STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC 28619

(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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility failed to have a documented medical symptom for 1 of 3 residents for the use of a restraining device related to the side rail position on the left side of the bed and the right side of the bed pushed against the wall (Resident #55). The findings included: A review of the facility's policy on "Restraints" dated 11/01/13 documented: "This facility believes each patient has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient's medical symptoms. The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the patient has medical symptoms that warrant the use of restraints." Resident #55 was admitted to the facility on 04/07/11 with diagnoses which included Alzheimer's disease, muscle weakness, difficulty in walking /mobility, and history of falls.	F 221	This plan of correction constitutes my written allegation of compliance for deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. This facility believes each patient has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient□s medical symptoms. The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the patient has medical symptoms that warrant the use of restraints. Resident #55 had 1/2 side rails applied to the bed at the request of the family 3 days before the annual survey in order to enhance her ability to assist with turning	11/18/15

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

Electronically Signed | 11/30/2015

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F 221	Continued From page 1 Review of the most recent Side Rail Screen dated 10/08/15 indicated Resident #55 was to have half side rails up for positioning and support. Resident #55 desired/declined the use of side rails at this time. Review of the quarterly Minimum Data Set (MDS) dated 10/13/15 indicated Resident #55 had severe cognitive impairment and was coded to need limited assistance with bed mobility, transfers, dressing, and toileting. The MDS further revealed Resident #55 was independent with ambulation and was not steady with balance when transferring between bed and wheelchair, but was able to stabilize without staff assistance. The resident was assessed as having no impairment in range of motion of upper and lower extremity on both sides of her body. The section for Physical Restraints documented the resident had no physical restraints. The section for falls documented that the resident had one fall with no major injury since admission/entry or reentry to the facility. Review of the Care Guides dated 10/29/15 through 11/06/15 which were used by the nursing aides (NAs) in caring for Resident #55 indicated the resident was to be reminded to walk, independent, assist to reposition in bed as needed, and half side rails. Under the section titled "safety/restraint" the resident was assessed at risk for falls, non-skid footwear prior to transfers/ambulation, call light within reach, and bed in lowest position when occupied. An updated care plan of 10/30/15 indicated Resident #55 was at risk for falls related to history of falls, difficulty in walking, lack of coordination, generalized weakness, and poor safety	F 221	and repositioning when in bed. The intent of this side rail was never to function as a restraint in order to keep the resident in the bed, but enhance resident quality for helping/assisting self. The maintenance supervisor readjusted the location of the side rail so it was nearer the head location of the bed during the annual survey. Resident #55 prefers her bed be pushed against the wall and this has been ongoing for a long period time. Resident # 55 side rail use was reevaluated 11/11/15 to ensure the device continued to be an enabler and not a restraint. The MDS nurse was observing the resident during the survey for a significant change. Resident #55 experienced no negative outcomes related to this cited deficiency. For other residents with the potential to be affected by this cited deficiency the following has been accomplished. All direct care staff were in serviced on the state and federal regulation regarding use of restraints and that this facility strives to ensure the least restrictive device is applied as indicated to the specific resident. Under supervision of the director of nurses, a 100% observation audit was completed for all bed side rails to ensure proper placement on the bed. Any concerns identified with placement of current side rails on bed were corrected immediately. Also, all residents and or responsible party with bed placed against wall were interviewed regarding if they were content with the bed placement and if it restricted them in any way. No issues noted at this time. Further, staff	

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F 221	Continued From page 2 awareness. The care plan had no goal indicated with interventions which included a fall risk assessment, check the bed alarm every shift, call light within reach, and check alarm every shift. There was no side rail intervention documented on the care plan. There was no side rail screening and/or assessment for the use of the restraining device. On 11/04/15 at 10:30 AM, Resident #55 was observed lying in bed with 2 lacerations with sutures intact above the resident's left eye, bruising around both eyes, and forehead area with the half side rails attached/positioned in the middle portion on the left and right sides of the bed. The right side of the bed was also positioned against the wall. On 11/04/15 at 3:00 PM, Resident #55 was observed asleep in bed with the half side rails attached in the middle portion on the left and right sides of the bed. The right side of the bed was also positioned against the wall. The resident's family member indicated to this writer that the resident had 2 "bad" falls and stated "she will not get out of bed now with these side rails here." On 11/05/15 at 6:30 AM, Resident #55 was observed asleep in bed with the side rails positioned upright in the middle portion on the left and right sides of the bed. The right side of the bed was also positioned against the wall. During an interview on 11/05/15 at 6:50 AM, NA #3 stated she was unaware Resident #55 was a fall risk until after the resident had the 2 "bad" falls on 10/29/15. NA #3 confirmed the side rails were attached to the bed after the resident had	F 221	in-serviced and aware that this facility utilizes only 1/2 side rails to enhance bed mobility and educated as to proper placement of side rails on bed. Each resident is assessed on admission, quarterly, and as needed to ensure each resident's side rail(s) is used for mobility or that the resident has chosen/requested a side rail to bed. This facility currently has no restraint devices for any resident.For any resident who is assessed to need a restraint the following is completed by the facility. A pre restraint assessment is completed, consent from the responsible party is obtained, and the resident and the responsible party are informed for the possible negative outcomes for restraint use, that only the least restrictive device is used and that the facility is required to assess the restraint and attempt reduction at least quarterly. Each restraint is placed in the care plan and a goal applied for the resident. The restraint is evaluated/assessed at least quarterly and as needed for reduction and to ensure the least restrictive device is utilized and that medical symptoms continue to warrant the use of the restraint. A quality assurance program is implemented under the supervision of the director of nurses to monitor all residents for the need of a restraint. The following systematic changes have been implemented: Any resident who requires a restraint applied due to a medical symptom, must be reviewed in the	

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F 221	Continued From page 3 the falls. During an interview on 11/05/15 at 7:10 AM, NA #4 stated Resident #55 was independent and was capable of doing things on her own and after the 2 falls on 10/29/15 the resident was dependent on staff for care including eating. NA #4 confirmed the side rails were placed on the resident's bed after she had the falls. During an interview on 11/05/15 at 7:30 AM, Nurse #3 confirmed the side rails were attached to the resident's bed after she had the 2 falls on 10/29/15. Nurse #3 indicated with the side rails being attached in the middle portion of the bed in the areas of the resident's stomach to her knees would not be used for positioning and would be consider as a restraint. On 11/05/15 at 10:00 AM, Resident #55 was observed asleep in bed with the side rails positioned upright in the middle portion on the left and right sides of the bed. The right side of the bed was also positioned against the wall. On 11/05/15 at 11:15 AM, Resident #55 was again observed asleep in bed with the left side rail attached as close to the HOB as possible and the right side rail remained attached in the middle portion of the bed and also positioned against the wall. On 11/05/15 at 11:23 AM, the MDS Coordinator was interviewed. The MDS Coordinator stated she did not consider the side rails to be a restraint because they assisted the resident in being able to reposition while in bed. The MDS Coordinator stated Resident #55's side rails were placed on the bed after the resident had 2 falls on 10/29/15.	F 221	restraint Quality assurance meeting unless it is an emergency situation as per state and federal regulation. The medical justification is reviewed, a prescreen assessment is completed, the committee decides the least restrictive device which is discussed with the responsible party and resident. Under supervision of the director of nurses each new admission is assessed for safety needs, side rails needs/preference, fall□s needs, using questionnaires in the electronic health record. Any concerns identified are immediately addressed and corrected on the spot as indicated. All concerns are documented and the Director of nurses reports them to the quarterly QA committee for further review and corrective action. The Director of nurses is responsible for compliance.	

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F 221	Continued From page 4 During an interview on 11/06/15 at 1:50 PM, the Director of Nursing (DON) stated the facility beds were old and the side rails were used for residents to assist them to move around in bed and not fall from the bed. The DON indicated with the side rails being attached in the middle portion of the bed would not be considered for turning and positioning but as a restraint.	F 221		
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, medical record reviews, and staff interviews the facility failed to serve the lunch meal at the same time to the residents setting at the same table and failed to prevent a resident from handling another residents food for 2 of 2 residents observed during the dining observation (Resident #118 and #84). The findings included: Resident #118 was admitted to the facility on 11/07/14 with diagnoses of high blood pressure, Alzheimer's disease, and depression. Review of the quarterly Minimum Data Set (MDS) dated 10/08/15 indicated Resident #118 was cognitively intact, required limited assistance with activities of daily living (ADLs) and was	F 241	It is the facility policy to 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. One way this has been achieved is having a process in place to identify concerns in the dining area. Residents #118 and #84 did not have any negative outcomes as a result of the cited deficiency. Resident #118 was relocated to an alternate seat in the dining room. Resident #84 sits with other residents who require no assistance with feeding. NA#1 and NA#6 were re-educated by Assistant Director of Nursing and Staff	11/18/15

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F 241	Continued From page 5 independent with eating. Resident #84 was admitted to the facility on 12/13/10 with diagnoses of anemia, high blood pressure, diabetes mellitus, dementia, and cerebrovascular accident (stroke). Review of the quarterly Minimum Data Set (MDS) dated 10/01/15 indicated Resident #84 was cognitively intact, required limited assistance with activities of daily living (ADLs) and was independent with eating. On 11/02/15 at 12:00 PM, Resident #118 and Resident #84 was observed sitting at table #1. Resident #118 was observed to nod off to sleep while she attempted to drink her coffee, spilling her coffee on the table and onto her clothes. Resident #84 was observed to take Resident #118's coffee cup from her & set it in the middle of the table. There was no staff observed to acknowledge and/or assist Resident #118 with her spilled coffee. On 11/02/15 at 12:15 PM, Resident #118 was observed to have her lunch meal delivered to her at table #1 by Nurse Aide (NA) #4. NA #4 was observed to set the resident's meal tray onto the table in the spilled coffee and continued to set up Resident #118's meal tray which included the removal of the silverware from the paper wrap, removed the lid from the cup of tea, and removed the roll from the plastic wrap and placed the roll onto the resident's plate. NA #4 was observed as to not wipe the coffee from the table and/or assist Resident #118 with the removal of the skin from the baked chicken. NA #4 was observed to return to the tray line and there she obtained another tray and delivered that tray to another table within	F 241	Development Nurse on assuring that all trays are served in a timely manner to residents at the same table. Also educated to continually observe all residents while in dining area for need of assistance and to promptly notify charge nurse of any concerns. Because all residents have the potential to be affected by the cited deficiency, all staff in-serviced by Administrator, DON, and ADON regarding dignity and respect. Specifically in relation to residents being served timely at each table, observation of residents in need of assistance, and notification of charge nurse when concerns identified. DON/Designee conducts dining observation five times a week for one week, three times weekly for one week, and then random weekly checks will continue in order to ensure compliance. Any deficiencies will be corrected immediately and findings will be documented and submitted to the quarterly Quality Assurance Committee for further review or need for corrective action. The Director of Nursing is responsible for monitoring compliance and reporting to the Quality Assurance Committee.	

