STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING _____ B. WING _____	C 09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION CENTER	2006 S 16TH STREET WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide care in a manner to maintain dignity by leaving 2 of 6 residents (Resident #8, #89) wet during the night who needed extensive to total assist with toileting and personal hygiene and failed to maintain a resident's dignity by failing to cover the resident during care for 1 of 6 residents (Resident #35) observed to receive care. The findings included: 1. Resident #8 was admitted to the facility on 7/30/14. Diagnoses included diabetes, benign prostatic hypertrophy, incontinence and a history of urinary tract infection. The comprehensive Minimum Data Set (MDS) assessment dated 1/31/15 indicated the Resident was moderately cognitively impaired, was always incontinent of bowel and bladder, and needed extensive assistance in toileting and limited assistance in personal hygiene. According to the Care Area Assessment (CAA) dated 2/2/15 the Resident was incontinent of bowel and bladder and required extensive to total assist for toileting. The Resident was care planned 4/4/15 for incontinence with interventions to include use of disposable briefs to be changed frequently and	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #8 was provided incontinent care and clean linens were applied to the bed by NA #1 on 08/30/15. Resident #89 was provided incontinent care by NA #1 on 08/30/15 and by Restorative NA #1 on 09/01/15. Clean linens were applied to Resident #89 bed on 08/30/15 and 09/01/15. NA #6 was verbally in-serviced by the Staff Development Coordinator (SDC) 8/31/15 on maintaining privacy with an emphasis on ensuring residents are covered appropriately while assisting	10/6/15

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

Electronically Signed | 09/25/2015

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F 241	Continued From page 1 prn. The most recent quarterly MDS assessment dated 6/25/15 indicated the Resident was moderately cognitively impaired, was always incontinent of bladder and frequently incontinent of bowel, and needed extensive assistance in toileting and personal hygiene. The Nursing Assistant (NA) care guide documented the Resident used briefs and needed to be checked frequently for incontinence. The care guide documented protective or barrier lotion should be used after incontinence episodes. Review of NA flow sheets revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:46 PM on 8/30/15. NA #1 was observed to provide incontinence care for Resident #8 on 8/30/15 at 6:12AM. When the NA turned the resident over onto his side the brief, under pad, linen and bed cover were observed to be saturated with strong smelling urine. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #8 from 11:30 PM on 8/29/15 until 6:12 AM on 8/30/15. The NA stated she knew she was supposed to check on the incontinent residents every 2 hours but she had 25 residents and the call lights were constantly ringing and she could not get to everyone. Resident #8 stated in an interview on 8/30/15 at 9:05 AM that he had not been changed all night and it bothered him to be wet for that long. The DON stated in an interview on 9/1/15 at 5:10 PM that her expectations were that the NA's	F 241	with/providing activities of daily living (ADL) care. 2. Interventions for residents identified as having the potential to be affected: Resident care observations were completed on 09/01/15 by the facility Director of Nursing (DON), Unit Manager (UM) and SDC on all residents residing in the facility to ensure incontinent care had been provided timely and care needs did not exist. After resident care observations were completed, no other residents were identified as having been affected by this deficient practice. 3. Systematic Change: Newly hired Licensed Nurses and certified nursing assistants (C.N.A.'s) will be educated by the SDC during their orientation period on Peri-care with emphasis on the performance of timely incontinent care to dependent residents to maintain personal hygiene. Education will also include maintaining resident privacy and dignity. Directed in-services for A) Incontinent Care, B) Maintaining Dignity and Respect during ADL care were provided by a clinical consulting company for all licensed nurses, (C.N.A's) and restorative nursing assistants by October 6th. 4. Monitoring of the change to sustain system compliance ongoing: Resident care observation rounds will be performed (across all shifts: 1st, 2nd and 3rd) by the facility DON, Unit Manager, RN Supervisor and/or SDC to ensure	

