STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to notify the physician after a resident fell and developed a new onset of pain	F 157	Resident# 48 no longer resides in the facility however; Corrective action for the alleged deficient	12/17/15

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

Electronically Signed | 12/17/2015

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F 157	Continued From page 1 and the resident had a fractured femur for 1 of 1 sampled resident (Resident #48). The findings included: Resident #48 was admitted to the facility on 08/14/15 diagnosed with respiratory failure, pneumonia and others. Resident #48 died in the facility on 09/27/15. The Minimum Data Set (MDS) dated 08/21/15 specified the resident did not have impaired cognition, required limited assistance with activities of daily living and no history of falls. Review of Resident #48's medical record revealed a nurse's entry made by Nurse #2 dated 08/29/15 at 11:20 PM specified Resident #48 was found on the floor and no injury was noted but the resident complained of tenderness on her left side where she landed. Nurse #2 documented on the MAR that she administered as needed Tylenol (pain medication) 650mg (milligrams) for left hip pain. Nurse #2 did not document the time the medication was given and did not document if the pain medication was effective. There was no documentation in the medical record that the physician was notified of the fall or complaints of pain after the fall. The next nurse's entry made by Nurse #3 on 08/30/15 at 7:30 AM read in part that Resident #48's left hip was bruised, her left lower extremity was weaker than the right and the resident complained of tenderness in her left hip and leg. There was no documentation in the medical record of notification to the physician regarding pain or medication administration related to the Resident's complaint of pain.	F 157	practice was accomplished by retraining licensed nurses beginning 11/19/2015 continuing until 12/17/15. Any staff member who has not attended will be required to do so before being allowed to work after 12/16/2015. The staff was trained on calling physician with resident complaint of new onset of pain with falls. This has been added to facility fall protocol. In order to ensure others are not affected by the same alleged deficient practice the facility fall protocol was changed to include calling physician with new on set of pain. All incident reports were audited for the last 6 months by DON or designee. all reports will be monitored daily by the DON or designee.Any issues will be corrected immediately and staff will be held accountable for any non compliance leading up to and including termination for repeated violations. to ensure this system remains in place an audit will be compiled weekly X 4 weeks then Monthly thereafter ongoing. All reports Will be audited to ensure documentation, notification, and appropriate intervention. A report of the findings will be compiled and addressed in QAPI monthly for 1 quarter then quarterly X 1 year. A report will be compiled and reviewed in QA	

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On 08/30/15 at 2:00 PM Nurse #3 documented in the medical record that Resident #48 complained of pain in her left hip and leg upon movement. Nurse #3 contacted the on-call physician and obtained orders for a mobile x-ray. Nurse #3 documented on 08/30/15 at 6:20 PM the x-ray had been performed and Resident #48 was comfortable as long as left leg wasn't moved.

The Radiology Report dated 08/30/15 specified no fracture or dislocation was detected.

A nurse's entry dated 08/31/15 at 10:00 AM specified Resident #48 continued to complain of pain to her left upper leg and hip. There was no documentation in the medical record that the physician was notified of the pain. On 08/31/15 at 1:00 PM the physician was notified and ordered a 2 view x-ray of the left femur and left hip. The Radiology Report dated 08/31/15 indicated Resident #48 had a left femoral fracture. Orders were obtained and Resident #48 was sent to the Emergency Department.

On 11/18/15 at 4:30 PM the resident's physician was interviewed on the telephone and stated he expected nurses to notify him right away when a resident had new pain after a fall especially if it was hip pain because he didn't want a resident sitting on a fracture. The physician could not recall if he was notified on 08/29/15 when the resident fell or when the resident complained of pain on 08/30/15.

On 11/19/15 at 12:30 PM Nurse #3 was interviewed on the telephone and explained that she worked 7 AM to 7 PM on Friday, Saturday and Sunday. Nurse #3 explained that on 08/30/15 she was told in report that Resident #48 had

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F 157	Continued From page 3 fallen "but nothing was different" with the Resident. Nurse #3 stated on 08/30/15 that Resident #48 was weaker on the left side which was different for the resident but she did not attempt to contact the physician. Nurse #3 explained that later in the shift Resident #48 started to "holler" when her hip was touched and that was when she contacted the physician. On 11/19/15 at 2:00 PM the Director of Nursing (DON) was interviewed and explained that if Resident #48 had any pain after a fall the nurse should have contacted the physician right then. On 11/19/15 at 3:55 PM Nurse #2 was interviewed on the telephone and explained that she was not Resident #48's nurse on 08/29/15 when the resident fell but was called by a nurse aide who found the resident on the floor. Nurse #2 stated Resident #48 complained her "butt" hurt from the fall. Nurse #2 stated she did not contact the physician of the resident's fall or complaints of pain. A document titled "Incident/Accident Report" dated 08/29/15 completed by Nurse #2 specified the physician was contacted on 08/29/15 at 9:16 PM. Nurse #2 stated she did not call the physician and was not sure why she documented that the physician was notified of the fall.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		12/17/15

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F 225	Continued From page 4 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to notify the administrator and failed to investigate and submit 24 hour and 5 working day reports to the North Carolina Health Care Personnel Registry (state agency) of a resident's complaint that staff was rough with her during a shower and caused	F 225	Corrective action was accomplished by completing a 24 hour report and 5 day investigation immediately upon being made aware of the alleged incident. The employee was suspended until outcome was determined. A full investigation was submitted to the department of health and	

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F 225	Continued From page 5 shoulder pain for 1 of 1 resident sampled for abuse. (Resident #38). The findings included: Resident #38 was admitted to the facility on 10/08/15 with diagnoses which included arthritis, muscle weakness, vision deficit and dementia. A review of the most recent admission Minimum Date Set (MDS) dated 10/19/15 revealed Resident #38 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #38 required extensive assistance with bathing. A review of facility abuse investigations revealed there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Registry for Resident #38. A review of a physician's progress note dated 11/12/15 revealed during a routine visit Resident #38 complained of right shoulder pain. A section labeled assessment and plan indicated in part to schedule an appointment for right shoulder steroid joint injection. During an interview on 11/17/15 at 10:44 AM with Resident #38 she stated a shower technician (tech) was rough with her during a shower last week during the day shift but could not recall the day of week. Resident #38 explained while the shower tech was giving her a shower she was rough with her and hurt her shoulder and she had told her to stop. She further explained the shower tech had placed her hand on Resident #38's right arm between her elbow and shoulder and twisted her around and was rough. She stated she reported it to a nurse but did not know	F 225	human services who in turn found the event unsubstantiated. To ensure others are not affected by the same alleged deficient practice all staff was in serviced beginning 11/19/2015 through 12/16/2015 regarding reporting any alleged abuse immediately to supervisor and/or DON/administrator. New employees will be trained on reporting abuse during new hire orientation. All alert and oriented residents were interviewed by the social Worker on 11/19/2015 to determine if any other resident had a similar issue. The system put into place To ensure that this does not recur is all interviewable residents will be interviewed weekly regarding mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property 4 weeks then a sample will be interviewed monthly thereafter. A tool will be completed with findings. Any findings will be reported immediately to DHHS and facility protocol (investigation will occur) To ensure this system remains and is effective the Social worker or Designee will complete an audit of the monitoring tools and bring to QAPI quarterly.	

