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	345140	A. BUILDING _____ B. WING _____	C 08/14/2015

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BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 000	INITIAL COMMENTS The NH submitted IDR materials that the team reviewed and the team deleted F 332. At the IDR meeting on 9/28/15 it was revealed that F 333 was cited on an adult care home resident and therefore this tag was deleted	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide privacy and dignity for one of 30 sampled residents (Resident #77) by not keeping the resident from being exposed. The findings included: Resident #77 was admitted to the facility on 5/6/15 with diagnoses including acute respiratory failure, seizures, dysphagia and stroke. The Minimum Data Set dated 5/14/15 an admission, indicated Resident #77 was severely cognitively impaired with communication, decision making abilities and did not respond verbally to questions. Totally assistance was required by one to two staff for transfers, toileting, hygiene and bed mobility. Resident #77 was unable to walk. The MDS indicated functional limitation of all extremities could not be determined. The care plan dated 5/21/15 included problems of	F 241	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: It is the facilities policy to promote residents dignity and respect. Clothing was obtained for Resident # 77, and a privacy curtain has been put up in her room that provides full visual privacy. An in-service was provided on September 8, 2015 to all staff by the Director of Nursing on: Knocking on doors before entering resident¿s rooms and When to get assistance if resident is in need of care if the resident is not able to provide care for self.	9/8/15

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

Electronically Signed | 09/07/2015

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F 241	Continued From page 1 total dependence on staff for all care needs and was incontinent of bowel and bladder. This care plan included a problem that she did not give any indication that she realized anything was going on around her and did not respond unless direct care was being done. Approaches included use of pullups/briefs for containment and dignity. Staff were to provide bathing, dressing, grooming/hygiene and incontinence care as needed. Staff were to explain what they were doing during care to keep resident calm. Observations on 08/13/2015 at 8:46 AM revealed Resident #77 was in bed uncovered with her hospital gown above her hips and the disposable brief was showing. The left side rail was padded and the right side of the bed was against the back wall of the room. The head of the bed was on the door side of the room. Interview with roommate (Resident #80, who was alert, cognitively intact) on 08/13/2015 at 8:46 AM revealed the staff usually pull the curtain between her bed and this resident, but not always. She stated it did not bother her. A short curtain was located at the foot of Resident #77 ' s bed. The curtain could be pulled between the roommate and the foot of Resident #77 ' s bed. Interview on 08/13/2015 at 10:30 AM revealed nurse aide #3 and #2 were aware Resident #77 moved about in the bed and removed her brief. When asked if Resident #77 had worn street clothes, they explained the resident did not have any clothing. Observations on 8/11/15 at 10:15 am revealed Resident #77 ' s was in a hospital gown and had kicked her sheet off. She had removed her	F 241	Ensuring that privacy curtains are maintained in each resident's room at all times. If privacy curtains are noted to not be in place staff members are responsible to report this immediately to Administration, who is responsible to ensure the privacy curtain(s) are replaced. The in-service also covered specific items related to all CNAS and Nurses in regards to: Pulling privacy curtains between resident¿s sharing rooms while providing individual personal care. Clothing residents in clothing that promotes dignity and keeps their body covered to prevent exposure if they are unable to verbalize their own needs. Ensuring residents have proper clothing, and if they don¿t notifying administration of the need to supply clothing or notification to families. Action rounds were initiated for resident #77 on August 17, 2015 on an hourly basis for two (2)weeks and then every 2 hours thereafter by nursing staff to ensure resident is covered and not exposed while in bed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Each resident who is unable to verbalize their needs that is unable to keep themselves covered to prevent exposure will be identified through the care plan	

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F 241	Continued From page 2 disposable brief exposing her private area. Continued observations on 08/11/2015 revealed at10:25 AM a maintenance man knocked on the door and entered the room. Resident #77 remained exposed. The maintenance man looked briefly towards Resident #77 when beside her bed, continued into the room and checked the roommate ' s side rail to the bed. Observations on 08/11/2015 at10:27 AM revealed the unit manager entered Resident #77 ' s room at her bedside, looked at the resident but did not cover her or pull door closed. Resident #77 remained exposed during this observation. On 08/13/2015 at 2:30 PM an interview was conducted with the Director of Nursing (DON). The DON explained she would hope the maintenance man would leave the room and get someone if a resident was exposed. When asked how staff would ensure privacy and dignity for Resident #77 she explained any non-nursing staff would leave the room and get a nurse if she was exposed and make sure the sheets covered the resident. The DON explained a hospital gown was being used instead of street clothes. Further explanation provided included the resident stayed in bed most of the time and a hospital gown would be appropriate. The DON was aware Resident #77 would remove the sheets, was scratching her peri area and loosen her brief. When asked how staff would ensure the resident would not be exposed due to brain injury, the DON explained the staff would have to check on her frequently and keep her covered with sheets. Observations on 08/14/2015 at 8:04 AM revealed Resident #77 was in bed with her gown pulled down and her breasts were exposed. The	F 241	process. Each resident will be identified on the ¿Daily Care Guide¿ for the CNA'S. Interventions will be listed on the Daily Care Guide for each specific resident. An in-service was provided on September 8, 2015 to all staff by the Director of Nursing on: Knocking on doors before entering resident¿s rooms and When to get assistance if resident is in need of care if the resident is not able to provide care for self. Ensuring that privacy curtains are maintained in each resident's room at all times. If privacy curtains are noted to not be in place staff members are responsible to report this immediately to Administration, who is responsible to ensure the privacy curtain(s) are replaced. The in-service also covered specific items related to all CNAS and Nurses in regards to: Pulling privacy curtains between resident¿s sharing rooms while providing individual personal care. Clothing residents in clothing that promotes dignity and keeps their body covered to prevent exposure if they are unable to verbalize their own needs. Ensuring residents have proper clothing, and if they don¿t notifying administration of the need to supply clothing or notification to families. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT	

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F 241	Continued From page 3 hospital gown was pulled up exposing her disposable brief. When entering the room, about 2 feet, you could see her exposed body. Resident #77 did not have sheets covering her. Interview with the DON on 08/14/2015 at 8:07 AM revealed she was asked to observe the resident. The DON observed the resident exposed and covered her with her gown. Interview with the DON revealed she was going to ask the staff to get her up today. On 08/14/2015 at 8:27 AM an interview was conducted with the maintenance director. He stated a maintenance staff from a " sister " facility had assisted him that day. The assisting staff member should have got an aide prior to going into Resident #77 ' s room if she was exposed.	F 241	OCCUR: Action rounds were initiated for resident #77 on August 17, 2015 on an hourly basis for two (2)weeks and then every 2 hours thereafter by nursing staff to ensure resident is covered and not exposed while in bed. The 24 hour report will be utilized by the nurses to record any resident identified with a need for clothing to prevent exposure. This report will be reviewed each morning in the Administrative morning meeting at which time it will be determined what plan of action is required for the resident identified. Action rounds by the Nursing staff will be initiated on each resident identified as having potential for exposure due to lack of clothing or inability to keep self covered every two hours and will be recorded on an Action Round Form to ensure privacy and dignity is maintained until proper clothing can be obtained. Through the care plan process the resident will be identified as being at risk for exposure and will be identified on the ¿Daily Care Guide¿ for the CNA'S. Any resident identified as having any need for clothing will be immediately reported to the Social Worker or other Administrative staff for attention. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING	

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F 241	Continued From page 4	F 241	THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The 24 hour report will be utilized by the nurses to record any resident identified with a need for clothing to prevent exposure. This report will be reviewed each morning in the Administrative morning meeting at which time it will be determined what plan of action is required for the resident identified. Action rounds by the Nursing staff will be initiated on each resident identified as having potential for exposure due to lack of clothing or inability to keep self covered every two hours and will be recorded on an Action Round Form to ensure privacy and dignity is maintained until proper clothing can be obtained. Through the care plan process the resident will be identified as being at risk for exposure and will be identified on the ¿Daily Care Guide¿ for the CNAS. Any resident identified as having any need for clothing will be immediately reported to the Social Worker or other Administrative staff for attention. The QA Committee will review the facility¿s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed	

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F 241	Continued From page 5	F 241	to achieve and maintain corrective solutions.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, record review and staff interview the facility failed to provide a specialty mattress that fit the bedframe for 1 of 1 resident (Resident #41). The findings included: Resident #41 was admitted to the facility on 1/16/15 with diagnoses that included depressive disorder, late effect hemiplegia non-dominate, and cellulitis of leg. The most recent Minimum Data Set (MDS) assessment dated 6/14/15 revealed Resident #41 required extensive assistance by 2 staff persons for bed mobility and transfers. Resident #41 had upper and lower extremity impairment and was coded as cognitively intact. Review of Resident #41 ' s physician order dated 7/3/15 stated, Air mattress - low loss - for pressure reduction and decrease risk of wounds. Write in past tense. Review of Resident #41 ' s care plan dated 7/10/5 indicated a problem of " falls " that stated, Resident #41 had some impairment with balance during transition, he	F 246	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The extra mattress was removed for Resident #41. An overlay was placed on top of the current mattress and Dycem (an anti-slip material) was placed between the mattress and the overlay to prevent the overlay from shifting. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Quality assurance rounds were made on September 2, 2015 by the Administrator and there are no other residents in the	9/8/15

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F 246	Continued From page 6 required extensive assistance with transfers due to left hemiplegia. He takes Ativan, Cymbalta, Trazadone, and Ambien and Norco daily. He was at risk for fall related injuries. The goal stated Resident #41 would be free from major fall injury should any fall occur through next review. The interventions included air mattress low loss for pressure reduction and decrease risk of wounds, and keep bed at lowest level when resident is in bed and care not being rendered. Review of resident #41 ' s incident report dated 7/7/15 revealed Resident #41 had a fall from his bed. The resident ' s account of the event indicated the he slid out of his bed. The description of the accident stated, " Resident has a new mattress on bed and he states that when he rolled over in bed he slid off the mattress. The assistive devices included mattress topper (blow up). The interventions put into place included overlay removed from bed. Observation of Resident #41 ' s bed on 8/11/15 at 2:47pm revealed 2 mattresses. The top mattress and bottom mattress were observed to be too long for the bed frame. The 2 mattresses were observed to have slick surfaces. The mattresses freely moved from one another when slightly touched. Observation on 8/12/15 at 11:44am revealed Resident #41 ' s bed to have 2 pressure relieving mattresses applied. The mattresses were observed to be too long for the bed frame. The mattresses had slick surfaces and moved freely. Observation on 8/12/15 at 2:07pm revealed the resident ' s bed to have double mattresses. The top mattress slid easily when touched from the mattress underneath it. Interview with Resident #41 ' s Nurse (Nurse #2) on 8/12/15 at 2:09pm revealed Resident #41 ' s	F 246	facility who have two mattresses and all mattresses were noted to be appropriate for the beds. An in-service was completed on September 8, 2015 by the Administrator who made staff aware that we are not allowed to use two mattresses on the resident's beds even if requested to do so if the resident's health or safety is at risk. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: Quality assurance rounds were made on September 2, 2015 by the Administrator and no other beds had two mattresses observed and all mattresses were noted to be appropriate for the beds. An in-service was completed on September 8, 2015 by the Administrator who made staff aware that we are not allowed to use two mattresses on the resident's beds even if requested to do so if the resident's health or safety is at risk. If the residents complain about the mattress on the bed a different mattress can be attempted or a new one purchased. If an overlay is used on the mattress then a anti-slip material must be used. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE	

