STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews the facility failed to promote dignity in dining, by not promoting assisting residents to eat for 8 of 9 residents who required supervision, feeding assistance or cueing during meals during two meal observations. (Residents #8, # 27, #37, #32, #62, #67#101, #141, #169,and #172) Findings Included: 1.On 3/13/16 at 12:24pm, Residents #27, #37, #141, and # 172 were observed sitting in the dining room waiting for lunch. Resident # 62 was eating lunch. Resident # 101 had a tray set up in front of her and wasn ' t eating. Resident # 32 had a covered tray in front of her and was asleep. Aide # 1 was feeding Resident # 8. During an interview 3/13/16 at 12: 27 pm, Family Member #1 indicated on weekends there was one Aide to feed everyone in the dining room. It was had been this way for years. He indicated on weekdays there was more help. He indicated he came every day to make sure his family member was fed. On 3/13/16 at 12:34pm, an activity aide came in and began to feed Resident # 32. Another family member arrived and put a clothing protector on Resident # 172. During observation on 3/13/16 at 12:37 PM, Resident # 62 had finished her food and yelled	F 241	Jacob□s Creek Healthcare and Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob□s Creek□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Jacob□s Creek reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. On 3/18/2016 residents #8, #27, #37, #32, #62, #67, #101, #141, #169 and #172 were assessed by the Director of Nursing to ensure the residents were eating independently and or with assistance. The Director of Nursing assessed dining room service to ensure that all residents were eating at the same time. The	4/14/16

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

Electronically Signed | 04/01/2016

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F 241	Continued From page 1 out, " Where is their food? " Resident # 172 indicated he was hungry and said, " Where ' s my food. " During observation on 3/13/16 at 12:41pm, a second food cart arrived and Aide #2 arrived and gave Resident # 172 his tray. Family members retrieved food off the cart for residents # 27 and #37 and began to feed them. Aide #2 fed Resident #141 food from the tray. Resident #101 continued to sit and not eat. Aide # 1 moved Resident #101 and began to cue her. During an interview on 3/13/16 at 1:07pm, a second family member indicated she came to the facility 6 days a week to make sure her family member was fed once a day and got her fluids. She indicated there was one aide sometimes two to feed or help all the residents in the dining room. The normal routine was the aide would set up the people who could feed themselves and the other residents sat and waited to eat with the trays covered. 2. During a continuous observation on 3/15/16 at 12:15 pm, Resident # 62, and #67 were eating. Residents # 27, # 37, #141, #169, and #172 had no meal. Resident # 8 and #32 had trays sitting in front of them with no one to feed them. At 12:19 pm, another cart of lunch trays arrived for Resident ' s #27, #37 and #172. A family member retrieved a tray and began to feed Resident # 37. Nurse #1 arrived to feed Resident # 32 and at 12:22 pm. Aide# 3 arrived and began to feed Resident #8. Resident # 141 continued to sit with his tray covered in front of him on the table. The trays for Resident # 134 and #141 trays were distributed to them covered. No one uncovered the tray or set the trays up to eat. Resident # 134 began to rock vigorously side to side. No one was available to feed either resident. During observation on 3/15/16 at 12:49 pm, Aide	F 241	Director of Nursing ensured each resident was being provided care in a manner in which promotes dignity and respect in full recognition of his or her individuality. The facility will promote dignity in dining by assisting residents to eat and or require supervision, feeding assistance or cueing during meals. On 3/18/2016 all residents were assessed by the Administrator and the Director of Nursing via facility rounds to ensure the residents were eating independently and or with assistance. The Administrator and Director of Nursing assessed all dining room services to ensure that all residents were eating at the same time. The Administrator and Director of Nursing ensured each resident was being provided care in a manner in which promotes dignity and respect in full recognition of his or her individuality. The facility will promote dignity in dining by assisting residents to eat and or require supervision, feeding assistance or cueing during meals. No other issues were identified by the Administrator and Director of Nursing on 3/18/16 during dining room service rounds. On 4/1/2016 nursing staff and paid feeding assistants retraining was initiated and completed on 4/14/2016 by the Staff Facilitator regarding the importance of promoting dignity to all residents when providing care including but not limited to: 1) ensure all residents are fed at the same time 2) assist residents to eat if they require supervision 3) provide feeding	