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F 225	Continued From page 6	F 225		

the nurse's name because she could not see and could not remember the shower techs name. She stated she had also told nurse aides (NAs) who had provided care to her about what had happened in the shower. She further stated she did not feel staff had listened to her concerns because no one had followed up with her or had asked her questions about what had happened.

A review of a physician's progress note dated 11/18/15 indicated a right shoulder rotator cuff injury and a steroid injection was placed in Resident #38's right shoulder.

During an interview on 11/18/15 at 4:58 PM with Nurse #5 she stated Resident #38 had told her a shower tech had pulled on her shoulder when she was in the shower but couldn't remember the name of the tech. She stated she did not report it because the Nurse Practitioner had ordered medication and an injection so she thought someone else had already reported it.

During an interview on 11/18/15 at 5:04 PM with Nurse #7 she stated Resident #38 had not reported to her any concerns that staff was rough with her in the shower and she did not recall if staff had reported Resident #38's concerns about the shower incident to her.

During an interview on 11/18/15 at 5:12 PM with NA #2 she stated Resident #38 had complained to her that a shower tech was rough with her during a shower. She explained she did not know the exact date it happened but thought it had happened in the last 2 weeks because Resident #38 had talked about it several times and she thought Resident #38 had reported it to a nurse.

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F 225	Continued From page 7	F 225		

During a telephone interview on 11/18/15 at 6:47 PM with Nurse #6 she verified Resident #38 had told her one of the shower techs was rough with her and she had asked Resident #38 who the tech was but Resident #38 was visually impaired and couldn't tell her. She stated she may have reported the incident to nurse #7 during shift report but was not sure if she did. Nurse #6 confirmed she did not report it to the Director of Nursing (DON) and did not document what Resident #38 had told her in her medical record because she thought she wasn't supposed to write about incidents in the nurse's notes.

During a telephone interview on 11/18/15 at 6:58 PM shower tech #1 confirmed she gave Resident #38 a shower last week but could not remember the day of week. She verified Resident #38 complained of right shoulder pain and kept saying "be careful" when she tried to get Resident #38's clothes off before her shower and when she put them back on after her shower.

During an interview on 11/19/15 at 12:58 PM with Nurse #8 she verified Resident #38 went to the physician's office yesterday for an injection in her right shoulder but she was not sure what was going on because there was no information in the nurses notes about her shoulder and nothing had been reported to her.

During a follow up interview on 11/19/15 at 1:09 PM with shower tech #2 she stated she did not remember which day Resident #38 told her about the shower incident. She further stated she remembered she reported to Nurse #8 that Resident #38 had pain in her shoulder and Nurse #8 told her Resident #38 had arthritis.

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During an interview on 11/19/15 at 2:23 PM with the Director of Social Work she confirmed she assisted with investigations of grievances, abuse and neglect. She stated if a resident reported a staff member had been rough with them staff was expected to report it immediately and the Director of Nursing (DON) and Administrator were to be notified. She stated no one had reported to her that Resident #38 had complained staff was rough with her in the shower. She explained it was her expectation when Resident #38 reported staff was rough with her in the shower staff should have reported it immediately so that an investigation could have been done and if there was an injury of unknown origin staff should have filled out an incident report so they could investigate to figure out what caused the injury.

During an interview on 11/19/15 at 2:37 PM with the DON she confirmed there had been no abuse or neglect investigations related to Resident #38 and there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Registry. She stated no one had reported to her about Resident #38's complaint and it was her expectation staff should have notified her immediately when Resident #38 complained a staff member was rough with her in the shower and the Administrator and Director of Social Work should also have been notified.

During an interview on 11/19/15 at 3:53 PM the Administrator stated no one had reported to her that staff was rough with Resident #38 during a shower so there were no 24 hour or 5 working day reports completed. She stated it should have been reported to her so an investigation could have been done and it was her expectation for staff to report immediately when a resident

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F 225	Continued From page 9 reported staff were rough with them so she could investigate it.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident, physician, nurse practitioner and staff interviews the facility failed to follow their abuse policy and procedure to investigate a resident's complaint that staff was rough with her during a shower and caused shoulder pain for 1 of 1 resident sampled for abuse. (Resident #38). The findings included: A review of a policy and procedure titled Abuse Reporting and Investigations with a modified date of 03/11/04 revealed in part it was the policy of the facility that all residents have the right to be free of physical abuse. A section labeled procedure indicated in part the residents of the facility would not be subjected to abuse by anyone including, but not limited to, facility staff. A section labeled investigation and reporting revealed in part it was the policy of the facility to investigate and report all alleged incidents of resident abuse or mistreatment and the facility would complete a thorough investigation of an alleged incident by the appropriate staff. The	F 226	Corrective action for the alleged deficient practice was achieved by through investigation including interview with resident#38 niece who revealed that in her opinion this incident did not occur but was a common delusion of her aunt which has been investigated by numerous agencies. Interview with the staff members revealed that staff members were aware of resident #38 shoulder pain, and aware that she was not happy with the hurriedness of the staff member and that the resident is always cold. however; did not reveal anyone had been aware of an accusation of abuse. Nonetheless the investigation was completed immediately and staff member accused was suspended pending the investigation. The outcome of the investigation prompted the Administrator to contact Psychiatric services to ensure the resident is receiving appropriate follow up. the residents behaviors are documented as they occur and the care plan updated for	12/17/15

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F 226	Continued From page 10 policy indicated in part the Administrator would provide notice to all appropriate state and regulatory agencies. Resident #38 was admitted to the facility on 10/08/15 with diagnoses which included arthritis, muscle weakness, vision deficit and dementia. A review of the most recent admission Minimum Date Set (MDS) dated 10/19/15 revealed Resident #38 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #38 required extensive assistance with bathing. A review of abuse investigations revealed there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Registry (state agency) for Resident #38. A review of a physician's progress note dated 11/12/15 revealed during a routine visit Resident #38 complained of right shoulder pain. A section labeled assessment and plan indicated in part to schedule an appointment for right shoulder steroid joint injection. During an interview on 11/17/15 at 10:44 AM with Resident #38 she stated a shower technician (tech) was rough with her during a shower last week during the day shift but could not recall the day of week. Resident #38 explained while the shower tech was giving her a shower she was rough with her and hurt her shoulder and she had told her to stop. She further explained the shower tech had placed her hand on Resident #38's right arm between her elbow and shoulder and twisted her around and was rough. She stated she reported it to a nurse but did not know	F 226	current needs. To ensure others are not affected by the same alleged deficient practice all staff was in serviced on the abuse policy with emphasis on reporting any allegation regardless of the residents mental status. the system put into place to ensure that this is being done will include the social worker interviewing a sample of alert and oriented residents weekly for 4 weeks then monthly for 6 months to ensure prompt investigation and reporting by staff members. any issues will be addressed immediately by the Administrator. to ensure the system remains A report of the findings will be presented to QA quarterly for 6 months for review.	

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the nurse's name because she could not see and could not remember the shower techs name. She stated she had also told nurse aides (NAs) who had provided care to her about what had happened in the shower. She further stated she did not feel staff had listened to her concerns because no one had followed up with her or had asked her questions about what had happened.

A review of a physician's progress note dated 11/18/15 indicated a right shoulder rotator cuff injury and a steroid injection was placed in Resident #38's right shoulder.

