STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING _____ B. WING _____	C 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID # Z8TG11 for Intakes: NC00116168 and NC00116256.	F 000		
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 review, resident and staff interview, the facility failed to specify in their abuse policy that the Administrator would be notified immediately of all alleged, known or suspected incidences of abuse and failed to follow their abuse policy and procedures for reporting and thoroughly investigating an allegation from a resident of inappropriate sexual contact with a staff member for 1 of 1 residents. (Resident #117). The findings included: A policy titled "Abuse, Neglect and Exploit Policy" dated 04/10/2001 and signed as last reviewed by the Administrator in 2012 read in part: "Employees having knowledge or suspecting abuse, neglect or exploitation are directed to report this immediately to the Social Service Director (SSD) or in her absence to their supervisor or charge nurse. When an incident or suspected incident of abuse is reported, the	F 226	This Plan of Correction is being submitted pursuant to the applicable Federal and State regulation. Nothing contained herein shall be construed as an admission that the facility violated any Federal or State regulation or failed to follow any applicable standard of care. Resident #117 was discharged on April 14, 2016. No further corrective action can be taken. Reports of any allegation or suspicion of abuse, neglect and/or exploitation received during the last 30 days will be audited for proper reporting and thorough investigation. Any discrepancies identified will receive corrective action immediately or as soon as practicable. On April 14, 2016, nurse #3 was	5/11/16

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

Electronically Signed | 05/05/2016

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F 226	Continued From page 1 Administrator will appoint a representative to investigate the incident. The representative's investigation shall consist of: interviews with the resident's roommate, family members and visitors." Resident #117 was admitted to the facility on 02/26/16 with diagnoses including spinal cord injury, spina bifida, major depressive disorder, generalized anxiety disorder, panic disorder and personality disorder. An Admission Minimum Data Set (MDS) assessment dated 03/03/16 indicated resident was cognitively intact for daily decision making. The MDS indicated she had rejection of care for 1 to 3 days of observation period. On 04/11/16 at 11:40 AM Resident #117 requested to speak to a member of the survey team. Resident #117 had multiple complaints about her care at the facility and stated Nurse # 2 fondled her breasts while doing her admission nursing assessment on February 29, 2016, the day she was admitted (Resident was admitted 02/26/16). Resident #117 stated she told him she wasn't comfortable with what he was doing and asked him why he was doing that. Resident #117's speech was pressured and rapid during the conversation and she moved quickly from one area of concern to another. Her affect remained the same throughout the conversation and she didn't exhibit any emotional distress when talking about her breasts being fondled. When asked if any other staff member was present with the nurse, the resident stated she couldn't remember. When asked if she reported the incident, she stated she told two Nurse Aides (NA # 5 and NA #6) on the evening shift of 04/03/16. Review of the abuse investigations completed by	F 226	counseled by the Director of Nursing (DON) to report any suspected incident of abuse, neglect, or exploitation of a resident to the Administrator immediately. On May 9, 2016, the DON and/or Social Services Director (SSD) will inservice staff on the facility□s abuse, neglect and exploitation policy and procedures including immediate reporting to the Administrator and thorough investigation. The inservice will be videotaped for later viewing by staff unable to attend on May 9, 2016, and staff not attending on May 9, 2016, will receive a make-up inservice. On May 11, 2016, the State Ombudsman will inservice staff on the policy and procedures for reporting and investigating any suspected or alleged abuse, neglect, or exploitation of a resident. Staff will take a posttest to verify understanding of the subject matter. The Administrator and/or Personnel Manager will conduct an audit to determine that all staff have received education on the facility□s abuse, neglect and exploitation education at either the May 9, 2016, inservice, the May 11, 2016, inservice or both. Staff identified as not attending at least one of the inservices will not be allowed to work until they have completed a makeup inservice on the facility□s abuse, neglect and exploitation policy and procedures. The facility□s Abuse, Neglect, and Exploitation Policy and Procedures was updated and approved by the Administrator on May 3, 2016. The	

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F 226	Continued From page 2 the facility revealed the facility initiated an investigation of Resident #117's allegations on 04/04/16. There was no indication that the SSD, Administrator or Director of Nursing (DON) were made aware of the allegation until 04/04/16. Review of the facility's documentation did not indicate that Resident #117's roommate, any other residents, family members or visitors were interviewed, as the policy indicated would be done. An interview with NA # 5 on 04/12/16 at 2:48 PM revealed she ordinarily worked the 7:00 AM - 3:00 PM shift but was working 04/03/16 on the 3:00 PM - 11:00 PM shift. NA # 5 stated she was assisting NA # 6 with providing care to Resident # 117 on 04/03/16 when Resident # 117 reported that Nurse #2 fondled her breasts when he was doing her admission assessment. NA # 5 stated Resident # 117 often talked about other residents and staff in a sexual manner. NA # 5 stated Resident # 117 had made sexual overtures to male and female staff so all care was provided by 2 staff members. NA # 5 stated she asked Resident # 117 if she was scared and the resident laughed and said she thought Nurse # 2 was 'hot'. When asked if she reported the allegations made by Resident # 117, NA # 5 stated she didn't report the allegations but her co-worker NA # 6 reported it to Nurse # 3. An interview with NA # 6 on 04/13/16 at 3:40 PM revealed she regularly worked the 3:00 PM - 11:00 PM shift and was frequently assigned to provide care for Resident # 117. NA # 6 stated Resident # 117 often talked about sexual activity, desires and fantasies when staff were providing care. NA # 6 stated the first time Resident # 117 said anything to her about Nurse # 2 was on	F 226	revised policy and procedures for abuse, neglect and exploitation will be in a manual maintained at each nurses station. Newly hired employees will receive training on the facility s abuse, neglect and exploitation policy and procedures including reporting time frames and need for a thorough investigation during orientation at the time of hire and annually thereafter. Allegations and/or suspicions of abuse, neglect and/or exploitation will be immediately reported to the Administrator. The Administrator will be responsible to assign a staff member or members to investigate any allegations or suspicions of abuse, neglect and/or exploitation. A thorough investigation, including interviews of appropriate persons, will be completed within 5 working days. The Administrator will monitor the progress and review the outcome of the investigation including directing any reporting and corrective action necessary. The Director of Social Services will review any report of abuse, neglect, and/or exploitation of a resident to monitor that the facilities policy and procedures for abuse, neglect, and exploitation are being followed; the SSD will review the reports for a minimum of 4 weeks or until substantial compliance has been achieved and maintained as determined by the Quality Assurance (QA) Committee. Any areas of concern will be	

