

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
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F 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family and staff interview, the facility failed to investigate or attempt to resolve grievances for 3 of 3 Residents (Resident #6, #3 and #2). The findings included: 1. Resident #6 was admitted 4/26/06 and readmitted 10/2/14. The resident ' s cumulative diagnoses included: diabetes, hypertension, cervical spondylosis and depressive disorder. Resident #6 also had an indwelling suprapubic urinary catheter. At the time of the survey the resident ' s room was on 100 hall. The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/20/15, revealed Resident #6 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bowel and had an indwelling catheter. Review of the Concern Form for Resident #6, dated 6/1/15 revealed the following concern description " Resident states on 5/29 3rd shift his call bell light was out of reach so he called the facility on his phone. He reports the charge RN that answered the phone was rude and hung up on him and told him he had to wait till staff was done with rounds for his meds (medications). He also reports that third shift staff also talk and smoke more than they work. He states they talk</p>	F 166	<p>Criteria 1 Grievances filed by Residents #6, #3, and #2 were reviewed and addressed by the Director of Nursing on 6/18/15. An acceptable resolution was identified and discussed with the resident and/or responsible party by the Director of Social Services on 6/23/15. Documentation of this follow up and resolution was completed on the Concern Form by the Director of Nursing by 7/20/15.</p> <p>Criteria 2 Residents filing concerns and grievances have the potential to be affected by the alleged deficient practice. On 6/18/15 the Director Of Nursing and Social Services Director initiated an audit of the concern log and concern forms received during the last 30 days to verify the development of an acceptable resolution and validate the completion of documentation on each of these concern forms. An acceptable resolution was identified and discussed with the resident and/or responsible party by the Director of Social Services. This audit was completed by 7/20/15. Documentation of this follow up and resolution will be</p>	7/24/15	

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

TITLE

(X6) DATE

Electronically Signed

07/24/2015

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

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F 166	<p>Continued From page 1</p> <p>about residents in front of other residents as well. He also reported that on 5/29 he was waiting for a package and was told by front desk numerous times that it had not yet arrived but his friend who sent it had it tracked and someone had already signed for it. " The box for " Is the individual who raised the concern satisfied with the resolution " was checked " yes " . Under the heading " Please describe the Action that has been taken the following was handwritten " Admin (Administrator) notified to address concerns.</p> <p>On 6/17/15 at 11:30 AM resident #6 was interviewed. He indicated that the above concerns had not been addressed or resolved.</p> <p>On 6/17/15 at 5:45 PM the Director of Nursing was interviewed. She said that she had not been aware of this complaint but that Resident #6 had another Concern Form dated 6/1/15 that was sent to her that she did address. The DON also indicated that notification of the Administrator without further investigation and action was insufficient in terms of addressing a grievance. The DON said that the Administrator was out of the facility at this time and unavailable but that she believed the Administrator was aware of the concern as the form had been located in a binder in the Administrators office.</p> <p>2. Resident #3 was admitted on 8/20/14. The resident ' s diagnosis included: Parkinson ' s disease. Resident #3 also had a colostomy. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 6/3/15, revealed Resident #3 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of</p>	F 166	<p>completed on the Concern form.</p> <p>Criteria 3 The Director of Nursing will re-educate the Department Managers including the Social services Director, on the process for collecting concerns, investigating and developing resolution. This Education was completed by 7/20/15. Resident concern forms will be reviewed by the Interdisciplinary Team during the Morning Meeting 4 times per week 12 weeks to ensure investigations are complete with acceptable resolution developed , communicated with the resident and documented accurately. Opportunities identified as a result of this review will be corrected daily.</p> <p>Criteria 4 The results of these audits and observations will be reported by the Director of Nursing in the monthly Quality Assurance Performance Improvement Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance is July 20, 2015</p>		

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F 166	<p>Continued From page 2</p> <p>bladder and had an ostomy for bowel elimination. Review of the Concern Form for Resident #3, dated 6/1/15, revealed the following concern description " Resident wife stated that her husband (name) has been sitting outside of his room for an hour soaking wet until her finally got changed. Resident wife was very upset about the situation. " Under the heading " Please describe the Action that has been taken " the following was hand written " spoke to family and explained new position and we would be addressing call light issue, attitude and customer services. Also asked which CNA ' s (Nursing Assistants) were assigned to hall (In-service on 6/9/15 and sensitivity training on 6/16/15) 6/29/15 My Life in LTC (Long Term Care) - training. The follow-up date was listed as 6/4/15 but whether or not the person who raised the concern was satisfied was not indicated.</p> <p>On 6/17/15 at 5:30 PM Resident #3 ' s wife was interviewed with the Resident present. The resident ' s wife stated that Resident #3 has had to wait more than an hour for incontinent care on a couple of occasions. She stated that it had happened again just after lunch today (6/17/15) and indicated that the problem had not been resolved. Resident #3 ' s wife said and that when she left the resident she turned the call light on but when she got back an hour later the call light was off and the resident was still wet.</p> <p>On 6/17/15 at 5:45 PM interview with the Director of Nursing (DON) revealed that she was aware some residents and families had complaints of residents being left wet for long periods but that she was working to resolve the issue and just needed more time. She stated that she had only started as the Director of Nursing (DON) on June 1, 2015 and had already had 10 new Nursing Assistants start on 6/17/15 and had done staff</p>	F 166			