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F 246	Continued From page 7 mattresses were both pressure reduction. It was her understanding that Resident #41 did not like his previous mattress. It was not common practice to place one mattress on top of another. She assumed the mattresses were doubled at resident request. Interview with the Maintenance director on 8/12/15 at 3:52pm revealed it was Resident #41 ' s request to have two mattresses. Maintenance indicated the top and bottom mattress measured at 78 inches in length. The bedframe measured at 75 inches in length. Maintenance revealed it was not facility practice to put one mattress on top of another. The bed currently sits at 11 inches in height and most are between 6 ½ and 7 ½ inches in height. Resident #41 ' s bed is 4 inches higher than most beds. Interview with the Director of Nursing (DON) on 8/12/15 at 5:03pm revealed she was not aware Resident #41 had 2 mattresses on his bed. It was her expectation that the mattress fits the bed and the bed is the appropriate length for the bedframe.	F 246	SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. On a monthly basis the Maintenance Supervisor will conduct a Quality Assurance Round to observe all resident's beds to ensure that only one mattress is present. If more than one mattress is noted it will be reported to the Administrator/or Designee who will speak with the resident(s) involved and the second mattress will be replaced. The QA Committee will review the facility¿s progress on a quarterly basis for six months for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		9/11/15

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F 253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to make repairs to walls and baseboards, repair constant dripping water faucet and replace cracked electrical outlet covers in 12 of 30 rooms. (Room 101,103,106,107,200,201,202,204,206,302,303 and 306) The findings included: The following observations were made on 8/10/15 and 8/11/15 during day 1 and day 2 of the survey: a. Room 101- small holes and shaved sheetrock on 2 walls in the bathroom b. Room 103-b sheetrock behind the head of the bed has a 6 inch hole in the wall and bed frame was sticking into the sheetrock. c. Room 106- the air conditioning (a/c) unit cover has a crack above the controls, towel rack behind the door has towel bar missing and brackets hanging loose from the wall leaving holes in sheetrock. d. Room 107-the corner baseboard panel at the right side of the bathroom door missing. e. Room 200-toilet water tank had a missing cover exposing water and tank valve. f. Room201- electrical outlet cover in bathroom cracked, hot water constantly running from water faucet from bathroom sink. g. Room 202-residents personal fan in room on over-bed table missing cover exposing plastic blades. h. Room 204- sheetrock missing under window and above a/c unit the entire length of the window. The screen outside of the window was torn and missing approximately a 6 inch section.	F 253	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility maintains a facility that provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment. On September 2, 2015 Quality Assurance Rounds were made by the Administrator to determine any like areas of concern were noted. The areas identified on the CMS-2567 as (A-L) as deficient practices have all been corrected. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On September 2, 2015 Quality Assurance Rounds were made by the Administrator to determine any like areas of concern were noted. The areas identified on the CMS-2567 as (A-L) as deficient practices as well any identified on the QA rounds have all been corrected. An in-service/staff meeting was held with the housekeeping/maintenance department on August 20, 2015 at which time a new Deep Clean Schedule was implemented along with the appropriate documentation required. During this weekly Deep	

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F 253	Continued From page 9 i. Room 206- water constantly running from water faucet from bathroom sink. j. Room 302-hole in the wall in the bathroom to the left of the bathroom sink approximately 3 inches in circumference. k. Room 303- floor in the bathroom has cracked flooring at the baseboard on the right side of the sink approximately 18 inches in length. No hot water would come out of faucet from the bathroom sink when turned on. The electrical outlet for the TV and cable was broken at wall beside the bed. l. Room 306-No hot water would come out of the faucet from the bathroom sink when turned on. Positioning device in wheelchair under right arm for resident in bed B was torn exposing foam and had been stapled together. An interview with Nurse #6 on 8/13/15 at 9:00 AM revealed a clip board is kept at each nurse ' s station with maintenance request forms. When a repair is needed the form is filled out and maintenance checks the clip board each morning. If it is an urgent repair then she calls him immediately. He is available any hour. During an interview with housekeeping aide #1 on 8/13/15 at 9:15 AM indicated that she reports any concerns to the maintenance director and she fills out a maintenance request form that are kept at the nurses station on a clip board. An interview with NA #2 on the East hall at 9:30 AM on 8/13/15 revealed that any equipment or room environment needs would be communicated to the maintenance director. She was not aware of any maintenance request forms that needed to be completed to communicate the	F 253	Cleaning of the resident's rooms they were instructed to check the room for not only cleanliness but the following items as well: 1. Any repairs including equipment (facility or resident), building or otherwise that needs to be made; 2. Privacy curtains are in place, clean and in good working order; 3. Bathrooms are clean, equipment not broken or faucets leaking or not working; 4. Ensure the air conditioning vents are in good repair. Anything that is in need of repairs must be written on the Maintenance Request Form and placed on the clipboard on each unit. Another in-service for all staff was held on September 8, 2015 by the Administrator to ensure staff is aware of the importance of placing any repairs to facility or resident equipment on the Maintenance Request Form that is on each unit of the facility as well as in the kitchen and laundry room. The Maintenance Supervisor is responsible to check these areas twice daily and make the necessary repairs as soon as possible. If parts need to be ordered or other materials obtained the area of concern will be corrected as soon as possible as long as it does not place the resident at risk for harm or injury. If necessary the nursing staff will notify Maintenance Supervisor via telephone of any areas of concern. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT	

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F 253	Continued From page 10 repair needs to maintenance. During a second observation with the Maintenance Director on 8/14/15 at 8:00 AM revealed the following: a. Room 101- the maintenance director revealed that the electric wheelchair was causing the small holes and shaved sheetrock on the walls, he has repaired it before and was not aware that new repairs were needed. b. Room103-maintenance was not aware of the 6 inch hole in the sheetrock behind the bed and the damage the bed was making to the wall. c. Room 106-maintenance was not aware of the crack a/c unit cover and the broken towel rack with brackets hanging off the wall behind the door. d. Room 107-maintenance was not aware of the corner panel baseboard missing on the right side of the bathroom door. e. Room 200- maintenance was not aware that the toilet water tank lid was missing, it was located on the floor beside the toilet and maintenance replaced the lid on the tank. f. Room 201-maintenance was not aware of the cracked electrical outlet cover in the bathroom, he indicated that the washers were bad and the stems had to be replaced in the faucet. That is why the water is constantly running from the faucets. He has notified plumbing and they will be here next week. g. Room 202-maintenance was not aware of the fan in the room without a protective cover over the fan blades. He indicated that normally he is aware of items that are brought from home. He was not aware of the fan in room 202. He further indicated that he does not know how long the fan has been in the room, no one has reported it.	F 253	THE DEFICIENT PRACTICE WILL NOT OCCUR: On September 2, 2015 Quality Assurance Rounds were made by the Administrator to determine any like areas of concern were noted. The areas identified on the CMS-2567 as (A-L) as deficient practices as well any identified on the QA rounds have all been corrected. An in-service/staff meeting was held with the housekeeping/maintenance department on August 20, 2015 at which time a new Deep Clean Schedule was implemented along with the appropriate documentation required. During this weekly Deep Cleaning of the resident's rooms they were instructed to check the room for not only cleanliness but the following items as well: 1. Any repairs including equipment (facility or resident), building or otherwise that needs to be made; 2. Privacy curtains are in place, clean and in good working order; 3. Bathrooms are clean, equipment not broken or faucets leaking or not working; 4. Ensure the air conditioning vents are in good repair. Anything that is in need of repairs must be written on the Maintenance Request Form and placed on the clipboard on each unit. Another in-service for all staff was held on September 8, 2015 by the Administrator to ensure staff is aware of the importance of placing any repairs to facility or resident equipment on the Maintenance Request Form that is on each unit of the facility as	

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F 253	Continued From page 11 h. Room 204-maintenance was not aware of the sheetrock missing under the window and above the a/c unit. He was not aware of the torn window screen outside the window. i. Room206-maintenace was not aware of the water constantly running from the faucet from the bathroom sink. j. Room 302-maintenance was not aware and it was not reported of the 3 inch hole in the wall on the left side of the sink. k. Room 303-maintenance was not aware of the cracked flooring in the bathroom, was not aware of no hot water from faucet, he indicated that someone turned the water off under the sink. He was not aware of the broken electrical outlet and it was not reported. l. Room 306-maintenance indicated that someone turned the hot water off under the sink and that is why there is no running water from the faucet, no one has reported the positioning device in the wheelchair needed repaired. He indicated that the device would be removed today. The use of staples in the device was not appropriate. During an interview with the Maintenance Director on 8/14/15 at 8:30 AM revealed that things are being missed and the maintenance department is not aware. He plans to get a system and get it corrected. His expectation is that maintenance request forms be used for communication. He indicated that the mode of communication is the use of the work order forms located at each nurses station. He further indicated that he does not have a process to check rooms, he makes his observations during rounds. If anything is out of order or needs repair then it is repaired at that time.	F 253	well as in the kitchen and laundry room. The Maintenance Supervisor is responsible to check these areas twice daily and make the necessary repairs as soon as possible. If parts need to be ordered or other materials obtained the area of concern will be corrected as soon as possible as long as it does not place the resident at risk for harm or injury. If necessary the nursing staff will notify Maintenance Supervisor via telephone of any areas of concern. The Maintenance Supervisor is responsible to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern. He is responsible to document these findings on a Maintenance QA Rounds Sheet and it will be given to the Administrator for review after the repairs have been made with the date of identification and date of correction. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Maintenance Supervisor is responsible to check the clipboards for the Maintenance Request Forms twice daily	

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F 253	Continued From page 12	F 253	and make the necessary repairs as soon as possible. If parts need to be ordered or other materials obtained the area of concern will be corrected as soon as possible as long as it does not place the resident at risk for harm or injury. If necessary the nursing staff will notify Maintenance Supervisor via telephone of any areas of concern. The Maintenance Supervisor is responsible to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern. He is responsible to document these findings on a Maintenance QA Rounds Sheet and it will be given to the Administrator for review after the repairs have been made with the date of identification and date of correction. The Administrator will conduct QA Rounds on a monthly basis for three (3) months to ensure that all facility repairs are made and the facility maintain a sanitary, orderly and comfortable environment. If after three months the necessary corrections are being made then the Administrator will do QA Rounds on a Quarterly Basis. The QA Committee will review the facility¿s progress monthly and quarterly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		9/10/15