During an interview on 11/18/15 at 4:58 PM with Nurse #5 she stated Resident #38 had told her something had happened in the shower and had requested to see her physician because her shoulder was hurting. She further explained Resident #38 had told her a shower tech had pulled on her shoulder when she was in the shower but couldn't remember the name of the tech. She stated she did not know if Resident #38 had reported the incident to anyone else and she had not reported it because the Nurse Practitioner had ordered medication and an injection so she thought it had already been reported.

During an interview on 11/18/15 at 5:04 PM with Nurse #7 she stated Resident #38 had not reported to her any concerns that staff was rough with her in the shower and she did not recall if staff had reported Resident #38's concerns about the shower incident to her.

During an interview on 11/18/15 at 5:12 PM with NA #2 she stated Resident #38 had complained to her that a shower tech was rough with her

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during a shower. She explained she did not know the exact date it happened but thought it had happened in the last 2 weeks because Resident #38 had talked about it several times and she thought Resident #38 had reported it to a nurse.

During a telephone interview on 11/18/15 at 6:47 PM with Nurse #6 she verified Resident #38 had told her one of the shower techs was rough with her and she had asked Resident #38 who the tech was but Resident #38 was visually impaired and couldn't tell her. She stated she may have reported the incident to nurse #7 during shift report but was not sure if she did. Nurse #6 confirmed she did not report it to the Director of Nursing (DON) and did not document what Resident #38 had told her in her medical record because she thought she wasn't supposed to write about incidents in the nurse's notes.

During a telephone interview on 11/18/15 at 6:58 PM shower tech #1 confirmed she gave Resident #38 a shower last week but could not remember the day of week. She verified Resident #38 complained of right shoulder pain and kept saying "be careful" when she tried to get Resident #38's clothes off before her shower and when she put them back on after her shower.

During an interview on 11/19/15 at 8:53 AM with shower tech #2 she explained she had given Resident #38 a shower on 2 different days last week and Resident #38 had told her somebody had messed her shoulder up. She stated she reported to a nurse Resident #38 complained of her shoulder hurting but could not remember who she told.

During an interview on 11/19/15 at 12:58 PM with

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Nurse #8 she verified Resident #38 went to the physician's office yesterday for an injection in her right shoulder but she was not sure what was going on because there was no information in the nurses notes about her shoulder and nothing had been reported to her.

During a follow up interview on 11/19/15 at 1:09 PM with shower tech #2 she stated she did not remember which day Resident #38 told her about the shower incident. She further stated she remembered she reported to Nurse #8 that Resident #38 had pain in her shoulder and Nurse #8 told her Resident #38 had arthritis.

During an interview on 11/19/15 at 2:15 PM with the Nurse Practitioner she explained she saw Resident #38 on 11/12/15 and Resident #38 had complained of pain in her right shoulder. She stated when she examined Resident #38's shoulder she had tenderness in the joint area but she saw no visible signs of injury or bruising. She further stated she was not told of the shower incident.

During an interview on 11/19/15 at 2:23 PM with the Director of Social Work she confirmed she assisted with investigations of grievances, abuse and neglect. She stated if a resident reported a staff member had been rough with them staff was expected to report it immediately and the Director of Nursing (DON) and Administrator were to be notified. She stated no one had reported to her that Resident #38 had complained staff was rough with her in the shower. She explained it was her expectation when Resident #38 reported staff was rough with her in the shower staff should have reported it immediately so that an investigation could have been done and if there

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was an injury of unknown origin staff should have filled out an incident report so they could investigate to figure out what caused the injury.

During an interview on 11/19/15 at 2:37 PM with the DON she confirmed there had been no abuse or neglect investigations related to Resident #38 and there were no 24 hours or 5 working day reports submitted to the North Carolina Health Care Personnel Registry. She stated it was her expectation staff should have notified her immediately when Resident #38 complained a staff member was rough with her in the shower. She further stated the Administrator and Director of Social Work should also have been notified so the resident could have been interviewed. She explained staff should have been interviewed and other residents should have been interviewed and an investigation should have been done to determine if staff was rough with Resident #38 or of if there was a medical condition that caused her shoulder pain.

During a telephone interview on 11/19/15 at 3:37 PM with Resident #38's physician who was also the facility Medical Director he verified he saw Resident #38 on 11/18/15 for right shoulder pain and he thought she had a rotator cuff injury. He explained it didn't look like a serious injury and did not require an x-ray but Resident #38 had definite pain in the right shoulder joint. He stated due to Resident #38's age he supposed if staff jerked her shoulder or moved her in a rough way it could have caused an injury but there was no way for him to know if staff caused the injury or if it was related to her medical condition.

During an interview on 11/19/15 at 3:53 PM the Administrator stated no one had reported to her

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F 226	Continued From page 15 that staff was rough with Resident #38 during a shower so there were no 24 hour or 5 working day reports completed. She stated it should have been reported to her so an investigation could have been done. She further stated it was her expectation for staff to report immediately when a resident reported staff were rough with them so she could investigate it.	F 226		
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 and staff interviews the facility failed to maintain dignity during meals when staff stood over residents while they fed them and failed to engage them in conversation during 2 of 2 meal observations. (Resident #2, #32, and #30). The findings included: 1. Resident #2 was re-admitted to the facility on 05/04/15 with diagnoses which included thyroid disease, chronic lung disease, diabetes, esophageal reflux, depression and altered mental status. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/17/15 revealed Resident #2 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #2 required	F 241	Corrective action for the alleged deficient practice was accomplished by in servicing staff member #2, and #3 on policy, dignity and residents rights immediately beginning 11/19/2015 through 12/16/2015. Any staff member not in serviced prior to 12/17/15 will not be allowed to work is in serviced. Chairs were placed beside all residents beds who require assistance with meals. To ensure others are not affected by the same alleged deficient practice all staff members will be in serviced on dignity, policy and procedure of assisting with meals on 11/19/2015 through 12/16/2015. To ensure that the system remains monitoring of all meals for one week, one	12/17/15

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F 241	Continued From page 16 total assistance by staff for activities of daily living. During continuous observations on 11/16/15 starting at 5:54 PM Nurse Aide (NA) #3 carried a meal tray into Resident #2's room and placed it on an overbed table on the left side of the bed. There was no chair in the room for NA #3 to sit on. Resident #2 was turned slightly toward her left side toward the overbed table with the head of the bed slightly elevated. NA #3 towered over Resident #2 and looked down at her as she fed her supper. NA #2 asked Resident #2 if she wanted more to eat but Resident #2 did not reply and NA #3 continued to feed Resident #2 and did not engage her in conversation. At 6:09 PM NA #3 carried Resident #2's meal tray out to a metal cart in the hallway. During continuous observations on 11/17/15 at 6:06 PM NA #2 carried a meal tray into Resident #2's room and placed it on an overbed table on the left side of the bed. There was no chair in the room for NA #2 to sit on. Resident #2 was turned slightly toward her left side toward the over bed table with the head of the bed slightly elevated. NA #2 towered over Resident #2 and looked down at her while Resident #2 looked up at her as she fed her supper. NA #2 continued to feed Resident #2 and did not engage her in conversation. At 6:18 PM NA #3 carried Resident #2's meal tray out to a metal cart in the hallway. During an interview on 11/17/15 at 6:23 PM with NA#3 she explained sometimes she stood while she fed residents. She stated if there was not a chair in the room then she stood next to the resident to feed them. She further stated she	F 241	meal of each shift weekly for 1 month and 1 weekly random monitor for 4 months by the social director or designee. A report of the findings will be compiled and presented to QA monthly for review.	