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F 241	Continued From page 2 #2 finished feeding Resident # 32 and took her out of the dining room. She returned at 12:42 pm, and encouraged Resident # 27 to drink her fluid and eat her dessert. At 12:45 pm. She prepared to feed Resident # 134 and at 12: 49 pm Aide #4 began to feed resident # 141. During an interview on 3/15/16 at 1: 13 pm, Aide # 3 indicated there were two aides assigned to feed on the 1st shift during the week. The Aide added that there were more people that had to be fed, then staff assigned to feed them. She indicated usually they had more residents than this to feed. During interview on 3/15/16 at 1:14 pm, Aide #4 indicated the trays used to come out on one cart. No resident was fed until all the trays arrived. Residents who were able to feed themselves got their trays first. Trays were left covered until an aide was available to feed the resident. Sometimes a housekeeper fed a resident. During an interview on 3/15/16 at 3:54 pm, the Dietary Manager indicated she had a list of residents who sat in the 1st dining room daily. The dining room trays came out together on the first cart. Lunch was scheduled for 12:08 pm in the 1st dining room, Cart A. She indicated the aides came to the kitchen door and told kitchen staff any changes to the scheduled seating and the kitchen staff put the meal on the appropriate cart. She was not aware of any distribution problems. During an interview on 3/15/16 at 4:16 pm, Aide #5 indicted she was scheduled alone in the 1st dining room on second shift. She indicated she had 6 residents she fed nightly. She indicated she fed 2 residents at a time, the other 4 residents waited. Some residents sat without food while other residents ate. If the Aide on the hall had no one to feed, they came into the dining room to	F 241	assistance or cueing during meals 4) ensure the correct number of staff to residents 5) follow the carts during meal pass to ensure all residents have the required assistance before moving to the next dining room. Any newly hired nursing staff and paid feeding aides will be trained on promoting dignity to all residents when providing care including but not limited to: 1) ensure all residents are fed at the same time 2) assist residents to eat if they require supervision 3) provide feeding assistance or cueing during meals 4) ensure the correct number of staff to residents 5) follow the carts during meal pass to ensure all residents have the required assistance before moving to the next dining room. No staff will be allowed to complete a shift without being trained. Audits will be conducted by Administrator, Director of Nursing, Restorative Nurse, Staff Facilitator and weekend Nurse Manager on 10 residents' care delivery, to include promoting assisting residents to eat who require supervision, feeding assistance or cueing during meals, to ensure residents' dignity daily for 4 weeks, 10 audits weekly for 4 weeks and 10 audits monthly for 12 weeks utilizing the Safe Work Practice/Resident Care Audit. Any issues identified will be corrected immediately by with further re-training and/or accountability as appropriate. Resident Council will be questioned by the Social Worker regarding dignity related issues at the next 5 monthly meetings. Any issues reported will be documented on a Resident Council concern form and	

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F 241	Continued From page 3 help. During an interview on 3/17/16 at 5:54pm, the Director of Nursing indicated she expected nursing and housekeeping staff to feed the residents, any residents who remain had had to wait.	F 241	forwarded to the Administrator or the Director of Nursing for follow-up. The QA Committee (Administrator, Director of Nursing, Quality Improvement Nurse, Staff Facilitator, MDS Nurse, Dietary Manager, Treatment Nurse, RN Supervisor, Social Worker, Rehab Manager) will review the audits weekly for 8 weeks and monthly for 12 weeks to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review staff and family interviews, the facility failed to monitor splint application for 1 of 3 sampled residents (#37). Finding included: Resident # 37 was admitted on 2/17/06 with diagnoses including contractures, quadriplegia and dementia. The most recent Restorative Nursing Rehab	F 318	Jacob's Creek Healthcare and Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is	4/14/16