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F 241	Continued From page 6	F 241		

the dining room.

On 11/02/15 at 12:20 PM, Resident #84 stated "I wished they would bring ours, I am hungry."

On 11/02/15 at 12:26 PM, Resident #84 was observed to take Resident #118's spoon out of her hand, placed the resident's fork in her hand, and would not allow Resident #118 to have her spoon. Resident #84 was then observed to take Resident #118's knife away and lay it on the table by the spoon out of the reach of Resident #118.

At 12:30 PM, Resident #84 was observed to take the resident's fork and knife and attempted to cut up Resident #118's chicken and potatoes.

At 12:33 PM, Resident #84 was observed to use her hands and removed the skin and the bone from the baked chicken that was in Resident #118's plate. Resident #84 was observed to toss the bone and the skin off of the chicken into the middle of the table.

At 12:35 PM, Resident #84 was served her lunch meal tray by NA #6.

On 11/05/15 at 7:15 AM, NA #4 was interviewed. NA #4 stated the expectation was for each resident at a table to be served consecutively. NA #4 further stated due to the way the plates were filled in the tray line the NAs would deliver the meal trays to the residents as soon as the tray was ready regardless of who was at the table. NA #4 indicated it was not unusual for the resident's at a table to have to wait for their meal tray. NA #4 stated Resident #84 and Resident #118 had sat at the same table for a long time and she was unaware Resident #84 handled Resident #118's

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F 241	Continued From page 7 food. On 11/05/15 at 7:30 AM, NA #6 was interviewed. NA #6 stated the resident's meal trays were delivered to their tables as quickly as the tray was picked up from the tray line. NA #6 further stated she was unaware the resident's were supposed to be served at a table consecutively. NA #6 indicated she had taken the meal trays to the residents table as quickly as it was ready. NA #6 further indicated it was not uncommon for a resident to have to wait for their meal tray. On 11/05/15 at 5:15 PM, MDS Coordinator #1 was interviewed. She stated she was responsible for the seating arrangements of the residents in the dining room. She further stated she expected the residents to be served consecutively at a table before another table was served. She indicated she was unaware Resident #84 had handled Resident #118's food.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood on 4 of 4 skilled resident hallways (Resident room #104, #106, #108, #112, #113, #114, #203, #206, #208, #211, #401, #404, #405, #406, #410, #411, #500, #501, #503), failed to repair a sink cabinet with	F 253	It is the facility policy to provide housekeeping and maintenance services necessary to maintain sanitary, orderly, and comfortable interior. No resident was named in this deficiency and no resident experienced negative	11/18/15

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F 253	Continued From page 8 broken and splintered wood and laminate (room #208) and failed to repair caulk around 2 toilets in resident rooms. (Resident room #208 and #211). The findings included: 1. a. Observations of Room 104 on 11/02/15 at 11:52 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:32 AM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 8:43 AM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:30 PM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door. b. Observations of Room 106 on 11/02/15 at 11:54 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:35 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 8:47 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:32 PM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half	F 253	outcomes. All doors (RMs 104, 106, 108, 112, 113, 114, 203, 206,208,211,401,404,405,406,410,411,500,501,503), sink cabinet (RM 208), and grout around toilet (RM 208 and 211) documented in observation have been repaired. Maintenance Supervisor and Assistant in-serviced by Administrator as to prioritization of work orders to ensure resident safety. Instructed to notify Administrator in morning meeting of concerns noted and track all maintenance repairs with work order.All staff in-serviced on proper identification of environmental concerns, specifically related to resident safety. Educated on completing Repair Requisition for all request and procedure to assure all necessary staff have been notified, including placing copy in DON box for Administrator review. A 100% audit has been completed on resident doors, sink cabinets, and grout around toilet by Maintenance Supervisor and Assistant. Areas identified are reviewed with Administrator and placed on a log in order of level of importance and a weekly schedule for repair has been created. Under the supervision of the Administrator, Maintenance Supervisor/Designee conducts monthly audits to ensure compliance. Any problems identified are placed on repair log, scheduled for date of repair, and	

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F 253	Continued From page 9 of the door. c. Observations of Room 108 on 11/02/15 at 11:57 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:40 AM revealed the door of resident room 108 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 8:52 AM revealed the door of resident room 108 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:35 PM revealed the door of resident room 108 had broken and splintered laminate on the front of the bottom half of the door. d. Observations of Room 112 on 11/02/15 at 11:59 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:42 AM revealed the door of resident room 112 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 8:55 AM revealed the door of resident room 112 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:37 PM revealed the door of resident room 112 had broken and splintered laminate on the front of the bottom half of the door. e. Observations of Room 113 on 11/02/15 at 12:02 PM revealed the door of the resident's room had broken and splintered laminate on the	F 253	submitted to the quarterly Quality Assurance Committee for further review or need of corrective action.	

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F 253	Continued From page 10 front of the bottom half of the door. Observations on 11/03/15 at 9:45 AM revealed the door of resident room 113 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 8:57 AM revealed the door of resident room 113 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:39 PM revealed the door of resident room 113 had broken and splintered laminate on the front of the bottom half of the door. f. Observations of Room 114 on 11/02/15 at 12:04 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:47 AM revealed the door of resident room 114 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 9:02 AM revealed the door of resident room 114 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 4:45 PM revealed the door of resident room 114 had broken and splintered laminate on the front of the bottom half of the door. g. Observations of Room 203 on 11/02/15 at 12:07 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 9:50 AM revealed the door of resident room 203 had broken and splintered laminate on the front of the bottom half of the door.	F 253		

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Observations on 11/04/15 at 9:05 AM revealed the door of resident room 203 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 4:47 PM revealed the door of resident room 203 had broken and splintered laminate on the front of the bottom half of the door.

h. Observations of Room 206 on 11/02/15 at 12:10 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 9:57 AM revealed the door of resident room 206 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:08 AM revealed the door of resident room 206 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 4:50 PM revealed the door of resident room 206 had broken and splintered laminate on the front of the bottom half of the door.

i. Observations of Room 208 on 11/02/15 at 12:12 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:01 AM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:11 AM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 4:52 PM revealed

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the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door.

j. Observations of Room 211 on 11/02/15 at 12:15 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:05 AM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:15 AM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 4:55 PM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door.

k. Observations of Room 401 on 11/02/15 at 12:18 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:07 AM revealed the door of resident room 401 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:18 AM revealed the door of resident room 401 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:02 PM revealed the door of resident room 401 had broken and splintered laminate on the front of the bottom half of the door.

l. Observations of Room 404 on 11/02/15 at 12:20

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PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:12 AM revealed the door of resident room 404 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:20 AM revealed the door of resident room 404 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:06 PM revealed the door of resident room 404 had broken and splintered laminate on the front of the bottom half of the door.

m. Observations of Room 405 on 11/02/15 at 12:22 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:15 AM revealed the door of resident room 405 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:23 AM revealed the door of resident room 405 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:12 PM revealed the door of resident room 405 had broken and splintered laminate on the front of the bottom half of the door.

n. Observations of Room 406 on 11/02/15 at 12:24 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:17 AM revealed the door of resident room 406 had broken and

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splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:26 AM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:14 PM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door.

o. Observations of Room 410 on 11/02/15 at 12:27 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:20 AM revealed the door of resident room 410 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:28 AM revealed the door of resident room 410 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:17 PM revealed the door of resident room 410 had broken and splintered laminate on the front of the bottom half of the door.

p. Observations of Room 411 on 11/02/15 at 12:30 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:23 AM revealed the door of resident room 411 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:30 AM revealed the door of resident room 411 had broken and splintered laminate on the front of the bottom half

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F 253	Continued From page 15 of the door. Observations on 11/05/15 at 5:20 PM revealed the door of resident room 411 had broken and splintered laminate on the front of the bottom half of the door. q. Observations of Room 500 on 11/02/15 at 12:32 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 10:25 AM revealed the door of resident room 500 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 9:32 AM revealed the door of resident room 500 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 5:24 PM revealed the door of resident room 500 had broken and splintered laminate on the front of the bottom half of the door. r. Observations of Room 501 on 11/02/15 at 12:35 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/03/15 at 10:27 AM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/04/15 at 9:35 AM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/05/15 at 5:27 PM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door.	F 253		

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s. Observations of Room 503 on 11/02/15 at 12:37 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/03/15 at 10:30 AM revealed the door of resident room 503 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/04/15 at 9:38 AM revealed the door of resident room 503 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/05/15 at 5:30 PM revealed the door of resident room 503 had broken and splintered laminate on the front of the bottom half of the door.

2. Observations of Room 208 on 11/02/15 at 12:12 PM revealed the sink cabinet had broken and splintered wood and laminate at the left edges of the cabinet.
Observations on 11/03/15 at 10:01 AM of resident room 208 revealed the sink cabinet had broken and splintered wood and laminate at the left edges of the cabinet.
Observations on 11/04/15 at 9:11 AM of resident room 208 revealed the sink cabinet had broken and splintered wood and laminate at the left edges of the cabinet.
Observations on 11/05/15 at 4:52 PM of resident room 208 revealed the sink cabinet had broken and splintered wood and laminate at the left edges of the cabinet.

3. a. Observations in the bathroom of Room 208 on 11/02/15 at 12:13 PM revealed caulk around the base of the toilet was broken and stained with black and brown substance.

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Observations on 11/03/15 at 10:02 AM in the bathroom of resident room 208 revealed caulk around the base of the toilet was broken and stained with black and brown substance.
Observations on 11/04/15 at 9:12 AM in the bathroom of resident room 208 revealed caulk around the base of the toilet was broken and stained with black and brown substance.
Observations on 11/05/15 at 4:53 PM in the bathroom of resident room 208 revealed caulk around the base of the toilet was broken and stained with black and brown substance.

b. Observations in the bathroom of Room 211 on 11/02/15 at 12:15 PM revealed caulk around the base of the toilet was broken and stained with black and brown substance.
Observations on 11/03/15 at 10:05 AM in the bathroom of resident room 211 revealed caulk around the base of the toilet was broken and stained with black and brown substance.
Observations on 11/04/15 at 9:15 AM in the bathroom of resident room 211 revealed caulk around the base of the toilet was broken and stained with black and brown substance.
Observations on 11/05/15 at 4:55 PM in the bathroom of resident room 211 revealed caulk around the base of the toilet was broken and stained with black and brown substance.