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F 166	<p>Continued From page 3</p> <p>training to start addressing the issue as well.</p> <p>3. Resident #2 was admitted on 12/19/12 and readmitted on 2/10/15. The resident ' s cumulative diagnoses included: diabetes, chronic kidney disease, convulsions and depressive disorder. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/8/15, revealed Resident #2 was cognitively intact, required extensive assistance for toileting and extensive assistance of two people for hygiene. The MDS also indicated the resident was always incontinent of bowel and bladder.</p> <p>Review of the Concern Form for Resident #2, dated 5/26/15, revealed the following concern description: " 1. Resident in dinning room on 5/25 (with) feces all over her and her wheelchair. 2. Sunday 5/24 they visited and resident was wet and said she had been wet awhile. They were very concerned resident was only cleaned with a dry rag. 3. They have asked to be contacted when an appointment is needed so they can arrange it according to their schedule and they are never notified of appointments. The box for " Have you previously voiced this concern to a staff member " was checked " yes " . Under " Please describe the action that has been taken " the following was hand written " Admin (Administrator) and DON (Director of Nursing) notified to address. There was no documentation regarding an investigation or of any corrective actions taken however the box for " Is the individual who raised the concern satisfied with the resolution " was checked " yes " .</p> <p>On 6/17/15 at 4:17 PM Resident #2 was interviewed. She stated that on more than one occasion she had been left wet and dirty for at least an hour but she did not know when the last</p>	F 166			

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F 166	Continued From page 4 time was and did not elaborate further when asked. On 6/17/15 at 5:45 PM interview with the Director of Nursing (DON) revealed that she had just started at the facility June 1, 2015 so she did not have any knowledge of this specific concern. She stated however that notification of the Administrator and DON without further investigation and action was insufficient in terms of addressing a grievance. The DON said that the Administrator was out of the facility at this time and unavailable but that she believed the Administrator was aware of the concern as the form had been located in a binder in the Administrators office.	F 166			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family and staff interview, the facility failed to treat residents with dignity by knowingly leaving residents wet or soiled for an hour or more while attending to other residents care needs for 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6). The findings included: 1. Resident #1 was admitted on 5/16/14 and had cumulative diagnoses that included: diabetes, chronic kidney disease, chronic airway obstruction and cardiac dysrhythmias. At the time of the survey the resident ' s room was on	F 241	Criteria 1 The Director of Nursing and Unit Managers re-assessed Residents #1, #2, #3, #4, #5 and #6 for Incontinent care needs and updated the care plan to reflect current needs by 7/20/15. Documentation was completed on the Bowel and Bladder Evaluation Form. The Director of Social Services offered residents #1, #2, #3, #4, #5 and #6 to opportunity to express concerns related to dignity and provided emotional support by 7/20/15.	7/24/15	

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F 241	<p>Continued From page 5</p> <p>100 hall.</p> <p>The most recent Minimum Data Assessment (MDS) an Annual assessment dated 4/3/15, revealed Resident #1 was cognitively intact, required extensive assistance for hygiene and toileting and was frequently incontinent of bowel and bladder.</p> <p>Review of the Care Plan dated last updated 4/13/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown, or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " .</p> <p>On 6/17/15 at 11:30 AM, interview with Resident #1 revealed that when the 100 hall, where her room was, did not have enough staff due to staff calling out sick, she would be left wet or soiled for 1-2 hours until the staff that were working could get to her. Resident #1 added that sometimes staff would turn off her call light and say they would be back, or not say anything at all, but it would be 1-2 hours before they or someone else came to change her because they were busy with other residents. At other times she said they did not turn off her call light at all and it would be on for two hours. Resident #1 also said that if she was incontinent when the meal trays were out on the hall staff said they could not provide incontinent care until the trays were off the hall. When asked how it made her feel to wait with wet briefs or so long her eyes started to water and she stated that " it makes me feel like I don ' t matter. "</p>	F 241	<p>Criteria 2</p> <p>All residents requiring assistance with incontinent care have the potential to be affected by this alleged deficient practice. Residents requiring incontinent care were interviewed to offer an opportunity to express concerns related to dignity, concerns expressed will be documented on a concern form and emotional support provided as identified by the Social Services Director. This will be completed by 7/20/15.</p> <p>Criteria 3</p> <p>The Director of Nursing, Staff Development Coordinator or Unit Managers will re- educate all Nursing Staff regarding the facility policy for dignity and policy for providing incontinent care, including timely response to call lights and communication of the plan for providing care upon entry of the resident room and providing for the resident's dignity when conducting incontinent care. This re-education will be completed by 7/20/15. The Director of Nursing, Staff Development Coordinator or Unit Managers will randomly interview and observe 10 residents requiring incontinent care weekly for 12 weeks to validate timely response to the call light and maintenance of dignity while providing incontinent care. Audits will be conducted randomly on all 3 shifts and on weekends. Opportunities for improvement will be corrected as identified.</p> <p>Criteria 4</p>		