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F 318	Continued From page 4 Referral Form dated, 3/21/14, included a plan to prevent further contractures. The referred interventions were passive range of motion for the bilateral lower extremities and splint application to both hands to be tolerated 6 hours per day. The most recent Minimum Data Set dated 12/18/15, revealed severe cognitive impairment, constant psychomotor retardation and impairment with upper and lower extremities. She had 7 days of range of motion exercises and no splint was applied. Review of the most recent care plan dated 3/25/14, revealed splint/brace 6-7 times per week splint to both hands for at least 6 hours. May place rolled wash cloth in hands after splinting. The responsible staff member delegated this task was the restorative aid. Review of the most recent care guide last updated 2/17/15 had no planned hand splinting program interventions. The restorative nursing documentation dated 1/1/16-3/17/16, revealed splint application was documented when applied. No range of motion or splinting occurred on dates that fell on a weekend, including, 1/3/16, 1/17/16, 1/23/16, 1/31/16, 2/14/16 and 2/28/16. On 03/13/16 at 12:27pm, while in the dining room, splints were not applied and no wash cloths were noted in Resident #37 ' s hands. She required total assistance to be fed. On 03/15/16 at 12:19 pm, while in the dining room, splints were not applied and no wash cloths noted in Resident #37 ' s hands. She required total assistance to be fed. During an interview on 3/16/16 at 3:37 pm, Restorative Aide #1 indicated all aides had been trained how to put on and take off the splints. Wash cloths go into her hands when the splints were off. The splints were put on every day	F 318	submitted as a written allegation of compliance. Jacob's Creek's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. On 3/18/2016 resident #37 was assessed by the Director of Nursing and is receiving appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion including monitoring splint application. On 3/17/2016 resident #37 was referred to therapy for splint modification. On 4/1/2016 all residents were reviewed by the Restorative Nurse via facility rounds to ensure they were receiving appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion including monitoring splint application. On 4/1/2016 no other issues were identified during the round. On 4/1/2016 nursing staff training was initiated and completed on 4/14/2016 by the Staff Facilitator regarding documenting on the Medication Administration Record the donning and doffing of splints based on the physician's orders. On 4/1/2016 nursing staff training	

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F 318	Continued From page 5 except Sunday for 4- 6 hours. The restorative aide put the splints on and documented the time in the care tracker. The splints were removed in the evening. There was no schedule time when the aide removed the splints. There was no documentation for how long the splints were worn. Resident #37 wasn ' t able to remove the wash cloths from her hands. She was able to loosen the splints with movement. Review of the Restorative Passive Range of Motion Log dated 03/17/16, revealed passive range of motion was conducted at 10:00am for 17 minutes and the splints were applied at 9:59 am. On 03/17/16 at 10:05 am, Resident #37 was sitting up in her custom recliner. Splints were not applied and there were no wash cloths in her hands. The splints were observed laying on the night stand. During interview on 3/17/16 at 10:06 am, Aide # 3 indicated she had removed the splints to do morning care and had to call a restorative aide to put them back on because the restorative aide keeps track of how long the splints were worn. During an interview on 3/17/16 at 10:38 am, Restorative Nurse indicated the restorative staff follow the therapy order. Resident #37 had worn splints for years. A restorative summary nursing note was written quarterly. Due to the spastic movement of her hands, Resident #37 ' s splints would loosen and come off. The restorative aide put the time the splints were put on Resident #37. There was no place to put what time the splints were removed. The total time worn was not documented. During an interview on 3/17/16 at 12:10 pm, a family member indicated the when the splints came off and the wash cloths were placed in her hands, they didn ' t stay in Resident #37 ' s palms.	F 318	was initiated and completed on 4/14/2016 by the Staff Facilitator on the doffing of resident splints. Any newly hired nursing staff will be trained on documenting on the Medication Administration Record the donning and doffing of splints based on the physician's orders and/or doffing of resident splints. No nursing staff will be allowed to complete a shift without being trained. Audits will be conducted by Restorative nurse and weekend Nurse Manager on 100% of residents with splint Medication Administration Records receiving treatment and services to increase range of motion and/or to prevent further decrease in range of motion daily for 4 weeks, 100% of the residents with splints weekly for 4 weeks and 100% of the residents with splints monthly for 12 weeks utilizing the Splint Medication Administration Record Audit. Any issues will be corrected immediately by the Restorative Nurse and weekend Nurse Manager with further re-training and/or accountability as appropriate. The QA Committee (Administrator, Director of Nursing, Quality Improvement Nurse, Staff Facilitator, MDS Nurse, Dietary Manager, Treatment Nurse, RN Supervisor, Social Worker, Rehab Manager) will review the audits weekly for 8 weeks and monthly for 12 weeks to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that	