During a tour and interview on 11/06/15 at 12:24 PM with the Maintenance Director he stated he worked on resident room doors when he changed hinges or had to repair the doors. He explained he had put some laminate skins on some resident doors to protect them from damage but he had no defined schedule and worked on them when he could. He further explained he had to take the door down and take it outside to sand and glue it

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F 253	Continued From page 18 and if it was too hot or cold outside the glue to attach the laminate to the door would not stick. He stated the sink cabinet in resident room 208 needed to be sanded to remove the splinters and he removed and repaired caulk around toilets all at the same time. He stated the last time he caulked around toilets was in June 2015 but was not sure if he caulked around the toilets in rooms 208 and 211. He explained he made rounds in the facility daily and made repairs as he had time. He explained work orders were available for staff to fill out for maintenance repairs but he had not received any work orders for damaged resident doors or cabinets or stained caulk in bathrooms. During an interview on 11/06/15 at 2:52 PM with the Administrator she stated it was her expectation for the maintenance staff to do their rounds and address patient safety issues first. She further stated repairs needed to be on a schedule and she expected for them to prioritize and fix things that were damaged or broken.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility failed to provide oral care to a resident receiving tube feedings for 1 of 3 sampled residents requiring total	F 312	It is the facility policy to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and	11/18/15

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F 312	Continued From page 19 assistance for activities of daily living (Resident #40). The findings included: Resident #40 was re-admitted to the facility on 09/05/06 with diagnoses of diabetes mellitus, cerebrovascular accident (stroke), dementia, dysphagia (difficulty in the ability to swallow), and aphasia (loss of ability to understand or express speech). Review of the quarterly Minimum Data Set (MDS) dated 09/15/15 assessed the resident as having severe cognitive impairment and was totally dependent on staff for all of her activities of daily living (ADLs). The MDS further assessed Resident #40 as requiring the physical assistance of 2 staff members for personal hygiene. Review of a care plan dated 09/23/15 revealed a focus area of oral/dental needs: the resident required total assist, nothing by mouth, provide mouth care every shift, and as needed. There was no goal listed and the interventions was for the resident to have total hygiene care by staff, oral care every shift and as needed. An observation was made on 11/03/15 at 9:07 AM of Resident #40 lying in her bed. Resident #40 was observed to have a white film on her teeth and white foamy saliva drool was observed to be coming down the corners of her mouth. An observation was made on 11/03/15 at 2:45 PM of Resident #40 lying in her bed. She was observed to have white colored substance/coating on her teeth and white foamy drool running down the left side of her mouth.	F 312	personal and oral hygiene. This is achieved for resident #40 by in-servicing the staff members involved during the survey. Resident #40 receives oral care daily and as needed provided by staff and it is documented in the electronic healthcare record. Resident #40 experienced no negative outcomes from the cited deficiency. All residents who require assistance with any ADL task including oral hygiene are at risk for this cited deficiency. To better ensure oral care is provided for residents who require assistance the following has been completed. The Administrator, DON, and ADON in-serviced all nursing staff, including CNAs listed in observation, as to proper oral care for dependent residents with an emphasis on tube fed residents. To further enhance compliance, audits to ensure proper oral care is being performed were completed by ADON five times a week for one week, three times a week for one week, and then random observation audits are done weekly for four weeks. Any deficiencies will be corrected at time of identification. All findings will be documented and submitted to the quarterly Quality Assurance Committee for further review or need of corrective action. The Director of Nursing is responsible for monitoring compliance and reporting to the Quality Assurance Committee.	

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Resident #40 was observed on 11/04/15 at 10:30 AM lying in her bed with her mouth opened and her bottom teeth were observed to be heavily coated with a white substance around the gum line of the teeth. Resident #40 was also observed to have dried white substance on the left side of her mouth.

On 11/04/15 at 11:08 AM, Nurse Aides (NAs) #5 and NA #6 were observed to provide incontinence care for Resident #40. After the NAs completed incontinence care appropriately for the resident, NA #5 was observed to use a towel and wiped the corners of the resident's mouth and removed the sputum which was streaming down the both sides of Resident #40's mouth. NA #5 and/or NA #6 was not observed to provide oral care for Resident #40.

On 11/04/15 at 1:45 PM, NA #6 was interviewed. She stated she was assisting the other NAs during her shift and did not have a specific assignment. NA #6 confirmed she had assisted NA #5 with incontinence care and had not observed and/or had not provided oral care for Resident #40.

On 11/04/15 at 3:00 PM, Resident #40 was again observed lying in her bed, with her bottom teeth coated in a white substance and the gum line of the teeth was observed to be more heavily coated with the white substance.

On 11/05/15 at 6:30 AM, NA #1 was interviewed. NA #1 stated the NAs were expected to provide oral care to Resident #40 every shift. NA #1 further stated he had not provided oral care during his shift due to being busy during the night.

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On 11/05/15 at 6:50 AM, NA #3 was interviewed. NA #3 stated Resident #40 was to have oral care provided every shift. NA #3 further stated she had not provided oral care to Resident #40 and had no explanation as to why she had not done so.

On 11/05/15 at 7:40 AM, Resident #40 was observed lying in her bed and her teeth remained coated in a white substance up to and around the gum line of the teeth.

On 11/05/15 at 2:45 PM, NA #5 was interviewed. He confirmed he cleaned the sputum drool from the corners and chin of Resident #40's mouth/face. NA #5 further confirmed he was responsible for the care of Resident #40 on 11/04/15. NA #5 stated he had not provided oral care to Resident #40 and no explanation as to why he had not provided the oral care.

On 11/06/15 at 7:25 AM, NA #8 was interviewed. NA #8 stated she had not provided any oral care for Resident #40 during the week. NA #8 further stated she was expected to provide oral care every shift for Resident #40 and she had no explanation when asked why she had not provided the oral care.

On 11/06/15 at 12:10 PM, the nurse supervisor was interviewed. She stated she expected for oral care to be provided to Resident #40 every shift. She indicated she was unaware that oral care had not been provided to the resident.

On 11/06/15 at 1:50 PM, the Director of Nursing was interviewed. She stated she would have expected the NAs to have provided oral care to Resident #40 every shift. She indicated she was

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F 312	Continued From page 22 unaware that oral care had not been provided to the resident.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and physician and staff interviews the facility failed to provide supervision for a resident who fell from bed and had a subarachnoid hemorrhage (bleed in the brain) and for a resident who fell from bed with facial lacerations and a concussion for 2 of 3 sampled residents sampled for falls. (Resident #58 and #55). The findings included: 1. Resident #58 was admitted to the facility on 07/08/11 with diagnoses which included muscle weakness, osteoarthritis, Alzheimer's disease, dementia and depression. A review of the most recent discharge Minimum Data Set (MDS) dated 10/09/15 indicated Resident #58 was severely impaired in cognition for daily decision making and required extensive assistance with bed mobility and transfers. The MDS also indicated Resident #58 was always incontinent of bladder and bowel.	F 323	It is the facility policy to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents. Resident #58 no longer resides in this facility. Some of the ways compliance has been accomplished with Resident #55 was by MDS nurse reviewing resident's care guide, care path, and care plan to assure all interventions were in place. Fall history and medical record reviewed by DON and Administrator to ensure all appropriate interventions were implemented. Because all residents have the potential to be affected by the cited deficiency, all nursing staff were in-serviced related to fall prevention with emphasis on reporting all changes in condition promptly.	11/18/15

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F 323	Continued From page 23 A review of a nurse's note revealed on 09/13/15 at approximately 11:00 PM a Nurse Aide (NA) informed Nurse #1 she heard someone talking while making rounds and saw Resident #58 lying on the floor in her room, on her right side facing the sink, with her back to the night stand. A review of a fall investigation report revealed Resident #58 had an unwitnessed fall in her room on 09/13/15 at 11:00 PM. The report indicated Resident #58 was disoriented and confused and had poor safety awareness. The report further indicated Resident #58 was barefoot and had last been toileted around 9:00 PM. The report revealed additional interventions were put into place to provide frequent re-direction from staff and increase visual checks. A review of a care plan titled fall risk needs dated 09/17/15 indicated Resident #58 needed extensive assistance related to cognitive impairment, had poor safety awareness and a history of falls. The goal was for Resident #58 to have no injuries from falls through next review and interventions were listed in part for frequent visual checks, non-skid strips to bedside floor, bed in low position, therapy referrals as needed and offer toileting during care rounds and as needed. A review of a nurse's note dated 10/09/15 at 5:45 AM indicated Nurse #4 who was also a nursing supervisor was called to Resident #58's room and the resident was observed lying in floor on her right side. The notes revealed Resident #58 was assisted back into bed and had a contusion (bruising) to right side of forehead and red area to right hip. The notes further revealed physician's	F 323	Instruction given that when using "Frequent Visual Checks" in conjunction with other fall interventions it must be documented and a time frame of checks must be established. All facility staff in-serviced on fall prevention in relation to their scope of practice. MDS Nurses did 100% audit of current residents who had any type of incident in the last 30 days to ensure care plans and care guides were updated as indicated. A Falls Prevention Committee has been formed and meets weekly and as needed to review all incidents. All incidents are reviewed under supervision of Director of Nursing, Administrative Nurses, Administrator, and Therapy representative to ensure thorough investigation is complete and appropriate interventions are in place. Concerns identified during the weekly incident meetings are corrected promptly and are presented at the quarterly Quality Assurance Committee meeting for further review or need for corrective action. The Director of Nursing is responsible for compliance.	

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orders were obtained to send Resident #58 to the emergency room (ER) for evaluation.

A review of a nurse's note dated 10/09/15 indicated at approximately 5:45 AM NA #2 called Nurse #1 in to Resident #58's room and the resident was lying on the floor next to her bed on her right side in between the bed and night stand. The notes further indicated Resident #58 was transferred back to bed with a mechanical lift and a physical assessment revealed a laceration on the right side of her head with a small amount of bleeding and her right hip was red.

A review of a nurse's note dated 10/09/15 revealed emergency medical services was called at approximately 6:00 AM and Resident #58 was transported to the ER for evaluation.

A review of an ER documentation dated 10/09/15 indicated Resident #58 presented to the ER following a fall. The notes revealed Resident #58 had bleeding on her right scalp and a section labeled impression and plan revealed a traumatic subarachnoid (a space in the brain that is filled with cerebrospinal fluid and contains large blood vessels that supply the brain and spinal cord) hemorrhage and admit to intensive care unit.

A review of a hospital history and physical dated 10/09/15 revealed Resident #58 was transferred to the hospital for further evaluation after a fall and was found to have a subarachnoid hemorrhage that was discussed with the neurosurgeon and there was no intervention recommended. A section labeled impression and plan revealed a subarachnoid hemorrhage, acute kidney injury and dementia.

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A review of a computerized axial tomography (CT) scan dated 10/09/15 revealed a small amount of subarachnoid hemorrhage over the left occipital temporal area (at the back of the head) and critical findings of acute subarachnoid hemorrhage was discussed with the ER physician.