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F 226	Continued From page 3 04/03/16 about 9:00 PM when she and NA # 5 were getting the resident ready for bed. NA # 6 stated the resident reported that Nurse #2 fondled her breasts when he was doing her admission assessment. NA # 6 stated that Resident # 117 had not previously made any allegations against staff and had not made any allegations against staff since that night. NA # 6 stated she reported the allegation to Nurse # 3, who was the charge nurse on 04/03/16. NA # 6 stated Nurse # 3 instructed her to leave a note on the DON's door. NA # 6 stated she didn't report the allegation to anyone else. An interview with NA # 7 on 04/13/16 at 4:04 PM revealed she was regularly assigned to provide care for Resident # 117. NA # 7 stated she was present with Nurse # 2 when he did the admission nursing assessment for Resident # 117. NA # 7 reported that she and NA # 8 were moving the resident and her clothing so Nurse # 2 could see her skin and document her tattoos and any skin breakdown or bruises. NA # 7 stated she didn't recall Nurse # 2 touching Resident # 117 at any time during the assessment. An interview on 04/13/16 at 5:36 PM with Nurse # 3 revealed she had received training on abuse and neglect during orientation and during inservices in the past year. When asked what the facility policy was for reporting allegations of abuse, she stated she was supposed to notify the DON right away. When asked about the allegation made by Resident # 117 against Nurse # 2, Nurse # 3 stated she was first made aware of the allegation on 04/03/16 on the 3:00 PM - 11:00 PM shift. When asked what action she took at that time, Nurse # 3 stated she instructed NA # 6 to leave a note for the DON. When asked why	F 226	brought to the attention of the Administrator for corrective action as soon as practicable. The Administrator will monitor for compliance. The audits by the Social Services Director will be reviewed by the QA Committee and any trends and/or patterns identified will receive corrective action.	

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she didn't call the DON, Nurse # 3 stated she didn't put any credence in Resident # 117's allegation.

An interview on 04/14/16 at 1:52 PM with the SSD revealed she was first made aware of Resident # 117's allegation against Nurse # 2 on 04/04/16 about 10:00 AM. When asked about the investigation, the SSD stated she interviewed Resident # 117 and staff who were assigned to provide care for her. The SSD stated Resident # 117 didn't have a roommate at the time of the alleged incident. The SSD stated she didn't interview any other residents because she didn't think any other residents would have any knowledge about the alleged incident. The SSD stated she wasn't aware that the facility's Abuse Policy indicated other residents should be interviewed.

An interview on 04/14/16 at 2:16 PM with the DON revealed she was first made aware of Resident # 117's allegation against Nurse # 2 on 04/04/16 when Nurse # 2 called her. The DON stated she would have expected Nurse #3 to call her as soon as the allegation was made.

An interview on 04/14/16 at 2:28 PM with the Administrator about his expectation for when staff were to report allegations or suspicions of abuse revealed he expected staff to report any allegations or knowledge of abuse immediately. He stated he expected the charge nurse or supervisor to notify either himself, the DON or the SSD right away. When asked if would have expected Nurse # 3 to call on Sunday evening, 04/03/16, he stated he would have expected Nurse # 3 to call him regardless of the time or day the allegation was made.

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F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews the facility failed to provide good grooming, fingernail care and shaving for 5 of 7 sampled residents reviewed for activities of daily living care to dependent residents (Resident #s 30, 12, 2, 81, and 100). The findings included: 1. Resident #30 was admitted to the facility on 11/21/08 with diagnoses which included intellectual difficulties, neuralgia, visual impairment, and dementia without behaviors. The most recent quarterly Minimum Data Set (MDS) dated 01/14/16 revealed the resident was cognitively impaired for daily decision making skills and required extensive assistance with all activities of daily living (ADL) including eating, dressing, personal hygiene and total assistance with bathing. No behaviors of rejection of care were coded during the quarterly MDS look back period. The current care plan last reviewed 04/11/16 revealed Resident #30 required limited to extensive assistance with ADL due to diagnosis of dementia, and visual impairment. The goal was for Resident #30 to be neat and clean. The	F 312	On April 14, 2016, resident #30's nails were trimmed and cleaned and the chipped nail polish was removed by a Certified Nursing Assistant (CNA). Chin hairs were removed and clothes were turned the correct way on Resident #30 by a CNA. Resident #30's face and hands were cleansed by a CNA during care on April 14, 2016. Resident #30's will continue to receive assistance with nail care, shaving, facial cleansing and dressing from nursing staff on a daily or more frequent basis as needed. On April 14, 2016, resident #12's nails were trimmed and cleaned by a CNA. The resident's face and hands were cleansed by a CNA and the CNA assisted Resident # 12 to put on clean clothing on April 14, 2016. Resident # 12 will continue to receive assistance with nail care and facial cleansing by nursing staff on a daily or more frequent basis as needed. On April 13, 2016, resident #2's shower was given by a CNA. Resident # 2 was shaved and nails were trimmed and cleaned by a CNA on April 13, 2016.	5/9/16