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F 280	Continued From page 13 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update the care plan and add an intervention to relieve pressure and prevent a pressure ulcer on the right outer thigh that progressed to an unstageable pressure ulcer for 1 or 2 residents reviewed for pressure ulcers (Resident#28) and 2 of 3 residents reviewed for positioning (Resident #77 and #15). Findings included: 1. Resident #28 was admitted to the facility on 6/8/15 with the diagnosis of chronic kidney disease, pressure ulcer, hypertension, chronic pain and paraplegia and neurogenic bladder.	F 280	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #28 had his care plan updated on 08/17/2015 by the MDS Nurse to identify the unstageable pressure ulcer on the right outer thigh. Interventions were entered for prevention of future areas as well as interventions for current pressure ulcers. Resident #15 had her care plan updated on 08/17/2015 by the MDS Nurse to remove the wheelchair, soft neck collar	

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F 280	Continued From page 14 The most recent Minimum Data Set (MDS) assessment with an assessment reference date of 7/1/15 revealed that Resident #28 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s). The MDS further indicated that Resident #28 was at risk for pressure ulcers and had two stage 4 pressure ulcers present on admission and 7 unstageable present on admission. The most severe with eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges). The care plan initiated on 7/16/15 indicated a problem of impaired skin integrity-pressure ulcer stage 4, has history of infections to ulcers and refuses care at times, incontinent care and dressing changes. The approaches included monitor diet, medicate per order, measure and record weekly, inform physician of changes, encourage to be off site as much as possible, plexus low air loss mattress at all times for pressure reduction and comfort, monitor for signs and symptoms of infection, temperature, change in condition, incontinent care timely- resident refuses incontinent care at times, evaluate plan of treatment if not improvement or worsening noted 2-4 weeks time, reassess the treatment plan, pressure reduction cushion in wheelchair to assist with pressure reduction at all times. The weekly wound and skin status report dated 8/13/15 revealed an area to the right outer thigh that was facility acquired on 7/1/15 described as a blister that opened, measurements .5 cm in length , 1.5 cm in width and depth .10 cm. The measurements on 8/11/15 revealed measurements of 7.5 cm in length, 4.5 cm in width and 1.5 cm in depth described as	F 280	and posture vest as they no longer apply to this resident. Resident #77 had her care plan updated by the MDS Nurse on 08/24/2015 to reflect the use of only the left side bedrail to have padding. All of the residents future care plans will be updated with necessary interventions using the following methods: Review of the 24 hour report in the Administrative morning meeting M- F; MDS nurse will review of all physician telephone orders (pink slips); Review Physician¿s Progress Notes; Information reported to the MDS nurse throughout the day concerning changes in resident¿s condition; MDS nurse will attend weight/wound committee meetings; Chart review will be done three (3) times a week by administrative staff; MDS nurse will receive a copy of the weekly wound report. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Resident Care plans have been audited for compliance of appropriate interventions. The residents future care plans will be updated with necessary interventions by the MDS Nurse using the following methods: Review of the 24 hour report in the Administrative morning meeting M- F; MDS nurse will review of all physician	

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F 280	Continued From page 15 unstagable with 50% slough and 50% eschar. The care plan was not updated on 8/4/15 to identify a new unstageable pressure ulcer on the right outer thigh with specific interventions for pressure reduction and positioning for Resident #28 ' s thighs while in the wheelchair. The physical therapy progress note dated 7/31/15 revealed that Resident #28 was treated 7/2/15-7/31/15 for muscle weakness. The discharge summary indicated under clinical impression that Resident #28 would benefit from being in a larger wheelchair where he would fit better and his lower extremities would be in a better position with patient refusing to go into a larger wheelchair at this time. The discharge summary further indicated that Resident #28 was educated on why he should go into a larger wheelchair with instructing him it would help with position on his lower extremities and keep him from pressing against the sides of the wheelchair and if patient continues to sit in his wheelchair the way he is he will most likely develop pressure sores and his lower extremities will get stiffer and it will become harder to do ADL ' s. A review of the physicians progress note dated 8/4/15 indicated the visit was for a wound check and patient was noted to have a new wound on his right lateral thigh. The wound has a black area and has significant drainage, redness and warmth around the new wound. Per staff the patient is sitting in his wheelchair all day and his legs pressed against the metal bar of the arm rest. Patient shows no signs of pain. The right lateral thigh is unstagable with thick eschar. A physicians order dated 8/4/15 indicated to give	F 280	telephone orders (pink slips); Review Physician¿s Progress Notes; Information reported to the MDS nurse throughout the day concerning changes in resident¿s condition; MDS nurse will attend weight/wound committee meetings; Chart review will be done three (3) times a week by administrative staff; MDS nurse will receive a copy of the weekly wound report. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The MDS Nurse completed training at the State Sponsored training on 09/08/2015 and 09/09/2015 which included instructions on care plans. A MDS Consultant also provided training on Care Plans which included how to write a problem, goals and interventions that are specific to the resident. Also instructed her on updating care plans as new problems arise, problems are resolved and new orders by physician may occur. This training was completed on 09/10/2015. The residents care plans will be updated with necessary interventions by the MDS Nurse using the following methods: Review of the 24 hour report in the Administrative morning meeting M- F; MDS nurse will review of all physician telephone orders (pink slips);	

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F 280	Continued From page 16 Omnicef 300 milligrams 2 tablets by mouth every day for 10 days for infected thigh wound and treat thigh wound with santyl (enzyme debriding ointment), calcium alginate (antimicrobial action that absorbs drainage) and cover with occlusive dressing. During an interview with the wound care nurse on 8/13/15 at 10:00 AM revealed that all of Resident #28 ' s wounds were present on admission and have improved and decreased in size. The right lateral thigh is facility acquired and about a week ago the nurse aide reported a blister on the right outer thigh caused by wheelchair armrest. The patients thigh rest against the armrest. The patient gets up in the morning and wants to stay up all day. The physical therapist recommended foam to be applied and maintenance applied foam to both armrest bars on 8/4/15. An observation on 8/13/15 at 10:38 AM revealed Resident #28 being self-mobile in the reclining wheelchair and interacting with other residents in the hall. The pressure reduction cushion was in the wheelchair and both armrest were covered with foam. Resident #28 was positioned in the center of the chair and there was approximately a 2 inch space between his thighs and the wheelchair armrest. During an interview with Resident #28 he indicated that he felt his thigh pressing on the arm rest and reported it and that is when the foam was applied by maintenance. Resident #28 indicated that the area on his thigh was a blister and now it is a large area they are treating. He stated that if staff would position him in the center of the wheelchair his thighs did not touch the bars. He did not want another wheelchair because he was comfortable in the one he had.	F 280	Review Physician¿s Progress Notes; Information reported to the MDS nurse throughout the day concerning changes in resident¿s condition; MDS nurse will attend weight/wound committee meetings; Chart review will be done three (3) times a week by administrative staff; MDS nurse will receive a copy of the weekly wound report. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Administrative Staff will review the resident's Care Plans on a weekly basis for one (1) month, bi-weekly for two (2) months, and monthly for six (6) months to ensure that changes in the resident and the interventions are being identified in a timely manner. The QA Committee will review the facility¿s progress monthly for nine (9) months for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain	

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F 280	Continued From page 17 During an interview with Nurse Aide (NA) #1 on 8/13/15 at 1:30 PM indicated that she was aware to keep Resident #28 thighs away from the wheelchair armrest. The " Daily Care Guide " is used to inform the NA ' s on the resident care needs. An interview with Nurse #1 at 2:30 PM on 8/13/15 indicated that the area on Resident #28 ' s right thigh started as a blister and was treated with skin prep. It was reported that the area was caused by the wheelchair. Nurse #1 further indicated that therapy checked the wheelchair and recommended foam covering in the bars. The NA ' s are aware to report any skin changes to the nurse and use the " Daily Care Guide " to inform them of the resident care needs. An interview with the MDS coordinator on 8/13/15 at 2:07 PM revealed that the care plan is updated each morning by the report from morning clinical meeting and review of pink physician ' s telephone orders. She further indicated that she was not aware of a new pressure ulcer on Resident #28 ' s right thigh that needed pressure reduction when in the wheelchair from wheelchair armrest bars. During an interview with the Director of Nurses on 8/13/15 at 3:20 PM revealed that it is her expectation that the NA ' s report any skin changes to the nurse on duty and to keep resident turned and repositioned as indicated on their " Daily Care Guide " . It is her expectation that care plans be updated each morning with residents change in condition by the MDS coordinators.	F 280	corrective solutions	

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During an interview with the physical therapist #1 on 8/14/15 at 11:00 AM revealed that Resident #28 was discharged from therapy on 7/31/15 and she recommended a wider wheelchair which the resident totally refused and the physician asked her to look at the wheelchair for pressure relief and she asked maintenance to get some foam on the arm rest bars and it has been applied. There is a space on each side between his legs and the arm rest bars, it depends on his positioning.

2. Resident #15 was admitted to the facility on 8/6/12 with diagnosis of stroke, seizures and hemiparesis.

The quarterly Minimum Data Set (MDS) dated 7/13/15 indicated Resident #15 had moderate impairment with memory and cognition, no behaviors were exhibited and she required extensive assist of 2 staff for bed mobility, transfers and toileting. This MDS assessed her balance for transfers as "unsteady" without human assistance.

Review of the care plan dated 7/22/15 indicated Resident #15 had problems of right hemiparesis, poor balance, curvature of the spine and weakness. The approaches for this problem included the use of a standard high back reclining wheelchair which was to be positioned to recline at 10 degrees for comfort. This care plan included a problem of being at risk for decline in range of motion which required restorative nursing. The approaches for restorative included application of a posture vest which was to be worn every day as tolerated when seated in the wheelchair. A soft neck collar was to be applied

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after range of motion was provided to her neck.

Review of the most recent physician ' s orders revealed no orders for the high back reclining wheelchair, soft neck collar or the posture vest.

Observations of Resident #15 on 8/13/15 at 11:30 AM revealed she was seated in a standard wheelchair without a soft neck collar or the posture vest.

Interview with the Administrator on 8/13/15 at 2:45 PM revealed care plans should be updated as needed when changes occur.

Interview with the MDS nurse on 08/14/15 at 9:27 AM revealed the restorative care plan was not updated. The interventions were no longer required for the resident. A previous MDS nurse may have missed it due to human error. The MDS nurse also missed it as she was in training. The MDS nurse further explained Resident #15 was the first care plan she had updated while in training.

3. Resident #77 was admitted to the facility on 5/6/15 with diagnoses including acute respiratory failure, seizures, dysphagia and stroke.