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was aware if there was a chair in the room she was supposed to sit next to the resident. She explained staff were not allowed to sit on a residents chair or their bed. She confirmed she stood while she fed Resident #2 yesterday on 11/16/15 because there was not a chair in the room.

During an interview on 11/17/15 at 6:48 PM with NA #2 she stated sometimes she stood to feed residents and sometimes she sat next to them. She explained sometimes it was easier for her to stand next to residents to feed them because she could see what she was doing. She verified she stood to feed Resident #2 because the resident had swallowing issues.

During an interview on 11/18/15 at 11:09 AM with the MDS Coordinator she explained it was the expectation for nurse aides (NAs) to sit in a chair next to the resident while they fed them and they should be at eye level with the resident upright.

During an interview on 11/18/15 at 11:18 AM with the Director of Nursing she stated it was her expectation for NAs to sit in a chair at eye level when they fed residents. She explained some resident rooms did not have chairs and the facility needed to get extra chairs so they would be available for NAs to sit and feed residents. She stated NAs should not sit in the resident's wheelchair or on the resident's bed. She further stated she wanted them to sit down at eye level and they should talk with the resident as they fed them.

2. Resident #32 was admitted to the facility on 10/08/15 with diagnoses which included heart disease, esophageal reflux, Alzheimer's disease,

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dementia, anxiety and depression. A review of the most recent admission Minimum Data Set (MDS) dated 10/19/15 revealed Resident #32 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #32 required total assistance by staff for activities of daily living.

During continuous observations on 11/16/15 at 6:09 PM Nurse Aide (NA) #3 carried a meal tray into Resident #32's room and placed it on an overbed table on the left side of the bed. There was no chair in the room for NA #3 to sit on. NA #3 raised the head of the bed slightly and Resident #2 was turned slightly toward her left side toward the overbed table. NA #3 towered over Resident #2 and looked down at her as she fed her supper. NA #3 continued to feed Resident #2 and did not engage her in conversation. At 6:21 PM NA #3 carried Resident #2's meal tray out to a metal cart in the hallway.

During an interview on 11/17/15 at 6:23 PM with NA #3 she explained sometimes she stood while she fed residents. She stated if there was not a chair in the room then she stood next to the resident to feed them. She further stated she was aware if there was a chair in the room she was supposed to sit next to the resident. She explained staff were not allowed to sit on a residents chair or their bed. She confirmed she stood while she fed Resident #32 yesterday on 11/16/15 because there was not a chair in the room.

During an interview on 11/18/15 at 11:09 AM with the MDS Coordinator she explained it was the

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expectation for nurse aides (NAs) to sit in a chair next to the resident while they fed them and they should be at eye level with the resident upright.

During an interview on 11/18/15 at 11:18 AM with the Director of Nursing she stated it was her expectation for NAs to sit in a chair at eye level when they fed residents. She explained some resident rooms did not have chairs and the facility needed to get extra chairs so they would be available for NAs to sit and feed residents. She stated NAs should not sit in the resident's wheelchair or on the resident's bed. She further stated she wanted them to sit down at eye level and they should talk with the resident as they fed them.

3. Resident #30 was admitted to the facility on 10/21/14 diagnoses which included heart disease, Alzheimer's disease, dementia, anxiety and depression. A review of the most recent quarterly Minimum Data Set dated 09/21/15 revealed Resident #30 was moderately impaired in cognition for daily decision making and required extensive assistance with activities of daily living.

During observations on 11/17/15 at 6:19 PM Nurse Aide (NA) #3 stood on the left side of Resident #30's bed while she fed her ice cream. There was no chair in the room for NA #3 to sit on. Resident #2 was turned slightly toward her left side with the head of bed slightly elevated and facing toward an overbed table with a meal tray on top of it. NA #3 towered over Resident #30 and looked down at her as she fed her ice cream. At 6:23 PM NA #3 carried Resident #30's meal tray out to a metal cart in the hallway.

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F 241	Continued From page 20 During an interview on 11/17/15 at 6:23 PM with NA #3 she explained sometimes she stood while she fed residents. She stated if there was not a chair in the room then she stood next to the resident to feed them. She further stated she was aware if there was a chair in the room she was supposed to sit next to the resident. She explained staff were not allowed to sit on a residents chair or their bed. She stated Resident #30 was not eating her supper so she stood while she fed Resident #30 ice cream because there was not a chair in the room. During an interview on 11/18/15 at 11:09 AM with the MDS Coordinator she explained it was the expectation for nurse aides (NAs) to sit in a chair next to the resident while they fed them and they should be at eye level with the resident upright. During an interview on 11/18/15 at 11:18 AM with the Director of Nursing she stated it was her expectation for NAs to sit in a chair at eye level when they fed residents. She explained some resident rooms don't have chairs and the facility needed to get extra chairs so they would be available for NAs to sit and feed residents. She stated NAs should not sit in the resident's wheelchair or on the resident's bed. She further stated she wanted them to sit down at eye level and they should talk with the resident as they fed them.	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.	F 253		12/17/15

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F 253	Continued From page 21 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 17 of 26 resident doors (Resident room #101, #102, #104, #106, #109, #110, #201, #202, #204, #206, #207, #208, #302, #304, #305, #307 and #308) and failed to repair broken and splintered laminate and wood on 2 of 2 shower doors (shower door #1 and #2) and failed to repair smoke prevention doors with broken and splintered laminate and wood on 200 and 300 halls. The findings included: 1. a. Observations of Room 101 on 11/17/15 at 11:37 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 11/18/15 at 4:04 PM revealed the door of resident room 101 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/19/15 at 11:50 AM revealed the door of resident room 101 had broken and splintered laminate on the front of the bottom half of the door. b. Observations of Room 102 on 11/17/15 at 11:38 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 11/18/15 at 4:06 PM revealed the door of resident room 102 had broken and splintered laminate on the front of the bottom half of the door. Observations on 11/19/15 at 11:52 AM revealed	F 253	Corrective action was achieved by ordering laminate for doors affected on 12/14/15. All doors were puttied and sanded by the maintenance Director. Laminate was replaced. To ensure that other doors are not affected the maintenance director completed an audit on 12/16/2015 of all facility doors. The system put into place to maintain compliance is to complete an audit monthly on all facility doors. Any areas will be reported and fixed immediately. Extra laminate will be maintained in inventory. To ensure that the system remains in place and is effective a report of the findings and doors replaced will be brought to QAPI monthly ongoing.	