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F 241	Continued From page 2 would check incontinent residents every 2 hours to see if they needed incontinent care during all shifts. She further stated that a resident should not have to lay in a wet incontinent brief all night without being changed. 2. Resident #89 was admitted to the facility on 11/20/14 with diagnoses that included diabetes and cerebral vascular accident (CVA) with right sided paralysis. The comprehensive admission MDS assessment dated 11/27/14 indicated the Resident was cognitively intact, frequently incontinent of bladder and occasionally incontinent of bowel and needed extensive assistance with toileting and personal hygiene. The CAA dated 11/28/14 revealed the Resident required extensive assistance for toileting and was frequently incontinent of urine. The Resident was care planned 6/1/15 for incontinence with staff interventions to include frequent and whenever necessary (PRN) incontinence care. The Quarterly MDS dated 8/17/15 revealed the Resident was cognitively intact, frequently incontinent of bowel and bladder and needed extensive assistance with toileting and personal hygiene. The NA care guide revealed the resident was to have incontinence care frequently and prn and his bed linen kept clean and dry. Review of NA flow sheet revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:23 PM on 8/30/15. On 8/30/15 at 6:15 AM, NA #1 was observed to	F 241	residents are provided incontinent care in a timely manner and resident dignity/privacy is maintained during ADL care. These care observation rounds will be performed on 10 residents daily for (4) weeks, three times weekly for (4) weeks and then weekly for (4) weeks. Monthly for a minimum of three months, the DON will report resident care observation round results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 241	Continued From page 3 provide incontinence care for Resident #89. When the NA turned the Resident over onto his side the brief, incontinence pad, linen and bed cover were observed to be saturated with strong smelling urine. On 9/1/15 at 7:25 AM, Restorative NA #1 was observed to provide incontinence care for Resident #89. When the Restorative NA turned the Resident over onto his side the back of his brief and incontinence pad were observed to be ¾ saturated with strong smelling urine. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #89 from 11:30 PM on 8/29/15 until 6:15 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours but she had 25 residents and the call lights were constantly ringing and could not get to everyone. Resident #89 stated in an interview on 9/1/15 at 7:20 AM it irritated him that the last three nights he had to wait in a wet brief from 11 PM until 5 AM and not be changed. Restorative NA #1 stated in an interview on 9/1/15 at 7:40 AM the NA ' s were to check incontinent residents every 2 hours and the night shift NA ' s make their last rounds at 6 AM in the morning and she could not explain why Resident #89 was so wet (with urine) on 9/1/15at 7:25 AM. The DON stated in an interview on 9/1/15 at 5:10 PM that her expectations were that the NA's would check incontinent residents every 2 hours to see if they needed incontinent care during all shifts. She further stated that a resident should not have to lay in a wet incontinent brief all night without being changed.	F 241		

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F 241	Continued From page 4	F 241		

3. Resident #35 was admitted to the facility on 5/4/07 and had a diagnosis of Vascular Dementia.
The Care Area Assessment dated 3/23/15 revealed the resident had advanced dementia and was incontinent of bowel and bladder.
The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/10/15 revealed the resident had severe cognitive impairment and was rarely/never understood. The MDS revealed the resident was incontinent of bowel and bladder and required extensive assistance with toileting and personal hygiene.
The resident ' s Care Plan for Activities of Daily Living (ADLs) dated 8/10/15 noted the resident was totally dependent for all ADLs. The Care Plan for bowel and bladder incontinence noted the resident wore incontinent products for dignity.
On 8/31/15 at 2:36PM NA (Nursing Assistant) #6 was observed in the hall near the resident ' s room removing linen from the linen cart. Upon entering the room the privacy curtain was observed to be pulled parallel to the left side of the bed closest to the door ending at the footboard. The resident was observed from the foot of the bed lying on her right side uncovered with no clothing on except for socks. The bed spread was observed to be fan folded at the foot of the bed. NA#6 entered the room and stated she had to change the resident ' s bed because the resident and the bed was soiled. The NA was questioned but did not explain why she left the resident lying on the bed uncovered. During the care, no visitors or staff entered the room.
On 9/1/15 the Director of Nursing stated in an interview that residents should not be exposed for dignity and privacy reasons.

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F 312	Continued From page 5	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide incontinence care in a manner to maintain personal hygiene for 3 of 6 residents (Resident #89, #8, and #45) who needed extensive assistance to total assistance with toileting/personal hygiene. The findings included: 1. Resident #89 was admitted to the facility on 11/20/14 with diagnoses that included left below the knee amputation, diabetes and cerebral vascular accident (CVA) with right sided paralysis. The comprehensive admission Minimum Data Set (MDS) assessment dated 11/27/14 indicated the resident was cognitively intact, frequently incontinent of bladder and occasionally incontinent of bowel and needed extensive assistance with toileting and personal hygiene. The Care Area Assessment (CAA) dated 11/28/14 revealed Resident #89 required extensive assistance for toileting and frequently was incontinent of urine. The record stated the resident would have a care plan for urinary	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #8 was provided incontinent care by NA #1 and clean linens placed on the bed 08/30/15. Resident #89 was provided incontinent care and clean linens placed on the bed 08/30/15 by NA # 1. Incontinent care and clean linens placed on the bed on 9/1/15 by Restorative NA #1. Resident #45 was provided incontinent care and clean linens placed on the bed by NA #1 8/30/15.	10/6/15