The admission Minimum Data Set dated 5/14/15 indicated Resident #77 was severely impaired with communication, decision making abilities and did not respond verbally to questions. Total assistance was required by one to two staff for transfers, toileting, hygiene and bed mobility. Resident #77 was unable to walk. The MDS indicated functional limitation of the extremities could not be determined.

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The care plan dated 5/21/15 included problems of totally dependent on staff for all care needs and was incontinent of bowel and bladder. The care plan included a problem that she did not give any indication that she realizes anything is going on around her and does not respond unless direct care is being done. Approaches included staff were to provide bathing, dressing, grooming/hygiene and incontinence care as needed. The care plan addressed a problem of at risk for injury due to left side flaccid and receives an anticoagulant. The care plan was updated on 8/4/15 due to Resident #77 had her left leg caught in the side rail. The approaches included padding of both side rails.

Observations on 8/11/15 at 9:57 AM revealed the left full side rail was padded. The right full side rail was not padded.

Observations o 08/13/15 at 8:12 AM revealed the right side rail did not have padding.

Observations on 8/13/15 at 9:36 AM revealed Resident #77 was sideways in the bed. Her legs were positioned to the right side of the bed with her right foot pushed against the inside of the full side rail. The right side rail was not padded.

Observations on 08/13/15 at 9:59 AM revealed Resident #77 moved her right foot freely, and put the right foot through the side rail. Resident #77 was able to remove the foot from the side rail.

On 8/13/15 at 2:38 PM an interview was conducted with the Director of Nursing (DON). Interview with the DON revealed Resident #77 was to have the left side rail padded. She was not aware the care plan included the right side

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 21 rail. Further interview revealed she " favored " the left side of the bed and would turn to that side. Observations on 8/14/15 at 7:56 AM and 8/14/15 at 8:08 AM revealed Resident #77 was lying in bed with her legs and feet on the right side of the bed. Observations were made with the DON on 8/14/15 at 8:08 AM. The DON observed the resident with her legs and feet sideways towards the right side rail. The DON was informed the resident had her foot on the side rail at a previous observation that morning. On 8/14/15 at 9:24AM an interview was conducted with the MDS nurse regarding the care plan updates for padding to both side rails. The MDS nurse explained she wrote both side rails during a morning staff meeting when the incident occurred with Resident #77 ' s foot through the side rail. She had written to use padding on both side rails. Further interview revealed the incident involved the left side rail and she favored that side rail. The MDS nurse explained she may have updated the care plan incorrectly.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		9/8/15

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F 282	Continued From page 22 Based on observation, record review, and staff interview the facility failed to provide care according to the care plan for 1 of 10 sampled residents (Resident #31) who was care planned for adaptive eating equipment. The findings included, Resident #31 was admitted to the facility on 2/1/13 with a diagnosis that included stomach dysfunction, depressive disorder, late effect cardiovascular disease cognitive deficit, osteoarthritis, and chronic pain. The most recent Minimum Data Set (MDS) Assessment dated 6/9/15 indicated Resident #31 had upper extremity impairments and was moderately cognitively impaired. Review of Resident #31 care plan dated 6/23/15 revealed a problem of " nutrition " . The care plan stated, Resident #31 was at risk for weight fluctuations with history of weight gain/loss. He received chopped meats for lunch and supper. Resident #31 used built up utensils to assist with the use of forks/spoons and cups with handles for easier grips. The goal included Resident #31 would continue to feed himself with minimal assistance and not experience complications related to significant weight gain/loss changes though next review. The approaches included provide built up utensils, mugs with handles and refer to speech therapy. Review of Physician order dated 8/2/15 indicated use built up handles applied to feeding utensils to increase handling area. Observation on 8/10/15 at 12:33pm revealed Resident #31 having his meal tray set up by a nursing assistant (NA). The NA was observed to unroll Resident #31 standard silver wear. The dining utensils were observed to not have built up handles. No built up device was applied to the resident ' s silverware. Review of Resident #31 '	F 282	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident number 31 is receiving the adaptive equipment ordered by his physician. An In-service on adaptive equipment was conducted on August 17, 2015 for the dietary staff and September 8, 2015 for dietary and nursing staff by the Certified Dietary Manager and the Director of Nursing. The in-service included the uses of adaptive equipment and how to determine which residents have a physician's order for the equipment. The Dietary staff was instructed to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants were instructed to read the tray card to determine if adaptive equipment is needed and if not present to obtain the equipment prior to serving the tray. The Daily Care Guide and Tray Card are updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff. Care plans will be updated through review of the physician telephone orders (pink slips) by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s conditions or needs.	

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F 282	Continued From page 23 s meal cared indicated handled cup and included special eating utensils. Observation on 8/14/15 at 7:54 am revealed Resident #31 to eating breakfast in his room. The resident did not have any build up eating utensils. Review of Resident #31 ' s meal cared indicated handled cup and included special eating utensils. Interview with the Nursing Aid (NA) #5 on 8/14/15 at 9:11am revealed she read the meal card when she provided resident #31 with a meal on 8/14/15 for breakfast. NA#5 indicated she had never observed Resident #31 to utilize build up eating equipment. NA#5 stated she typically gave the resident a standard spoon to eat with. In the instance a resident received adaptive eating equipment it typically comes out on the meal tray. Interview with the Administrator on 8/14/15 at 1:03pm revealed it was her expectation that staff follow the care plan in regards to resident care. Eating equipment is care planned in the expectation all staff are aware of the resident ' s needs.	F 282	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's physician's orders were reviewed to determine that resident's with adaptive equipment were being supplied with the equipment on their meal trays. An In-service on adaptive equipment was conducted on August 17, 2015 for the dietary staff and September 8, 2015 for dietary and nursing staff by the Certified Dietary Manager and the Director of Nursing. The In-service included the uses of adaptive equipment and how to determine which residents have a physician's order for the equipment. The Dietary staff was instructed to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants were instructed to read the tray card to determine if adaptive equipment is needed and if not present to obtain the equipment from Dietary prior to serving the tray. The Daily Care Guide and Tray Card are updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff. Care plans will be updated through review of the physician telephone orders (pink slips) by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s	

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F 282	Continued From page 24	F 282	conditions or needs. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Dietary staff is to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants are to read the tray card prior to serving the tray to resident to determine if adaptive equipment is needed and if not present to obtain the equipment from Dietary. The Daily Care Guide and Tray Card will be updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff. Care plans will be updated through review of the physician telephone orders (pink slips) by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s conditions or needs. The Certified Dietary Manager will conduct a QA Check on the tray service on a daily basis for one (1) week, three (3) times weekly for one (1) month to ensure that adaptive equipment is being provided to the residents with an physician's order. INDICATE HOW THE FACILITY PLANS	

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F 282	Continued From page 25	F 282	TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Certified Dietary Manager will conduct a QA Check on the tray service on a daily basis for one (1) week, three (3) times weekly for one (1) month to ensure that adaptive equipment is being provided to the residents with an physician's order. Care plan/Daily Care Guide review will be done weekly for one (1) month, bi-weekly for two (2) months, and monthly for six (6) months. The QA Committee will review the facility¿s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		9/8/15

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F 309	Continued From page 26 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to maintain a helmet on one of one resident with use of a helmet due to seizures. (Resident #77) The findings included: Resident #77 was admitted to the facility on 5/6/15 with diagnoses including acute respiratory failure, seizures, dysphagia and stroke. The Minimum Data Set dated 5/14/15 an admission, indicated Resident #77 was severely cognitively impaired with communication, decision making abilities and did not respond verbally to questions. Totally assistance was required by one to two staff for transfers, toileting, hygiene and bed mobility. Resident #77 was unable to walk. The MDS indicated functional limitation of all extremities could not be determined. Review of the physician ' s order dated 5/19/15 indicated Resident #77 was to wear a soft helmet at all times. The care plan dated 5/21/15 included problems of total dependence on staff for all care needs. The care plan indicated a problem of seizures. The approaches included the use of a soft helmet to be worn at all times.	F 309	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: After review by the attending Physician the helmet for Resident # 77 was discontinued while in bed. While out of bed the helmet is to still be placed on the resident. A fastening device is on the helmet to prevent the helmet from moving around which causes it to cover resident's face. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Each resident¿s medical record and care plan were reviewed to ensure compliance of interventions is in place. The resident¿s TAR was reviewed to ensure the orders are on the TAR and that nurses are signing to verify that the helmet is in place. The DON/Designee will review the 24 hour report in the Administrative morning	

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F 309	Continued From page 27 Review of the most recent physician ' s monthly orders for July 2015 indicated a soft helmet was to be worn at all times due to seizure disorder. Review of the Treatment Administration Records (TAR) for August 2015 revealed the order for the resident to wear the soft helmet at all times. The TAR indicated nurses were to initial the helmet was worn each shift. The documentation included initials for " Shift 1 " for the dates of 8/1/15 to 8/12/15. Observations on 08/10/2015 at 11:40 AM revealed Resident #77 was in bed and had a blue helmet on her head. Observations revealed the helmet did not stay in place, moved if she turned her head and the left side covered her face due to movement of helmet. Observation of Resident #77 on 08/11/2015 at 9:57AM revealed the helmet was on her head sideways covering her face. The right side of her head was not protected with the helmet. Observation of Resident #77 on 08/13/15 at 8:12 AM revealed the blue helmet was off. Observations on the same date at 8:44 AM and 9:36 AM revealed the blue helmet remained off Resident #77 ' s head. The blue helmet was observed in be beside the resident on the bed. Continued observations on at 08/13/15 from 9:59 AM to 10:17 AM during personal care revealed aides #2 and #3 applied the helmet after the bed bath was completed. Interview on 8/13/15 at 10:25 AM with aides #2 and #3, who provided care for Resident #77, revealed they knew to keep the helmet on Resident #77. Aide #2 explained the resident would remove the helmet herself at times. Aides	F 309	meeting M- F to determine if there are any new orders for equipment or adaptive devices. The Unit Manager will be responsible to ensure the orders have been entered in computer and being signed off by the nurses. MDS nurse review of all pink slips and will ensure that any new equipment or adaptive devices are placed on the resident care plan and the Daily Care Guide for the CNA¿s. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The DON/Designee will review the 24 hour report in the Administrative morning meeting M- F to determine if there are any new orders for equipment or adaptive devices. The Unit Manager will be responsible to ensure the orders have been entered in computer and being signed off by the nurses. MDS nurse review of all pink slips and will ensure that any new equipment or adaptive devices are placed on the resident care plan and the Daily Care Guide for the CNA¿s. QA rounds will be completed weekly for one (1) month, bi-weekly for two (2) months and weekly for six months by the DON/Designee to ensure that if a resident is ordered to have a helmet has proper placement and is functioning properly.	