A review of a fall investigation document dated 10/09/15 revealed Resident #58 had an unwitnessed fall in her room on 10/09/15 at approximately 5:45 AM. The document indicated Resident #58 was disoriented and confused at the time of the fall, had poor safety awareness and both half-length side rails were up.

A fall scene investigation report indicated Resident #58 had a fall on 10/09/15 at 5:45 AM and revealed the last time Resident #58 was checked was 3:00 AM and she was dry. A root cause of the fall was safety unawareness and new interventions to prevent future falls was frequent checks.

A review of a hospital discharge summary dated 10/11/15 revealed Resident #58 was admitted to the hospital after she had fallen and was found to have a subarachnoid hemorrhage on her CT scan. The summary further revealed neurosurgery was consulted and there was nothing for them to do and due to worsening dementia, worsening clinical status and current clinical condition, Resident #58's family was interested in hospice. The notes indicated hospice was consulted and Resident #58 would be discharged for comfort care.

A review of a written statement dated 10/11/15 by NA #2 indicated around 5:45 AM on 10/09/15 she

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walked into Resident #58's room to get her dressed and found her lying on the floor next to her bed. The statement further indicated she notified the nurse and they used a lift to get Resident #58 off the floor and she noticed a small cut on the side of Resident #58's head. The statement also indicated Resident #58's bed was in the low position.

A review of a nurse's note dated 10/12/15 at 4:15 PM revealed in part Resident #58 returned to the facility and had a small scabbed area to her right forehead above her eye.

A review of a nurse's note dated 10/12/15 at 8:00 PM indicated hospice services.

A review of a nurse's note dated 10/21/15 at 8:35 PM indicated Resident #58 had expired at the facility.

During an interview on 11/05/15 at 6:35 AM with NA #2 she confirmed she was assigned to Resident #58's care during the night shift when she fell on 10/09/15. She explained she was making her last rounds of the night after 5:00 AM and Nurse #1 was standing at a medication cart in the hallway near Resident #58's room. She stated she walked inside the door of Resident #58's room and saw the resident on the floor and she turned back to the doorway and told Nurse #1 that Resident #58 was on the floor. She explained she saw Resident #58 in the floor with her head pointed toward the head of bed and her feet were toward the foot of bed. She further explained there was a short side rail that moved some when she wiggled it and there was no bed alarm. She stated she was not told anything about increasing visual checks or rounds and she

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was unaware Resident #58 had a fall previously. She explained Resident #58 could not walk and she did not know how she fell out of the bed but she had seen her squirming in bed that night so she had raised the foot of the bed up a little and made sure she was in the center of the bed when she had last checked her on her routine rounds.

During an interview on 11/05/15 at 7:02 AM with Nurse #4 she confirmed she was working on night shift as the nursing supervisor on 10/09/15 and was called to Resident #58's room and she was lying on her right side on the floor with her head pointed toward the head of the bed and close to being in between the night stand and bed. She stated Nurse #1 and NA #2 were in the room and they were checking Resident #58 over. She explained she assessed Resident #58 and she had a bruise to her right forehead and side of head but did not recall seeing blood. She stated Resident #58 did not talk but made sounds and she was not making any loud noises. She explained it was facility policy to send residents out to the ER if there was suspicion they hit their head. She confirmed Resident #58 had fallen once a couple of weeks before the fall on 10/09/15 and stated Resident #58 was totally dependent on staff for care, could not use a call bell and after the fall on 09/13/15 staff were supposed to redirect and watch her closer. She explained the nurse aides (NAs) made rounds to check residents every 2 hours and if residents were to have increased visual checks that meant NAs should watch the resident more closely. She stated it was her expectation if Resident #58 had acted restless staff should have let her know and if a NA saw a resident wiggling or squirming they should check them to see if they were wet or soiled and reposition them. She explained she

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put new interventions in the computer for the NAs but she had never looked to see what the NAs could see once the interventions were put it in and there was also a care guide in the resident's closet that listed fall interventions.

During an interview on 11/06/15 at 6:41 AM with NA #7 she stated she had provided care for Resident #58 on occasion at night. She explained Resident #58 could not get up by herself and required 2 staff assistance and had not been on fall precautions that she was aware of. She further stated if a resident was supposed to have frequent checks that meant to check on the resident between rounds that were done every 2 hours.

During an interview on 11/06/15 at 6:54 AM with Nurse #1 she verified she worked the night shift on 10/09/15 and she had just pulled the medication cart past Resident #58's room when NA#2 called her to come in the resident's room. She explained when she walked in the room she saw Resident #58 on the floor and she was laying on her right side with her back toward the bed and her head toward the night stand. She stated she had a red mark on her right hip and she had a small laceration on the right side of her forehead at the hairline and there was a small amount of blood. She explained she called the nursing supervisor and she came and they assessed Resident #58 and then they lifted her into bed with a full body mechanical lift. She stated she recalled Resident #58 had side rails on her bed that were up and she had fallen a few weeks before and was in the same position on the floor as on 10/09/15. She stated she did not hear anything when Resident #58 fell and she had put in the computer system for Resident #58

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to have frequent visual checks. She explained NAs made rounds every 2 hours but frequent visual checks meant staff should peek in on Resident #58 every hour. She stated NA #2 did not report to her that Resident #58 had been moving around in bed or anything that might have made her think Resident #58 would fall. She explained they put in the computer system for NAs to do frequent visual checks when a resident required them and it was supposed to be on the care guide in the resident's closet but she could not recall what was listed on Resident #58's care guide.

During an interview on 11/06/15 at 9:41 AM with Resident #58's physician who was also the facility Medical Director he stated Resident #58 had been declining due to Alzheimer's disease and could not communicate clearly. He further stated he was surprised Resident #58 fell out of bed but that's why they had to have fall precautions in place. He explained Resident #58's family had requested she receive hospice services and to keep her comfortable when she was re-admitted to the facility because of advanced stage dementia.

During an interview on 11/06/15 at 1:24 PM with the Assistant Director of Nursing she stated NAs were expected to make rounds on residents every 2 hours and if they were to have frequent visual checks that meant the resident needed to be checked more frequently. She explained frequent visual checks was entered in the computer and on the care guide so the NA would know to go to the resident's room and check them more frequently.

During an interview on 11/06/15 at 1:50 PM with

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the Director of Nursing she stated it was her expectation to treat every resident as a fall risk. She stated frequent visual checks meant for staff to pay more attention to the resident more closely. She explained it was her expectation for NAs to make routine rounds on residents every 2 hours but if frequent visual checks were indicated they should check on them in between the every 2 hour routine rounds. She explained the fall team met every morning Monday through Friday and discussed each resident's fall and recommendations and interventions were documented and communicated with direct care staff. She further explained falls that occurred on the weekend were discussed at the Monday morning meeting. She stated it was also her expectation for nurses and NAs to communicate about residents and to monitor them.

During an interview on 11/06/15 at 3:40 PM with physical therapist #2 he explained after Resident #58 fell on 09/13/15 she was evaluated by therapy and was assessed to be at her previous baseline level so no therapy was indicated. He stated after the second fall on 10/09/15 she went to the hospital and when she came back she was on hospice care so no therapy was indicated.

2) Resident #55 was admitted to the facility on 04/07/11 with diagnoses which included Alzheimer's disease and history of falls.

Review of Resident #55's medical record revealed an unwitnessed fall on 02/02/15 at 3:10 AM. The fall investigation specified the resident was found sitting on the floor, wearing non-skid plain white socks, and had sustained no injuries. Further review of the medical record revealed no

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new interventions were put into place to prevent future falls, resident was encouraged to be careful, and the resident had declined the use of side rails.

Further review of Resident #55's care plan did not indicate a fall risk needs care plan, goal, and/or interventions after the fall on 02/02/15.

Review of the quarterly Minimum Data Set (MDS) dated 10/13/15 indicated Resident #55 had severe cognitive impairment and was coded to need limited assistance with bed mobility, transfers, dressing, and toileting. The MDS further revealed Resident #55 was independent with ambulation and was unsteady with balance and required staff assistance. Further review of the MDS indicated Resident #55 used a walker and a wheelchair as her mobility devices.

Further review of the medical record revealed Resident #55 had a fall on 05/16/15 at 8:40 PM. The fall investigation specified the fall was unwitnessed, the resident was trying to assist another resident when both fell on the floor, and Resident #55 sustained a 2.5 centimeter (cm) laceration to the back of the head and was transported to a local hospital for evaluation and treatment. The report further indicated the resident obtained a staple to the back of the head and was transported back to the facility and an intervention for Resident #55 to have non-skid socks on every shift.

Review of a care plan dated 05/17/15 indicated Resident #55 had fall risk needs with no goal indicated and an intervention of non-skid socks on every shift. There was no care plan for fall risk needs prior to 05/17/15.

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Resident #55 had an unwitnessed fall on 09/10/15 at 6:30 AM. The fall investigation specified the resident had poor safety awareness, history of falls, was not wearing non-skid socks and/or shoes and was encouraged to always wear proper foot wear and call for assistance when needed. The report further indicated interventions for Resident #55 was for non-skid footwear, frequent visual checks, non-skid strips to the floor at bedside, call light within reach and bed and chair alarms.

Resident #55's care plan was updated on 09/23/15 for fall risk needs with no goal indicated and interventions which included a risk for falls assessment, frequent visual checks, safety reminders, non-skid strips in the floor at bedside, non-skid footwear for transfers and/or ambulation, call light within reach, bed alarm and chair alarm.

Review of the medical record indicated Resident #55 had an unwitnessed fall on 10/29/15 at 9:00 AM. The fall investigation revealed the resident had poor safety awareness transferring from the bed to the wheelchair with the wheelchair brakes unlocked, history of falls and unable to remember to wait for assistance. The interventions included frequent visual checks, non-skid footwear, call bell within reach, bed in lowest position when occupied, an order was received for an antibiotic related to a urinary tract infection (UTI) and therapy to screen due to increased weakness.

Further review of the medical record indicated Resident #55 had sustained unwitnessed fall on 10/29/15 at 4:00 PM. The fall investigation revealed Resident #55 had fallen in her

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bathroom, sustained 2 lacerations to the forehead, and a hematoma (swelling of clotted blood within the tissues) over the left eye with no loss of consciousness. Resident #55 was transported to a local hospital by emergency medical services (EMS) ambulance for evaluation and treatment. The investigation report indicated a "new intervention" for frequent monitoring of the resident.

A review of the hospital records dated 10/29/15 indicated Resident #55 had a traumatic injury, with forehead lacerations, a concussion with unknown loss of consciousness, and pain to the left side of the face and head. Laceration #1 was 2 centimeters (cm) in length to the left scalp area and laceration #2 was 2 cm in length at the left side forehead area with both lacerations being sutured and the bleeding controlled.