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F 312	Continued From page 6 interventions documented limited to extensive assist with dressing, limited to total assist with eating, showers and personal hygiene. Further interventions were to provide Resident #30 with assistance needed to be neat, clean and free of odors and dressed appropriately for the season. A review of the facility's weekly shower schedule indicated Resident #30 was scheduled for showers on Monday and Thursday during the day shift. Review of the Physician Progress notes dated 03/08/16 revealed Resident #30 had dementia, visual impairment and mental retardation and was able to ambulate in facility but had noted decrease in her ADL functional abilities. The Physician assessment and plan indicated Resident #30's dementia required significant support, management and frequent monitoring. The note further revealed Resident #30 demonstrated slow progressive cognitive and functional decline. On 04/11/16 at 12:27 PM Resident #30 was observed ambulating on her own into the activity room on the secured dementia unit wearing a red long sleeved shirt inside out and backwards with her name on the collar showing, purple pants, sneakers; her face around the mouth had what appeared to be milk or something white in color at the corners; all five finger nails on both hands were noted with ragged edges, tan substance under the nails, bits of old pink colored nail polish on all fingers, and her chin was observed with about a dozen grey chin hairs, about 1/2 to 1 inch long. On 04/11/16 at 2:32 PM Resident #30 was	F 312	Resident # 2 will continue to receive assistance with nail care, shaving and facial cleansing by nursing staff on a daily or more frequent basis as needed. On April 13, 2016, resident #81 was shaved by a CNA. Resident #81's nails were trimmed and cleaned by a CNA. Resident #81 will continue to receive assistance with shaving, nail care and facial cleansing by nursing staff on a daily or more frequent basis as needed. On April 13, 2016, resident #100 was shaved and nails were trimmed and cleaned by a CNA. Resident #100 will continue to receive assistance with shaving and nail care by nursing staff on a daily or more frequent basis as needed. On April 14, 2016, the Director of Nursing counseled nursing assistant #1 and #2 on proper grooming, fingernail care, and shaving of dependent residents. Nursing staff conducted rounds of all of other facility residents on April 14, 2016, to identify residents in need of shaving, nail care, facial cleansing and/or other hygiene measures; any discrepancies identified during the rounds received corrective action by a CNA. On May 9, 2016, the Director of Nursing will inservice all nursing assistants on proper grooming, fingernail care, and shaving of will take a posttest to verify understanding of the subject. The inservice will be videotaped and a makeup	

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F 312	Continued From page 7 observed with her shirt turned the right way but the corners of her mouth remained with the white substance, her nails remained unchanged and the chin hairs remained as observed earlier. On 04/12/16 at 9:41 AM Resident #30 was observed ambulating the halls, wearing a clean pink sweat suit, visiting with staff and other residents. Resident #30 was observed to remain with untrimmed, unclean finger nails with old chipped polish, and the 1/2 to 1 inch long hairs on her chin. On 04/12/16 at 4:25 PM Resident #30 was observed to have the long grey chin hairs and also a brown substance staining all around her upper and lower lips, her finger nails remained the same as previous observations with brown substance under the nails, untrimmed and rough edges. The Activity Director was observed to come into the room and offered snacks and drinks of little cakes and lemonade. Resident #30 took the offered snack cake with her hands and started to eat it. On 04/13/16 at 8:43 AM Resident #30 was observed in the small dining room on secured unit having breakfast. Resident #30's fingernails remained untrimmed, unclean and with old nail polish. Resident #30 was observed with her breakfast in front of her on a tray eating with a spoon in her right hand and her left hand and fingers were in her oatmeal. No staff were observed in the dining room supervising the residents' breakfast meal. During an observation on 04/13/16 at 9:15 AM Resident #30 came up to the surveyor and placed her hands on the surveyor's hand and wrist. Both	F 312	inservice provided to nursing staff not attending on May 9, 2016. Newly hired nursing staff will receive training on proper grooming including nail care and shaving during the orientation period. The facility's policy and procedure on assistance with activities of daily living (ADLs) will be updated to provide more specific guidance and direction to nursing staff. Copies will be maintained in the policies and procedures manuals at the nurses' stations. Licensed nurses will be responsible during their shift of duty to monitor that residents under their direct supervision are receiving timely and appropriate assistance with ADLs. Any discrepancies identified will receive immediate corrective action as soon as practicable. A random audit of a minimum of 15 residents will be conducted by the DON, ADON, or Nsg. Supervisor of resident appearance and hygiene including nail care, shaving, clothing appropriateness, and overall cleanliness weekly at a minimum of 4 weeks or longer until substantial compliance is achieved and maintained as approved by the QA Committee. Any discrepancies identified during the audit will receive corrective action as soon as practicable. The Director of Nursing will monitor for compliance. The QA Committee will	