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F 312	Continued From page 6 incontinence to monitor for any skin issues related to incontinent episodes and would be at risk for complication from immobility Resident #89 had a recently revised care plan on 6/1/15 for bowel/bladder incontinence related to immobility with staff to do incontinence care frequently and as needed. The quarterly MDS dated 8/17/15 indicated Resident #89 was cognitively intact, frequently incontinent of bowel and bladder and needed extensive assistance with toileting and personal hygiene. The nursing assistant (NA) care sheet list documented that Resident #89 was to have incontinence care followed by barrier cream to the skin frequently and as needed and his bed linen was to be kept clean and dry. Review of NA computerized flow sheets revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:23 PM on 8/30/15. On 8/30/15 at 6:15 AM, urinary incontinence care was observed to be provided to Resident #89. NA #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with urine and replaced with clean linen and protective brief. A strong urine odor was noted. The NA did not apply protective lotion after incontinence care. Resident #89 was observed to have pink skin around the perirectal area with no skin breakdown noted.	F 312	2. Interventions for residents identified as having the potential to be affected: Resident care observations were completed on 09/01/15 by the facility Director of Nursing (DON), Unit Manager (UM) and SDC on all residents residing in the facility to ensure incontinent care had been provided timely and care needs did not exist. After resident care observations were completed, no other residents were identified as having been affected by this deficient practice. 3. Systematic Change: Newly hired Licensed Nurses and certified nursing assistants (C.N.A.'s) will be educated during their orientation period on Incontinent Care with emphasis on the performance of timely incontinent care to dependent residents to maintain personal hygiene, application of skin protective ointments and maintaining resident privacy and dignity during ADL care. Directed in-services for A) Incontinent Care, application of skin protective ointments and B) Maintaining Dignity and Respect during ADL care were provided by a clinical consulting company for all licensed nurses, (C.N.A's) and restorative nursing assistants by October 6th. 4. Monitoring of the change to sustain system compliance ongoing: Resident care observation rounds will be performed (across all shifts: 1st, 2nd and 3rd) by the facility DON, Unit Manager, RN Supervisor and/or SDC to ensure residents are provided incontinent care in	

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F 312	Continued From page 7 On 9/1/15 at 7:25 AM Resident #89 was observed to have incontinence care by Restorative NA #1 after the resident complained of not having incontinence care done all night. The NA greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The back of his brief and under pad were observed to be ¾ saturated with urine and replaced with clean linen and protective brief. A strong urine odor was noted. A small open red area was noted on the skin on the right buttock and the NA applied protective cream to the perineal/rectal area. On 8/31/15 at 10 AM, NA #3 stated that Resident #89 was alert and oriented and was able to use the call bell for assistance when he needed incontinence care. She stated the Resident had been given a urinal to use but found it difficult to use with his right sided paralysis. NA #3 stated she checked him every 2 hours to see if he needed incontinent care and as needed if he called. Resident #89 stated in an interview on 8/31/15 at 10:01 AM that he did not think there was enough staff on night shift (11PM-7AM) to meet his needs without having to wait a long time. Resident #89 stated he called for assistance and it might take several hours before they actually came to change him. Resident #89 stated in an interview on 9/1/15 at 7:20 AM it irritated him that the last three nights he had to wait in a wet brief from 11 AM until 5 AM and not to be changed.	F 312	a timely manner and resident dignity/privacy is maintained during ADL care. These care observation rounds will be performed daily on 10 residents for (4) weeks, three times weekly for (4) weeks and then weekly for (4) weeks. Monthly for a minimum of three months, the DON will report resident care observation round results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #89 from 11:30 PM on 8/29/15 until 6:12 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours and as needed but that she had 25 residents and the call lights were constantly ringing and it was her first night by herself and could not get to everyone.

On 9/1/15 at 7:40 AM, Restorative NA #1 stated in an interview the NAs were to check incontinent residents every 2 hours and the night shift NAs made their last rounds at 6 AM in the morning and she could not explain why Resident #89 was so wet (of urine).

2. Resident #8 was admitted to the facility on 7/30/14. Diagnoses included diabetes, benign prostatic hypertrophy (BPH), incontinence and a history of urinary tract infection (UTI).
The comprehensive Minimum Data Set (MDS) assessment dated 1/31/15 indicated Resident #8 was moderately cognitively impaired, was always incontinent of bowel and bladder, and needed extensive assistance in toileting and limited assistance in personal hygiene.
According to the Care Area Assessment (CAA) dated 2/2/15 Resident #8 was incontinent of bowel and bladder, required extensive to total assistance for toileting needs and had a history of BPH and UTI.
The most recent quarterly MDS assessment dated 6/25/15 indicated Resident #8 was moderately cognitively impaired, was always incontinent of bladder and frequently incontinent of bowel, and needed extensive assistance in

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F 312	Continued From page 9 toileting and personal hygiene. Resident #8 ' s care plan, dated 4/4/15, for incontinence included interventions to use disposable briefs and to change them frequently and as needed. The nursing assistant (NA) care sheet list documented Resident #8 used briefs that needed to be checked frequently and as required for incontinence. The care sheet documented protective or barrier lotion should be used after incontinence episodes. Review of NA computerized flow sheets revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:46 PM on 8/30/15. On 8/30/15 at 6:12 AM, urinary incontinence care was observed being provided to Resident #8. Nursing Assistant (NA) #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with strong smelling urine and replaced with clean linen and protective brief. No protective lotion was applied after incontinence care. Resident #8 was observed to have an intact protective dressing on his sacrum and a small open red area on the skin over the right ischium bone. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #8 from 11:30 PM on 8/29/15 until 6:12 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours and as needed but that she had 25 residents and the call lights were constantly ringing and it was her first	F 312		

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night by herself and could not get to everyone.