An updated care plan of 10/30/15 indicated Resident #55 was at risk for falls related to history of falls, difficulty in walking, lack of coordination, generalized weakness, urinary tract infection and poor safety awareness. The care plan had no goal indicated with interventions which included medical record charting related to the falls for 3 days, a fall risk assessment, check the bed alarm every shift, neurological checks for 72 hours, call light within reach and check chair alarm every shift.

On 11/04/15 at 10:30 AM, Resident #55 was observed lying in bed and was observed to have a large hematoma and 2 lacerations with sutures intact above the left eye and in the area of the forehead with bruising across the resident's forehead and around both eyes. Resident #55's bed was observed to have bilateral side rails in

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the upright position attached in the middle portion of the resident's bed.

On 11/05/15 at 6:30 AM, Resident #55 was observed lying on her back in bed asleep. Resident #55's bed was observed with bilateral side rails in the upright position attached in the middle portion of the resident's bed.

On 11/05/15 at 6:40 AM, an interview was conducted with nurse aide (NA) #1. NA #1 stated he was unaware of what "frequent monitoring" of a resident meant and that he was expected to make rounds (check) on his assigned residents every 2 hours which also included turning and positioning and the changing of the residents brief if it was wet or soiled. NA #1 indicated Resident #55 required limited assistance with her activities of daily living (ADLs) and he would not have considered the resident to be a fall risk prior to the falls on 10/29/15. NA #1 further indicated after Resident #55's 2 falls on 10/29/15 she was considered a fall risk and the side rails was placed on the resident's bed after the falls.

On 11/05/15 at 6:50 AM, an interview was conducted with NA #3. She stated she was unaware of what "frequent monitoring" meant and that she was expected to check, change the brief if it was wet or soiled and turn and reposition a resident every 2 hours. She further stated Resident #55 required limited assistance from staff and was unaware of the resident being a fall risk until after the resident had the 2 "bad" falls on 10/29/15 at which time Resident #55 was considered to be a fall risk and the side rails were placed in the middle portion of the resident's bed.

On 11/05/15 at 7:30 AM, an interview was

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conducted with Nurse #3. She stated Resident #55 was independent before the 2 falls on 10/29/15. Nurse #3 further stated after the falls the resident had declined rapidly, was placed on Hospice services and was dependent on staff for most all of her ADLs.

On 11/05/15 at 2:50 PM, an interview was conducted with NA #5. He stated Resident #55 was not considered a fall risk, required limited assistance with ADLs and had not had any side rails on her bed until after the 2 falls on 10/29/15. NA #5 indicated he was unaware Resident #55 required "frequent monitoring." NA #5 further indicated he made rounds on Resident #55 every 2 hours and that he had not been advised and/or asked to make additional rounds/checks on the resident.

On 11/06/15 at 6:35 AM, an interview was conducted with Nurse #1. She stated Resident #55 required limited assistance of ADLs before the resident had the falls on 10/29/15 and since the falls the resident has been more dependent on staff for all of her ADLs. Nurse #1 further stated she was unaware of "frequent visual checks/monitoring" of Resident #55 and expected the NAs to make rounds/check on residents every 2 hours. Nurse #1 indicated when the resident had returned from the hospital on 10/30/15 she had initiated the frequent nurse monitoring as per the facility policy which included neurological checks every 2 hours for the first 24 hours, then every 4 hours for the next 24 hours, and then every 8 hour shift for the next 24 hours.

On 11/06/15 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). She stated Resident #55 was independent with

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F 323	Continued From page 36 her ADLs before the 2 falls on 10/29/15. The DON indicated frequent visual checks/monitoring would alert the staff that they should pay more attention to the resident and lay eyes on the resident every 15 minutes. The DON stated she was unaware that the interviewed NAs were unaware of what frequent visual checks/monitoring meant and that frequent visual checks/monitoring was not the sole intervention for falls.	F 323		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility failed to assess and provide a resident sufficient fluids to maintain hydration for 1 of 3 residents sampled for hydration. (Resident #58). The findings included: Resident #58 was admitted to the facility on 07/08/11 with diagnoses which included muscle weakness, osteoarthritis, Alzheimer's disease, dementia and depression. A review of the most recent discharge Minimum Data Set (MDS) dated 10/09/15 indicated Resident #58 was severely impaired in cognition for daily decision making and was totally dependent on staff for eating. The MDS also indicated Resident #58 was always incontinent of bladder and bowel.	F 327	It is the policy of this facility to provide each resident with sufficient fluid to maintain proper hydration and health. One way this has been achieved is by in-servicing all nursing staff on the importance adequate hydration and identification and reporting of residents with poor fluid intake. Resident #58 no longer resides at this facility. For residents having the potential to be affected by the cited deficiency, Administrator and DON implemented "Stop and Watch" tool to assist certified nursing assistants and all other non-nursing staff to effectively	11/18/15

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F 327	Continued From page 37 A review of a physician's order dated 09/11/15 indicated Mighty shake with meals three times daily for weight loss. A review of a quarterly nutrition note dated 09/30/15 at 4:04 PM revealed Resident #58 was on a puree diet and her meal intake was poor and now required total assistance with meals. The notes further indicated Resident #58 received magic cups with meals to promote weight gain and HI Cal supplement 120 milliliters (ml) three times a day for added calories and nutrition and dietary would continue to observe for changes in nutritional status. A review of meal intakes, fluid intakes and supplements revealed the following daily oral intakes: 09/30/15 total oral fluid intake was 1,020 ml 10/01/15 total oral fluid intake was 1,140 ml 10/02/15 total oral fluid intake was 1,320 ml 10/03/15 total oral fluid intake was 1080 ml 10/04/15 total oral fluid intake was 780 ml 10/05/15 total oral fluid intake was 1,140 ml A review of a nurse's note dated 10/06/15 at 1:50 PM revealed Resident #58 continued to not eat well. The notes indicated Resident #58 blew bubbles in drinks and her positioning was a factor because she leaned over with her hand over her mouth most of time. A review of meal intakes, fluid intakes and supplements revealed the following daily oral intakes: 10/06/15 total oral fluid intake was 540 ml 10/07/15 total oral fluid intake was 95 ml	F 327	communicate any change in resident condition to nursing. This tool contains common changes observed in the elderly population, including poor fluid intake, and gives area for comments related to other identified changes. Charge nurse is to document any follow-up needed and completed tool is turned in to Director of Nursing. All staff in-serviced on the tool and the importance of prompt notification of changes in resident status. Audit completed by generating Monitoring Assessments-Out of Range Results Report, to review daily fluid intakes beginning on 11/13/15 and reviewed by Administrator and DON/Designee for two weeks to identify residents with poor fluid intake. Residents identified as being at risk were scheduled a nursing intervention stating that 120ml of fluid are to be given four times daily. Nursing to continue to monitor and assess residents with a change in condition and report to MD as needed. DON/Designee will generate and review fluid intakes twice weekly for two months to ensure compliance. Any concerns are corrected immediately and findings are reported to the quarterly Quality Assurance Committee for further review or need for corrective action. The Director of Nursing is responsible for monitoring compliance.	

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A review of a nurse's note dated 10/08/15 at 2:30 PM revealed Resident #58's meal intake had been poor for several days and at lunch meal today, resident had a blank look and refused meal. The notes indicated Resident #58 was assisted back to her room into bed by staff and staff noted Resident #58 had a non-productive cough during transfer into bed. The notes revealed her blood pressure was 126/58, temperature 96.9 Fahrenheit, pulse 97 and respirations were 20. The notes further revealed staff was unable to obtain an oxygen percentage reading and oxygen was placed on Resident #58 and her oxygen saturation was 95 percent on 2 liters of oxygen via nasal cannula. The notes indicated information was faxed to the physician with a request for chest x-ray and urinalysis with culture and sensitivity and was awaiting a return facsimile (fax) from the physician.

A review of meal intakes, fluid intake and total supplements for 10/08/15 revealed there was no indication of any meal intake or fluid intake.

A review of a nurse's note dated 10/09/15 indicated at approximately 5:45 AM NA #2 called Nurse #1 in to Resident #58's room and the resident was lying on the floor next to her bed on her right side in between the bed and night stand. The notes further indicated Resident #58 was transferred back to bed with a mechanical lift and a physical assessment revealed a laceration on the right side of her head with a small amount of bleeding and her right hip was red.

A review of a nurse's note dated 10/09/15 revealed emergency medical services was called at approximately 6:00 AM and Resident #58 was transported to the emergency room (ER) for

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evaluation.

A review of an ER visit note dated 10/09/15 revealed Resident #58 presented to the ER following a fall and was frail and elderly. A section labeled impression and plan revealed acute renal failure; hypernatremia (high sodium levels in the blood) and hyperkalemia (high potassium levels in the blood) and admit to the intensive care unit.

A review of laboratory results dated 10/09/15 revealed the following:
Sodium 177 high (normal range 136-145)
Potassium 5.9 high (normal range 3.5-5.1)
BUN (to evaluate kidney function) 217 high (normal range 7-22)
Creatinine (to evaluate kidney function) 12.70 high (normal range 0.6-1.0)

A review of a hospital history and physical dated 10/09/15 revealed Resident #58 was transferred to the hospital for further evaluation and was found to have severe hypernatremia as well as kidney injury. A section labeled impression and plan indicated nephrology (kidney specialist) had been consulted and Resident #58 had received intravenous fluids and follow up with urine sodium, urine creatinine and a renal (kidney) ultrasound studies.

A review of renal ultrasound results dated 10/10/15 revealed no evidence of renal obstruction.

A review of a hospital discharge summary dated 10/11/15 revealed Resident #58 had been admitted to the hospital after she had fallen and was found to have azotemia (a high build-up of

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nitrogen waste products) with acute kidney injury and was also found to have hypernatremia due to sodium was as high as 177. The summary revealed Resident #58 appeared to be in an infantile position and woke up with a sternal rub but only moaned and a discussion with family revealed this was worse than her normal baseline. The summary also revealed nephrology was consulted and she was given intravenous fluids of 5 percent dextrose and water and her sodium had been improving and creatinine improved mildly but was still much more elevated. The summary indicated due to worsening dementia, worsening clinical status for the past few weeks, not receiving nutrition and due to current clinical condition family was interested in hospice and would be discharged for comfort measures.

During an interview on 11/05/15 at 6:35 AM with Nurse Aide (NA) #2 she stated was assigned to care for Resident #58 on the night shift and the resident would drink water when she offered it to her but slept most of the night so she didn't drink much.

During an interview on 11/05/15 at 7:02 AM with Nurse #4 she stated sometimes she was assigned to care for Resident #58 and sometimes she was the nursing supervisor on night shift. She stated normally Resident #58 did not drink water during the night and she was not aware Resident #58 had decreased oral intake before she fell out of bed on 10/09/15.