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F 318	Continued From page 6 During an interview on 3/17/16 at 5:02 pm, the Director of Nursing indicated when the restorative aides were pulled to work as aides on the floor. The assigned aide or the restorative nurse was expected to apply the resident ' s splint.	F 318	time.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and family interviews, the facility failed to provide enough staff to supervise, feed and assist residents during 3 meal observations in 1 of 6 dining rooms.	F 353	Jacob□s Creek Healthcare and Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually	4/14/16

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F 353	Continued From page 7 Findings included: The " feeding list " which was not dated revealed sixteen residents required feeding or assistance with feeding on hall 100, one on the 200 hall, seven on the 400 hall, three on the 500 hall and five on the 600 hall. Review of the feeding assistant training log revealed 27 staff had been trained to assist in feeding 4/3/04- 1/9/15. 1. On 3/13/17 at 12:24pm, Aide #1 was observed feeding Resident #8 and Resident #27, #37, 141 and #172 had no lunch. Resident #32 had a tray in front of her and was asleep. Resident #101 had lunch and was not eating. Resident #62 was feeding herself a pureed diet. There was Aide#1 was the only aide in the room. During an interview on 3/13/16 at 12:27 pm, Family Member #1 indicated he came to ensure Resident # 37 was fed at least once daily. He indicated there was one aide for everyone in the dining room. On 3/13/16 at 12:34pm, an activity aide came in and began to feed Resident # 32. Another family member arrived and put a clothing protector on Resident # 172. During observation on 3/13/16 at 12:37 PM, Resident # 62 had finished her food and yelled out, " Where is their food? " Resident # 172 indicated he was hungry and said, " Where ' s my food. " During observation on 3/13/16 at 12:41pm, a second food cart arrived and Aide #2 arrived and gave Resident # 172 his tray. Family members retrieved food off the cart for residents # 27 and #37 and began to feed them. Aide #2 fed Resident #141 food from the tray. Resident #101 continued to sit and not eat. Aide # 1 moved Resident #101 and began to cue her. During an interview on 3/13/16 at 1:07 pm,	F 353	correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob□s Creek□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Jacob□s Creek reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. On 3/18/2016 the Administrator and the Director of Nursing reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. On 3/18/2016 the Administrator and the Director of Nursing reviewed the staffing schedule through 6/7/16 to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. On 4/4/2016 the Administrator completed a contract with a staffing agency to assist with facility needs for nurse staffing on an as needed basis. On 4/4/2016 the Administrator and Director of nursing implemented a staffing coverage schedule to include certified staff to be utilized during off hours in cases of call offs and vacations. On 3/18/2016 the Administrator and	