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F 312	Continued From page 8 of the resident's hands felt sticky with some substance. On 04/13/16 at 11:04 AM Nursing Assistant (NA) #1, who provided care for Resident #30, was interviewed. NA #1 stated Resident #30 required limited to extensive assistance with all ADL including showers, grooming, eating, dressing and personal hygiene. NA #1 further stated Resident #30 received her showers every Monday and Thursday and that showers included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #1 explained that nail care and shaving were also provided daily and as needed. NA #1 further explained Resident #30 was normally very cooperative but sometimes required multiple attempts to complete nail care. NA #1 revealed she had worked the prior Monday and Tuesday and did not provide nail care or shaving for Resident #30. On 04/13/16 at 09:15 AM NA #2, who provided care for Resident #30, was interviewed. NA #2 stated Resident #30 required limited to extensive assistance with all ADL including showers, grooming, eating, dressing and personal hygiene. NA #2 further stated Resident #30 received her showers on Mondays and Thursdays and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #2 explained that nail care and shaving were also provided daily and as needed. NA #2 further explained Resident #30 was normally very cooperative but sometimes required multiple attempts to complete nail care. NA #2 revealed she had worked the prior Monday, Tuesday, and Wednesday. NA #2 revealed she did not provide	F 312	review the audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with oversight from the Director of Nursing as necessary when trends and/or patterns are identified.	

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nail care or shaving for Resident #30. NA #2 further revealed Resident #30 had spaghetti for lunch and she, NA #2 did not wash Resident #30's face or hands after lunch and does not make it a normal routine to wash residents' face or hands after meals.

On 04/13/16 at 1:40 PM the Director of Nursing (DON) was interviewed. The DON stated the residents' care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NAs were responsible for nail care and keeping residents clean and neat, shaved daily, keeping their nails trimmed and cleaned, faces washed and dressed appropriately.

On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily and have their nails trimmed and cleaned, faces washed and dressed appropriately.

2. Resident #12 was admitted to the facility on 12/21/14 with diagnoses which included paralysis, lack of coordination, dementia and debility. The most recent annual Minimum Data Set (MDS) dated 01/25/16 revealed the resident was severely cognitively impaired for daily decision

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making skills and required extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing.

The current care plan last reviewed on 02/04/16 revealed Resident #12 required extensive to total assistance with ADL due to diagnosis of dementia. The goal recorded was for Resident #12 to be clean, neat and free of odors and dressed appropriately. The interventions included up in her Geri chair daily and required extensive to total assistance with all ADL except will feed herself occasionally.

A review of the facility's weekly shower schedule indicated Resident #12 was scheduled for showers on Monday and Thursday on the 3-11 PM shift.

During an observation on 04/11/16 at 2:34 PM Resident #12 was up in the Geri chair, hair was combed and all her fingernails on both hands including the thumb were approximately 1/2 inch + long with jagged and pointed edges and a brownish tan substance under all the nails.

On 04/12/16 at 9:19 AM Resident #12 was observed in dining area in the Geri chair dressed in a light blue sweat shirt. Her fingernails on both hands including the thumb were observed approximately 1/2 inch+ long with jagged and pointed edges and a brownish tan substance under all the nails.

On 04/12/16 at 4:40 PM Resident #12 was observed in her room in the Geri chair, wearing a light blue sweat shirt that had reddish brown stains dripped on the front of it and reddish brown

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stains were also observed around her top and bottom lips and stained around the cuticles of her first, second and third fingers of her right hand. Resident #12's fingernails remained unchanged, untrimmed with brown substance under the nails and with the additional reddish brown stains around the cuticles.

On 04/13/16 at 8:51 AM Resident #12 was observed in her room in the Geri chair with her breakfast tray in front of her having breakfast. Her fingernails were observed unchanged on both hands including the thumb and were approximately 1/2 inch + long with jagged and pointed edges and a brownish tan substance under all the nails. Resident #12 was observed with a spoon in her right hand dipping into her oatmeal with the first three fingers and thumb of her left hand in her oatmeal. She then placed these fingers with oatmeal on them into her mouth.

On 04/13/16 at 11:04 AM Nursing Assistant (NA) #1, who provided care for Resident #12, was interviewed. NA #1 stated Resident #12 required extensive assistance with all ADL including showers, grooming, dressing and personal hygiene. NA #1 further stated Resident #12 received her showers on Mondays and Thursdays during evening shift and that showers included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #1 explained that nail care was provided daily and as needed. NA #1 further explained Resident #12 sometimes required multiple attempts to complete finger nail care. NA #1 revealed she had worked the prior Monday and Tuesday and did not provide finger nail care for Resident #12.

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On 04/13/16 at 09:15 AM NA #2, who provided care for Resident #12, was interviewed. NA #2 stated Resident #12 required extensive assistance with all ADL including showers, grooming and personal hygiene. NA #2 further stated Resident #12 received her showers on Mondays and Thursdays during evenings and that showers included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #2 explained that nail care was provided daily and as needed. NA #2 further explained Resident #12 sometimes required multiple attempts to complete nail care. NA #2 revealed she had worked Monday, Tuesday, Wednesday and Thursday. NA #2 revealed she did not provide nail care for Resident #12. NA #2 further revealed Resident #12 had spaghetti for lunch and she did not wash her face or hands or change her shirt after lunch and does not make it a normal routine to wash residents' face or hands after meals. NA #2 verified that Resident #12 feeds herself but only recently started to eat with her fingers.