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F 241	<p>Continued From page 6</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would</p>	F 241	<p>The results of these audits and observations will be reported by the Director of Nursing in the monthly Quality Assurance Performance Improvement Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.</p> <p>Date of compliance is July 20, 2015</p>		

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F 241	<p>Continued From page 7</p> <p>have about 19 residents to take care so the residents did then wait a long time to receive care.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .</p> <p>2. Resident #2 was admitted on 12/19/12 and readmitted on 2/10/15. The resident ' s cumulative diagnoses included: diabetes, chronic kidney disease, convulsions and depressive disorder. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/8/15, revealed Resident #2 was cognitively intact, required extensive assistance for toileting and extensive assistance of two people for hygiene. The MDS also indicated the resident was always incontinent of bowel and bladder.</p> <p>Review of the Interim Plan of Care dated 2/10/15 revealed that incontinence was not checked off as a problem/need for the resident however the following " Interventions Initiated " were checked for the resident " provide assistance as required for toileting " and observe bladder and bowel habits and function to determine retraining abilities " .</p> <p>On 6/17/15 at 4:17 PM Resident #2 was interviewed. She stated that on more than one</p>	F 241			

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F 241	<p>Continued From page 8</p> <p>occasion she had been left wet and dirty for at least an hour but she did not know when the last time was and did not elaborate further when asked. When asked how being left wet and dirty made her feel she said " it makes me feel bad, I don ' t like it " .</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents. Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .</p> <p>3. Resident #3 was admitted on 8/20/14. The resident ' s diagnosis included: Parkinson ' s disease. Resident #3 also had a colostomy. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 6/3/15, revealed Resident #3 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bladder and had an ostomy for bowel elimination. Review of the Care Plan dated last updated 6/15/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown,</p>	F 241			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
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F 241	<p>Continued From page 10</p> <p>or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " .</p> <p>On 6/17/15 at 5:30 PM a family member of Resident #3 was interviewed with the Resident present. The family member stated that Resident #3 has had to wait more than an hour for incontinent care on a couple of occasions. She stated that it had happened again just after lunch today (6/17/15) and that when she left turned the call light on but when she got back an hour later the call light was off and the resident was still wet. The family member also said that after Resident #3 finished eating in the dinning room Nursing Assistant staff were busy on the hall passing out trays and said that they could not give incontinent care while the meal trays were out on the hall. Resident #3 was intrviewed on 6/17/15 with his wife present at 5:35 PM and indicated that he felt angry when he had to wait so long for incontinent care. He also stated that a staff member had come in his room while his wife was gone but didn ' t say anything to him and he had wondered why she had come in.</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes</p>	F 241			

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F 241	<p>Continued From page 11</p> <p>for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time. Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident 's on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident 's needs on 100 hall if the hall had fewer than 5 NA 's on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA 's assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had</p>	F 241			

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F 241	<p>Continued From page 12</p> <p>also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .</p> <p>4. Resident #4 was admitted on 11/22/14 and had cumulative diagnoses including: diabetes, atrial fibrillation, hypertension and depressive disorder. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 4/23/15, revealed Resident #4 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bladder and frequently incontinent of bowel. Review of the Care Plan dated last updated 4/23/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown, or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " .</p> <p>On 6/17/15 at 4:45 PM Resident #4 was interviewed. She stated that she has been left wet so long that her private area was sore (she declined to have this area observed). Resident #4 said that she thought the long wait for care had to do with being short staffed when there were call outs. She felt most of the staff were trying to do a good job but sometimes didn ' t have enough help since it took two people to do her incontinent care. Resident #4 stated that it</p>	F 241			

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F 241	<p>Continued From page 13</p> <p>made her feel uncomfortable when she was left wet for a long time and that she sometimes pulled her brief off herself so she would feel better. Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p>	F 241			

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F 241	<p>Continued From page 14</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .</p> <p>5. Resident #5 was admitted on 8/8/12 and readmitted on 8/27/14. The resident ' s cumulative diagnoses included: quadriplegia, anemia and depressive disorder. At the time of the survey the resident ' s room was on 100 hall. The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 3/5/15, revealed Resident #5 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was frequently incontinent of bladder and always incontinent of bowel. Review of the Care Plan dated last updated 6/14/15 revealed a plan of care for incontinence. The goal was " will remain free from skin breakdown due to incontinence and brief use. " The approaches for this plan of care included: " clean peri-area with each incontinence episode " , " have call light within easy reach " and " check (during care) and as required for incontinence,</p>	F 241			