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F 309	Continued From page 28 #2 and #3 were asked to explain how the helmet was applied and secured on the resident ' s head. Aide #2 explained it sits on her head, it is not secured in any manner. Aide #3 explained the blue helmet did have a strap, but there was nothing to fasten it to. Interview with Physical Therapist on 08/13/15 at 1:44 PM revealed Resident#77 had the helmet ordered by therapy. The blue helmet had a working chin strap when provided to nursing. She did not know the helmet was not secured on the resident's head. Interview with nurse #3 on 8/13/15 at 2:38PM revealed the resident was at times "irritated" with the helmet. This nurse explained it was impossible to keep the helmet on at all times. Further interview revealed nurse #3 had talked to the physical therapist about not securing the strap a " couple of weeks ago Observations on 08/14/15 at 7:56 AM of Resident #77 revealed she was in bed and the blue helmet was on the bedside table. The helmet did not have any means of securing the strap on the other side of the device. A strap was on left side of the helmet and there was not a securing device on right side of helmet. Interview with the Director of Nursing (DON) on 8/14/15 at 8:08 AM revealed she would ask the primary care physician about the helmet today. The physician ordered the use of the helmet, and would make the decision for her to continue wearing it or not. If the physician wanted it to be worn, she would get another helmet type. The DON explained she was not comfortable with the use of a strap due to possible choking with her	F 309	INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. QA rounds will be completed weekly for one (1) month, bi-weekly for two (2) months and weekly for six months by the DON/Designee to ensure that if a resident is ordered to have a helmet has proper placement and is functioning properly. A Chart review will be done three (3) times weekly by administrative staff to ensure compliance with physician orders. Care plan review will be done weekly by the administrative staff for one (1) month, bi-weekly for two (2) months, and monthly for six (6) months to ensure that equipment or adaptive devices have been documented on the Care Plan and the Daily Care Guide for the CNA¿s. The QA Committee will review the facility¿s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective	

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F 309	Continued From page 29 history of a seizure disorder.	F 309	solutions	
F 314 SS=G	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 observation, record review, staff and resident interviews the facility failed to ensure a clean and sanitary pressure ulcer on the right heel and failed to implement an intervention to relieve pressure and prevent a pressure ulcer on the right outer thigh that progressed to an unstageable pressure ulcer for 1 or 2 residents reviewed for pressure ulcers. (Resident#28) Findings included: Resident #28 was admitted to the facility on 6/8/15 with the diagnosis of chronic kidney disease, pressure ulcer, hypertension, chronic pain and paraplegia and neurogenic bladder. The most recent Minimum Data Set (MDS) assessment with an assessment reference date of 7/1/15 revealed that Resident #28 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s).	F 314	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility provides a clean and sanitary environment to promote healing and prevent infection and new pressure ulcers from developing. Education was provided to resident concerning the risk of having wounds and being outside for long periods of time during hot weather and the benefits of protection to wounds and need for compliance with showers and cleanliness of the wound. Resident was re-educated concerning the benefit(s) of a larger wheelchair that would accommodate him better, and not have the potential to increase pressure on his thighs. A pressure reducing overlay	9/9/15

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F 314	Continued From page 30 The MDS further indicated that Resident #28 was at risk for pressure ulcers and had two stage 4 pressure ulcers present on admission and 7 unstageable present on admission. The most severe with eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges). The care plan initiated on 7/16/15 indicated a problem of impaired skin integrity-pressure ulcer stage 4, has history of infections to ulcers and refuses care at times, incontinent care, dressing changes. The approaches included monitor diet, medicate per order, measure and record weekly, inform physician of changes, encourage to be off site as much as possible, plexus low air loss mattress at all times for pressure reduction and comfort, monitor for signs and symptoms of infection, temperature, change in condition, incontinent care timely- resident refuses incontinent care at times, evaluate plan of treatment if not improvement or worsening noted 2-4 weeks time, reassess the treatment plan, pressure reduction cushion in wheelchair to assist with pressure reduction at all times. The care plan was updated on 7/28/15 and a problem was added- maggots in wound right foot. The approach added was -removed (maggots)-no roommate x 7 weeks and room cleaned daily. The weekly wound and skin status report dated 8/13/15 revealed an area to the right heel that was present on admission (6/5/15) that was unstageable, 90% necrotic, measurements 2 centimeters (cm) in length, 1.6 cm in width and depth was undetermined. The measurements on 8/11/15 revealed measurements of 2cm in length,2cm in width, .5cm in depth at a stage 4 with 25% granulation and 75% slough and skin	F 314	was placed in his wheelchair to reduce the risks of breakdown. Repairs to the broken window screens have been done. Extra pest control measures were placed on the outside of the facility in the courtyard to attract flies while residents are outside and fly traps were placed outside the facility to attract flies. An in-service was provided to the nursing staff on September 8, 2015 by the Director of Nursing concerning the need for pressure reduction and proper equipment to prevent pressure ulcers from developing. All residents¿ equipment/devices were evaluated by nursing staff to determine if any were at risk for causing pressure ulcers. An in-service was conducted by the Administrator to all staff on September 8, 2015 concerning the need to monitor pest control within the facility and the need to report any damaged equipment that would put facility at risk for pests to the Maintenance Supervisor or Administrative staff as soon as aware so that measures can be put into place to prevent this from occurring. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Education was provided to residents	

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F 314	Continued From page 31 edges well defined and healthy. The weekly wound and skin status report dated 8/13/15 revealed an area to the right outer thigh that was facility acquired on 7/1/15 described as a blister that opened, measurements .5 cm in length , 1.5 cm in width and depth .10 cm. The measurements on 8/11/15 revealed measurements of 7.5 cm in length, 4.5 cm in width and 1.5 cm in depth described as unstagable with 50% slough and 50% eschar. Review of the physicians progress note dated 7/28/15 revealed that Resident #28 had black eschar on the right heel last week, today the area has a large amount of maggots coming in and out of the wound and the black eschar has completely resolved. The resident was taken to the bathroom and the wound was cleaned out with Anasept and Dakin ' s solution and all the maggots were removed from the wound. The wound bed was clean with good granulation tissue. A physician ' s order dated 7/28/15 indicated to 1- clean wound with Anasept and Dakins to clean out maggots and eggs, 2- continue current wound care orders, 3- deep clean room. The physical therapy progress note dated 7/31/15 revealed that Resident #28 was treated 7/2/15-7/31/15 for muscle weakness. The discharge summary indicated under clinical impression that Resident #28 would benefit from being in a larger wheelchair where he would fit better and his lower extremities would be in a better position with patient refusing to go into a larger wheelchair at this time. The discharge summary further indicated that Resident #28 was educated on why he should go into a larger	F 314	concerning the risk of having wounds and being outside for long periods of time during hot weather and the benefits of protection to wounds and need for compliance with showers and cleanliness of the wound. Education was also provided by the Unit Nurse Managers to residents on the need to relieve pressure and the risks associated with and results of non-compliance on September 9, 2015. Repairs to the broken window screens have been done. Extra pest control measures were placed on the outside of the facility in the courtyard to attract flies while residents are outside and fly traps were placed outside the facility to attract flies. Physical Therapy will be consulted at any time a resident is having issues related to possible pressure areas requiring adaptive equipment. An in-service was provided to the nursing staff on September 8, 2015 by the Director of Nursing concerning the need for pressure reduction and proper equipment to prevent pressure ulcers from developing. All residents¿ equipment/devices were evaluated by nursing staff to determine if any were at risk for causing pressure ulcers. An in-service was conducted by the Administrator to all staff on September 8, 2015 concerning the need to monitor pest control within the facility and the need to report any damaged equipment that would put facility at risk for pests to the Maintenance Supervisor or Administrative	

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F 314	Continued From page 32 wheelchair with instructing him it would help with position on his lower extremities and keep him from pressing against the sides of the wheelchair and if patient continues to sit in his wheelchair the way he is he will most likely develop pressure sores and his lower extremities will get stiffer and it will become harder to do ADL ' s. A review of the physicians progress note dated 8/4/15 indicated the visit was for a wound check and patient was noted to have a new wound on his right lateral thigh. The wound has a black area and has significant drainage, redness and warmth around the new wound. Per staff the patient is sitting in his wheelchair all day and his legs pressed against the metal bar of the arm rest. Patient shows no signs of pain. The right lateral thigh is unstagable with thick eschar. A physicians order dated 8/4/15 indicated to give Omnicef 300 milligrams 2 tablets by mouth every day for 10 days for infected thigh wound and treat thigh wound with santyl (enzyme debriding ointment), calcium alginate (antimicrobial action that absorbs drainage) and cover with occlusive dressing. During an interview with the wound care nurse on 8/13/15 at 10:00 AM revealed that all of Resident #28 ' s wounds were present on admission and have improved and decreased in size. The right lateral thigh is facility acquired and about a week ago the nurse aide reported a blister on the right outer thigh caused by wheelchair armrest. The patients thigh rest against the armrest. The patient gets up in the morning and wants to stay up all day. The physical therapist recommended foam to be applied and maintenance applied foam to both armrest bars. The wound care nurse	F 314	staff as soon as aware so that measures can be put into place to prevent this from occurring. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: QA rounds of the facility will be conducted on a daily basis by the Maintenance Supervisor and Administrative Staff and recorded on a log noting any issues. If issues are noted concerning pests then the Pest Control Company that is contracted with will be notified of the issues right away. Education was also provided by the Unit Nurse Managers to residents on the need to relieve pressure and the risks associated with and results of non-compliance on September 9, 2015. Body/skin checks will be completed by licensed nurses on a weekly basis to ensure there are no new reddened areas that could result in pressure ulcers. Physical Therapy will be consulted anytime there is a resident having issues related to possible pressure areas requiring adaptive equipment and pressure reduction. All wounds will be assessed by the treatment nurse for indication of increase or decrease in size on a daily basis. A wound report will be completed weekly	

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F 314	Continued From page 33 indicated that on 7/28/15 the maggots were noted by Nurse # 1 who was doing wound care that day. The wound care nurse further indicated that Resident #28 sits outside a lot to smoke and he also will refuse his showers. An observation on 8/13/15 at 10:38 AM revealed Resident #28 being self-mobile in the reclining wheelchair and interacting with other residents in the hall. The pressure reduction cushion was in the wheelchair and both armrest were covered with foam. Resident #28 was positioned in the center of the chair and there was approximately a 2 inch space between his thighs and the wheelchair armrest. During an interview with Resident #28 he indicated that he felt his thigh pressing on the arm rest and reported it and that is when the foam was applied by maintenance. Resident #28 indicated that the area on his thigh was a blister and now it is a large area they are treating. During an interview with Nurse Aide (NA) #1 on 8/13/15 at 1:30 PM indicated that she was aware to keep Resident #28 thighs away from the armrest. NA #1 further indicated that there has been a problem with fly ' s because of the door going out to the smoking area. She has seen fly traps hanging in other rooms but never in his room. An interview with Nurse #1 at 2:30 PM on 8/13/15 indicated that the area on Resident #28 ' s right thigh started as a blister and was treated with skin prep. It was reported that the area was caused by the wheelchair. Nurse #1 further indicated that therapy checked the wheelchair and recommended foam covering in the bars. Nurse #1 revealed that she was doing wound	F 314	and presented to the Weight/Skin Committee for review and recommendations. The attending physician will assess wounds and make recommendations as needed for changes in orders. Physician will do weekly assessment of all wounds and change orders as needed. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. QA rounds of the facility will be conducted on a daily basis by the Maintenance Supervisor and Administrative Staff and recorded on a log noting any issues. Body/skin checks will be completed by licensed nurses on a weekly basis to ensure there are no new reddened areas that could result in pressure ulcers. QA of weekly body/skin checks will be done by the Unit Nurse Managers every week for compliance.	

