation for residue, increased mastication times and increased oral-pharyngeal	F 369	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law 1. Resident # 96 was monitored during meal times to ensure that bowls were present for meal times and that staff were following the care plan and placing food in bowls for consumption to reduce risk of aspiration and or adverse events. 2 Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All residents receiving adaptive/assistive dining utensils have the potential to be affected. No negative outcomes were identified. Meal times have been audited. Bowls were noted to be present and staff utilizing them appropriately.	8/7/15

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F 369	Continued From page 47 transit times. A diet order and communication sheet dated 12/02/14 signed the ST revealed the need for adaptive equipment of placing an extra empty bowl and empty cup on the tray. A care plan was developed on 12/03/14 to address the problem of packing food in her mouth during meals to the point of vomiting and placing her at risk for aspiration. The goal was to have no signs or symptoms of aspiration. Interventions included: *during meals supervise her and cue her to take small bite; *give fluid after she swallows a bite; *during meals put one large bite in an bowl and give it to her and allow her to eat. take the bowl back and add another bite to bowl and continue this process until she completes the meal or is finished eating. ST discharged Resident #96 on 01/14/15 with recommendation for a mechanical soft/chopped meats, mechanical soft/ground textures, thin liquids by cup and by straw, sitting in upright position, small single boluses, presented one at a time in separate bowl/cup, double swallows, until buccal cavity and oral residue are cleared, and to alternate consistencies as needed to clear residue. Close supervision was also recommended. The quarterly Minimum Data Sets, dated 02/09/15 and 05/01/15, coded Resident #96 with having no speech, sometimes being understood and sometimes understanding, having long and short term memory impairments, having moderately impaired decision making skills, and	F 369	3 Measures/ systems put into place to ensure the alleged deficient practice does not re occur: Dietary and nursing staff has been re- educated to provide bowls with meals and ensure staff are using them accordingly. DON/ADON will audit for placement of bowls and appropriate usage 3x a week for 4 weeks, then weekly x4 weeks and then monthly until compliance is met. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed. 4 Audits will be reviewed by QA committee members monthly x 3 months and then quarterly till compliance is established. Changes will be made accordingly to meet and ensure compliance with providing and using bowls for meal times.	

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F 369	Continued From page 48 requiring extensive assistance of one person for eating. The care plan related to aspiration risk was last reviewed 05/15/15 and the interventions listed above which included small boluses in a separate bowl/cup remained in effect. Review of the Activities of Daily Living Care book, maintained for easy review of resident care by the nurse aides, revealed a separate undated hand written note which stated "Attention" with the instructions for staff that during meals put one large bite in an empty bowl, hand the bowl to the resident and let her eat the bite, take the bowl back and add another bite to bowl and continue this until she completes the meal or no longer wants to eat. Resident #96 was observed during the evening meal on 07/06/15. She was served at 5:38 PM. Her tray included a plate included a whole sandwich, cauliflower and a separate plate of pie. There were no extra bowls or cups observed and food was served all at once. Resident #96 was observed feeding herself slowly at this meal. Nurse Aide #7 did encourage Resident #96 to chew her food a couple of times during the meal. Staff did not follow the plan of care to put bites of food in a bowl and serve individually. During interview with NA #7 on 07/09/15 at 5:00 PM, NA #7 stated that an extra bowl came on the resident's trays but she will only use it when she sees Resident #96 put too much food in her mouth. If it was observed toward the end of the meal, then she will cue her to slow down and chew. NA #7 stated that the resident will become anxious when the tray is removed once she starts eating and putting food in bowls after the tray has	F 369		