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F 241	<p>Continued From page 15</p> <p>wash rinse and dry perineum " .</p> <p>On 6/17/15 at 3:04 PM interview with Resident #5 revealed that on numerous occasions he has waited 1-2 hours to receive incontinent care or even to have someone answer his call light. He stated he was tired of hearing staff say they hadn ' t gotten to him sooner because they were working short due to call outs and having to wait so long for care made him feel angry.</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>On 6/18/15 at 10:58 AM interview with Resident #5 revealed that he had not been offered incontinent care from 9:30 PM 6/17/15 to 9:00 AM 6/18/15. He stated that he had used his call bell twice that night and both times the Nurse eventually answered and got him what he wanted. However he said the Nursing assistant did not wake him for incontinent care and he did not see her do incontinent rounds while he was awake which he said was most of the night. Resident #5 said that he was soaked wet in the</p>	F 241			

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F 241	<p>Continued From page 16</p> <p>morning and so annoyed that he didn ' t bother to use his call bell and no one came in to help him until 9:00 AM. He added that the incident had put him in a bad mood for the day and that was why he had refused to get dressed in regular day clothes and chose to wear a gown for the day instead.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>On 6/18/15 at 11:43 AM Nurse #2 was interviewed. She stated she was the staff member who found Resident #5 soaking wet this morning and that it did appear that he had not been changed all night since he was so wet. She stated that Resident #5 was really upset about it and that she immediately had one of the Nursing Assistants provide care to Resident #5.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 241			

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F 241	<p>Continued From page 17</p> <p>6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .</p> <p>6. Resident #6 was admitted 4/26/06 and readmitted 10/2/14. The resident ' s cumulative diagnoses included: diabetes, hypertension, cervical spondylosis and depressive disorder. Resident #6 also had an indwelling suprapubic urinary catheter. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/20/15, revealed Resident #6 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bowel and had an indwelling catheter.</p> <p>Review of the Care Plan last updated 5/20/15 revealed a plan of care for staff assistance with activities of daily living care and a plan of care for an indwelling suprapubic catheter. The approaches included in the care plan did not specifically address incontinence care.</p> <p>The Wound Care Specialist Evaluation dated 6/3/15 revealed Resident #6 was being seen for a fungal infection of his groin and peri-anal area that covered the entire surface of both buttocks and was erythematous (reddened). The treatment noted was a topical anti-fungal agent.</p> <p>Interview with Nursing Assistant #1 (NA#1) on</p>	F 241			

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F 241	<p>Continued From page 18</p> <p>6/18/15 at 10:37 PM revealed that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>On 6/18/15 at 11:30 AM interview with Resident #6 revealed that there have been times when he has waited 1-2 hours after he has had a bowel movement and used his call bell. He stated that staff would answer his call bell and then tell him they were not assigned to his room but that they would find his Nursing Assistant; then it would be 1-2 hours before someone came back to clean him up. Resident #6 said when this happened staff would tell him they were working short and busy with other residents before they got to him.</p>	F 241			

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F 241	Continued From page 19 Resident #6 said he felt angry about being left for so long waiting for incontinent care and he wanted the problem fixed. Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents. Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA 's assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15) and that she had another one planned for 6/29/15 called " My Life in Long Term Care " .	F 241			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		7/24/15	

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F 312	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family and staff interview, the facility failed to provide timely incontinent care so that resident ' s did not have to wait a long time (an hour or more) to receive incontinent care for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5 and #6). The findings included: 1. Resident #1 was admitted on 5/16/14 and had cumulative diagnoses that included: diabetes, chronic kidney disease, chronic airway obstruction and cardiac dysrhythmias. At the time of the survey the resident ' s room was on 100 hall. The most recent Minimum Data Assessment (MDS) an Annual assessment dated 4/3/15, revealed Resident #1 was cognitively intact, required extensive assistance for hygiene and toileting and was frequently incontinent of bowel and bladder. Review of the Care Plan dated last updated 4/13/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown, or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " . On 6/17/15 at 11:00 AM Resident #1 was observed in bed after receiving incontinent care. Her buttox had reddened and pink areas and her inner thighs were also pink. The areas were covered with a protective cream.	F 312	Criteria 1 The Director of Nursing and Unit Managers re-assessed Residents #1, #2, #3, #4, #5 and #6 for Incontinent care needs, a head to toe skin assessment completed to evaluate skin breakdown and treatment provided as required for identified opportunities. The care plan was updated to reflect current needs by 7/20/15. Documentation was completed on the weekly skin assessment form and the Bowel and Bladder Evaluation form. Criteria 2 All residents requiring assistance with incontinent care have the potential to be affected by this alleged deficient practice. Residents requiring incontinent care will be offer an opportunity to express concerns related to dignity, concerns expressed will be documented on a concern form and emotional support provided as identified by the Social Services Director. Residents requiring Incontinent care will be re-assessed for incontinent care needs, head to toe skin assessment completed to evaluate skin breakdown and treatment provided as required for identified opportunities. Care plans will be updated as required based on these assessments. This will be completed by 7/20/15. Criteria 3 All Nursing Staff will be re-educated by the Director of Nursing, Staff		