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F 353	Continued From page 8 Family Member #2 indicated she came to the facility 6 days a week to make sure Resident #27 was fed once a day and got fluids. She indicated there was one aide assigned in the dining room to help feed all the residents. The residents sat with food covered until they could be fed. 2. During a continuous observation on 3/15/16 at 12:15 pm, Resident #62 and #67 were eating. Residents # 27, #37, #141, #169, #172 had no meal. Resident #8 and #32 had trays sitting in front of them with no one to feed them. A second meal cart arrived at 12:19 pm, Family Member #1 retrieved a tray and began to feed Resident # 37. Nurse #1 fed Resident # 32 and Aide # 3 arrived to feed Resident # 8. Residents # 134 and # #141 had covered trays and no one to feed them. During an interview on 3/15/16 at 1: 13 pm, Aide # 3 indicated there were two aides assigned to feed on the 1st shift during the week. The Aide added that there were more people that had to be fed, then staff assigned to feed them. She indicated usually they had more residents than this to feed. During interview on 3/15/16 at 1:14 pm, Aide #4 indicated the trays used to come out on one cart. No resident was fed until all the trays arrived. Residents who were able to feed themselves got their trays first. Trays were left covered until an aide was available to feed the resident. Sometimes a housekeeper fed a resident. During an interview on 3/15/16 at 4:16 pm, Aide #5 indicted she was scheduled alone in the 1st dining room on second shift. She indicated she had 6 residents she fed nightly. She indicated she fed 2 residents at a time, the other 4 residents waited. Some residents sat without food while other residents ate. If the Aide on the hall had no one to feed, they came into the dining room to help.	F 353	Director of Nursing were retrained by the Regional Vice President regarding processes for monitoring and ensuring sufficient staff to provide nursing care to all residents in accordance with resident care plans. Retraining included obtaining nurse agency contract and utilizing certified staff during off hours in cases of call offs and vacations. Audits will be conducted by Administrator, Director of Nursing, Quality Improvement Nurse and weekend Nurse Manager to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. The Administrator, Director of Nursing, Quality Improvement Nurse and weekend Nurse Manager will utilize the Staffing Audit daily to include nights and weekends for 4 weeks, weekly to include nights and weekends for 4 weeks, monthly to include nights and weekends for 12 weeks. Any identified issues will be addressed immediately. The QA Committee (Administrator, Director of Nursing, Quality Improvement Nurse, Staff Facilitator, MDS Nurse, Dietary Manager, Treatment Nurse, RN Supervisor, Social Worker, Rehab Manager) will review the audits weekly for 8 weeks and monthly for 12 weeks to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 9	F 353		

3. During a continuous observation on 3/17/16 at 12:10 pm, the meal cart arrived to the 1st dining room. Aide # 4 distributed trays to Residents #62, #101 and #169 began to eat. Resident #101 sat and stared at her food. The trays for Residents #8, #32, #134 and #141 were sat in front of them covered. The second cart arrived at 12:18 pm, Family Members #1 and #2 retrieved meal trays for Residents #27 and #37. Resident #172 received his tray. Aide #3 left the dining to retrieve a meal tray for Resident #132 from the 400 hall dining room. Aide #5 began to feed Resident #169. Aide # 4 was feeding Resident # 8. Residents #32, #134 and #141 sat with covered trays in front of them. Housekeeper # 1 arrived at 12:26 pm and attempted to feed Resident #32 unsuccessfully. During an interview at 12:32 pm, the housekeeper indicated he had been sent from the 400 hall and wasn ' t familiar with these residents. He fed people who were easy to feed. Housekeeper # 2 arrived at 12:36 pm, and attempted to feed resident #32 unsuccessfully. During interview Housekeeper #2 indicated she doesn ' t usually feed anyone in the first dining room. She was assigned to feed a resident in the back dining room. At 12:39 pm Aide #4 began to feed Resident # 141 and Aide #3 began to feed Resident #134. At 12:40 Resident # 101 continued to sit with her tray in front of her. She had eaten her bread. She hadn ' t attempted to eat with her utensils. Aide #5 had told resident #101 to eat and she picked up her fork and began to eat. Aide # 4 began to successfully feed resident #32 at 12:56pm.

During an interview on 3/17/16 at 5:54pm, the Director of Nursing indicated she expected assigned nursing staff and housekeeping staff to feed the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	03/17/2016

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