During an interview on 11/05/15 at 4:33 PM with Nurse #3 she explained Resident #58 held her hands in front of her mouth and staff had to assist her to lower them to eat and drink. She stated

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NAs were supposed to report to the nurse when a resident did not eat or drink. She explained Resident #58 drank a high calorie supplement and as soon as they noticed a decrease in meal intake or fluid intake they were to report it to the physician or nurse practitioner. She stated she did not recall talking with dietary or the physician or nurse practitioner about Resident #58's decreased meal intake or fluid intake before she went to the hospital on 10/09/15.

During an interview on 11/06/15 at 6:54 AM with Nurse #1 she verified she was assigned to care for Resident #58 during the night shift on 10/09/15. She stated she was not aware Resident #58 had decreased meal intakes and decreased fluid intakes. She further stated no one had reported to her Resident #58 was not eating or drinking and no information was passed on to her in shift report. She explained she got a urine specimen before Resident #58 fell on 10/09/15 but did not remember what color the urine was or if it was dark or had an odor.

During an interview 11/06/15 at 9:41 AM with Resident #58's physician who was also the facility Medical Director he confirmed after review of the emergency room documentation on 10/09/15 Resident #58 was in acute dehydration and her fluid volume was low. He stated usually staff let him know if a resident declined in appetite and fluids but he did not remember if staff had called him or what specifically they reported. He stated he expected staff to let him know if a resident was not eating or drinking so options could be considered. He further stated staff did not report a dramatic change in her condition before she fell and went to the hospital on 10/09/15.

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During an interview on 11/06/15 at 1:24 PM the Assistant Director of Nursing explained she expected for NAs to inform the nurse when a resident was not eating or drinking well. She stated then the nurse should follow up with family and get with dietary and see what they could do. She stated she didn't remember anything specific about Resident #58's decrease meal intakes or fluid intakes. She further stated what should have happened was staff should have immediately let the nurse know and should have documented it. She confirmed there were days before 10/09/15 when no meal intake or fluid intake was documented and somebody should have reported it and it should have been caught.

During an interview on 11/06/15 at 1:50 PM with the Director of Nursing (DON) she stated she expected for nursing staff to monitor residents for any acute changes and NAs were expected to notify the nurses if there was a change. She explained the Medical Director called the facility every day at lunch time and he came to the facility 2 days a week to see residents and the Nurse Practitioner also visited residents in the facility and she expected for nursing staff to recognize changes and notify the physician or nurse practitioner. She stated after review of meal intakes and fluid intakes for Resident #58 there should have been a more thorough assessment completed and documented in Resident #58's medical record and the physician should have been notified to discuss options. She explained Resident #58 needed encouragement to eat and had always been a resident staff had to prompt to eat. The DON confirmed Resident #58 was last seen by dietary on 09/30/15 for her quarterly nutrition review but should have been seen when her meal intakes

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F 327	Continued From page 43 and fluid intakes decreased.	F 327		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to follow recipes when preparing pureed rice and pureed collard greens to conserve nutritive value and flavor of these food items. The findings included: During an observation on 11/05/15 at 11:12 AM the Food Service Director (FSD) proceeded to prepare puréed rice for the lunch meal. The FSD added 2 and ½ cups of cooked rice and a ½ cup of gravy and blended in the blender. The rice was observed to be thick. She then heated 1 cup of tap water in an 8 ounce bowl in the microwave, this was then added to the blended rice which was the consistency of baby food. The puréed rice was then placed in a stainless bowl and covered with foil. The FSD repeated the process a second time and added to the rice to the bowl which was labeled and placed in the oven. The FSD then proceeded to prepare puréed collard greens. The FSD blended 2 cups of cooked collard greens and added ½ cup of heated tap water to the blended greens. The puréed collard	F 364	It is the facility policy to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. No resident experienced negative outcomes as a result of this cited deficiency. On 11/5/15, dietary staff in-serviced by Food Service Director on the importance of following recipes to conserve nutritive value on menu items and on-site training was provided in relation to the correct procedure to puree food. Because all residents who have a pureed diet have the potential to be affected by the cited deficiency, a list of all residents with pureed diet orders was reviewed with dietary staff. All staff instructed to follow recipes, which are provided and approved by Registered Dietician, when food is pureed. Food Service Director/Designee observed dietary staff during puree	11/13/15

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F 364	Continued From page 44 greens were the consistency of baby food. The puréed greens were placed in a stainless steel bowl and covered with foil. The FSD repeated the process a second time and added the collard greens to the bowl which was labeled and placed in the oven. During the observation the FSD was interviewed and reported she added water to get the rice and greens to the right consistency. She explained they like to use as much of the original product as possible and then we use water to thin products to the right consistency in order to not change the taste of the product being puréed. The puréed rice and puréed collard greens were served to 9 residents on puréed diets for the lunch meal on 11/05/15 starting at 12:00 PM. On 11/05/15 at 4:28 PM a follow-up interview was conducted with the FSD. She explained she used recipes that were provided by the corporate office when preparing food for the residents. The facility's recipe for puréed rice was reviewed and specified ingredients of rice, whole milk, and margarine. Process, check consistency and add 1/3 cup liquid for each 10 cups of product. The recipe was observed to have a hand written note on the side to add hot water or gravy to blend smooth like mashed potatoes. The facility's recipe for puréed collard greens was reviewed and specified ingredients of collard greens, bread and margarine. Process until smooth consistency is achieved. The recipe was observed to have a hand written note on the side to add hot water to blend smooth like mashed potatoes. The FSD explained she did not follow the recipes for preparing the puréed rice and puréed collard greens served during the lunch meal on 11/05/15 because she does not keep the recipe book out and knows the recipes by heart. She further	F 364	process one time daily for two weeks to ensure puree diet recipes are followed as written. Food Service Director/Designee performs random weekly audits to ensure compliance and report any findings to the Quality Assurance Committee quarterly meeting for further review or need for corrective action. The Certified Dietary Manager is responsible for ensuring compliance.	

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F 364	Continued From page 45 explained the tap water was used instead of gravy to not change the taste of the rice or the collards. The FSD stated she did not use gravy or broth and used plain water in the rice and collards because she did not have any water left from the cooked collards and did not want to change the taste of the rice or collards. On 11/05/15 at 4:28 PM the Registered Dietician (RD) was interviewed. The facility's recipe for puréed rice was reviewed and specified ingredients of rice, whole milk, and margarine. Process, check consistency and add 1/3 cup liquid for each 10 cups of product. The recipe was observed to have a hand written note on the side to add hot water or gravy to blend smooth like mashed potatoes. The facility ' s recipe for puréed collard greens was reviewed and specified ingredients of collard greens, bread and margarine. Process until smooth consistency is achieved. The recipe was observed to have a hand written note on the side to add hot water to blend smooth like mashed potatoes. The RD stated the hand written note was written by the Assistant Food Service Director (AFSD). The RD further stated the AFSD periodically tweaks recipes. The RD explained when a recipe was changed it was reviewed and approved with her signature. The RD further explained she could not recall if this change was approved and could not tell if the nutritive value of the food was changed without watching the preparation.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		11/18/15

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F 371	Continued From page 46 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and date food items in the freezer and dry storage areas, clean 2 of 2 microwaves in the kitchens, repair edging on a steam table and replace microwave equipment in the kitchen in disrepair for review of kitchen equipment maintained in safe operating condition. The findings included: During the tour of the kitchen on 11/02/15 at 10:31 AM the dry food storage area, freezer and refrigerators were observed and food preparation equipment was inspected. The Food Service Director (FSD) was present during all kitchen observations. During the initial tour of the kitchen the dry food storage area, freezer, and food prep areas were observed as follows: 1. On 11/02/15 at 10:31 AM the undated, unlabeled items were observed stored in the kitchen's freezer as follows: a) One - open clear plastic package with a half dozen bagels not dated and not labeled. b) Two - clear plastic packages each with 1 dozen pancakes not dated and not labeled. c) One - 10 pound clear plastic bag of frozen breaded fish nuggets not dated and not labeled. d) One - clear plastic package containing 30 hot	F 371	It is the facility policy to (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. No resident experienced negative outcomes as a result of this cited deficiency. On 11/2/15 microwave cited with rust replaced, 11/3/15 all microwaves inspected and cleaned, and steam table edging repaired on 11/5/15. Because all residents have the potential to be affected by the cited deficiency all dietary staff in-serviced by 11/5/15 by Food Service Director regarding proper storage, labeling, and dating. Also educated on labeling all containers removed from the manufacturer's original packaging with the removed from container date and expiration date. All dietary staff in-serviced on daily guidelines implemented for cleaning duties. A thorough inspection of all food storage areas was conducted by Food Service Director on 11/3/15, to ensure no food was stored incorrectly, all was labeled and	

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F 371	Continued From page 47 dogs not labeled and not dated. e) One - clear plastic package ½ full of frozen biscuits not labeled, not dated, and not sealed. f) Five - clear plastic packaged bags of frozen broccoli not labeled, and not dated. g) Six - clear plastic packaged bags of brussel sprouts not labeled, and not dated. h) One - clear plastic bag of frozen battered vegetable sticks not labeled, and not dated. i) Five - brown paper packaged bags of frozen fries, one bag was ripped open not labeled, and not dated. An interview was conducted with the Food Service Director (FSD) on 11/02/15 at 11:39 AM. The FSD stated she was not aware the items in the freezer had not been labeled or dated. The FSD further stated we have very limited storage space and to maximize space the staff take food items out of the original shipping cartons and put them in the freezer. The FSD explained that individual bags should have been resealed and dated with the open date and use by date. The FSD further explained any food item taken from the original dated carton should have been labeled and dated. The FSD verified the food items observed in the freezer were not properly, labeled and dated. The FSD stated that it was her expectation for all food items in the freezers should have been securely wrapped, labeled and dated. 2. On 11/02/15 at 10:31 AM the undated, unlabeled items were observed stored in the kitchen's dry food storage as follows: a) Three - packaged bags 5 pounds (lb.) each of yellow cake mixes not in original labeled carton, and bags were not labeled, and not dated. b) Two - packaged bags 4 lb. each of	F 371	dated, and food items were rotated according to proper procedure. All staff in-serviced by Administrator and Designee regarding the importance of reporting maintenance needs timely and instructed to always complete a repair requisition when requests are made. The Food Service Director/Designee conducts a food storage audit using Food Storage Tracking tool twice a week for two months and then monthly to ensure compliance. Dietary staff checking equipment cleaning list daily and completing task as assigned. The Food Service Director monitors cleaning list and inspects equipment for need of repair weekly to ensure compliance. Any findings are reported to the Quality Assurance Committee quarterly for further review or need for corrective action. Food Service Director is responsible for monitoring and ensuring compliance.	