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F 312	<p>Continued From page 21</p> <p>On 6/17/15 at 11:30 AM, interview with Resident #1 revealed that when the 100 hall, where her room was, did not have enough staff due to staff calling out sick, she would be left wet or soiled for 1-2 hours until the staff that were working could get to her. She said that this could happen on any shift but it was worse on first shift (6 AM - 2 PM). Resident #1 said that being left wet had been an ongoing problem and had caused the skin on her buttox to breakdown and get sore and raw. Resident #1 added that sometimes staff would turn off her call light and say they would be back, or not say anything at all, but it would be 1-2 hours before they or someone else came to change her because they were busy with other residents. At other times she said they did not turn off her call light at all and it would be on for two hours.</p> <p>Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has many residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short.</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA ' s due to call outs. NA #1 acknowledged there were times when residents had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA ' s on first shift but when there were just 3 NA ' s on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short</p>	F 312	<p>Development Coordinator or Unit Manager on the facility policy for providing assistance with Activities of Daily Living and the facility policy for providing Incontinent Care, to include timely response to call lights, communication of the plan for providing care upon entry of the resident room and providing for the resident's dignity when conducting incontinent care by 7/20/15. . The Director of Nursing, Staff Development Coordinator or Unit Managers will randomly interview and observe 10 residents requiring incontinent care weekly for 12 weeks to validate timely response to the call light and maintenance of dignity while providing incontinent care, effective technique. Audits will be randomly conducted on all 3 shifts and on weekends. Opportunities for improvement will be corrected as identified.</p> <p>Criteria 4 The results of these audits and observations will be reported by the Director of Nursing in the monthly Quality Assurance Performance Improvement Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance is July 20, 2015</p>		

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F 312	<p>Continued From page 22</p> <p>staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as</p>	F 312			

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F 312	<p>Continued From page 23</p> <p>needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 1:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in that time she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15).</p> <p>2. Resident #2 was admitted on 12/19/12 and readmitted on 2/10/15. The resident ' s cumulative diagnoses included: diabetes, chronic kidney disease, convulsions and depressive disorder. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/8/15, revealed Resident #2 was cognitively intact, required extensive assistance for toileting and extensive assistance of two people for hygiene. The MDS also indicated the resident was always incontinent of bowel and bladder.</p> <p>Review of the Interim Plan of Care dated 2/10/15 revealed that incontinence was not checked off as a problem/need for the resident however the following " Interventions Initiated " were checked for the resident " provide assistance as required for toileting " and observe bladder and bowel habits and function to determine retraining abilities " .</p> <p>On 6/17/15 at 4:17 PM Resident #2 was interviewed. She stated that on more than one occasion she had been left wet and dirty for at</p>	F 312			

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F 312	<p>Continued From page 24</p> <p>least an hour but she did not know when the last time was and did not elaborate further when asked. She denied having any skin breakdown due to being left wet.</p> <p>Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has a lot of residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short.</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA ' s due to call outs. NA #1 acknowledged that there had been times when residents were left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA ' s on first shift but when there were just 3 NA ' s on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone</p>	F 312			

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F 312	Continued From page 25 particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could. Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift. Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents. Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much. Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in time she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and	F 312			

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F 312	<p>Continued From page 26</p> <p>sensitivity training (6/16/15).</p> <p>3. Resident #3 was admitted on 8/20/14. The resident ' s diagnosis included: Parkinson ' s disease. Resident #3 also had a colostomy. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 6/3/15, revealed Resident #3 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bladder and had an ostomy for bowel elimination. Review of the Care Plan dated last updated 6/15/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown, or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " .</p> <p>Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has a lot of residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short.</p> <p>On 6/17/15 at 5:30 PM a family member of Resident #3 ' s was interviewed with the Resident present. The family member stated that Resident #3 has had to wait more than an hour for incontinent care on a couple of occasions. She stated that it had happened just after lunch today (6/17/15). The family member said she turned on the resident ' s call light after he returned to his room from lunch so staff would know he was wet</p>	F 312			

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F 312	<p>Continued From page 27</p> <p>and needed care. She said she left and when she came back the light was off but Resident #3 still had not been changed. The family member said that after Resident #3 finished eating in the dining room Nursing Assistant staff were busy on the hall passing out trays and said that they could not give incontinent care while meal trays were out on the hall.</p> <p>Resident #3 was intrviewed on 6/17/15 with a family member present at 5:35 PM and stated that the skin between his legs had become raw and blistered and that it felt like a burn. His wife added at this time that Resident #3 ' s skin was really fair and if it wasn ' t dried right away it would get red. Resident #3 declined to have his skin condition observed at this time.</p> <p>Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA ' s due to call outs. NA #1 said that 100 hall was very hectic and demanding and that everyone wanted to get up at the same time. She acknowledged that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents.</p> <p>Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA ' s on first shift but when there were just 3 NA ' s on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the</p>	F 312			