On 04/13/16 at 1:40 PM the Director of Nursing (DON) was interviewed. The DON stated the residents' care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and

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neat, shaved daily, keeping their nails trimmed and cleaned, faces washed and dressed appropriately.

On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily and have their nails trimmed and cleaned, faces washed and dressed appropriately.

3. Resident # 2 was admitted to the facility on 01/22/08 with diagnoses which included dementia, history of stroke with right sided paralysis, and gait instability. The most recent quarterly Minimum Data Set (MDS) dated 02/18/16 revealed the resident was cognitively impaired for daily decision making skills and required extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing. No behaviors of rejection of care were coded during the quarterly MDS look back period.

The current care plan last reviewed on 02/18/16 revealed Resident #2 required extensive assistance with ADL due to diagnosis of dementia and paralysis related to stroke history. The ADL care plan goal was for the resident to experience cleanliness, be neat and free of body odor. The ADL care plan included approaches to provide extensive assistance for Resident #2 daily with toileting, personal hygiene, shave daily, and provide showers as scheduled on shower days.

A review of the facility's weekly shower schedule indicated Resident #2 was scheduled for showers on Wednesday during the day shift.

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During an observation on 04/11/16 at 2:38 PM Resident #2 was in bed watching TV. Resident #2 was observed with 1/2 inch long chin hairs. The fingernails of all fingers on both hands were observed very long approximately 1/2 to 3/4 inches long with jagged edges. All the fingernails were observed with a brown and tan substance under the nails.

On 04/12/16 at 9:34 AM Resident #2 was observed in bed with ½ inch long chin hairs. Resident #2's fingernails were observed the same as the previous observation on 04/11/16. The fingernails of all the fingers on both hands were observed very long approximately 1/2 to 3/4 inches long with jagged edges. All the fingernails were observed with a brown and tan substance under the nails.

During an observation on 04/12/16 at 4:23 PM Resident #2 was in his wheel chair with 1/2 inch long chin hairs. Resident #2's fingernails were observed the same as the previous observations on 04/11/16 and 04/12/16. The fingernails of all the fingers on both hands were observed very long approximately 1/2 to 3/4 inches long with jagged edges. All the fingernails were observed with a brown and tan substance under the nails.

During an observation on 04/13/16 at 8:43 AM Resident #2 was in his wheel chair with 1/2 inch long chin hairs. Resident #2's fingernails were observed the same as the previous observation. The fingernails of all the fingers on both of the resident's hands were observed very long approximately 1/2 to 3/4 inches long with jagged edges. All the fingernails were observed with a brown and tan substance under the nails.

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F 312	Continued From page 15 On 04/13/16 at 11:04 AM Nursing Assistant (NA) #1, who provided care for Resident #2, was interviewed. NA #1 stated Resident #2 preferred to be in his room, fed himself, and required extensive assistance with all ADL including showers, grooming, shaving daily, and personal hygiene. NA #1 further stated Resident #2 received his showers on Wednesdays and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #1 explained that nail care and shaving were also provided daily and as needed. NA #1 further explained Resident #2 sometimes required multiple attempts to complete shaving and nail care. NA #1 revealed she had worked the prior Monday and Tuesday and did not provide nail care or shaving for Resident #2. On 04/13/16 at 09:15 AM NA #2, who provided care for Resident #2, was interviewed. NA #2 stated Resident #2 preferred to be in his room, fed himself, and required extensive assistance with all ADL including showers, grooming, daily shaving and personal hygiene. NA #2 further stated Resident #2 received his showers on Wednesdays and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #2 explained that nail care and shaving were also provided daily and as needed. NA #2 further explained Resident #2 sometimes required multiple attempts to complete shaving and nail care. NA #2 revealed she had worked the prior Monday, Tuesday, Wednesday and Thursday. NA #2 further revealed she did not provide nail care or shaving for Resident #2 until the afternoon of 04/13/16	F 312		

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On 04/13/16 at 1:40 PM the Director of Nursing (DON) was interviewed. The DON stated the residents' care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and neat.

On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator further stated that the staff normally come to get him or the maintenance director to assist in encouraging Resident #2 to have his showers, shaving and nail care completed. The Administrator revealed it has been at least a month since they came to request his assistance. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed appropriately.

4. Resident #81 was admitted to the facility on 05/14/15 with diagnoses which included mental disorder, conduct disorder, and dementia without behaviors. The most recent quarterly Minimum Data Set (MDS) dated 02/17/16 revealed Resident #81 was severely cognitively impaired for daily decision making skills and required

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extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing. No behaviors or rejection of care were coded during the quarterly MDS look back period.

The current care plan last reviewed 02/25/16 revealed Resident #81 required extensive assistance with ADL due to diagnosis of dementia, depression and mental disorder. The goals recorded included Resident #81 will be clean, neat, free of odors and dressed appropriately. The interventions included Resident #81 required extensive assistance with personal hygiene including shaving and bathing.

A review of the facility's weekly shower schedule indicated Resident #81 was scheduled for showers on Monday and Thursday on the day shift.

During an observation on 04/11/16 at 2:50 PM Resident #81 was observed to have a heavy growth of beard stubble.

During an observation on 04/12/16 at 9:25 AM Resident #81 was again observed to have a heavy growth of beard stubble that was longer than on 04/11/16.