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cheesecake mix not in original labeled carton, and bags were not labeled, and not dated.
c) One - packaged 2 lb. bag of instant lemon pudding not in original labeled carton, and bags were not labeled, and not dated.
d) Two - 2 lb. bags of tortilla chips not in original labeled carton, and bags were not labeled, and not dated.
e) Two - bags seasoning mix not in original labeled carton, and bags were not labeled, and not dated.
f) Two - bags quick start vegetarian chili not in original labeled carton, and bags were not labeled, and not dated.

An interview was conducted with the Food Service Director (FSD) on 11/02/15 at 11:39 AM. The FSD stated she was not aware the items in the kitchen's dry storage had not been labeled or dated. The FSD further stated we have very limited storage space and to maximize space the staff take food items out of the original shipping cartons and put them in the dry storage The FSD explained that individual bags should have been resealed and dated with the open date and use by date. The FSD further explained any food item taken from the original dated carton should have been labeled and dated. The FSD verified the food items observed in the kitchen's dry storage were not properly, labeled and dated. The FSD stated that it was her expectation for all food items in the kitchen's food storage areas dry storage area should have been securely wrapped, labeled and dated.

3. a) During the tour of the kitchen on 11/02/15 at 10:31 AM the microwave in the main floor kitchen was observed to have dried food particles on the inside walls and the inside ceiling of the

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microwave. The microwave in the downstairs kitchen was observed on 11/02/15 at 11:51 AM to have dried food particles on the inside walls and the inside ceiling of the microwave.

During the tour of the kitchen on 11/02/15 at 10:31 AM the FSD stated she did not know how long the microwave in the main floor kitchen was rusted. She further stated it was her expectation that the kitchen staff clean the microwaves after each use if food particles sprayed on the inside during usage. The FSD further stated that rusted equipment should have been reported to her so that it would be replaced.

3. b) During the tour of the main kitchen on 11/02/15 at 10:31 AM the microwave was observed to have rust on the bottom inside ledge of the microwave door.

During the tour of the kitchen on 11/02/15 at 10:31 AM the FSD was interviewed and stated she did not know how long the microwave was rusted. She further stated it was her expectation that the kitchen staff should have reported microwave was rusted do it could be replaced.

During a follow up interview on 11/05/15 at 10:16 AM the Food Service Director (FSD) stated it was her expectation that the kitchen staff notify her of any equipment in disrepair or to be replaced immediately. The FSD further stated she was unaware of the rusted microwave. The FSD explained there was a spare microwave in the storage that would have been used to replace the rusted one.

During an interview on 11/05/15 at 3:18 PM the Maintenance Supervisor (MS) stated the kitchen

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staff normally would let him know verbally or with a written work order that an equipment item in the kitchen required repairs or to be replaced. The MS further stated he was unaware of the rusted microwave. The MS explained he had a spare microwave in the storage that he would have used to replace the rusted one.

During an interview on 11/06/15 at 1:35 PM the Administrator (AD) stated it was her expectation for the Maintenance Supervisor to keep her informed of all equipment repairs required in the facility The AD explained the rusted microwave should have been reported and replaced. The AD stated it was her expectation that all repairs should have been reported by staff to their supervisors in order to have the MS make repairs as needed.

4. During the tour of the downstairs kitchen and dining room on 11/02/15 at 10:31 AM the steam table in the dining room was observed to have a lose stainless steel strip connecting the two parts of the steam table in the front serving area. The strip was noted to be approximately 18 inches long by 2 inches wide. The strip was further observed to have 7 screw holes with only one screw holding it in place. The bottom 6 inches of the strip was observed to be sticking out at ankle and calf height from the main frame of the steam table.

On 11/04/15 at 9:22 AM the steam table in the downstairs dining room was observed with the metal strip remained without screws and bent out at the bottom on the front serving side of the steam table.

On 11/05/15 at 10:10 AM the steam table in the

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F 371	Continued From page 51 downstairs dining room was observed with the metal strip remained without screws and bent out at the bottom on the front serving side of the steam table. During an interview on 11/05/15 at 10:16 AM the Food Service Director (FSD) stated it was her expectation that the kitchen staff notify her of any equipment in disrepair or to be replaced immediately. The FSD further stated she was unaware of the lose piece on the steam table. During an interview on 11/05/15 at 3:18 PM the Maintenance Supervisor (MS) stated the kitchen staff normally would let him know verbally or with a written work order that an equipment item in the kitchen required repairs or to be replaced. The MS further stated he was unaware of the lose piece on the steam table. The MS explained he would have fixed it if he had known about it. During an interview on 11/06/15 at 1:35 PM the Administrator (AD) stated it was her expectation for the Maintenance Supervisor to keep her informed of all equipment repairs required in the facility The AD explained she had already addressed with the corporate office the need for a new steam table to replace a piece of equipment of age, but was not aware there was a repair needed to the steam table. The AD stated it was her expectation that all repairs should have been reported by staff to their supervisors in order to have the MS make repairs as needed.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		11/19/15

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F 431	Continued From page 52 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to properly label and/or place a sticker on a medications bubble pack as to indicate a change in the dosage and frequency of the medication for 1 of 1 sampled	F 431	It is the facility policy to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	

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F 431	Continued From page 53 residents (Resident #114). The findings included: Review of the facility's policy titled "Medication Ordering and Receiving from Pharmacy" dated 06/2012 read in part: Medication labels are not altered, modified or marked in any way by nursing personnel. If the physician's directions for use change and the label is inaccurate, the nurse may place a "change of order-check chart" label on the container indicating there is a change in directions for use, taking care not to cover important label information. When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information. The pharmacy is informed prior to the next refill of the prescription so the new container will contain an accurate label." Resident #114 was admitted to the facility on 12/18/14 with diagnoses including heart disease pain, high blood pressure, and dementia. Review of a significant change in status Minimum Data Set (MDS) dated 10/06/15 indicated Resident #114 was severely cognitively impaired and required extensive assistance from staff with activities of daily living (ADLS). Review of the physician's orders dated 10/29/15 revealed Gabapentin 100 milligrams (mg) take 3 capsules oral (= 300 mg) TID (three times a day) for Neuropathy Pain. On 11/06/15 at 7:13 AM, Nurse #6 was observed to remove 3 capsules from a bubble pack into a dispensing cup for Resident #114. The bubble	F 431	instructions, and the expiration date when applicable. Resident #114 did not have any negative outcomes as a result of the cited deficiency. Because all residents have the potential to be affected by the cited deficiency, all nurses and medication aides, including those named in the deficiency, were in-serviced on the proper labeling of medications including medications with direction changes. A 100% audit completed by Director of Nursing/Designee of all medication direction labels were compared to the order and administration record in the electronic health record. Under the supervision of the Director of Nursing, Quality Assurance Nurse to audit random medication order, medication labels, and medication administration record for accuracy. Any concerns will be corrected immediately and findings will be documented and submitted to the quarterly Quality Assurance Committee for further review or need for corrective action. Director of Nursing is responsible for monitoring and ensuring compliance.	

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pack was reviewed and revealed the bubble pack label read in part Gabapentin Cap 100 mg take 2 capsules (200 mg) twice daily (BID) by mouth.

On 11/06/15 at 7:15 AM, Nurse #6 was interviewed. Nurse #6 confirmed the bubble pack indicated Gabapentin Capsules 100 mg administer 2 capsules (200 mg) twice daily by mouth. Nurse #6 stated "the order has been changed and the resident was supposed to have 3 capsules (300 mg) three times a day." The nurse was observed to mark a line through the dosage instructions on the bubble pack which read 200 mg (2 capsules) twice daily with a black sharpie pen. Nurse #6 indicated the facility had stickers that was supposed to be placed on the bubble packs as to indicate a change in the dosage of the medication, she stated "I will take care of it later."

On 11/06/15 at 9:08 AM, a telephone interview was conducted with Nurse #7. He stated he was responsible for obtaining the new order from the physician on 10/29/15 when the dosage was changed from 200 mg to 300 mg and the frequency was changed from BID to TID (three time a day). Nurse #7 confirmed he had not placed a sticker on the bubble pack as to indicate a change in the medication and when asked why he had not placed a sticker on the bubble pack Nurse #7 replied "I must have forgot but I changed the dosage and frequency of the medication in the computer system on the Medication Administration Record (MAR) and that is what we go by to administer medicines anyway."

On 11/06/15 at 12:08 PM, Nurse #8, a nurse supervisor was interviewed. She stated she would

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F 431	Continued From page 55 have expected a sticker to have been placed on the bubble pack as to indicate a change in the directions of medication. On 11/06/15 at 12:38 PM, a telephone interview was conducted with the Pharmacist. He confirmed there was a change in the frequency and dosage of the medication on 10/29/15. The pharmacist stated the Gabapentin was changed from 200 mg BID to 300 mg TID for Resident #114. He indicated the Gabapentin was last dispensed to the facility on 10/28/15 and the facility had stickers that was to be placed on the bubble packs as to indicate a change in the directions of the medications. The pharmacist further indicated he would have expected the nurse to have placed a sticker on the bubble pack instead of the marking out of the directions. On 11/06/15 at 1:15 PM, an interview was conducted with the Director of Nursing (DON). She stated she expected the nursing staff to have placed a sticker on the bubble pack as to indicate a change in the medications directions. The DON provided a copy of the bubble pack with the sticker for which should have been placed on the bubble pack at the time the new order was obtained. The sticker was white in color with red letters which read: "Directions changed refer to chart."	F 431		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469		11/18/15

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F 469	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to report to the supervisor and treat for ants in 1 of 2 kitchens observed to maintain an effective pest control program. The findings included: On 11/02/15 at 11:51 AM during the initial tour of the downstairs kitchen little ants were observed climbing the wall between the door frame of the door leading to the dining room and the hand washing sink. The Dietary Aide (DA) #1 confirmed and stated "yes, those are ants and that isn't good." On 11/03/15 at 12:00 PM prior to the lunch meal being served little ants were observed in the downstairs kitchen climbing the wall between the door frame of the door leading to the dining room and the hand washing sink. On 11/04/15 at 9:26 AM little ants were observed in the downstairs kitchen climbing the wall between the door frame of the door leading to the dining room and the hand washing sink. The Assistant Food Service Director (AFSD) stated she thought they were supposed to have sprayed for ants but could not explain which day this was completed. During an interview on 11/05/15 at 10:16 AM the Food Service Director (FSD) stated the pest control service came on Wednesday 11/04/15. The FSD further stated it was her expectation for her dietary staff to notify herself and the maintenance supervisor right away of any pest	F 469	It is the facility policy to maintain an effective pest control program so that the facility is free of pests and rodents. No resident experienced negative outcomes as a result of this cited deficiency. To achieve compliance for this cited deficiency, Maintenance Supervisor sprayed area upon notification and then contacted pest control company during survey to treat area identified. Pest control company had made monthly visits to facility changing products to rid facility of ants. Pest control company came on 11/3/15 during meal time and could not spray and returned on 11/4/15 to treat affected area with a new product. Because the entire facility has the potential to be affected by the cited deficiency, on 11/18/15 a deep cleaning was performed on the downstairs kitchen area and steam table by Administrator, DON, ADON, Assistant Dietary Supervisor, and Admissions Coordinator. The facility maintains a contract for monthly pest control and more often as needed. A visual audit has been conducted daily for two weeks to ensure area is free of pest. Food Service Director/Designee and/or dietary staff to review daily and notify supervisor and Maintenance of any findings. Maintenance Supervisor will contact pest control company promptly	