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F 312	<p>Continued From page 28</p> <p>resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much.</p>	F 312			

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F 312	<p>Continued From page 29</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in time she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15).</p> <p>4. Resident #4 was admitted on 11/22/14 and had cumulative diagnoses including: diabetes, atrial fibrillation, hypertension and depressive disorder. At the time of the survey the resident ' s room was on 100 hall.</p> <p>The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 4/23/15, revealed Resident #4 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bladder and frequently incontinent of bowel. Review of the Care Plan dated last updated 4/23/15 revealed a plan of care for incontinence. The goal was " will have incontinence episodes managed without signs and symptoms of potential complications including skin breakdown, or UTI (urinary tract infection) and will have dignity maintained with incontinent care. " The approaches for this plan of care included: " have call light within easy reach " , " provide perineal care daily and as needed " and " observe for incontinence episodes at regular and frequent intervals and as needed " .</p> <p>On 6/17/15 at 4:45 PM Resident #4 was interviewed. She stated that she has been was left wet so long that her private area was sore. She declined to have this area observed.</p>	F 312			

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F 312	Continued From page 30 Resident #4 said that she thought the long wait for care had to do with being short staffed when there were call outs. She felt most of the staff were trying to do a good job but sometimes didn't have enough help since it took two people to do her incontinent care. Resident #4 added that first shift (6 AM - 2 PM) was the worst but each shift would leave unanswered call bells for the next ones coming on. She added that this had been an ongoing problem for the past 4 months. Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has a lot of residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short. Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA's due to call outs. NA #1 said that 100 hall was very hectic and demanding and that everyone wanted to get up at the same time. She acknowledged that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents. Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA's on first shift but when there were just 3 NA's on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident's waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but	F 312			

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F 312	<p>Continued From page 31</p> <p>that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 312			

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F 312	<p>Continued From page 32</p> <p>6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in time she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15).</p> <p>5. Resident #5 was admitted on 8/8/12 and readmitted on 8/27/14. The resident ' s cumulative diagnoses included: quadriplegia, anemia and depressive disorder. At the time of the survey the resident ' s room was on 100 hall. The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 3/5/15, revealed Resident #5 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was frequently incontinent of bladder and always incontinent of bowel. Review of the Care Plan dated last updated 6/14/15 revealed a plan of care for incontinence. The goal was " will remain free from skin breakdown due to incontinence and brief use. " The approaches for this plan of care included: " clean peri-area with each incontinence episode ", " have call light within easy reach " and " check (during care) and as required for incontinence, wash rinse and dry perineum " .</p> <p>On 6/17/15 at 3:04 PM interview with Resident #5 revealed that on numerous occasions he has waited 1-2 hours to receive incontinent care or even to have someone answer his call light. He stated he was tired of hearing staff say they hadn ' t gotten to him sooner because they were working short due to call outs. Resident #5 said that the last time he waited a long time for</p>	F 312			

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F 312	Continued From page 33 incontinent care was 6/15/15. He said that his call light was on from 8 AM to 10:45 AM and no one came in to help him after he had a bowel movement. He added that he finally called the business office, the administrator ' s office and the Director of Nursing and when he spoke to her someone finally came to help him. Resident #5 denied having any skin breakdown due to lack of incontinent care. Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has a lot of residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short. Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA ' s due to call outs. NA #1 said that 100 hall was very hectic and demanding and that everyone wanted to get up at the same time. She acknowledged that there had been times when she could not get to residents quickly and they had been left wet longer than they should because she was busy with other residents. Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA ' s on first shift but when there were just 3 NA ' s on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could	F 312			

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F 312	Continued From page 34 not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time. On 6/18/15 at 10:58 AM interview with Resident #5 revealed that he had not been offered incontinent care from 9:30 PM 6/17/15 to 9:00 AM 6/18/15. He stated that he had used his call bell twice that night and both times the Nurse eventually answered and got him what he wanted. However he said the Nursing Assistant did not wake him for incontinent care and he did not see her do incontinent rounds while he was awake which he said was most of the night. Resident #5 said that he was soaked wet in the morning and so annoyed that he didn ' t bother to use his call bell and no one came in to help him until 9:00 AM. Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could. Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift. Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a	F 312			