In an interview on 8/30/15 9:05 AM, Resident #8 stated he did not feel there was enough staff on any shift to get his needs met without having to wait a long time. The Resident stated he had waited on several occasions (could not recall the day or month) at least 3 hours before he had his briefs changed by the staff. He stated he had used the call light and the staff would tell him they would come right back, turn off the light, and not come back for several hours. The Resident further stated that last night he was not changed from when he went to bed until the Surveyor came in and it bothered him to be wet and not changed.

In an interview on 8/31/15 at 10 AM NA #3 stated Resident #8 was a heavy wetter and incontinent of bowel and bladder. The NA stated Resident #8 was aware when he voided but will not always ring his call light for assistance so she checked him every 2 hours to see if he needed incontinence care and documented such on the computerized flow sheets.

3. Resident #45 was admitted to the facility on 8/11/15. Diagnoses included diabetes, Non-Alzheimer ' s dementia, chronic lung disease, abnormality of gait, and muscle weakness.
The comprehensive Minimum Data Set (MDS) assessment dated 8/18/15 indicated Resident #45 was cognitively intact, was frequently incontinent of urine and occasionally incontinent of bowel, and needed extensive assistance in toileting and personal hygiene.
The Care Area Assessment (CAA) dated 8/24/15 documented Resident #45 had bladder

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CYPRESS POINTE REHABILITATION CENTER	**2006 S 16TH STREET WILMINGTON, NC 28401**

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F 312	Continued From page 11	F 312		

incontinence, needed extensive assistance with toiletry and experienced shortness of breath with exertion.
Resident #45 had a care plan dated 8/24/15 for incontinence with interventions to include checking the resident every 2 hours, assisting with toileting as needed and providing pericare after each incontinent episode.
The nursing assistant care sheet list documented Resident #45 needed to be checked every 2 hours, assisted with toileting and provided incontinence care as needed.
On 8/30/15 at 5:38 AM, urinary incontinence care was observed being provided to Resident #45. NA #1 greeted the resident, washed her hands, applied disposable gloves and obtained supplies to provide care. The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with urine and replaced with clean linen and protective brief. Resident #45 was observed to have pink intact skin. No protective lotion was applied after incontinence care.

NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #45 from 11:30 PM on 8/29/15 until 5:38 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours and as needed but that she had 25 residents and the call lights were constantly ringing and it was her first night by herself and could not get to everyone.

The Director of Nursing (DON) stated in an interview on 9/1/15 at 5:10 PM that her

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F 312	Continued From page 12 expectations were that the NAs would check incontinent residents every 2 hours to see if they need incontinent care during all shifts.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to keep residents at risk for pressure ulcers dry and use barrier cream for 2 of 6 residents (Resident #89, # 8) at risk for pressure ulcers. The findings included: 1. Resident #89 was admitted to the facility on 11/20/14 with diagnoses that included left below the knee amputation, diabetes and cerebral vascular accident (CVA) with right sided paralysis. The most recent quarterly MDS assessment dated 8/17/15 indicated the Resident was cognitively intact and exhibited no delirium, behaviors or rejection of care. The assessment documented the Resident was frequently incontinent of bowel and bladder and needed	F 314	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #8 was provided incontinent care by NA #1 and clean linens placed on the bed 08/30/15.	10/6/15

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F 314	Continued From page 13 extensive assistance with bed mobility, transfer, toileting and personal hygiene. The resident had no weight loss of 5% or more in the last month or 10% or more in the last 6 months. The Resident was at risk for pressure ulcers but had none. The Resident was care planned (5/6/15) for impaired skin integrity and incontinence (6/1/15) with interventions to include use of pressure relieving device on bed/chair, frequent and prn incontinence care, application of barrier cream after incontinent episodes, and bed linen to be kept clean and dry. The NA care guide revealed the Resident was to have incontinence care and apply barrier cream frequently and prn and his bed linen kept clean and dry. Review of NA flow sheet revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:23 PM on 8/30/15. On 8/30/15 at 6:15 AM, urinary incontinence care was observed to be provided to Resident #89. NA #1 cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with strong smelling urine and replaced with clean linen and protective brief. The NA did not apply barrier cream after incontinence care. Resident #89 was observed to have pink skin around the perirectal area with no skin breakdown noted. On 9/1/15 at 7:25 AM Resident #89 was observed to have incontinence care by Restorative NA #1 after the resident complained of not having incontinence care done all night.	F 314	Resident #89 was provided incontinent care and clean linens placed on the bed 08/30/15 by NA # 1. Incontinent care and clean linens placed on the bed on 9/1/15 by Restorative NA #1. 2. Interventions for residents identified as having the potential to be affected: Resident care observations were completed on 09/01/15 by the facility Director of Nursing (DON), Unit Manager (UM) and SDC on all residents residing in the facility to ensure incontinent care had been provided timely and care needs did not exist. After resident care observations were completed, no other residents were identified as having been affected by this deficient practice. DON and Unit Manager performed a skin assessment on all residents residing in the facility on 9/17/15 and 9/18/15. No other residents were identified as having been affected by this deficient practice. 3. Systematic Change: Newly hired C.N.A.'s will be educated during their education period on their responsibility in preventative skin care with emphasis on ensuring residents who are dependent for personal hygiene and toileting are kept clean, dry and barrier cream is applied (as ordered). Directed in-services for A) Incontinent Care, application of skin protective ointments and B) Maintaining Dignity and Respect during ADL care were provided by a clinical consulting company for all licensed nurses, (C.N.A's) and restorative nursing assistants by October 6th. 4. Monitoring of the change to sustain	