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F 469	Continued From page 57 control problems. The FSD revealed the pest control service used by the facility had a standard monthly treatment for pest control service contract. The FSD further revealed she was unaware of the ants in the kitchen until Wednesday 11/04/15. During an interview on 11/05/15 at 3:18 PM the Maintenance Supervisor (MS) stated the kitchen staff normally let him know verbally or with a written work order when they had a pest problem. The MS further stated he had called the pest control service and they came on Tuesday 11/03/15 but did not treat because it was at meal time when they arrived. The MS explained he was not notified of the ants till Tuesday and he sprayed with a household spray for ants on Tuesday after the meal was finished. The MS indicated they have had an ant problem for a long time and further indicated the pest control service came back on Wednesday 11/04/15 around 10 am between the breakfast and lunch meals and placed some bait caulk inside and outside the facility. The MS revealed the pest control service used by the facility had a standard monthly service contract for pest control. During an interview on 11/06/15 at 1:35 PM the Administrator (AD) stated it was her expectation for the Maintenance Supervisor to keep her informed of any insects/pests in the building as well as call and inform the Pest Control Technician for needed treatment. The AD confirmed the pest control service used by the facility had a standard monthly service contract for pest control. The AD further confirmed she was unaware of the ants in the kitchen until Wednesday 11/04/15.	F 469	upon notification. All findings will be reported to the Quality Assurance Committee quarterly for further review or need for corrective action. Under supervision of the Administrator, Maintenance Supervisor monitoring to ensure compliance.	

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F 514	Continued From page 58	F 514		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, staff interviews and review of facility dietary records the facility failed to ensure the records were accurate for residents documented with food allergies for 1 of 2 sampled residents with documented food allergies (Resident #86). The findings included: Resident #86 was admitted to the facility on 01/20/14 with diagnoses which included chronic kidney disease, diabetes, high blood pressure, anxiety, depression, and altered mental status. The annual Minimum Data Set (MDS) dated 01/20/15 indicated Resident #86 was severely cognitively impaired for daily decision making skills. The MDS further indicated Resident #86 required staff assistance for meal set up and supervision with eating.	F 514	It is the facility policy to maintain clinical records on each resident in accordance with accepted professional standards that are complete; accurately documented; readily accessible; and systematically organized. One way this has been achieved is by in-servicing nursing staff on the proper way to document a food allergy as opposed to a food dislike. Resident #86 did not have any negative outcomes as a result of the alleged deficiency. Because all residents have the potential to be affected by the alleged cited deficiency, all dietary staff and nursing staff were in-serviced on the importance of food allergies and the potential	11/19/15

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	345222	A. BUILDING _____ B. WING _____	C 11/06/2015

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F 514	Continued From page 59 Review of the medical record of Resident #86 revealed a documented allergy to "peanuts." This allergy was documented on the Physician Orders dated 09/30/15 and 10/30/15, the diagnosis list last updated 09/30/14 signed by the physician 10/14/15, and the Dietary Food Preferences Screening form Completed by the Food Service Director dated 12/29/14. Review of the quarterly nutrition dietary progress notes dated 05/21/15, 08/21/15, and the annual nutrition dietary progress note dated 11/04/15 revealed documentation that Resident #86 had an allergy to peanuts. The tray card review for Resident #86 revealed a mechanical soft diet and allergy to peanuts. Review of the facility recipe for peanut butter icing revealed the icing contained 1 pound of margarine, 2 pounds of confection sugar, 1 teaspoon vanilla extract and 2 cups of creamy peanut butter. On 11/05/15 at 12:13 PM observations were made of Resident #86 eating her lunch meal. The menu for the lunch meal included a chewy peanut butter bar but was substituted with a yellow cake with peanut butter icing. Review of the Resident #86's tray card at the time of the observation revealed her diet order was mechanical soft and allergic to peanuts. The FSD reported the cake icing contained peanut butter. Immediately after learning this, the FSD was directed to Resident #86's lunch meal tray. She confirmed the tray card noted a peanut allergy and the cake was removed from Resident #86's tray. Resident #86 had not eaten any of the cake with peanut butter icing at the time, she was provided an alternate	F 514	outcomes of food-related allergies. A food allergy audit check sheet was developed and a list of resident's food allergies is posted in the kitchen. The allergy list is to be updated as needed and will be audited weekly by the Food Service Director. A 100% audit was completed by the Assistant Director of Nursing to ensure all food allergies were documented correctly, and that dietary had an updated food allergy list. Food Service Director/Designee to conduct tray line audits for food allergies two times weekly for two weeks and then random weekly audits to ensure compliance. Nursing will continue to review all allergy listings upon admission and as needed to ensure compliance. Findings will be documented and submitted to the quarterly Quality Assurance Committee for further review or need for corrective action.	

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F 514	Continued From page 60	F 514		

dessert by the FSD and no problems were noted.

At the time of the observation the resident's medical record was reviewed to try and determine the extent of her allergy to peanuts. The FSD stated after lunch Resident #86's family member had arrived and was questioned about the peanut allergy. A hand written statement was obtained from the family member by the FSD stating Resident #86 had no peanut allergy. The FSD stated the family member explained she had difficulty chewing peanuts and because of this it was recorded as a peanut allergy.

On 11/05/15 at 4:28 PM the FSD was asked about the system in place to ensure staff checked for food allergies when food was plated for residents on the tray line. The FSD stated the aide in the first position on the tray line was responsible for calling out any dislikes or allergies and the aide plating the individual resident's food was responsible for checking the tray card for any dislikes or allergies. The final check was for the supervisor to check the residents' tray prior to being placed on the food delivery cart or served to the resident to ensure food items served were consistent with what was on the resident's tray card. The FSD could not explain why the cake with peanut butter icing had been served to Resident #86 on 11/05/15. The FSD could not further explain how the peanut allergy remained listed in Resident #86's medical record.

During an interview on 11/06/15 at 1:35 PM the Administrator (AD) stated it was her expectation that all resident allergies were documented and no resident should be served foods that were listed in their medical record or their dietary tray card as an allergy. The AD confirmed Resident

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F 514	Continued From page 61 #86 had a listed allergy to peanuts but was unable to explain when that peanut allergy had started in her medical record. The AD explained this was a serious problem if it were a true peanut allergy. The AD further explained the allergy to peanuts should have been confirmed by the physician and the medical record updated. During an interview on 11/06/15 at 2:34 PM the Nurse Practitioner (NP) for the Medical Director of the facility stated extra care and review should be given with allergies especially with residents with peanut allergies. The NP further stated it could be serious for residents who were allergic to peanuts to receive peanut butter which might result in complication of anaphylactic shock. The NP explained allergies to foods such as peanuts and seafood should trigger extra review. The NP further explained the review should probably start with the dietary manager or the dietician and include nursing to ensure a resident with a particular food allergy was not served those items.	F 514		
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		11/18/15

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F 520	Continued From page 62 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place to correct a deficiency for failure to provide supervision to prevent accident at tag F 323 that was cited during the recertification survey conducted in January 2015. F 323 was recited again on the current recertification and complaint survey. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 323 Provide supervision to prevent accidents: Based on observations, record reviews and physician and staff interviews the facility failed to provide supervision for a resident who fell from	F 520	It is the facility policy to maintain a quality assessment and assurance committee consisting of the Director of Nursing services; a physician designated by the facility; and at least three other members of the facility's staff. One way this facility achieves compliance is by conducting quarterly Quality Assurance Committee Meetings containing the Administrator, all department heads, Consultant Pharmacist, Medical Director, and any other identified staff . Committee is guided by Administrator and audits are identified through review of facility practices, quality measure indicators, facility identified continuous audits, and newly identified areas of concern. To achieve compliance with the cited deficiency related to the Quality Assurance Committee all department managers were instructed by Administrator to integrate areas of	

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F 520	Continued From page 63 bed and had a subarachnoid hemorrhage (bleed in the brain) and for a resident who fell from bed with facial lacerations and a concussion for 2 of 3 sampled residents sampled for falls. (Resident #58 and #55). During the previous recertification of 01/30/15, the facility was cited a deficiency at F 323 for failure to secure ½ side rails to residents' beds to prevent injuries for 3 of 6 beds (Resident #s 77, 45 and 57). During an interview on 11/06/15 at 2:52 PM the Administrator explained she and staff had just attended a fall prevention program and would be presenting information at the next Quality Assessment and Assurance Committee meeting in December. She stated resident falls were discussed in the morning meetings and they had implemented plans to decrease alarms in the facility. She further stated the biggest thing that had been done was to hire 5 additional staff for the bath team and an additional restorative aide to increase supervision of residents however, there had been no staff increases for night shift. She explained they had increased the number of activities in the evenings and they were planning to look at resident sleep patterns to keep residents up later in the evening to promote sleep and decrease falls.	F 520	concern into their departmental continuous audits for the following year. Administrator will assure all audits are completed timely and accurately. To achieve compliance with the cited deficiency, the following systems have been put in place 1)All nursing staff was in-serviced by Administrator/DON/ADON on 11/18/15 regarding fall prevention with an emphasis on reporting all changes in condition promptly. Instruction given that when "Frequent Visual Checks" are used in conjunction with other fall interventions it must be documented and a time frame of checks must be established 2)All facility staff in-serviced on 11/18/15 by Administrator on their role in fall prevention 3)All staff educated on use of "Stop and Watch" tool to identify changes in condition timely and assure follow-up 4)All incidents will be reviewed weekly by Fall Prevention Committee(Administrator, DON, Administrative Nurses, and Therapy Representative)to ensure no further interventions are needed. Any concerns identified will be corrected immediately and presented at the quarterly Quality Assurance Committee for further review or need of corrective action. To ensure compliance with cited deficiency, the Quality Assurance Committee will meet monthly through next quarter to review all findings from audits put in place related to annual survey and any other areas of concern identified. Quality Assurance Committee will review findings for any need of further corrective	

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F 520	Continued From page 64	F 520	action and Administrator will monitor to ensure compliance.	