During an observation on 04/12/16 at 4:31 PM Resident #81 was observed in the activity room to have a heavy growth of beard stubble.

During an observation on 04/13/16 at 8:43 AM Resident #81 was observed in the dining room with a heavy growth of beard stubble that was longer than the previous day.

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On 04/13/16 at 11:04 AM Nursing Assistant (NA) #1, who provided care to Resident #81, was interviewed. NA #1 stated Resident #81 required extensive assistance with all ADL including showers, grooming and personal hygiene. NA #1 further stated Resident #81 received his showers on Mondays and Thursdays during the day shift and that showers included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #1 explained that nail care and shaving were also provided daily and as needed. NA #1 further explained Resident #81 was normally cooperative with his grooming and showers. NA #1 revealed she had worked the previous Monday and Tuesday and did not provide shaving for Resident #81.

On 04/13/16 at 09:15 AM NA #2, who provided care to Resident #81, was interviewed. NA #2 stated Resident #81 required extensive assistance with all ADL including showers, grooming and personal hygiene. NA #2 further stated Resident #81 received his showers on Mondays and Thursdays during the day shift and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #2 explained that shaving was also provided daily and as needed. NA #2 further explained Resident #81 was normally cooperative with his grooming and showers. NA #2 revealed she had worked the prior Monday, Tuesday, and Wednesday of this week. NA #2 further revealed she did not provide shaving for Resident #81 until Wednesday afternoon.

On 04/13/16 at 1:40 PM the Director of Nursing (DON) was interviewed. The DON stated the

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residents care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for shaving and keeping residents clean and neat.

On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed appropriately.

5. Resident #100 was admitted to the facility on 01/13/16 and readmitted on 02/24/16 with diagnoses which included Alzheimer's dementia, depression and anxiety. The most recent Admission Minimum Data Set (MDS) dated 01/20/16 revealed the resident was severely cognitively impaired for daily decision making skills and required extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing. No behaviors of rejection of care were coded on the MDS during the look back period.

The current care plan last reviewed 01/28/16 revealed Resident #100 required extensive to total assistance with ADL due to diagnosis of dementia and cognitive impairment. The goal recorded was for Resident #100 to be clean,

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neat, fee of odors and dressed appropriately. The interventions included Resident #100 required total to extensive assistance with all ADL including personal hygiene, shaving and bathing.

A review of the facility's weekly shower schedule indicated Resident #100 was scheduled for showers on Tuesdays during the day shift.

On 04/11/16 at 12:50 PM Resident #100 was observed with a heavy growth of beard stubble.

On 04/12/16 at 9:41 AM Resident #100 was observed in the TV room with a heavy growth of beard stubble that was a little longer than the previous afternoon of 04/11/16.

On 04/12/16 at 4:31 PM Resident #100 was observed in the activity room and remained unshaved with a heavy growth of beard stubble.

On 04/13/16 at 8:43 AM Resident #100 was observed sitting in the TV room and remained unshaved with the heavy growth of beard stubble that appeared a little thicker than the previous day of 04/12/16.

On 04/13/16 at 11:04 AM Nursing Assistant (NA) #1, who provided care for Resident #100, was interviewed. NA #1 stated Resident #100 required extensive assistance with all ADL including showers, grooming and personal hygiene. NA #1 further stated Resident #100 received his showers on Tuesday during the day shift and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #1 explained that nail care and shaving were also provided daily and as needed. NA #1 further

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explained Resident #100 was normally cooperative with his grooming and showers. NA #1 revealed she had worked Monday and Tuesday and did not provide shaving for Resident #100.

On 04/13/16 at 09:15 AM NA #2, who provided care for Resident #100, was interviewed. NA #2 stated Resident #100 required extensive assistance with all ADL including showers, grooming and personal hygiene. NA #2 further stated Resident #100 received his showers on Tuesday during the day shift and that showers and grooming included hair washing, shaving and nail care and resident's needs were found in the care plan book at the nurses' station. NA #2 explained that nail care and shaving were also provided daily and as needed. NA #2 further explained Resident #100 was normally cooperative with his grooming and showers. NA #2 revealed she had worked Monday, Tuesday, Wednesday and Thursday. NA #2 further revealed she did not provide nail care or shaving for Resident #100 until Wednesday afternoon (04/13/16).

On 04/13/16 at 1:40 PM the Director of Nursing (DON) was interviewed. The DON stated the residents' care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible

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F 312	Continued From page 22 for shaving and keeping residents clean and neat. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed appropriately.	F 312		
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 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and date food items in the walk in refrigerator, date thawing juices when removed from the freezer, securely seal, label and date frozen food items to prevent freezer burn, date foods individually prepared in the walk-in refrigerator and the dry storage area, and label and date foods in the nourishment room refrigerator for resident consumption. The findings included: 1. On 04/11/16 at 10:31 AM the walk-in	F 371	On April 11, 2016, the 2 open and out of date boxes of juice were discarded by a dietary staff member. On April 11, 2016, the 3 open boxes of juice not labeled and out of date were discarded by a dietary staff member. On April 11, 2016, the unsealed bag of frosted biscuits not labeled or dated was discarded by a dietary staff member. On April 11, 2016, the unsealed bag of	5/9/16