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the door of resident room 102 had broken and splintered laminate on the front of the bottom half of the door.

c. Observations of Room 104 on 11/17/15 at 11:40 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 11/18/15 at 4:07 PM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:53 AM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door.

d. Observations of Room 106 on 11/17/15 at 11:41 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 11/18/15 at 4:09 PM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:54 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door.

e. Observations of Room 109 on 11/17/15 at 11:43 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 11/18/15 at 4:11 PM revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:55 AM revealed

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the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door.

f. Observations of Room 110 on 11/17/15 at 11:44 AM 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 11/18/15 at 4:12 PM revealed the door of resident room 110 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:57 AM revealed the door of resident room 110 had broken and splintered laminate on the front of the bottom half of the door.

g. Observations of Room 201 on 11/17/15 at 11:45 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 11/18/15 at 4:14 PM revealed the door of resident room 201 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:58 AM revealed the door of resident room 201 had broken and splintered laminate on the front of the bottom half of the door.

h. Observations of Room 202 on 11/17/15 at 11:47 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 11/18/15 at 4:15 PM revealed the door of resident room 202 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 11:59 AM revealed

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the door of resident room 202 had broken and splintered laminate on the front of the bottom half of the door.

i. Observations of Room 204 on 11/17/15 at 11:48 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 11/18/15 at 4:17 PM revealed the door of resident room 204 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:01 PM revealed the door of resident room 204 had broken and splintered laminate on the front of the bottom half of the door.

j. Observations of Room 206 on 11/17/15 at 11:50 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door with a large piece of laminate broken off the bottom of the door.
Observations on 11/18/15 at 4:19 PM revealed the door of resident room 206 had broken and splintered laminate on the front of the bottom half of the door with a large piece of laminate broken off the bottom of the door.
Observations on 11/19/15 at 12:02 PM revealed the door of resident room 206 had broken and splintered laminate on the front of the bottom half of the door with a large piece of laminate broken off the bottom of the door.

k. Observations of Room 207 on 11/17/15 at 11:51 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 11/18/15 at 4:20 PM revealed the door of resident room 207 had broken and

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splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:03 PM revealed the door of resident room 207 had broken and splintered laminate on the front of the bottom half of the door.

l. Observations of Room 208 on 11/17/15 at 11:53 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 11/18/15 at 4:22 PM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:05 PM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door.

m. Observations of Room 302 on 11/17/15 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 11/18/15 at 4:23 PM revealed the door of resident room 302 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:06 PM revealed the door of resident room 302 had broken and splintered laminate on the front of the bottom half of the door.

n. Observations of Room 304 on 11/17/15 at 11:55 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 11/18/15 at 4:24 PM revealed the door of resident room 304 had broken and

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splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:08 PM revealed the door of resident room 304 had broken and splintered laminate on the front of the bottom half of the door.

o. Observations of Room 305 on 11/17/15 at 11:56 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 11/18/15 at 4:25 PM revealed the door of resident room 305 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:09 PM revealed the door of resident room 305 had broken and splintered laminate on the front of the bottom half of the door.

p. Observations of Room 307 on 11/17/15 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 11/18/15 at 4:26 PM revealed the door of resident room 307 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:10 PM revealed the door of resident room 307 had broken and splintered laminate on the front of the bottom half of the door.

q. Observations of Room 308 on 11/17/15 at 11:58 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 11/18/15 at 4:28 PM revealed the door of resident room 308 had broken and

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splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:11 PM revealed the door of resident room 308 had broken and splintered laminate on the front of the bottom half of the door.

2. a. Observations of shower door #1 on 11/17/15 at 12:01 PM revealed the door had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/18/15 at 4:30 PM revealed shower door #1 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:15 PM revealed shower door #1 had broken and splintered laminate on the front of the bottom half of the door.

b. Observations of shower door #2 on 11/17/15 at 12:02 PM revealed the door had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/18/15 at 4:31 PM revealed shower door #2 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 11/19/15 at 12:16 PM revealed shower door #2 had broken and splintered laminate on the front of the bottom half of the door.

3. a. Observations of smoke prevention doors on the 200 hall on 11/17/15 at 12:05 PM revealed the doors had broken and splintered laminate on the edges of each of the bottom half of the doors.
Observations on 11/18/15 at 4:35 PM revealed smoke prevention doors on the 200 hall had

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broken and splintered laminate on the edges of each of the bottom half of the doors.
Observations on 11/19/15 at 12:20 PM revealed smoke prevention doors on the 200 hall had broken and splintered laminate on the edges of each of the bottom half of the doors.

b. Observations of smoke prevention doors on the 300 hall on 11/17/15 at 12:08 PM revealed the doors had broken and splintered laminate on the edges on the edges of each of the bottom half of the doors.
Observations on 11/18/15 at 4:40 PM revealed smoke prevention doors on the 300 hall had broken and splintered laminate on the edges of each of the bottom half of the doors.
Observations on 11/19/15 at 12:25 PM revealed smoke prevention doors on the 300 hall had broken and splintered laminate on the edges of each of the bottom half of the doors.

During an environmental tour and interview on 11/19/15 at 3:03 PM with the Maintenance Director he verified there were 26 resident room doors, 2 shower doors and smoke prevention doors on the 200 and 300 halls. He confirmed resident doors, shower doors and smoke prevention doors had broken and splintered laminate and needed to be repaired. He stated he did not have door repair on a routine schedule but would like to however, he was the only maintenance staff in the facility. He explained the building was old and he had to replace air conditioners and fix other damaged equipment and things were breaking all the time. He stated he hoped to eventually replace some of the doors that could not be repaired. He explained the doors were damaged when staff hit them with lifts or other equipment and the glue that held

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F 253	Continued From page 29 laminate in place on the doors loosened and then the laminate broke. He stated he was not aware some of the doors had broken chips of wood and splinters or were as badly damaged as they were. He explained he made routine rounds in the facility during the day and fixed things as he had time and staff could complete work orders if the saw something that needed to be repaired. He stated work orders were kept at the nurses station and he checked periodically throughout the day for things that needed to be fixed or staff called him if something needed repair. During an interview on 11/19/15 at 3:53 PM the Administrator stated it was her expectation that damaged doors should have laminate or protectors placed on them or if the doors were badly damaged they should be replaced. She further stated observation of doors should be part of the facility environmental tours and concerns should be brought to the quality assurance and assessment committee on a monthly basis.	F 253		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to completely assess a resident for	F 309	Resident# 48 no longer resides in the facility however;	12/17/15

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F 309	Continued From page 30 injury and respond to complaints of pain following a resident's fall which resulted in a fractured femur for 1 of 1 sampled resident (Resident #48). The findings included: Resident #48 was admitted to the facility on 08/14/15 diagnosed with respiratory failure, pneumonia and others. Resident #48 died in the facility on 09/27/15. The Minimum Data Set (MDS) dated 08/21/15 specified the resident did not have impaired cognition, required limited assistance with activities of daily living and no history of falls. Resident #48's Medication Administration Record (MAR) was reviewed and revealed that on 08/29/15 at 8:00 AM Resident #48's blood pressure medications (Norvasc and Lisinopril) and 2 diuretic medications (Lasix and Zaroxolyn) were held because the resident's blood pressure was 63/42 (low). Review of Resident #48's medical record revealed a nurse's entry made by Nurse #2 dated 08/29/15 at 11:20 PM specified Resident #48 was found in the floor and no injury was noted but the resident complained of tenderness on her left side where she landed. Vital signs were obtained and Resident #48's blood pressure was 112/64. Neurological checks were started, the resident was given Xanax (anti-anxiety medication) and put back to bed. Nurse #2 documented on the MAR that she administered as needed Tylenol (pain medication) 650mg (milligrams) for left hip pain. Nurse #2 did not document the time the medication was given and did not document if the pain medication was effective. There was no documentation in the medical record that the	F 309	Corrective action for the alleged deficient practice will be accomplished by retraining licensed nurses beginning 11/19/2015 through 12/16/2015. Any licensed staff not attending will not be allowed to work until training complete. Training included pain assessment of residents with falls and use of pain evaluation form with falls. In order to ensure others are not affected by the same alleged deficient practice incident reports for the last 6 months were audited by the DON and her designee. The system put into place to ensure compliance is daily review of incident reports for completion,and doctor notification, documentation of pain evaluation form, and acceptable follow up will be monitored by the DON or designee. Any issues will be corrected immediately and staff will be held accountable for any non compliance leading up to and including termination for repeated violations. Findings will be recorded and reported daily A report of the findings will be compiled and addressed in QAPI quarterly X 1 year.	