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F 314	Continued From page 14 The NA cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The back of his brief and under pad were observed to be ¾ saturated with urine and replaced with clean linen and protective brief. A strong urine odor was noted. A small open red area was noted on the skin on the right buttock and the NA applied protective cream to the perineal/rectal area. Resident #89 stated in an interview on 8/31/15 at 10:01 AM that he did not think there was enough staff on night shift (11PM-7AM) to meet his needs without having to wait a long time. Resident #89 stated when he called for assistance it might take several hours before they changed him. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #89 from 11:30 PM on 8/29/15 until 6:15 AM on 8/30/15. She further stated that she knew she was supposed to check on the incontinent residents every 2 hours but she had 25 residents and the call lights were constantly ringing and could not get to everyone. Restorative NA #1 stated in an interview on 9/1/15 at 7:40 AM the NA ' s were to check incontinent residents every 2 hours and the night shift NA ' s make their last rounds at 6 AM in the morning and she could not explain why Resident #89 was so wet (with urine) on 9/1/15at 7:25 AM. The Treatment Nurse stated in an interview on 9/1/15 at 8:56 AM that the Restorative NA had notified her that morning (9/1/15) of an area on the Resident ' s buttock and it was a stage II pressure ulcer. The nurse stated the doctor and responsible party would be notified and treatment	F 314	system compliance ongoing: Licensed nursing staff on all residents completes weekly skin checks routinely. The DON and Unit Manager will continue to monitor to assure the skin checks are completed as well as the results of the skin checks at least weekly. DON, Unit Manager, Wound Care Nurse and SDC will also complete skin checks on 4 incontinent residents weekly for 4 weeks. Monthly for a minimum of three months, the DON will report observation care round audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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begun. The Nurse stated that the Resident liked to favor lying on the right side and would slide into that position on his own even after being turned. She further stated that she could not rule out that if he was left in urine it might cause the area to be more prone to breakdown but believed it was more that the area was not open to air.

The DON stated in an interview on 9/1/15 at 5:10 PM that her expectations were that the NA's would check incontinent residents every 2 hours to see if they needed incontinent care during all shifts. She further stated that a resident should not have to lay in a wet diaper all night without being changed.

2. Resident #8 was admitted to the facility on 7/30/14. Diagnoses included diabetes, peripheral vascular disease, hypertension, hip fracture, pressure ulcer heel, incontinence and muscular wasting and disuse atrophy.
According to the Care Area Assessment (CAA) dated 2/2/15 the Resident was at risk for pressure ulcers, had a stage 3 pressure ulcer, needed extensive assistance in bed mobility and was always incontinent of bowel and bladder.
The most recent quarterly MDS assessment dated 6/25/15 indicated the Resident was moderately cognitively impaired, was always incontinent of bladder and frequently incontinent of bowel, and needed extensive assistance in bed mobility, transfer, toileting and personal hygiene. The assessment documented the Resident had no weight loss or gain of 5% or more in the last month or 10% or more in the last 6 months. The Resident did not have a pressure ulcer but was coded as having moisture associated skin damage (MASD) with ointment/medication treatment.

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The Resident was care planned 4/4/15 for skin impairment, potential for pressure ulcers, and incontinence with interventions to include use of pressure relieving device on bed/chair, disposable briefs to be changed frequently and prn, application of barrier cream after incontinent episodes, treatments as ordered, bed linen clean and dry.
On 8/30/15 at 6:12 AM, urinary incontinence care was observed being provided to Resident #8. Nursing Assistant (NA) #1 cleansed the perineal area using a front to back technique, assisted the resident to turn on his side and cleansed the perirectal region. The brief, under pad, linen and bed cover were observed to be saturated with strong smelling urine and replaced with clean linen and protective brief. No barrier cream applied after incontinence care. Resident #8 was observed to have an intact protective dressing on his sacrum and a small open red area on the skin over the right ischium bone.

An observation was made on 8/31/15 at 10:52 AM of the Treatment Nurse giving wound care to Resident #8. A small pink open area noted on the skin over the right ischium and zinc oxide ointment applied. The dressing on the right buttocks was removed and skin observed to be almost totally healed. New dressing applied. The Resident ' s brief noted to be dry.