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F 371	Continued From page 23 refrigerator was observed to contain: A. 2 open boxes, 1 each of apple and cranberry juice, partially thawed, not labeled and dated when removed from the freezer with the manufacturer's label of a use by date of 04/08/16 B. 3 open boxes, 1 each of apple, cranberry and prune juice, partially thawed, not labeled and dated when removed from the freezer with the manufacturer's label of a use by date of 04/05/16. 2. On 04/11/16 at 10:31 AM the walk-in freezer was observed to contain: A. One unsealed bag of frosted frozen country biscuits in an open box which was not labeled or dated when it was opened. B. One unsealed bag of frozen mixed vegetables in an open box which was not labeled or dated when it was opened. 3. On 04/11/16 at 10:31 AM the walk-in outside freezer truck was observed to contain: A. 2 unsealed bags of frosted frozen cookie dough in opened boxes which were not labeled or dated when they were opened. B. 1 unsealed bag of frosted frozen yellow squash in an opened box which was not labeled or dated when it was open. 4. On 04/11/16 at 10:31 AM the dry storage area shelf was observed to contain one tray containing 13 individually plastic wrapped cereal bowls which were not labeled or dated as to when they were prepared. 5. On 04/11/16 at 10:31 AM one of two nurse's station nourishment room refrigerators were	F 371	frozen vegetables was discarded by a dietary staff member. On April 11, 2016, the 2 unsealed bags of frozen cookie dough in open boxes not labeled or dated were discarded by a dietary staff member. On April 11, 2016, the unsealed bag of frozen yellow squash in an open box not labeled or dated was discarded by a dietary staff member. On April 11, 2016, the 13 individually unlabeled and undated plastic wrapped cereal bowls were labeled and dated by the dietary aide that prepared them earlier that morning before serving. On April 11, 2016, the brown paper bag with ice cream which was not dated when opened was discarded by a dietary staff member. On April 11, 2016, the fast food paper wrapped burrito not labeled or dated was discarded by a dietary staff member. On April 11, 2016, the plastic grocery bag with a Tupperware container lunch that was not labeled or dated was discarded by a dietary staff member. The Dietary Manager and/or designee will inspect food and beverage storage areas daily. Any discrepancies with labeling and/or dating will receive corrective action immediately or as soon as practicable.	

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	345193	A. BUILDING _____ B. WING _____	C 04/14/2016

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F 371	Continued From page 24 observed to contain: A. One brown paper bag with a pint container of ice cream with a residents name on it which was not dated. B. One fast food paper wrapped burrito which was not labeled or dated. C. One plastic grocery bag with a Tupperware container lunch which was not labeled or dated. On 04/11/16 at 11:48 AM Kitchen Aide (KA) #1 was interviewed. KA #1 verified all the above observations at the time they were observed. KA #1 stated all opened bags and boxes in the freezer should have been labeled and dated when they were opened; all boxes of juices in the refrigerator thawing should have been dated when they were removed from the freezer, and any individually prepared and wrapped bowls of foods should have dated labels on them. On 04/11/16 at 11:05 AM the Director of Nursing (DON) was interviewed. The DON stated it was her expectation that any food items in the nourishment room refrigerators should have been labeled and dated when they were placed in the refrigerator. On 04/11/16 at 11:12 AM the Registered Dietician (RD) was interviewed. The RD stated it was her expectation that all opened bags and boxes in the freezer should have been labeled and dated when they were opened, all boxes of juices in the refrigerator thawing should have been dated when they were removed from the freezer, and any individually prepared and wrapped bowls of foods should have dated labels on them. On 04/11/16 at 2:09 PM the Dietary Manager	F 371	On May 9, 2016, the registered dietician will inservice all dietary and nursing staff on the importance of checking products expiration dates, proper labeling, dating, and readiness of service. The nursing and dietary staff will take a post-test to verify understanding of the subject. A make-up inservice will be provided for staff not attending the May 9, 2016, inservice. Reminder signs about proper labeling and dating of food and beverage items will be posted in the dietary department and nourishment rooms. The dietary manager will conduct random audits of the walk-in refrigerator, walk-in freezer, dry storage area, and nourishment rooms for unsealed, unlabeled, or undated products weekly x 4 weeks at a minimum or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any deficient practice will be corrected immediately and/or as soon as practicable. The freezer truck is no longer in use or on the property. The Administrator will monitor for compliance. The QA Committee will review the audits conducted by the Dietary Manager to monitor for any trends and/or patterns and institute corrective action as necessary.	

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F 371	Continued From page 25 (DM) was interviewed. The DM stated it was his expectation that all opened bags and boxes in the freezer should have been labeled and dated when they were opened, all boxes of juices in the refrigerator thawing should have been dated when they were removed from the freezer, and any individually prepared and wrapped bowls of foods should have dated labels on them. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated it was his expectation that all opened bags and boxes in the freezer should have been labeled and dated when they were opened, all boxes of juices in the refrigerator thawing should have been dated when they were removed from the freezer, and any individually prepared and wrapped bowls of foods should have dated labels on them.	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to close the garbage dumpster and contain trash for 1 of 3 dumpsters located outside the facility. The findings included: On 04/11/16 at 11:05 AM one trash dumpster of three was observed not closed, trash bags were observed piled above the opening hanging from the sides, and the lid was hanging from the back	F 372	No specific residents were identified nor could be identified. On April 11, 2016, the trash dumpster lid was closed by a staff member and all trash was contained inside the dumpsters. On April 29, 2016, the Environmental Service Director inserviced staff on the importance of keeping the dumpster lids closed and containing the trash inside the	4/29/16