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physician was notified of the fall or complaints of pain after the fall.

The next nurse's entry made by Nurse #3 on 08/30/15 at 7:30 AM read in part that Resident #48's left hip was bruised, her left lower extremity was weaker than the right and the resident complained of tenderness in her left hip and leg. There was no documentation in the medical record of notification to the physician regarding pain or medication administration related to the Resident's complaint of pain.

On 08/30/15 at 2:00 PM Nurse #3 documented in the medical record that Resident #48 complained of pain in her left hip and leg upon movement. Nurse #3 contacted the on-call physician and obtained orders for a mobile x-ray. Nurse #3 documented on 08/30/15 at 6:20 PM the x-ray had been performed and Resident #48 was comfortable as long as left leg wasn't moved.

The Radiology Report dated 08/30/15 specified no fracture or dislocation was detected.

A nurse's entry dated 08/31/15 at 10:00 AM specified Resident #48 continued to complain of pain to her left upper leg and hip. There was no documentation in the medical record that the physician was notified of the pain. On 08/31/15 at 1:00 PM the physician was notified and ordered a 2 view x-ray of the left femur and left hip. The Radiology Report dated 08/31/15 indicated Resident #48 had a left femoral fracture. Orders were obtained and Resident #48 was sent to the Emergency Department.

On 11/18/15 at 4:30 PM the resident's physician was interviewed on the telephone and stated he

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expected nurses to notify him right away when a resident had new pain after a fall especially if it was hip pain because he didn't want a resident sitting on a fracture. The physician could not recall if he was notified on 08/29/15 when the resident fell or when the resident complained of pain on 08/30/15.

On 11/19/15 at 12:30 PM Nurse #3 was interviewed on the telephone and explained that she worked 7 AM to 7 PM on Friday, Saturday and Sunday. Nurse #3 explained that on 08/29/15 Resident #48 had refused to eat or drink anything and she was concerned the resident would become dehydrated. Nurse #3 stated that Resident #48's blood pressure was low (63/42) and she decided to not administer blood pressure medications or diuretic medications. She stated on 08/30/15 she did not contact the physician because Resident #48 did not appear in acute distress. Nurse #3 explained that on 08/30/15 she was told in report that Resident #48 had fallen "but nothing was different" with the Resident. Nurse #3 added that on 08/30/15 she did not perform range of motion (ROM) on Resident #48 because she "assumed the resident could move everything." Nurse #3 stated on 08/30/15 that Resident #48 was weaker on the left side which was different for the resident but she did not attempt to contact the physician. Nurse #3 explained that later in the shift Resident #48 started to "holler" when her hip was touched and that was when she contacted the physician. Nurse #3 did not recall if she administered pain medication to the resident on 08/30/15.

On 11/19/15 at 2:00 PM the Director of Nursing (DON) was interviewed and explained that she expected nurses to assess residents after a fall

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F 309	Continued From page 33 including range of motion before moving them and to call the physician if a resident had pain after a fall. The DON stated that if Resident #48 had any pain after a fall the nurses should have contacted the physician. On 11/19/15 at 3:55 PM Nurse #2 was interviewed on the telephone and explained that she was not Resident #48's nurse on 08/29/15 when the resident fell but was called by a nurse aide who found the resident in the floor. Nurse #2 added that she asked Resident #48 if she was okay and asked her if she could move all her extremities. Nurse #2 stated she did not perform ROM on Resident #48 but that the resident complained her "butt" hurt from the fall. Nurse #2 added that she and another staff person stood the resident up and transferred her to the wheelchair and then from the wheelchair to the bed. Nurse #2 explained that once the resident was back in bed she notified the nurse assigned to the resident of the incident, completed the incident report and continued on with her assignment. Nurse #2 stated she did not contact the physician of the resident's fall or complaints of pain. A document titled "Incident/Accident Report" dated 08/29/15 completed by Nurse #2 specified the physician was contacted on 08/29/15 at 9:16 PM. Nurse #2 stated she did not call the physician and was not sure why she documented that the physician was notified of the fall.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		12/17/15

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F 314	Continued From page 34 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to initiate appropriate treatment of a facility acquired stage 2 pressure ulcer for 1 of 1 resident with a pressure ulcer (Resident #20). The findings included: The facility's Standing Orders effective 02/09/10 for Wound Care Guidelines read in part, "Decubitus Ulcer Stage 2: - Option 1 - cleanse affected area with normal saline, apply solosite gel (or equivalent), cover with gauze dressing every shift and as needed - Option 2 - if slough present, cleanse affected area with normal saline, apply silvadine cream (SSD) and cover with gauze dressing every shift and as needed." Resident #20 was admitted to the facility 07/21/15 with diagnoses that included dementia, failure to thrive and cancer, among others. Resident #20 had a care plan dated 08/07/15 to address the problem for the potential for pressure ulcer development related to immobility and incontinent episodes. On 10/11/15 the care plan was updated to reflect that Resident #20 had developed a stage 2 on her sacrum. The care plan specified that interventions included administer treatments as ordered and monitor effectiveness. Review of the medical record revealed an original	F 314	Resident #20 is no longer in facility however; To ensure others are not affected by the same alleged deficient practice Skin treatments were audited for accuracy on residents in facility on November 19, 2015 by Director of Nursing. Wound orders were verified and residents are currently receiving correct treatment(s) per Wound Care Guidelines. Licensed nurses were trained beginning 11/19/2015 through 12/16/2015. Any licensed staff not attending will not be able to work until re-trained. The training was on standing orders for Wound Care Guidelines. Staff was instructed to follow these guidelines unless changed by the physician or Hospice. Any changes will be documented in resident chart and plan of care. To ensure compliance the Director of Nursing and/or designee will monitor wound care logs weekly x1 month and then monthly ongoing for accuracy and appropriate wound care standing orders or physician orders. A report of the findings will be compiled	

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F 314	Continued From page 35 physician's order dated 10/11/15 noted by nurse #1 to apply barrier cream to sacrum twice daily and as needed. Further review of the medical record revealed a document titled "Weekly Pressure Ulcer Record" dated 10/15/15 completed by nurse #1 that specified Resident #20 had a facility acquired stage 2 pressure ulcer on her coccyx that measured 0.5cm (centimeters) x 0.2cm x 0.1cm. The wound was assessed by Nurse #1 to have "scant serous" exudate, pink wound bed and pink edges surrounding the wound. A physician's order dated 10/25/15 noted by nurse #1 ordered to discontinue barrier cream and clean coccyx wound with normal saline apply hydrogel and cover with foam dressing daily and as needed. The most recent Minimum Data Set (MDS) dated 10/26/15 specified the resident had short and long term memory impairment, required extensive assistance with bed mobility and toileting and had unhealed stage 2 pressure ulcer. The Treatment Administration Record (TAR) was reviewed for 10/15 and revealed that Resident #20 received barrier cream treatment daily from 10/11/15 through 10/25/15 when treatment was changed on 10/25/15. The document titled "Weekly Pressure Ulcer Record" dated 11/12/15 Resident #20's coccyx wound had worsened and was considered unstageable measuring 3.5cm x 2.0cm x 0.7cm with large brown yellow exudate, odor present and wound bed was yellow and surrounding tissue was yellow. A physician's order dated 11/13/15 noted by nurse #1 specified to change treatment to cleanse coccyx wound and apply ½ strength solution soaked gauze cover with foam patch and change daily.	F 314	and addressed in QAPI quarterly X 1 year.	