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F 312	Continued From page 35 resident was left wet while she was caring for other residents. On 6/18/15 at 11:43 AM Nurse #2 was interviewed. She stated she was the staff member who found Resident #5 soaking wet this morning and that it did appear that he had not been changed all night since he was so wet. She stated that she immediately had one of the Nursing Assistants provide care to Resident #5. Interview with NA #6 on 6/18/15 at 11:46 AM revealed that she had been asked to give care to Resident #5 around 9:00 AM this morning. She stated that the resident was soaking wet when she saw him and he told her no one did rounds on him that night. NA #6 said she asked the resident if he used his call bell and he said that he did not. NA #6 also said she sometimes worked with only 3 NA 's assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much. Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in time she was working to address the issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15). 6. Resident #6 was admitted 4/26/06 and readmitted 10/2/14. The resident ' s cumulative diagnoses included: diabetes, hypertension,	F 312			

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F 312	Continued From page 36 cervical spondylosis and depressive disorder. Resident #6 also had an indwelling suprapubic urinary catheter. At the time of the survey the resident ' s room was on 100 hall. The most recent Minimum Data Assessment (MDS), a Quarterly assessment dated 5/20/15, revealed Resident #6 was cognitively intact and required extensive assistance of two people for both toileting and hygiene. The MDS also indicated the resident was always incontinent of bowel and had an indwelling catheter. Review of the Care Plan last updated 5/20/15 revealed a plan of care for staff assistance with activities of daily living care and a plan of care for an indwelling suprapubic catheter. The approaches included in the care plan did not specifically address incontinence care. The Wound Care Specialist Evaluation dated 6/3/15 revealed Resident #6 was being seen for a fungal infection of his groin and peri-anal area that covered the entire surface of both buttocks and was erythematous (reddened). The treatment noted was a topical anti-fungal agent. Interview with Nurse #1 on 6/17/15 at 5:17 PM revealed that 100 hall has a lot of residents that require a lot of assistance with care and can be a heavy hall for Nursing Assistants to work on especially if they are working short. Interview with Nursing Assistant #1 (NA#1) on 6/18/15 at 10:37 PM revealed that she thought that when 100 hall was fully staffed on first shift (6 AM - 2 PM) there was enough staff to meet resident care needs timely. She added that sometimes the hall was short staffed with only 3 or 4 NA ' s due to call outs. NA #1 said that 100 hall was very hectic and demanding and that everyone wanted to get up at the same time. She acknowledged that there had been times when she could not get to residents quickly and they	F 312			

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F 312	<p>Continued From page 37</p> <p>had been left wet longer than they should because she was busy with other residents. Interview with NA #2 at 10:38 AM revealed that she typically worked on 100 hall. She said that the hall usually had 4 or 5 NA ' s on first shift but when there were just 3 NA ' s on the hall due to call outs it was very busy and very hard to get all the work done. She stated when they were short staffed they would just try to do their best to get everything done but that sometimes resident ' s waited up to 45 minutes for care. NA #2 said that call bells should be answered and whatever the resident needed should be dealt with that time but that if she was with another resident she could not do that. She also stated that there were times when she had come on at the beginning of her shift and a resident was so wet that it appeared they had not had incontinent care for a long period of time.</p> <p>Interview with NA #3 on 6/18/15 at 11:23 PM revealed that the workload on 100 hall was very heavy and it was hard to please everyone particularly when there were 3-4 instead of 5 NA ' s working on the hall on first shift. NA #3 stated she had heard resident ' s on the hall complain that they had been left wet and added that she tried to get to everyone as soon as she could.</p> <p>Interview with NA #4 on 6/18/15 at 11:29 AM revealed that it was difficult to meet the resident ' s needs on 100 hall if the hall had fewer than 5 NA ' s on first shift.</p> <p>On 6/18/15 at 11:30 AM interview with Resident #6 revealed that there have been times when he has waited 1-2 hours after he has had a bowel movement and used his call bell. He stated that staff would answer his call bell and then tell him they were not assigned to his room but that they would find his Nursing Assistant; then it would be 1-2 hours before someone came back to clean</p>	F 312			

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F 312	<p>Continued From page 38</p> <p>him up. Resident #6 said when this happened staff would tell him they were working short and busy with other residents before they got to him. Resident #6 said he had some skin breakdown due to being left soiled for long periods but that the area was being treated.</p> <p>Interview with NA #5 on 6/18/15 at 11:39 AM revealed that she sometimes had 20 residents to take care of on 100 hall when she worked first shift. She said this happened when there were only 3 NA ' s working on the hall (instead of 5), due to call outs. NA #5 said working with 20 residents made it difficult to get to each resident timely so there had been instances where a resident was left wet while she was caring for other residents.</p> <p>Interview with NA #6 on 6/18/15 at 11:46 AM revealed that when they sometimes worked with only 3 NA ' s assigned to 100 hall, each NA would have about 19 residents to take care so the residents did then wait a long time to receive care. NA #6 said that the facility had prn (as needed) staff that could be called in to work when there were callouts but the prn staff didn ' t want to come in at times because they had already been working so much.</p> <p>On 6/18/15 at 11:50 AM Resident #6 agreed to have Nursing Assistant #1 roll him on his right side so the Resident ' s skin condition on his buttocks could be observed. Both buttock cheeks and an area extending approximately 4 inches down the backs of his thigh were observed to be dark pink in color.</p> <p>Interview with the Director of Nursing (DON) on 6/18/15 at 12:30 PM revealed that she was aware of residents complaining about having to wait a long time for incontinent care. She stated that she had only been the DON since June 1, 2015 but that in time she was working to address the</p>	F 312			