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F 372	Continued From page 26 side. On 04/11/16 at 11:05 AM Kitchen Aide (KA) #1 was interviewed. KA #1 verified the trash dumpster was open, trash was piled to the top above the opening, hanging from the sides, and the lid was hanging from the back side. KA #1 further verified that all trash should be contained in the dumpster and the lid closed to prevent overflow onto the ground and animals getting into it. On 04/11/16 at 11:05 AM the Environmental Services Director (ESD) was interviewed. The ESD verified the trash dumpster was open, trash was piled to the top above the opening, and hanging from the sides, and the lid was hanging from the back side. The ESD then pushed the trash bags in and closed it. The ESD further verified that all trash should be contained in the dumpster and the lid closed to prevent overflow onto the ground and animals getting into it. On 04/11/16 at 2:09 PM the Dietary Manager (DM) was interviewed. The DM stated it was his expectation that all departments disposing of trash in the outside dumpster should ensure that the trash was secure and the dumpster was closed. The DM further stated all trash should be contained in the dumpster and the lid closed to prevent overflow onto the ground and animals getting into it. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated it was his expectation that all departments disposing of trash in the outside dumpster should ensure that the trash was secure and the dumpster was closed. The Administrator further stated all trash	F 372	closed dumpster. Staff will take a posttest to verify understanding of the subject matter. The inservice was videotaped and a make-up inservice will be provided for staff not attending the April 29, 2016 inservice. Signs reminding staff to keep the dumpster lids closed will be posted in the dumpster area. Newly hired employees will be inserviced on proper disposal of refuse and keeping the dumpster lid closed by Environmental Services or designee at the time of hire during orientation. Random weekly audits will be conducted by the dietary manager of the dumpster to monitor for trash being contained inside the dumpsters and the lids closed for a minimum of 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. The Environmental Service Director will monitor for completion of the audits and report any deficient practice to the administrator. The Administrator will monitor compliance. The QA Committee will review the audits of the dumpster to monitor for any trends or patterns and will institute corrective action as necessary.	

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F 372	Continued From page 27 should be contained in the dumpster and the lid closed to prevent overflow onto the ground and animals getting into it.	F 372		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		5/9/16

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F 441	Continued From page 28 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to perform hand hygiene after each resident contact while delivering meal trays on 1 of 4 halls (B hall). The findings include: During observations on 04/11/16 at 12:20 PM of lunch delivery on the B Hall, NA #4 was observed removing the tray for Resident # 35 from the cart. NA #4 entered the resident's room and called her name. She then rubbed Resident #35 across her upper chest and told her to wake up. NA #4 removed the cover from the tray then took the bread out of the wrapper with her bare hands and spread butter on the bread. NA #4 then left the room of Resident #35 without washing or sanitizing her hands, returned to the meal cart and removed the tray for Resident #27. NA #4 took the tray in Resident #27's room, removed the bread from the bag with her bare hands and held the bread in her hand while spreading butter on it. Without washing or sanitizing her hands, NA #4 returned to the meal cart and removed the tray for Resident #54 and delivered the tray to his room. NA #4 removed the bread from the bag with her bare hands and held the bread in her hand while spreading butter on it. Without washing or sanitizing her hands, NA #4 started back toward the tray cart to deliver more trays. On 04/11/16 at 12:30 PM an interview with NA #4	F 441	Staff will appropriately sanitize and/or wash their hands with soap and water before and after direct resident contact and when delivering meal trays to Resident #35. On April 11, 2016, the Director of Nursing counseled the CNA #4 on proper hand hygiene and sanitary practices after during meal tray delivery. Also, the CNA #4 was counseled by the DON that hands must be sanitized or washed with soap and water after any direct contact with a resident. On April 15, 2016, DON and Nsg. Supervisor observed that nursing staff appropriately sanitized and/or washed their hands with soap and water before and after direct resident contact and when delivering meal trays to other residents. On May 9, 2016, the Director of Nursing will give an inservice on the requirement that staff must wash hands after each direct resident contact including during meal delivery. A make-up inservice will be provided to nursing staff not attending the May 9, 2016 inservice. Newly hired nursing employees will receive training on hand hygiene including	

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F 441	Continued From page 29 about what she was taught regarding hand hygiene and sanitary practices for meal delivery revealed she was taught to wash her hands if she had direct contact with a resident. NA #4 stated she didn't know why she didn't wash her hands after touching Resident #35. Additional observation of NA #4 immediately following the interview revealed NA #4 returned to the cart and removed a meal tray without washing or sanitizing her hands. On 04/04/16 at 2:44 PM an interview with the Administrator about his expectation for what staff should do when delivering trays if they have direct contact with a resident revealed he expected staff to wash their hands before continuing to deliver trays.	F 441	after direct resident contact including during meal tray deliver at the time of hire during the orientation period. Nursing staff will be provided with individual bottles of hand sanitizer to promote appropriate hand hygiene during their shift of duty and inclusive of meal service. The DON, ADON, or Nsg. Supervisor will conduct weekly audits on a minimum of 15 meal tray deliveries to monitor for appropriate hand hygiene. Weekly audits will be conducted at a minimum of 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Discrepancies identified during the audit will receive corrective action including performance of hand hygiene as directed by a licensed nurse. The Director of Nursing will monitor for compliance. The QA Committee will review audit finding to monitor for any trends or patterns and institute corrective action as necessary.	