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F 369	Continued From page 49 been placed in front of her became more of a hazard. Resident #96 was served her breakfast in the dining room on 07/08/15 at 7:38 AM. She was served a plate containing biscuits and gravy and eggs. No extra bowls or cups were observed in use. Resident #96 was served a second replacement tray at 8:07 AM after another resident grabbed a biscuit off her plate. No additional bowls or cups were served with this second plate and the plate was placed whole in front of her. Resident #96 began eating the eggs immediately and took large spoonful after spoonful of eggs quickly, not finishing what was in her mouth before taking another bite. Resident #96 was not cued to slow down or drink between bites. After she finished all the eggs, she began to eat the biscuits and gravy. Again she took large bites and after eating one third of the biscuit, she got up and left the room without any cueing to slow down or drink after bites of food. She drank no liquids off this second tray and staff did not follow the plan of care to put bites of food in a bowl and serve individually. Nurse Aide (NA) # 9 was in the room assisting the residents during this meal. On 07/08/15 at 11:53 Nurse Aide (NA) #9 was interviewed. She stated that she knew how to care for residents via word of mouth from the nurses, the medication administration records, the resident's chart or the care sheets. When asked about the tray card which included the need to place an extra bowl and cup on the tray, NA #9 stated she was not sure but staff used to put small amounts of her food in bowls in order to slow her eating down. She stated it had been about a month since she worked with the resident and she was not sure if the need to put food in bowls had changed. She stated at breakfast this	F 369		

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F 369	Continued From page 50 date, an extra bowl did not come on the tray so she did not use the bowl that came on the noon tray. On 07/08/15 at 11:37 PM, Resident #96 was served a plate of food including ground meat and gravy, potato wedges, greens and a roll. Peaches were placed in front of her at the same time in a separate bowl. An extra bowl was observed to the side of the plate, but was not used by staff or Resident #96. Staff did not separate the food in bowls per the plan of care. Resident #96 left at 11:42 AM after eating only the potatoes. Nurse Aide (NA) # 9 was in the room assisting the residents during this meal. On 07/08/15 at 11:53 Nurse Aide (NA) #9 was interviewed. She stated that she knew how to care for residents via word of mouth from the nurses, the medication administration records, the resident's chart or the care sheets. When asked about the tray card which included the need to place an extra bowl and cup on the tray, NA #9 stated she was not sure but staff used to put small amounts of her food in bowls in order to slow her eating down. She stated it had been about a month since she worked with the resident and she was not sure if the need to put food in bowls had changed. NA #8 was interviewed on 07/08/15 at 12:27 PM. She stated the Resident #96 used to eat very fast and staff were afraid the resident would choke. NA #8 stated therapy came up with the ideas to put a scoop of food in a bowl to slow her down. NA #8 further stated that now the kitchen still sent an extra bowl but staff only serve food in the bowl if the resident is observed eating too fast. ST who worked with Resident #96 was	F 369		

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F 369	Continued From page 51 interviewed on 07/09/15 at 4:43 PM. ST stated Resident #96 packed her mouth so full of food to the point she gagged, choked and vomited. It seemed to be more behavioral than a risk for aspiration. ST stated that the resident would eat slow, take one bite at a time as long as staff sat with her and watched her, but the minute staff turned away or was not right there with the resident, Resident #96 would stuff her mouth full of food. She would not eat pureed food so the facility went back to mechanical soft foods and developed a behavior modification plan to put 1 to 2 spoons of food in a bowl and let her eat that while assisting other residents. ST further stated that the care plan was still to be in effect and staff were to use bowls and cups individually to slow the resident's eating down. She further stated she was in the dining room about a month ago and she saw staff utilizing the bowls for Resident #96. MDS Nurse stated on 07/10/15 at 9:56 AM that the care plan to place spoons of food in bowls and serve it individually to Resident #96 was still a current intervention to be followed by direct care staff consistently.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	8/7/15