The Nursing Assistant (NA) care guide documented the Resident required pressure relieving device on bed/chair, turning every 2 hours, used briefs and needed to be checked frequently for incontinence. The care guide documented protective or barrier lotion should be used after incontinence episodes.
Review of Pressure Wound Assessment and

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F 314	Continued From page 17 Care Tool dated 8/23/15 revealed an open Stage II Pressure Ulcer to left buttock was noted measuring 1.3 cm length by 1.1 cm width by 0.1 cm depth with no drainage. Review of Pressure Wound Assessment and Care Tool dated 8/30/15 revealed the Stage II Pressure Ulcer to left buttock now measured 0.4 cm by 1 cm by 0.1 cm. A new area was documented as an excoriation from brief right ischium measuring 2 cm length by 1.5 cm width by 0.1 cm depth with a small amount of serosanguinous drainage. Review of NA flow sheets revealed no documentation of incontinent episodes from 10:20 PM on 8/29/15 to 2:46 PM on 8/30/15. NA #1 stated in an interview on 8/30/15 at 7 AM she had not been able to do rounds and give incontinence care on Resident #8 from 11:30 PM on 8/29/15 until 6:12 AM on 8/30/15. The NA stated she knew she was supposed to check on the incontinent residents every 2 hours but she had 25 residents and the call lights were constantly ringing and she could not get to everyone. The Treatment Nurse stated in an interview on 8/31/15 at 10:10 AM Resident #8 was admitted to the facility with multiple skin ulcers that were assessed and treated. The nurse stated all of the Resident ' s pressure ulcers were healed until 8/23/15 when she was notified of an open area to the left buttocks. The area was assessed, MD and responsible party notified and treatment begun. The Nurse stated this stage II pressure ulcer on the left buttocks was decreasing in size with treatment. The Nurse further stated that on 8/30/15 the Resident ' s family had called and notified her the family had noticed a new area of concern on the Resident ' s skin. The Nurse	F 314		

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F 314	Continued From page 18 checked the Resident and noted an open red area over the right ischium bone around the diaper line. She stated the Resident is a heavy wetter and the area could have been from being incontinent and/or from the brief rubbing the area. The Nurse stated that all incontinent residents were care planned to have barrier cream applied after incontinence care. The nurse stated that a special ointment (Zinc Oxide) was to be applied to the area as treatment. The DON stated in an interview on 9/1/15 at 5:10 PM that her expectations were that the NA's all shifts. She further stated that a resident should not have to lay in a wet diaper all night without being changed.	F 314		
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 observation, record review and resident and staff interviews, the facility failed to transfer a resident with a mechanical lift in a safe manner for 1 of 3 residents observed to be transferred with a mechanical lift (Resident #8). The findings included: Resident #8 was admitted to the facility on 7/30/14. Diagnoses included a history of	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	10/6/15

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F 323	Continued From page 19 poliomyelitis, muscle weakness, muscular wasting and disuse atrophy. A readmission on 1/25/15 revealed a diagnosis of closed fracture of femur with femoral nail placement. The annual comprehensive Minimum Data Set (MDS) dated 1/31/15 indicated Resident #8 required extensive assistance of two staff with transfers and was non-ambulatory. Resident #8 was moderately cognitively impaired and usually understood and usually able to understand others. The Care Area Assessment (CAA) summary dated 2/2/15 identified Resident #8 required extensive to total assistance for ADL ' s. The quarterly MDS dated 6/25/15 indicated Resident #8 required extensive assistance of two staff with transfers and was non-ambulatory. Resident #8 was moderately cognitively impaired and usually understood and able to understand others. The Care Plan dated 3/2/15 listed Resident #8 as having a performance deficit in ADL ' s related to limited mobility. The care guide revealed Resident #8 transferred by mechanical lift with 2 person assistance. An observation was made on 8/30/15 at 9:43 AM of Resident #8 being transferred by mechanical lift to a wheelchair with 2 person assistance. During the transfer, the wheelchair was put into position and locked. The mechanical lift was placed in front of Resident #8 ' s empty wheelchair. Nursing Assistant (NA) #2 was observed to tilt back the wheelchair at a 30 degree angle as Resident #8 was being lowered by the mechanical lift. The front wheels were observed to come in contact with the floor when	F 323	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No harm was caused to Resident #8 by the wheelchair being tilted back during the mechanical lift transfer. 8/31/15 NA #2 was provided one-on-one re-education by the facility Regional Clinical Director on ensuring a safe resident transfer while utilizing a mechanical lift. A return demonstration while utilizing a mechanical lift for transfers was required by NA #2 to ensure safe and competent mechanical lift transfers. 2. Interventions for residents identified as having the potential to be affected: A list of residents transferred by a mechanical lift was developed by the DON 9/23/15. All residents will be observed during transfer to determine if appropriate/safe technique is demonstrated by Regional Clinical Consultant. 8/31/15 the Staff Development Coordinator educated the C.N.A staff to assure all 4 wheels of the wheelchair remain on the ground and the wheels locked during transfer of residents using a mechanical lift. 3. Systematic Change: Newly hired Nursing Staff (Licensed Nurses and CNAs) will be educated during their orientation period on safe	