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On 11/18/15 at 4:30 PM the physician was interviewed and reported that he expected nursing staff to immediately implement appropriate treatment as outlined on the skin protocol when a new pressure ulcer was identified. He added that he expected nurses to take protective action to prevent a staged pressure ulcer from progressing.

On 11/19/15 at 11:10 AM nurse #1 was interviewed and explained that she worked two days a week in the facility and every other weekend. She added that she tried to help with treatments as time allowed but that during her time in the facility she wasn't always able to measure wounds and that no one was responsible for measuring and monitoring pressure ulcers. She stated that the facility utilized standing orders for skin protocol to follow when a new area was identified. Nurse #1 explained that the nurse who identified a new pressure ulcer was responsible for initiating the appropriate treatment and notifying the physician. Nurse #1 reported that she was notified that Resident #20 had a pressure ulcer which she assessed and determined to be a stage 2 pressure ulcer on her coccyx. Nurse #1 was unaware why she received an order to apply barrier cream to the area when there was depth to the wound. Nurse #1 did not clarify the order with the physician for the treatment. Nurse #1 added that several weeks had passed since she saw the resident's wound and stated it had gotten "much worse." Nurse #1 was not aware if treatment or measurements had been completed for Resident #20's pressure ulcer.

On 11/19/15 at 1:50 PM the Director of Nursing (DON) was interviewed and reported that currently the facility did not have a nurse assigned to oversee wounds but that she hoped

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F 314	Continued From page 37 to appoint someone to the role of wound nurse. The DON explained that when an area of pressure was identified she expected nurses to follow the standing orders for wound protocol and initiate the appropriate treatment but if the nurse determined the treatment needed to be changed the nurse would be required to contact the physician for new orders to treat. The DON stated that barrier cream was not an appropriate treatment for a stage 2 pressure ulcer.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		12/17/15

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F 356	Continued From page 38 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift. The findings included: On 11/16/15 at 2:33 PM an initial tour was made of the facility. Observations were made of the staffing data posted on a bulletin board across from the nurses' station. The data sheet was dated 11/01/15 and was not completed. On 11/16/15 at 2:35 PM the Director of Nursing (DON) was interviewed regarding the required staffing data and stated that the nurse at the start of each shift was responsible for completing the staffing data. The DON noted that the data posted was dated 11/01/15 and was able to find staffing data for 11/11/15. The DON stated that it had been an oversight and she would remind nurses to complete the required staffing data to post in the facility.	F 356	Nurse staffing information was updated immediately on November 16, 2015 by the Director of Nursing. On-duty staff were re-trained by Director of Nursing on November 16, 2015. To ensure that this does not happen again all Licensed nurse will post staffing data at beginning of shift and updated per shift or as needed daily. Licensed nurses were in serviced beginning 11/19/2015 - 12/16/2015 any licensed staff not attending was not allowed to work until in service training complete. The system put into place to ensure that this does not recur is for the Director of Nursing or designee to monitor Staffing Data form daily on on-going basis for completeness and accuracy. Any issues will be corrected immediately. A report will be compiled of all audits. A report of the findings will be compiled and addressed in QAPI monthly for 6 months	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		12/17/15

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F 364	Continued From page 39 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 review the facility failed to follow the recipe when pureeing lasagna by adding water and bread for 1 of 1 meal preparation observation. The findings included: On 11/16/15 at 2:20 PM observations were made of the cook pureeing lasagna for the evening meal. The cook pureed the lasagna and while the food processor was running, poured approximately 2 cups of water into the mixture. The cook was interviewed during the observation and explained that the facility had 7 residents on a pureed diet and that she was trained to puree the food to "baby food" consistency. She stated that she added water to make the food "smooth." The cook turned the food processor off, stirred the mixture and then added two slices of white bread torn into pieces. The cook proceeded to puree the mixture with bread added. The cook was interviewed and stated she added the bread to "make the mixture healthier" and by adding bread it made the mixture "thicker" so the residents would get full. The cook turned the machine off and then added approximately 1 - 2 more cups of water and proceeded to puree the mixture. Observations of the pureed lasagna with water and bread added to it looked light reddish-brown and did not resemble lasagna.	F 364	Corrective action for the alleged deficient practice was achieved by serving lasagna prepared according to the recipe for the dinner meal of 11/16/15 the initial batch was discarded. The cook was in served on food preparation and following company recipe. To ensure others were not affected by the same practice all dietary staff were in serviced on correct food/diet preparation and the importance of using company designed recipes. to ensure that this remains in place an audit of all meals by each cook was conducted from 12/11-12/16/ 2015. thereafter the Dietary manager or designee will conduct an audit of food preparation according to recipe for each meal for 5 days then monitor three times a week to include each cook for the week for 6 weeks. Thereafter once monthly ongoing. the ensure the system remains in place a report will be compiled and discussed monthly in QAPI ongoing.	

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F 364	Continued From page 40 The Dietary Manager (DM) was present while the cook added water and bread to the lasagna. On 11/18/15 at 4:35 PM the DM provided the recipe for pureeing lasagna. The recipe read in part, "for pureed: measure desired # of servings into food processor. Blend until smooth. Add broth or gravy if product needs thinning. Add commercial thickener if product needs thickening." On 11/18/15 at 4:46 PM the Registered Dietitian (RD) asked to clarify that the cook did not follow the recipe when she added bread to the pureed lasagna. The RD stated that the pureed lasagna was remade according to the recipe and not served to residents. On 11/19/15 at 11:34 AM the DM was interviewed and explained that she expected staff to follow recipes when preparing food. She added that she had rearranged the stock room and the cook was unable to find the food thickener and that was why the cook added water and bread to the lasagna. The DM offered no explanation why she did not correct the cook during the cook during the observations of pureeing lasagna using water and bread.	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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/17/15