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F 314	Continued From page 34 care the morning of 7/28/15 and when she removed the wound dressing she saw his skin crawling with approximately 15 maggots (fly larvae) and she immediately got the physician who was in the facility. Resident #28 was taken to the shower and all the wounds were irrigated with Dakin ' s solution and the room was deep cleaned by housekeeping. Nurse #1 revealed that flies have been noticed on the halls and it was reported to maintenance and fly strips were placed in a few rooms at the end of the hall. She further stated that Resident #28 goes outside a lot to smoke and flies could have got on his wound outside, he is independent with wheelchair mobility. During an interview with the Director of Nurses on 8/13/15 at 3:20 PM revealed that it is her expectation that the NA ' s report any skin changes to the nurse on duty and to keep resident turned and repositioned as indicated on their " Daily Care Guide " . An interview with the physician assistant on 8/14/15 at 11:00 AM confirmed that there were maggots in Resident #28 ' s right heel and there is significant improvement since that day. She further indicated that wounds are seen by the medical staff on a weekly basis. During an interview with the physical therapist #1 on 8/14/15 at 11:00 AM revealed that Resident #28 was discharged from therapy on 7/31/15 and she recommended a wider wheelchair which the resident totally refused and the physician asked her to look at the wheelchair for pressure relief and she asked maintenance to get some foam on the arm rest bars and it has been applied. There is a space on each side between his legs and the	F 314	All wounds will be assessed by the treatment nurse for indication of increase or decrease in size on a daily basis. A wound report will be completed weekly and presented to the Weight/Skin Committee for review and recommendations. Physician will do weekly assessment of all wounds and change orders as needed. All QA rounds and compliance checks will be presented to the QA Committee on a weekly basis who will review the facility¿s progress for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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F 314	Continued From page 35 arm rest bars, it depends on his positioning.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to provide ordered splints for contracture prevention for one of three residents with contracture management. (Resident #77) The findings included: Resident #77 was admitted to the facility on 5/6/15 with diagnoses including acute respiratory failure, seizures, dysphagia and stroke. The Minimum Data Set dated 5/14/15 an admission, indicated Resident #77 was severely cognitively impaired with communication, decision making abilities and did not respond verbally to questions. Totally assistance was required by one to two staff for transfers, toileting, hygiene and bed mobility. Resident #77 was unable to walk. The MDS indicated functional limitation of all extremities could not be determined. The care plan dated 5/21/15 included problems of	F 318	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #77 was re-evaluated and it was determined by physical therapy that the splints would be discontinued due to a decrease in range of motion. Resident will receive Range of Motion during care to extremities by the CNA¿s. A contracture assessment will be completed on a quarterly basis by the charge nurse to determine if risk has increased. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents¿ physician orders were	9/8/15

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F 318	Continued From page 36 total dependence on staff for all care needs and was incontinent of bowel and bladder. This care plan included a problem of decreased mobility, use of left hand and foot splint. Approaches included nurses to check skin to left hand and foot for signs of pressure before and after application of splints. The care plan did not indicate who was to apply the splints. Review of a telephone order dated 5/13/15 indicated Resident #77 was to wear a left hand splint and right foot splint from 7:00 AM to 7:00 PM daily. The order was written by the physical therapist. Review of the physical therapist note of 5/21/15 indicated the physical therapist trained aides " on how to apply safety helmet, left hand splint and right foot splint. " Review of the current monthly signed physician orders indicated Resident #77 was to have a left hand splint and a right foot splint applied at 7:00 AM and removed at 7:00 PM. Observations on 8/11/15 at 9:56 AM revealed Resident #77 was not wearing a hand or foot splint. Interview with restorative aide #1 on 08/12/15 at 3:19 PM revealed she had instructions in a book for restorative treatments for residents. She did not have Resident #77 on restorative caseload. Restorative aide #1 explained Resident #77 had a brace on her foot one time when she did weights, and she did remember a splint on her hand one time. It was the floor nurse that was supposed to put those on the resident each day.	F 318	reviewed by the Unit Nurse Managers to determine if any other residents have orders for splints. If the resident was identified of need for splints, the CNA¿s will be responsible for applying/removing the splints at designated times. The MDS nurse will review each new admission to ensure contracture/s has been assessed and documented and the Contracture Assessment Form will be updated quarterly thereafter. An in-service was provided on September 8, 2015 by the Director of Nursing concerning the application and removal of splints using a determined schedule. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: A Contracture assessment will be completed on admission by the Unit Nurse Manager. If the resident is at moderate risk for contractures then resident will be referred to physical therapy, who will evaluate for the determination of an appropriate program. If the resident was identified of need for splints, the CNA¿s will be responsible for applying/removing splints at designated times. Documentation of splints will be recorded on the handheld (TAR) by the charge nurse after she has observed for compliance. Splints if applicable will be monitored by the charge nurse on the	

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F 318	Continued From page 37 Observations on 8/13/15 at 10:00 AM revealed Resident #77 was not wearing a hand or foot splint. Resident #77 was observed with the left hand in a closed position. Interview with aide #3, who is a restorative aide, on 8/13/15 at 10:25 AM revealed she was able to get her hand into the resident's hand to wash it. When asked if she extended the resident's fingers, she said, I could get my hand in it. When asked if the resident could extend her fingers, she stated as much as she could. Aide #3 explained she had not received education on splinting for Resident #77. Further interview revealed she had not observed the resident with splints in use. Interview with aide #2 on 8/13/15 at 10:00 AM revealed Resident #77 kept her hand closed most of the time and did not open it. Aide #2 explained she had not received education on applying splints for Resident #77. Further interview revealed she had not observed Resident #77 with splints in use. Aide #2 explained they knew how to provide care for residents by the care plan in the aides book. Resident #77 did not have splint application on their care plan. Interview with the physical therapist (PT) that had provided services for Resident #77 was conducted on 8/13/15 at 11:17 AM. Interview with the PT revealed she was not aware the splints were not being used for the resident. Further interview revealed she had provided in-services for the aides working on the floor at the time of discharge from therapy. She did not know how nursing kept new aides informed. Interview on 8/14/2015 at 12:35 PM with the PT revealed when the resident came from the	F 318	appropriate shifts. An in-service was provided on September 8, 2015 by the Director of Nursing concerning the application and removal of splints using a determined schedule and assignment of responsibility. All residents identified with contractures and the need of splints will be care planned by the MDS Nurse. The Daily Care Guide will be updated to reflect the use of splints. . The Unit Nurse Managers will review documentation of splint application/removal for compliance on a weekly basis and conduct a QA Round on a daily basis to ensure splints are being applied and removed in a timely manner. This will be documented a QA Round Log. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Unit Nurse Managers will review documentation of splint application/removal for compliance on a	

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F 318	Continued From page 38 hospital she had the splints. Further interview revealed Resident #77 had some beginning contractures of the hand on admission. The splints were to prevent further contractures. This PT had observed Resident #77 and her hand and foot range of motion had not declined. Interview with the Director of Nursing on 8/13/15 at 2:43: PM revealed she was not aware Resident #77 was to wear splints. Further interview revealed she would expect splints to be used if ordered and needed.	F 318	weekly basis and conduct a QA Round on a daily basis to ensure splints are being applied and removed in a timely manner. This will be documented a QA Round Log. The QA Rounds Logs will be presented to the QA Committee on a weekly basis who will review for compliance. The QA Committee will review the facility¿s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	
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, resident and staff interviews, the facility failed to secure bedrails for 3 of 30 sampled residents (Resident #4, Resident #41, Resident #66) whose bedrails were not secured firmly to the bed. The findings included; 1. Resident # 66 was admitted to the facility on 6/24/15 with diagnoses that included paraplegia, backache, muscle weakness, T7-T12 spinal cord	F 323	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residents have new beds with rails that arrived on September 9, 2015.	9/9/15

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F 323	Continued From page 39 injury, and pressure ulcer of the buttock. The most recent Minimum Data Set (MDS) assessment dated 7/2/15 indicated Resident #66 had no upper extremity impairments. Resident #66 was further coded as being cognitively intact. Review of Resident #66 care plan, dated 7/13/15, revealed a "problem" with performing activities of daily living (ADL). The problem stated Resident #66 required extensive assistance with bed mobility, dressing, toileting, personal hygiene and bathing. He required total assistance with transfers due to being paralyzed from the waist down. He was able to self-propel his wheelchair and feed himself with tray set up. Physical therapy (PT) was currently working with him to improve his level of function. He was at risk for falls, skin breakdown due to being bed/wheelchair bound and contractures to his bilateral lower extremities due to nonuse. Review of Resident #66 side rail assessment dated 6/24/15 indicated the resident was currently using the side rail for positioning, turning and/or support. The resident expressed a desire to have rails up when in bed, and the side rail(s) enabled the resident to be more self-sufficient and independent. Observation on 8/10/15 at 3:20pm revealed both Resident #66 bed rails to be loose. One bedrail was observed to have an IV pole (a pole used to hang intravenous fluid bag) in between the bedrail and the mattress. No IV solution was observed hanging on the IV pole. The presence of the IV pole created a 2 inch space in-between the bedrail and the resident's bed. Observations on 8/11/15 at 9:20am revealed both Resident #66 bedrails to be loose. One bedrail was observed to have an IV pole in-between the bedrail and the mattress. No IV solution was observed on the IV pole.	F 323	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have new beds with rails that arrived on September 9, 2015. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: All residents have new beds with rails that arrived on September 9, 2015. The Maintenance Supervisor is responsible to check the bed rails on a weekly basis to ensure they are attached according to the Manufacturer's Recommendation. If the rails are loose then he will be responsible to tighten them back to the recommended position. An in-service for all staff was held on September 8, 2015 by the Administrator to ensure staff is aware of the importance of placing any repairs to facility or resident equipment on the Maintenance Request Form that is on each unit of the facility. The Maintenance Supervisor is responsible to check these areas twice daily and make the necessary repairs as soon as possible. If parts need to be ordered or other materials obtained the area of concern will be corrected as soon as possible as long as it does not place	