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F 323	Continued From page 20 the transfer was complete. NA #2 stated in an interview on 8/30/15 at 11:23 AM the wheelchair was tilted back during the transfer in order to position Resident #8 in a comfortable position that would not hurt his back. The Director of Nursing (DON) stated in an interview on 8/30/15 at 11:45 AM every new employee was trained and observed by a staff member in the proper technique of mechanical lift transfers during orientation. The DON stated the resident would be positioned and lifted up by the mechanical lift, lowered into a locked wheelchair, checked for positioning and moved away from the mechanical lift. The DON stated for the resident ' s safety, the wheelchair should never be tilted and all 4 wheels should be on the floor during the transfer.	F 323	transfers utilizing a mechanical lift. Licensed Nurses and CNAs will be required to provide a return demonstration utilizing a mechanical lift to ensure competency of skill. By October 6th, An in-service will be provided to Nursing Staff - Licensed Nurses (LN) and Certified Nursing Assistants (CNA) by the Staff Development Coordinator or Director of Nursing on safe transfers utilizing a mechanical lift. A DVD provided by the lift manufacturer will be used as the source material for training regarding appropriate safe transfers. Licensed Nurses and CNAs will be required to provide a return demonstration utilizing a mechanical lift to ensure competency of skill. 4. Monitoring of the change to sustain system compliance ongoing: Mechanical lift observations will be performed by the Staff Development Coordinator, Director of Nursing, or Nursing Supervisor. Staff Development Coordinator, Director of Nursing, or Nursing Supervisor will observe (3) CNAs perform a mechanical lift transfer to ensure transfer is performed safely. Observations will be performed across all shifts and will occur weekly for a minimum of (3) months. Monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing;	

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F 323	Continued From page 21	F 323	and determine the need for further auditing beyond the three months.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff to meet the resident ' s needs and failed to provide sufficient nursing staff to keep 3 of 6 residents observed during care clean and dry (Resident #89, #8 and #45) and 2 of 6 residents free from skin breakdown (Resident #89 and #8). The findings included:	F 353	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	10/6/15

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F 353	Continued From page 22 1. Cross refer F312. Based on observations, record review and resident and staff interviews the facility failed to provide incontinence care in a manner to maintain personal hygiene for 3 of 6 residents (Resident #89, #8 and #45) who needed extensive assistance to total assistance with toileting/personal hygiene. 2. Cross refer F314. Based on observations, record review and resident and staff interviews the facility failed to keep residents at risk for pressure ulcers dry and use barrier cream for 2 of 6 residents (Resident #89 and Resident #8) at risk for pressure ulcers. On 8/30/15 at 8:15PM Nurse #8 stated in an interview they had had trouble with the schedule lately and sometimes they were not sure who was supposed to be working. The Nurse stated a nursing schedule had been posted but then was changed and there were several different schedules floating around. On 8/30/15 at 8:25PM an interview was conducted with Resident #3 ' s Responsible Party (RP). The RP stated she visited the resident on 8/24/15 around 5:30PM and found the resident " totally soaked " up to her arm pits, the sheet on top of her was wet and the resident had had a bowel movement and was lying in all that. The RP stated later one of the NAs told her they were short staffed. On 8/31/15 at 12:31PM an interview was conducted with Nurse #5. The Nurse stated on 8/27/15 there were 3 NAs (Nursing Assistants) on day shift. The Nurse stated incontinent residents did not get changed, dependent residents did not get turned and repositioned every 2 hours and showers did not get done because they did not have enough staff. The Nurse stated both restorative aides were pulled to the floor to give them 5 NAs so the restorative duties did not get	F 353	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1.) Interventions for affected resident: Resident #8 was provided incontinent care by NA #1 and clean linens placed on the bed 08/30/15. Resident #89 was provided incontinent care and clean linens placed on the bed 08/30/15 by NA # 1. Incontinent care and clean linens placed on the bed on 9/1/15 by Restorative NA #1. Resident #45 was provided incontinent care and clean linens placed on the bed by NA #1 8/30/15. The staff schedule for the remaining shifts and the following day (8/31/15) were reviewed to ensure adequate staff (licensed nurses and C.N.A¿s) was scheduled by Director of Nursing. 2) Interventions for residents identified as having potential to be affected: The Administrator and DON reviewed the current process used for developing the nursing schedule (licensed nurses and C.N.A's) to ensure a systematic approach for scheduling existed and staff was notified in a timely manner of the days they were scheduled to work. The Administrator reviewed the process for creating a 6 week master schedule (to start September 3rd), posting daily staffing sheets and daily schedules,	

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	345002	A. BUILDING _____ B. WING _____	C 09/01/2015