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F 371	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent the walk-in cooler floor from developing rust, keep the kitchen floor free from dirt build-up and repair cracked tiles in the kitchen floor. The findings included: On 11/16/15 at 2:15 PM and initial tour of the facility's kitchen was made with the Dietary Manager (DM). The DM reported that this was her second week as the DM for the facility. During the tour, observations were made of the walk-in cooler floor that revealed spots of standing water on the floor. The DM reported that staff had not recently mopped and she was not sure why the cooler had standing water. The floor of the walk-in cooler was dark brown almost black in appearance and closer inspection revealed rust had formed covering the floor entirely. Also during the tour, observations were made of the floor of the food production area. On 11/16/15 at 2:22 PM the legs of the steam table, food production table and oven area were observed to have debris build-up on the floor extending up the legs of the units. On 11/16/15 at 2:25 PM observations were made of the tiled floor in the kitchen. An area approximately 25 inches x 30 inches next to the dish machine were noted to be cracked and loose. On 11/19/15 at 11:20 AM repeat observations were made of the kitchen floor that revealed there was dust, dirt debris build-up on the floor and	F 371	Corrective action for the alleged deficient practice was accomplished by removing debris and cleaning the steam table legs, sweep and mopping the entire kitchen floor, preparing and removing the rust from the walk in cooler, serving kitchen drains, and repair broken floor tiles. To ensure other areas are not affected by the same alleged deficient practice all areas and items in the kitchen were audited to ensure cleanliness. all areas were reviewed to insure that they are listed on the appropriate cleaning schedules, all areas were reviewed to ensure other areas do not contain rust or standing water, all drains were audited to ensure water does not stand, and all tiled areas were audited for tiles that need to be repaired. Any areas found were repaired or replaced. Staff was in serviced beginning 11/19/2015 through 12/16/2015. The system put into place to ensure that the same alleged deficient practice does not recur an audit tool was compiled by the PIP appointed through the QAPI steering committee. The monitoring tool will be completed daily for 6 weeks, twice a week for 2 weeks, then monthly ongoing to ensure that the system remains in place and is effective a report of the	

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F 371	Continued From page 42 along edges of table legs. The DM was present for the observations and the District Manager was present as well. The DM was interviewed and stated that she expected staff to sweep and mop after each shift. The DM added that the kitchen utilized a weekly cleaning schedule. The DM provided the weekly cleaning schedule. Review of the weekly cleaning schedule did not specify sweeping and mopping the kitchen floor. The DM was interviewed and reported that during her 2 weeks in her role she had not had time to review the cleaning schedule but stated her staff should have been sweeping and mopping. The DM observed to debris build-up and stated the floor needed to be cleaned. On 11/19/15 at 11:25 AM observations were made of the walk-in cooler's rusted floor. The District Manager stated that a rusty floor used to store food was unacceptable. He added that he hadn't noticed the extent of the rust. The DM was also present during the interview and had observed the water standing in the walk-in cooler and the rust covering the floor and stated she hadn't noticed the floor was rusty. On 11/19/15 at 11:28 AM the DM and District Manager were interviewed about the broken floor tiles. They both reported the kitchen was old and needed a lot of repairs. The District Manager stated the tiles should have been reported to the facility's Maintenance Director to be replaced.	F 371	findings will be presented to QAPI monthly ongoing.	
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	F 520		12/17/15

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F 520	Continued From page 43 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 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 in February 2015. This was for 5 recited deficiencies which were originally cited in February 2015 on a recertification and complaint survey and again on the current recertification survey. The deficiencies were in the areas to notify of a change in condition, provide dignity and respect, provide a safe, clean and comfortable homelike environment, provide care and services for highest well-being and to store, prepare and serve food under sanitary conditions. The facility's continued failure to implement and maintain	F 520	Corrective action for the alleged deficiencies e in the following areas: to notify of a change in condition, provide dignity and respect, provide a safe, clean and comfortable homelike environment, provide care and services for highest well-being and to store, prepare and serve food under sanitary conditions was accomplished by correcting each of the alleged deficient practice according to the proposed facility plan of correction. To ensure others are not affected by the same alleged deficient practices an all staff educational in services began 11/19/2015 and all staff were in serviced	

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F 520	Continued From page 44 procedures from a Quality Assessment and Assurance Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. a. F157 Notification of changes in condition: Based on staff interviews and record review the facility failed to notify the physician after a resident fell and developed a new onset of pain and the resident had a fractured femur for 1 of 1 sampled resident (Resident #48). The facility was recited for F157 for failure to notify the physician after a resident fell and had pain and a fracture. F157 was originally cited during the February 5, 2015 recertification and complaint survey for failure to notify the physician after a resident fall for 1 of 2 residents reviewed for unwitnessed falls. (Resident # 31). b. F241 Dignity and respect: Based on observations and staff interviews the facility failed to maintain dignity during meals when staff stood over residents while they fed them and failed to engage them in conversation during 2 of 2 meal observations. (Resident #2, #32, and #30). During the recertification and complaint survey on 02/05/15 the facility failed to maintain and promote the dignity of 4 residents during 1 of 2 meals which were observed for tray delivery services. Residents #4, #8, #25, and #46 were not served at the same time as their tablemates and had to watch others eat prior to being served	F 520	by 12/17/15 or prior to working there after 12/16/2015. Each staff member was informed of all findings and remedies. In addition these alleged deficient practices and plan of action will be discussed in orientation for all new hires ongoing until 12 months of substantial compliance. to ensure that each of these areas : notify of a change in condition, provide dignity and respect, provide a safe, clean and comfortable homelike environment, provide care and services for highest well-being and to store, prepare and serve food under sanitary conditions. Remain in compliance a Substantial compliance tool for each tag will be completed monthly by the DON, Administrator or designee. The tool will be created by the QAPI process Improvement team appointed by the QAPI steering Committee. This tool will be completed weekly for 1 month then monthly ongoing. Any negative findings from the completed tools will be discussed immediately with the Administrator with immediate correction and plan of action required. To ensure that the system is effective a report of the findings will be discussed monthly during QAPI for 12 months after continued substantial compliance.	

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themselves.

c. F253 Safe, clean, comfortable and homelike environment: Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood on 17 of 26 resident doors (Resident room #101, #102, #104, #106, #109, #110, #201, #202, #204, #206, #207, #208, #302, #304, #305, #307 and #308) and failed to repair broken and splintered laminate and wood on 2 of 2 shower doors (shower door #1 and #2) and failed to repair smoke prevention doors with broken and splintered laminate and wood on 200 and 300 halls.

During the recertification and complaint survey on 02/05/15 the facility failed to label bedpans and a urine hat stored in plastic bags from hooks and label an uncovered urine hat lying in the floor in resident bathrooms in 4 bathrooms on 2 of 3 halls.

d. F309 Maintain well-being: Based on staff interviews and record review the facility failed to completely assess a resident for injury and respond to complaints of pain following a resident's fall which resulted in a fractured femur for 1 of 1 sampled resident (Resident #48).

During the recertification and complaint survey on 02/05/15 the facility failed to assess and implement a bowel protocol for a resident who had not had a bowel movement for 9 days for 1 of 5 residents reviewed for unnecessary medications (Resident #17).

e. F371 Based on observations, staff interviews and record review the facility failed to prevent the

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walk-in cooler floor from developing rust, keep the kitchen floor free from dirt build-up and repair cracked tiles in the kitchen floor.

During the recertification and complaint survey on 02/05/15 the facility failed to 1) use proper hand hygiene when handling clean equipment and 2) air dry food trays and insulated domes before storing and 3) maintain the cleanliness of the exterior door panels of the reach-in refrigerator and freezer.

During an interview on 11/19/15 at 4:23 PM the Administrator explained they evaluated quality assurance topics for review through monitoring tools and audits. She explained when they developed quality assurance plans for the deficiencies cited on 02/05/15 they monitored for the specific concerns that were cited. She explained dignity was monitored for a different issue than the current deficiency so now they would have to think out of the box and look at why there was deficient practice for different issues. She stated they needed to look at the whole regulatory area instead of just looking at the specific issues that were cited to prevent deficiencies on future surveys.