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F 323	Continued From page 40 Observation on 8/11/15 at 1:57pm revealed both of Resident #66's bedrails to be loose to touch. One bedrail was observed to have an IV pole between the bedrail and the mattress. The IV pole was on an individual stand and not attached to the bedrail. No IV solution was observed on the IV pole. During an observation of Resident #66's bed and interview with the maintenance director on 8/11/15 at 8:22am, the maintenance director indicated he was unaware the bedrails were loose. He further stated that the IV pole was probably put in-between the bed and the rail for convenience for the resident but the rail should be fixed to the bed and it was not placed correctly. The Maintenance director indicated the Nursing assistants (NA) would have loosened it to get the pole in-between the bed and the rail. Interview with Nurse #2 on 8/12/15 at 4:38pm revealed she was unsure why there was an IV pole between the resident's bedrail and mattress. Nurse #2 indicated that she had not noticed that the resident's bedrails were loose. Staff were to report loose bedrails to the nurse and fill out a maintenance request in the instance loose bedrails were observed. 2. Resident #4 was admitted to the facility on 07/06/15 with diagnoses that included acute respiratory failure, muscle weakness, psychosis, depressive depression and epilepsy. Review of the most recent Minimum Data Set (MDS) assessment dated 7/20/15 revealed the resident required extensive assistance, with 2 staff persons, for bed mobility and had no upper or lower extremity impairments. Resident #4 was coded as being moderately cognitively impaired. Review of Resident #4 care plan dated 5/19/15 indicated a "problem" performing activities of daily living. He was receiving Physical therapy for	F 323	the resident at risk for harm or injury. If necessary the nursing staff will notify Maintenance Supervisor via telephone of any areas of concern. The Maintenance Supervisor is responsible to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern. He is responsible to document these findings on a Maintenance QA Rounds Sheet and it will be given to the Administrator for review after the repairs have been made with the date of identification and date of correction. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Maintenance Supervisor is responsible to check the clipboards for the Maintenance Request Forms twice daily and make the necessary repairs as soon as possible. If parts need to be ordered or other materials obtained the area of concern will be corrected as soon as possible as long as it does not place the resident at risk for harm or injury. If necessary the nursing staff will notify	

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F 323	Continued From page 41 therapeutic exercises, transfers and sitting balance and was non-ambulatory. He was alert and oriented with periods of forgetfulness and confusion and was receiving Aricept as ordered. He was receiving psychotropic meds and med for seizures. He required extensive assistance to total dependence with ADLs. The approaches included side rails up x 2 to be used as an enabler. Review of Resident #4 side rail assessment dated 8/3/15 indicated the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, was currently using the side rail for positioning, turning or support, and the side rails enabled the resident to be more self-sufficient and independent. The recommendations stated side rails up x 2 as a support to facilitate turning and repositioning in bed. On 8/10/15 at 2:45pm, an observation of Resident #4's room was conducted. Resident #4 was in the room at the time of the observation. The bedrails were observed to be very loose to touch and moved freely from the frame of the bed and the mattress. During the observation Resident #4 stated his bedrails had been loose for about a week. Resident #4 revealed the facility was aware and indicated nursing was aware and maintenance would fix his bedrails but had not. An observation on 8/11/15 at 9:00am revealed both bedrails to be very loose and would easily shift when touched or grabbed. 3. Resident #41 was admitted to the facility on 1/16/15 with diagnoses that included depressive disorder, late effect hemiplegia non-dominate, and cellulitis of leg. The most recent Minimum Data Set (MDS) assessment dated 6/14/15	F 323	Maintenance Supervisor via telephone of any areas of concern. The Maintenance Supervisor is responsible to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern. He is responsible to document these findings on a Maintenance QA Rounds Sheet and it will be given to the Administrator for review after the repairs have been made with the date of identification and date of correction. The Administrator will conduct QA Rounds on a monthly basis for three (3) months to ensure that all facility repairs are made and the facility maintain a sanitary, orderly and comfortable environment. If after three months the necessary corrections are being made then the Administrator will do QA Rounds on a Quarterly Basis. The QA Committee will review the facility¿s progress monthly and quarterly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	

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F 323	Continued From page 42	F 323		

revealed Resident #41 required extensive assistance by 2 staff persons for bed mobility and transfers. Resident #41 had upper and lower extremity impairment and was coded as cognitively intact.
Review of Resident #41's side rail evaluation dated 1/16/15 revealed the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, was currently using side rails for positioning, turning or support, expressed a desire to have side rails raised while in bed, and side rails enabled the resident to be more self-sufficient and independent.
Review of Resident #41 care plan dated 7/10/15 indicated a problem of " falls ". Resident #41 had some impairment in balance during transition, he required extensive assistance with transfers due to left hemiplegia. He took Ativan, Cymbalta, Trazadone, and Ambien and Narco daily. He was at risk for fall related injuries. The goals stated Resident #41 would be free from major fall injury should any fall occur through next review. The interventions included low loss for pressure reduction mattress, and keep bed at the lowest level when resident was in bed and care not being rendered.
Observation of Resident #41's bed on 8/11/15 at 9:32am revealed the residents bedrails to be loose. The two mattresses on the bed were observed to shift from one another and the bedrails. A 2 inch gap was observed between the mattress and the bedrail.
Observation of Resident #41's bed on 8/11/15 at 2:47pm revealed the residents bedrails to be loose. The two mattresses on the bed were observed to shift from one another and the bedrails.

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F 323	Continued From page 43 Review of the facility's maintenance log from 6/15/15 through 8/10/15 revealed no maintenance requests in regards to bedrails being loose. Interview with the Maintenance Director on 8/11/15 at 9:20am revealed in the instance staff observed bedrails to be loose they were to fill out a maintenance request form to make him aware of the maintenance need. Maintenance indicated he monitored bedrails every 2 weeks to ensure bedrails were correctly applied. Maintenance did not have documentation of the assessments. Interview with nursing assistant (NA) #4 on 8/11/15 at 10:37am revealed she was not aware of any loose bedrails. She indicated that in the instance she had observed a resident's bedrails to be loose she would notify the maintenance director. Staff were to fill out a maintenance request. Interview with NA#5 on 8/11/15 at 10:38am revealed she had communicated loose bedrails to the maintenance director in regards to Resident #41 loose bedrails about a week ago. The NA indicated she had not filled out a maintenance request but she had communicated the concern regarding the bedrail verbally to the Maintenance Director. Interview with the Director of Nursing (DON) on 8/12/15 at 4:46pm revealed it was her expectation that bedrails be correctly applied and not loose fitting. It was not facility practice to have resident equipment in-between bedrails such as IV poles. The DON further stated that she had implemented a new maintenance request form for staff to fill out in the instance there were any maintenance needs identified.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	F 369		9/11/15

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F 369	Continued From page 44 The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide 1 of 1 resident (Resident #31) with adaptive equipment for dining. The findings included, Resident #31 was admitted to the facility on 2/1/13 with a diagnoses that included stomach dysfunction, depressive disorder, late effect cardiovascular disease cognitive deficit, osteoarthritis, and chronic pain. The most recent Minimum Data Set (MDS) Assessment dated 6/9/15 indicated Resident #31 had upper extremity impairments and was moderately cognitively impaired. What kind of upper extremity impairment? Limitation of range of motion? Review of Resident #31 care plan dated 6/23/15 revealed a problem of related to " nutrition " . The care plan revealed, Resident #31 was at risk for weight fluctuations with history of weight gain/loss. He received chopped meats for lunch and supper. Resident #31 used built up handles to assist with the resident ' s use of forks/spoons and used cups with handles for easier grips. The goal included Resident #31 would continue to feed himself with minimal assistance and not experience complications related to significant weight gain/loss changes through next review. The approaches included providing built up utensils, mugs with handles and refer to speech therapy. Review of Physician order dated 8/2/15 indicated	F 369	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident number 31 is receiving the adaptive equipment ordered by his physician. An In-service on adaptive equipment was conducted on August 17, 2015 for the Dietary staff and September 8, 2015 for dietary and nursing staff by the Certified Dietary Manager and the Director of Nursing. The in-service included the uses of adaptive equipment and how to determine which residents have a physician's order for the equipment. The Dietary staff was instructed to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants were instructed to read the tray card to determine if adaptive equipment is needed and if not present to obtain the equipment prior to serving the tray. The Daily Care Guide and Tray Card are updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff. Care plans will be updated through review of the physician telephone orders (pink slips)	

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F 369	Continued From page 45 the resident had an order for built up handles applied to feeding utensils to increase holding area. Observation on 8/10/15 at 12:33pm revealed Resident #31 having his meal tray set up by a nursing assistant (NA). The NA was observed to unroll Resident #31 standard silverware. The dining utensils were observed to not have built up handles. No built up device was applied to the resident ' s silverware. Review of Resident #31 ' s meal card indicated cups with handles and special eating utensils should be used for this resident. Observation on 8/14/15 at 7:54 am revealed Resident #31 was eating breakfast in his room. The resident did not have any built up eating utensils. Review of Resident #31 ' s meal card indicated cups with handles and special eating utensils should be used for this resident. Interview with the nursing assistant (NA) #5 on 8/14/15 at 9:11am revealed she read the meal card when she provided resident #31 with a meal on 8/14/15 for breakfast. NA#5 indicated she had never observed Resident #31 to utilize built up handles to eating utensils. NA#5 stated she typically gave the resident a standard spoon to eat with. In the instance a resident received adaptive eating equipment it typically comes out on the meal tray. Interview with the dietary director on 8/14/15 at 8:20am indicated nursing and dietary staff became aware of the residents dining needs a meal card that accompanied each meal. She further revealed she was under the impression that the resident was refusing to eat with the built up eating utensils. The Kitchen did have built up eating utensils. At 9:00am the Dietary director indicated the residents built up eating appliance was located in his room. The appliance was	F 369	by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s conditions or needs. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's physician's orders were reviewed to determine that resident's with adaptive equipment were being supplied with the equipment on their meal trays. An In-service on adaptive equipment was conducted on August 17, 2015 for the Dietary staff and September 8, 2015 for dietary and nursing staff by the Certified Dietary Manager and the Director of Nursing. The In-service included the uses of adaptive equipment and how to determine which residents have a physician's order for the equipment. The Dietary staff was instructed to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants were instructed to read the tray card to determine if adaptive equipment is needed and if not present to obtain the equipment from Dietary prior to serving the tray. The Daily Care Guide and Tray Card are updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff.	