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F 312	Continued From page 39 issue by hiring 10 new Nursing Assistants that started work on 6/17/15. She stated that she had also been doing inservices with the Nursing Assistants on answering call bells (6/9/15) and sensitivity training (6/16/15).	F 312			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family and staff interview, the facility failed to provide sufficient nursing staff to maintain the dignity of residents dependent on staff for incontinent care and to provide	F 353	Criteria 1 An interview was conducted by the Director of Nursing by 7/9/15 with Residents #1, #2, #3, #4, #5 and #6 regarding their concerns related to facility	7/24/15	

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F 353	<p>Continued From page 40</p> <p>incontinent care without dependent resident ' s having to wait an hour or more for 6 of 6 residents (Resident #1, #2, #3, #4, #5, and #6). The findings included: 1a. This citation is cross referenced to F241 - the facility failed to treat residents with dignity by knowingly leaving residents wet or soiled for an hour or more while attending to other residents care needs for 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6). 1b. This citation is also cross referenced to F312 - the facility failed to provide timely incontinent care so that resident ' s did not have to wait a long time (an hour or more) to receive incontinent care for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5 and #6) Review of the daily staffing assignment sheets for 6/1/15 through 6/17/15 revealed 5 Nursing Assistants (NA) were preassigned to 100 hall for the 6 AM - 2 PM shift for 8 out of 17 days, 4 were preassigned for 8 out of 17 days and 3 were preassigned for 1 out of 17 days (Sunday, 6/6/15). During this time period there were staff that were crossed of the assignment or who had called out and were not replaced by an additional staff member on 5 occasions resulting in 4 additional days during the time period where there were 3 NA ' s caring for all the residents on 100 hall during the 6 AM - 2 PM shift (6/1/15, 6/11/15, 6/13/15 and 6/14/15) and one additional day where 4 Nursing Assistants were caring for all the residents on the hall. Review of the daily staff assignment sheet for second shift (2 PM - 10 PM) for the period of 6/1/15 through 6/17/15 revealed 4 NA ' s were caring for all the residents on 100 hall for 15 of 17 days. On 6/2/15 3 NA ' s were on the schedule for the hall and on 6/4/15 4 NA ' s were on the schedule but there was one replaced call out.</p>	F 353	<p>staffing needs.</p> <p>Criteria 2 All residents have the potential to be affected by the alleged deficient practice.</p> <p>Criteria 3 Staffing patterns were reviewed and staffing needs established by the Director of Nursing by 7/1/15 for each nursing unit based on total resident population and care needs. The Director of Nursing, Staff Development Coordinator and Unit Managers will monitor the effectiveness of this plan weekly for 12 weeks and implement changes to as opportunities are identified. The Director of Nursing has established a Master Schedule effective 7/15/15 based on the facility needs previously identified. The Director of Nursing will re-educate the Nursing Staff by 7/20/15 regarding the implementation of the Master Schedule and the process for communicating staffing needs to the Charge Nurse, Unit Manager and Director of Nursing as they occur. The Director of Nursing and Staff Development Coordinator have hired and oriented 16 new CNAs during the last 30 days to meet facility staffing needs, an Employee Experience Committee has been established to meet at least monthly to discuss and implement employee appreciation and retention activities. The Director of Nursing, Staff Development Coordinator and Unit Managers will review the staffing schedule 4 times per week for 12 weeks to validate staff are allocated to each nursing unit according the resident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 353	Continued From page 41 Review of the daily staff assignment sheet for third shift (10 PM - 6 AM) for the period of 6/1/15 through 6/17/15 revealed 3 NA ' s were caring for all the residents on 100 hall for 9 of 17 days and 2 NA ' s were caring for the residents on 100 hall for 8 of 17 days. Review of the resident census for 100 hall between 6/1/15 and 6/17/15 revealed that it was stable. The Census for 100 hall on 6/17/15 was 54 residents. On 6/18/15 at 12:30 PM interview with the Director of Nursing revealed that she did not believe the facility had a staffing issue. She stated that she thought that some of the staff were the wrong staff but that they did try to replace people when they called out sick. She also stated that 10 new NA ' s had been hired and had started orientation on 6/17/15.	F 353	population and care needs identified. Call out patterns and ongoing use of staffing agency to address needs will be included in this review and adjustments to the Master Schedule will be made accordingly based on the evaluation of these patterns. Criteria 4 The results of these audits and observations will be reported by the Director of Nursing in the monthly Quality Assurance Performance Improvement Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance is July 20, 2015.		