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F 353	Continued From page 23 done. The Nurse stated therapy could not do their job because the NAs could not get the residents ready in time for their therapy. The Nurse stated they should have 8 NAs on day shift. The Nurse stated the next day she told the Administrator they only had 3 NAs scheduled to work and the Administrator stated she was not aware only 3 NAs were scheduled to work. On 8/31/15 at 8:30 AM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated she expected the staff to round on incontinent residents at least every 2 hours and more often for the heavy wetters. The Administrator stated she was hiring as quickly as possible and had hired a total of 12 nurses and NAs in the past month. The Administrator stated she has had people come in extra and have offered bonuses to people who come in to work extra. The Administrator stated the DON did the nursing schedule and was working closely with her to ensure adequate staffing. The Administrator stated she had not used temporary staff because in the past she has had issues with training of temporary staff. On 8/31/15 at 2:26PM the Administrator stated in an interview that on 8/27/15 there were 3 NAs on day shift and the 2 restorative aides were pulled to work on the floor. The Administrator stated the day supervisor and the Director of Nursing went out and assisted the staff so the residents were cared for. On 8/31/15 at 2:36PM NA #4 stated in an interview she tried to change incontinent residents twice during the day shift but sometimes only changed them once because she was so busy bathing other residents and did not have time. The NA stated she was supposed to change incontinent residents every 2-3 hours but was not able to do this because she had so many	F 353	approving and denying Paid Time Off request, scheduling for census, filling vacancies in the schedule, and required minimal staffing coverage. The Administrator worked with the Director of Nursing to schedule a Nursing Staff Meeting on 9/10/15 to review the staffing and scheduling procedures. Another Nursing Staff Meeting was held on 9/24/15 and 9/25/15 to review scheduling processes and updates. Nursing Staff were also in-serviced individually as needed. The Administrator will compare the current budgeted hours for licensed nursing staff and C.N.A. to an employee list to determine vacant positions. 3.) Systemic Change A 6-week schedule (beginning with a start date of September 3) was developed for the licensed nurses and C.N.A's by the DON on 8/17/15. The schedule was posted in a (glassed in) case located in the staff break-room for easy viewing. The Nursing Supervisor, Staff Development Coordinator, and Human Resource Manager were designated to fill any staff vacancies in the 6-week schedule. The DON will verify staffing on a daily basis with the Nursing Supervisor and or SDC to ensure staffing is adequate. The Director of Nursing held a staff meeting with licensed nurses and C.N.A's on 9/10/15 (Administrator attended) to review the procedures for requesting PTO, scheduling and staffing procedures,	

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F 353	Continued From page 24 residents to bathe. The NA stated she usually had between 11 and 15 residents on day shift and most of them were incontinent. The NA stated she had not changed some residents since she gave them a bath between 9AM and 10AM that morning. On 9/1/15 at 7:40AM Nurse #3 stated in an interview they used to have 5 NAs on night shift then went down to 4 and then 3 and sometimes 2. The Nurse stated this was partly due to call ins, no shows and staff leaving. The Nurse stated the staff were fed up with working short of help and some had left. On 9/1/15 at 7:50AM Restorative Aide#1 stated in an interview when she was pulled to staff on the floor she could not do her restorative residents. The Restorative Aide stated they did range of motion, checked for skin issues and applied splints, assisted residents with exercises on the Nu Step machine, some would ambulate and some would do lower extremity exercises with weights, assisted residents with balancing exercises on the parallel bars, some residents would do bean bag toss and sit to stand exercises on the parallel bars. The Restorative Aide provided a list of 28 residents on restorative and stated due to staffing on the floor these residents did not receive restorative services on 8/23/15, 8/24/15, 8/27/15 or 8/28/15. The Nurse in charge of the Restorative NAs stated in an interview on 9/1/15 at 9:49AM restorative services were provided 6 days a week and when the restorative aides were pulled to the floor the restorative duties did not get done for the day and were adjusted for another day. The Restorative NA ' s worksheet was reviewed with the nurse showing restorative was not done for 4 days during the same week (August 23-29, 2015) and the Nurse stated she was not aware.	F 353	and minimal staff coverage needs. Staff were also re-educated regarding the procedure for staying over until coverage arrives. The following strategies were implemented to recruit licensed nurses and C.N.A's: 1) Contracts with Interim staffing agencies were initiated, 2) Vacancies will be posted on INDEED.com and 3) Vacancies will be posted in the local newspaper. 4.) Monitoring of the change to sustain system compliance ongoing: The Administrator will audit staffing and schedules weekly for 12 weeks to verify appropriate staffing. The Quality Assurance Committee will discuss and review the results of the Nurse staffing and schedule audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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F 353	Continued From page 25 On 9/1/15 at 10:23AM NA#5 stated in an interview that on 8/21/15 they had 4 NAs on day shift and they had 16 residents each. The NA stated one NA stayed over from night shift until 11AM and the Day Supervisor and the Staff Development Coordinator came out and helped. The NA stated everybody got a bath but had to do the minimum of washing their face and bottom and was unable to go back and change incontinent residents and turn and reposition them. On 9/1/15 the Administrator stated in an interview she expected the staffing to be adequate to provide resident care.	F 353		