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F 371	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to perform hand hygiene and remove soiled gloves between tasks during 2 of 2 tray line observations. The findings included: A. An observation of the breakfast meal tray line service occurred on 07/08/15 at 8:11 AM in the dining room. The meal included bananas, biscuits, sausage patties and pancakes. During this observation, dietary staff #2 was observed wearing gloves to plate breakfast foods for residents. During a continuous observation on 07/08/15 from 8:11 AM - 8:33 AM, while wearing the same gloves, dietary staff #2 pulled a banana from a bunch of bananas and placed it on a resident's breakfast tray. Then using a soiled cloth, dietary staff #2 wiped up a spill on the steam table, opened a cabinet to remove plastic lids for use and to remove a plastic tray of insulated bowls. Without completing hand hygiene or changing her gloves, dietary staff #2 was observed to complete the following tasks while wearing the same gloves: · At 8:16 AM, dietary staff #2 plated a biscuit for a resident and crumbled the biscuit on the resident's plate; · At 8:16 AM, dietary staff #2 picked up a biscuit and opened the biscuit into two halves; · At 8:19 AM dietary staff #2 picked up a biscuit for a resident and crumbled the biscuit on the resident's plate; · At 8:20 AM dietary staff #2 picked up a biscuit	F 371	1. Corrective action for the residents found to have been affected by the alleged deficient practice. The Dietary manager will ensure that facility stores, prepares, distributes, and serves food under sanitary conditions. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: All dietary staff in serviced on 7/15/2015 on proper hand hygiene including: no bare hand to food contact, rinsing all fresh fruit and vegetables prior to preparation or service, and proper use of disposable gloves. 3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are: CDM/RD consultant to monitor meal tray preparation in all areas for potential cross contamination through 15-30 minute observation periods. Will monitor on a weekly	

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F 371	Continued From page 53 and a sausage patty for a resident, separated the biscuit into two halves, placed the sausage patty on the bottom half of the biscuit and then placed the top half of the biscuit on top; · From 8:20 AM until 8:33 am, dietary staff #2 picked up biscuits and pancakes while wearing the same soiled gloves and plated these items for multiple residents. B. An observation in the kitchen of the lunch meal tray line service occurred on 07/08/2015 at 11:16 AM. The menu included rolls, sliced tomatoes and bread crumbs (used for residents on a pureed diet). During the observation, dietary staff #2 was observed wearing gloves to plate lunch foods for multiple residents. During a continuous observation from 11:16 AM until 11:51 AM and while wearing the same gloves, dietary staff #2 completed temperature monitoring of the hot foods on the tray line using a thermometer and opening packets of alcohol wipes, opened the oven door, used pot holders to remove two hot foods from the oven and placed these foods on the tray line and moved two metal carts which stored plates and insulated plate covers closer to the tray line. Without completing hand hygiene or changing her gloves, dietary staff #2 was observed to complete the following tasks while wearing the same gloves: · Picked up and plated dinner rolls for multiple residents; · Picked up and plated bread crumbs for multiple residents on pureed diets; · Picked and plated sliced tomatoes for multiple residents. During an interview on 07/08/2015 at 12:46 PM, dietary staff #2 stated that she routinely used gloves to plate rolls, bread, and pancakes, and	F 371	basis rotating through various staff and meal times x 1 month. CDM will counsel employees as needed. 4. Results of audits will be forwarded to monthly QAPI meeting. CDM/RD will monitor on monthly basis continuously.	

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F 371	Continued From page 54 stated that now she realized that she should not do that, but should use utensils. During an interview on 07/08/2015 at 12:52 PM, the CDM stated that the use of gloves to plate foods like breads and pancakes was acceptable as long as the gloves did not become soiled by staff touching non-food items. The CDM stated that once the gloves became soiled, she expected dietary staff to change gloves and perform hand hygiene. The CDM stated the best practice would be to plate foods with utensils.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	This plan of correction is the centers credible allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law	

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F 441	Continued From page 55 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, policy review and staff interviews, the facility failed to maintain proper handwashing during 1 of 4 dining observations in the secured unit and failed to maintain and store a suction machine in a manner to prevent the spread of infection for 1 of 1 sampled resident utilizing a suction machine. (Residents #19 and #100). The findings included: 1. The facility's Handwashing/Hand Hygiene policy, with a revised dated of April 2012, included: "3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies"; and "5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the	F 441	1. Corrective action for the residents found to have been affected by the alleged deficient practice. NA #3 was immediately in serviced and a mounted wall hand sanitizer was placed in the secure unit dining area. Staff were immediately in-serviced on hand washing policy and suction machine policy prior to survey exit.no negative out comes were identified as a result of this deficient practice. 2. Corrective actions taken for those residents having the potential to be affected by the alleged deficient practice: residents who receive assistance with meal set up and disposal. Residents who require suctioning all have the potential to be affected. DON/ADON conducted in-servicing prior to survey exit and held an all staff meeting 7/15/15. Education provided in reference to hand washing and suction machine policy and procedures. All staff in servicing completed 7/21/15.	8/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 56 following conditions:... c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);... g. Before and after assisting a resident with meals." Observations during a noon meal service on 07/07/15 revealed Resident #19 was served his pureed meal at 11:32 PM. At 11:39 PM, Resident #19 finished his entire lunch and stood up from the table. Nurse Aide (NA) #3 approached Resident #19, took the end of the clothing protector the resident was wearing and wiped his face. NA #3 was not wearing gloves at this time. Resident #19 left the dining room and NA #3 proceeded to prepare the next tray for Resident #100 without any hand hygiene. NA #3 was observed directly handling the sandwich, straw and utensils before serving the tray to Resident #100. On 07/07/15 at 11:41 AM, NA #3 was interviewed. NA #3 stated he should have washed his hands or used sanitizing rub after wiping Resident #19's mouth and before preparing the next tray. NA #3 stated he had no hand sanitizer in the dining room and since he was the only staff in the dining room, he did not want to leave the residents unattended in order to go into the hall to use the hand sanitizer mounted on the wall. He stated he normally had a pocket size hand sanitizer to use in the dining room, however, he was in a hurry and did not pick one up. Observations at this time revealed no wall mounted hand sanitizer was located in the dining room on the secured unit. Interview with the Director of Nursing on 07/09/15 at 2:24 PM revealed her expectation was for staff	F 441	3. Measures and systems put into place to ensure the allegation of deficient practice does not re occur are DON/ADON will in service appropriate staff members on policy and procedures for handwashing and suctioning. DON/ADON will conduct documented audits to monitor that staff are following policy for handwashing during meal times and for those requiring suctioning procedures through direct random observation. This will be monitored 3x week for 4 weeks, then weekly x 4 weeks then monthly till compliance is established. During orientation of new nursing personnel education will be provided with the facilities policy and procedure to ensure compliance. Documented audit observations will be reported during management meetings as audits are completed.	

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

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F 441	Continued From page 57 to use hand sanitizer between each tray preparation and staff should wash their hands after wiping a resident's mouth and preparing the next tray. 2. Observations were made on 07/06/15 at 5:30 PM, 07/07/2015 at 9:56 AM and 07/08/15 at 6:50 AM of a used suction machine in room 448 for Resident #106. The suction machine was observed on a stand against the left side of the wall. The canister to the suction machine was filled approximately a fourth with a white milky substance. The suction catheter was uncovered and placed on base of the suction machine. Interview on 07/08/2015 at 3:03 PM with the Director of Nursing revealed the canister should be discarded and changed out every shift if it had contents from suctioning. The suction catheter should be changed out every 24 hours. Interview on 07/08/15 at 10:30 AM with Nurse #2 revealed she was responsible for room 448. Interview revealed the canister should be disposed of in a red bag if it had contents. The suction catheter would be disposed of also. The nurse would dispose of the canister and suction catheter at the end of their shift. Nurse #2 had not noticed the used canister and suction catheter yesterday, but had discarded it this morning. She did not know how long it had been there. She knew the resident had a problem with aspiration about mid June 2015.	F 441	4. Audits will be reviewed and analyzed monthly by the QA committee for 3 months, then quarterly to review if current plan of action is effective till compliance is established. Revisions will be made by the QA committee team to the current plan of action to ensure compliance.	