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F 369	Continued From page 46 supposed to be placed on the resident ' s standard silverware. She was unsure of who to communicate refusals of adaptive ware. Interview with the Administrator on 8/14/15 at 1:03pm revealed it was her expectation that staff follow through with orders for adaptive eating equipment and that dietary was aware so that the equipment comes out on the meal tray. The order should be carried out until discontinued.	F 369	Care plans will be updated through review of the physician telephone orders (pink slips) by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s conditions or needs. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Dietary staff is to ensure that by using the tray cards for instructions that all adaptive equipment be placed on the resident's tray prior to the tray being served to the resident. The Nursing Assistants are to read the tray card prior to serving the tray to resident to determine if adaptive equipment is needed and if not present to obtain the equipment from Dietary. The Daily Care Guide and Tray Card will be updated when there is a change in any information regarding residents by the Nursing Staff or the Dietary Staff. Care plans will be updated through review of the physician telephone orders (pink slips) by MDS nurse, review of the 24 hour report in the Administrative morning meeting M- F. and information reported to the MDS nurse throughout the day concerning changes in resident¿s conditions or needs. The Certified Dietary Manager will conduct a QA Check on the tray service	

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F 369	Continued From page 47	F 369	on a daily basis for one (1) week, three (3) times weekly for one (1) month to ensure that adaptive equipment is being provided to the residents with an physician's order. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Certified Dietary Manager will conduct a QA Check on the tray service on a daily basis for one (1) week, three (3) times weekly for one (1) month to ensure that adaptive equipment is being provided to the residents with an physician's order. Care plan/Daily Care Guide review will be done weekly for one (1) month, bi-weekly for two (2) months, and monthly for six (6) months. The QA Committee will review the facility¿s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective	

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F 369	Continued From page 48	F 369	solutions	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, 1 of 2 male Dietary staff failed to use a chin guard or any type of facial hair covering while working around clean equipment and work station preparing snacks. Findings included: Review of the policy provided by the Dietary Manager titled: Hygienic Practices, Subpart: Hair Restraints- Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. During a Kitchen/Food Service observation at 11:30 AM on 8/12/13 Dietary Aide #1 was observed to be in the kitchen preparing snacks	F 371	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The male dietary aide covered his chin hair with a chin guard. In- service was provided for the dietary department by the dietary manager concerning policy of wearing a chin guard for facial hair while working in the Dietary Department. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: In- service was provided for the dietary	9/11/15

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F 371	Continued From page 49 with no chin guard to cover his chin hair. An interview with Dietary Aide #1 on 8/13/15 at 11:30 AM revealed that he had been on duty since 5:30 AM and working from 5:30 AM until 11:30 AM without a chin guard. He indicated that he knows that he should have his chin covered. During an interview with the Dietary Manager on 8/13/15 at 9:00AM indicated that she expected that facial hair to be covered. Dietary Aide #1 is usually clean shaven and she didn ' t notice that he needed a chin guard. There is a policy for hair nets and it is the same expectations as the Health Department.	F 371	department by the dietary manager concerning policy of wearing a chin guard for facial hair while working in the Dietary Department. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Certified Dietary Manager is responsible to do a QA daily of all employees for compliance with facial hair and the use of chin guards. She will document this QA on a daily log for one month, three (3) times weekly for one month and weekly for one (1) month. After compliance is achieved it will be the responsibility of the Dietary manager to ensure her staff follows sanitation policies. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Certified Dietary Manager is responsible to do a QA daily of all employees for compliance with facial hair	

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F 371	Continued From page 50	F 371	and the use of chin guards. She will document this QA on a daily log for one month, three (3) times weekly for one month and weekly for one (1) month. After compliance is achieved it will be the responsibility of the Dietary manager to ensure her staff follows sanitation policies The Certified Dietary Manager will bring her QA¿s to the QA Committee who will review the facility¿s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		9/11/15

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F 425	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, pharmacist interview and record reviews the facility failed to ensure a medication was available for administration resulting in a significant medication error during medication pass for one of 32 opportunites for error (Resident #48.) The findings included: Resident #48 was admitted to the facility on 6/12/14 with diagnosis of gastroesophagus reflux disease (GERD). Review of the physician ' s orders for July 2015 included Omeprazole 20 milligram (mg) capsule to be taken by mouth to times a day at 6:00 AM and 4:00 PM. The medication is to be given before meals. The medication according to the physician ' s desk reference was for conditions of too much stomach acid. Observations on 8/12/15 at 4:40 PM during medication pass with nurse #4 revealed the medication was not in the cart to be administered. Nurse #4 checked the back- up medications and was not able to locate the medication. Nurse #4 explained she would inform the pharmacy and the medication would be in that night. During interview with the nurse at the time of the medication pass, she explained she thought the medication may be a new order. Record review revealed the medication had an original order date of 8/25/14. Record review revealed Resident #48 had received the medication on a daily basis, two times a day since being ordered.	F 425	F:425 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 48 received his medication on the next available med pass. In-service was provided for all nurses on what to do when a medication is unavailable in the facility to ensure residents receive their medications as ordered by the physician. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident who receives medications has the potential to be affected. An In-service was presented on September 8, 2015 by the Director of Nursing with the Nurses on the protocol concerning lack of medication/s and use of local back-up pharmacy when medication is unavailable in facility. If the Nurse is unable to obtain the medication that is scheduled the Nurses will call the physician for ¿HOLD¿ order until medication is available in facility to administer. The schedule from	

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	345140	A. BUILDING _____ B. WING _____	C 08/14/2015

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F 425	Continued From page 52 08/14/2015 11:40:29 AM with a pharmacist at the contracted pharmacy revealed there was a 24 hour turn around for medication to be supplied to the pharmacy. The company had 5 facilities and she did not know what time the medications would have arrived. The driver leaves around 5:30 PM each day. The facility would have a policy for obtaining medications that would be needed if not available. The facility could obtain the medications from a local pharmacy, and she did not know their policy when a medication was not available. For some insurances, the pharmacy cannot fill the order until the end of the 30 days. The medication Omeprazole, was re ordered on 8/11/15 at 9:00 AM per the supervisor at the facility. The medication arrived at the facility per the packing slip on 8/12/15. A time of 5:27 PM was on the slip indicating the driver left the pharmacy with the medication at that time. 08/14/2015 12:20:44 PM interview with nurse #3 revealed if a medication is not available, the nurse can get the medication from the back up pharmacy. Review of a facility policy for "Ordering and Reordering of Medications from Pharmacy" undated gave instructions #5, 6, 7 and 10 as to when to reorder medications, when pharmacy would fill orders and to notify the physician if medications were not available. The policy indicated medications called to the pharmacy before 2:00 PM will arrive that day. Interview with nurse #4 on 8/14/15 at 1:20 PM revealed if a medication was not available, her understanding of the protocol to follow included looking in back up for the medication, then notify	F 425	the pharmacy was given to the nurses on the cut off times for receiving medications which will result in obtaining the medication from the local backup pharmacy. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: An In-service was presented on September 8, 2015 by the Director of Nursing with the Nurses on the protocol concerning lack of medication/s and use of local back-up pharmacy when medication is unavailable in facility. If the Nurse is unable to obtain the medication that is scheduled the Nurses will call the physician for ¿HOLD¿ order until medication is available in facility to administer. The schedule from the pharmacy was given to the nurses on the cut off times for receiving medications which will result in obtaining the medication from the local backup pharmacy. The Unit Nurse Managers will conduct a QA weekly for medication administration compliance. This will be documented on a Medication Administration Compliance QA Sheet. The QA Compliance Records will be presented to the QA Committee on a weekly basis to ensure compliance is	

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F 425	Continued From page 53 pharmacy. Further interview revealed she did not tell the physician the medication was not available and was not given. Interview with the Director of Nursing on 8/14/15 at 1:20 PM revealed she would expect medications to be given as ordered by the physician. Further interview revealed the medication should have been called in to the back-up pharmacy, delivered to the facility and given to the resident.	F 425	being achieved. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Unit Nurse Managers will conduct a QA weekly for medication administration compliance. This will be documented on a Medication Administration Compliance QA Sheet. This will be done weekly for one (1) month and then monthly for three (3) months and then on a as needed basis thereafter if compliance is achieved. The QA Committee will review the facility¿s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.	F 460		9/11/15

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F 460	Continued From page 54 In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide resident rooms with privacy curtains that extended all the way around the bed to provide full visual privacy for 5 of 30 rooms. (Rooms 201-A, 204-B, 206-B, 306-B and 308-A) Findings included: The following observations were made on 8/10/15 and 8/11/15 during day 1 and day 2 of the survey: a. Room 201-A- There were one privacy curtain available and it did not extend around the bed for full visual privacy. b. Room 204-B- There were one privacy curtain available and it did not extend around the bed for full visual privacy. c. Room 206-B-There were no privacy curtain available. d. Room 306-B-There were one privacy curtain available and it did not extend around the bed for full visual privacy. e. Room 308-A- There were no privacy curtain available. An interview with the Housekeeping Aide #1 on the 200 Hall on 8/13/15 at 9:15 AM revealed that if privacy curtains are needed or dirty then it is reported to the Maintenance Director. She was	F 460	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residents room were checked on September 2, 2015 by the Administrator to determine if privacy curtains were available and if they provided full visual privacy. Privacy curtains have been placed in all resident rooms and all provide the full visual privacy. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents room were checked on September 2, 2015 by the Administrator to determine if privacy curtains were available and if they provided full visual privacy. Privacy curtains have been placed in all resident rooms and all provide the full visual privacy. ADDRESS WHAT MEASURES WILL BE	

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F 460	Continued From page 55 not aware of any privacy curtains that were needed. During a second observation with the Maintenance Director on 8/14/15 at 8:00 AM confirmed the need of privacy curtains for Rooms 201-A,204-B,206-B,306-B and 308-A to provide full visual privacy curtains that extend all the way around the bed. An interview with the Maintenance Director on 8/14/15 at 8:30 AM revealed that it is his expectations that the housekeepers and nurse aides should communicate to him when a privacy curtain is needed or a privacy curtain needs to be cleaned and he is the one that would take care of it.	F 460	PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: An In-service was provided on September 8, 2015 by the Administrator to all staff to educate them concerning the need for privacy curtains in each resident¿s room which provides full visual privacy. The staff was instructed to complete a Maintenance Request Form if the curtains were noted to be soiled or in need of replacement. The Maintenance Request Form is located on each unit on a clip board. The Maintenance Supervisor is responsible to check the units to determine if repairs are needed or if privacy curtains need to be replaced. The Social Worker will conduct a Quality Assurance Round on a weekly basis to ensure privacy curtains are in place and provide full visual privacy for each resident. INDICATE HOW THE FACILITY PLANS TO MONITOR IT¿S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.	

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F 460	Continued From page 56	F 460	The Maintenance Supervisor is responsible to check the units to determine if repairs are needed or if privacy curtains need to be replaced at least two times daily. The Social Worker will conduct a Quality Assurance Round on a weekly basis for one (1) month, three (3) times weekly for one (1) month and then monthly for three (3) months to ensure privacy curtains are in place and provide full visual privacy for each resident. The QA Committee will review the facility¿s progress on a weekly basis for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions	