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	345258	A. BUILDING _____ B. WING _____	C 05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to allow one of one resident a choice in bathing type and frequency (Resident #149). The findings included: Resident #149 was admitted to the facility on 3/12/15 with diagnosis of history of motor vehicle accident, anxiety and depression. The Quarterly Minimum Data Set (MDS) dated 3/17/16 indicated Resident #149 was cognitively intact. Resident #149 required limited assistance for transfer, dressing and extensive assist for bathing with assistance of one staff. The care plan dated 4/16/16 included a problem with activities of daily living. Approaches for this problem included staff to provide set up for bathing. Interview with Resident #149 on 5/16/16 at 8:50 AM revealed she did not choose how many times a week she took a bath. Continued interview revealed she did not choose the type of bath that	F 242	1. Resident #149 has a choice in bathing type and frequency and it has been care planned and placed on Kardex. Resident will have shower preferences reviewed during resident rounds and care plan meeting to ensure choices are being honored. In 2567 it identifies resident #149 bathing preference honored. 2. The Interdisciplinary Team (IDT), Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records, interviewed residents and/or their responsible parties for bathing type and frequency preferences 6/6/2016-6/9/2016. Future residents will be asked on admission to the facility for their choice of bathing type and frequency by the Admissions Director as well as during resident rounds and care plan meetings. 3. Certified Nurse Assistants, Licensed Nurses were in-serviced by the Director of Clinical Services and/or Nursing	6/27/16

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

Electronically Signed | 06/11/2016

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F 242	Continued From page 1 was provided by the staff. Resident #149 stated she " had not had a shower in a month, they (staff) had cut back on them. " The type of bath provided was a pan bath at bedside. Review of the nurse aide ' s (NA) documentation for the date range of 4/16/16 to 5/17/16 revealed Resident #149 had not received a shower. During this timeframe there were five bed baths documented for Resident #149. Review of a "Kardex" that was not dated, for Resident #149 revealed the area of bathing was not completed for a type of bath, days bath to be provided or how much assistance would be required by staff. Interview with NA #1 on 05/18/2016 at 9:19 AM revealed she had provided care for this resident. NA#1 explained the residents in the second bed (next to the window) were assigned to the 3-11 shift. She worked on the 7-3 shift and would provide showers for residents in the first bed on her assignment. During interview NA#1 was asked how she would know which residents would receive a shower on her assignment. NA#1 explained " they (nursing administration) were working on a shower schedule. " She continued to explain a shower aide had been assigned to showers, but had quit. She did her own schedule for the residents in the first bed. " It (shower schedule) had been up in the air for about the past week. " NA#1 explained the Kardex was used by the aides for information regarding provision of care for residents. Interview with NA#2 on 05/18/2016 at 3:36:46 PM indicated she did not work last evening. NA#2 explained the list/schedule for showers was on	F 242	Supervisor on providing showers/bed baths per resident preference of days and frequency 6/13/16-6/17/16. Nursing staff was reeducated on honoring resident choices. Administrator to review Resident Council Meeting minutes for unresolved concerns related to bathing choices. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 15 residents receiving showers and/or bed baths for honoring preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks,2 times a week for 1 month, and 1 time a week for 1 month and quarterly thereafter. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement (QAPI) Committee on 6/21/16. The results of these QI Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 242	Continued From page 2	F 242		

the shower door.

Review of the list in the shower room indicated Resident #149 was scheduled to receive showers on Tuesday and Thursday, on the 3-11 shift.

Interview with the Nurse #1 on 05/18/2016 at 3:51 PM revealed she worked on 3-11 and was responsible for Resident #149 ' s care. During the interview Nurse #1 indicated she was not aware the resident had not had a shower in a month. She explained the aides do the showers, the 2nd bed is a 2nd shift shower. Nurse #1 indicated she had not been informed of any refusals or that Resident #149 had not had a shower per her choice. There were shower sheets in the shower room, but the sheets had not been turned in to the nurse. She gives her meds, and the aides are to inform her if a shower was not given. Nurse #1 explained a male aide had the resident last evening when her shower was due. Resident #149 does not allow male aides to give a shower. NA #3 (female NA) came on duty at 7 pm and would have given her a shower.

Interview with NA#3 on 05/19/2016 at 6:13 AM indicated she came in extra on 3-11 at 7 pm. NA#3 explained she was not told to do any showers last evening and had not given any showers. NA#3 further explained showers are not given on 11-7 shift.

Interview with Resident #149 on 05/19/2016 at 10:06 AM revealed she did not get her shower on Tuesday evening. She further indicated someone had talked to her about getting showers on Tuesday and Thursday, but she had not received a shower yet. She continued with "I hope I get one today."

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F 242	Continued From page 3 NA#5 was interviewed on 05/19/2016 at 10:55 AM. This interview revealed the showers were not provided due to not having time and there was not enough staff. Interview with NA#4 on 05/19/2016 at 10:56 AM revealed she was assigned to Resident #149 on Tuesday, 05/17/16 on the 3-11 shift. NA#4 indicated she had not provided a shower to Resident #149 on that date. NA#4 did not give a reason as to why the shower was not provided. Observations of Resident #149 on 05/19/16 at 10:59 AM revealed the NA was getting a basin and setting the resident up for a pan bath at her bedside. Interview with the Director of Nursing on 05/19/2016 at 2:24 PM indicated her expectation would be for the staff to honor the residents ' choice for a shower, and provide the shower. The facility had a shower team. One aide was on light duty and the second aide had quit. The nursing staff had received in-services regarding provision of showers in the past month. Further interview revealed she was not aware the shower had not been provided. The Director of Nursing explained the nurses were to do the " skin sweeps " on the residents ' shower day. That was a check for the nurses to know a shower was given.	F 242		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents	F 244		6/27/16

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F 244	Continued From page 4 and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, resident council minutes, and record review the facility failed to respond to Resident Council ' s ongoing grievances of not receiving showers. The findings included: Resident council meeting minutes dated 2/1/16 were reviewed. The section titled " old business " revealed showers were some better if there was a shower team that day. The section identified for " follow up " was left blank. Resident council meeting minutes dated 3/7/16 were reviewed. The section titled " old business " indicated February 2016 minutes were read and all problems and concerns were distributed to proper department managers. The section titled " new business " revealed residents complained about shower team not being in place and showers were not being given regularly. The section titled " resident complaints/concerns/suggestions " revealed shower team put back in place and more NAs needed on the floor. The section identified for " follow up " was left blank. Resident council meeting minutes dated 4/4/16 were reviewed. The section titled " old business " indicated March minutes were read and all concerns and problems were distributed to proper department managers. The section titled " Resident complaints/concerns/suggestions " indicated the residents complained over showers, missing showers, and not being offered showers. The section identified for " follow up " was left	F 244	1. Resident #25 was interviewed 6/6/16 on bathing type and frequency by the Nursing Supervisor and Resident #25 receives showers per choice. Resident #16 was interviewed 6/6/16 on bathing type and frequency by the Nursing Supervisor and Resident #16 receives showers per choice. Resident #28 was interviewed on 6/6/16 on bathing type and frequency by the Nursing Supervisor and Resident #28 receives showers per choice. Resident # 22 received a shower was interviewed 6/6/16 on bathing type and frequency by the Nursing Supervisor and Resident #22 receives showers per choice. 2. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records)interviewed residents and/or their responsible parties for bathing type and frequency preferences and to allow the opportunity for the resident to voice any further concerns and preferences. The Executive Director reviewed the last 30 days of grievances for any unresolved concerns 6/13/16-6/17/16. 3.The Activities Director and Social Service Director were in serviced by the	

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F 244	Continued From page 5 bank. Is the line highlighted in yellow, did the resident complained in the new business or the old business, it is not clear Resident council meeting minutes dated 5/2/16 were reviewed. The section titled " old business " revealed April 2016 minutes were reviewed and all problems and concerns were distributed to proper department managers. The section titled " resident complains/concerns/suggestions " revealed no concerns at this time. Resident #25 was admitted to the facility on 4/8/10 with diagnoses of lack of coordination, history of falling, difficulty in walking and chronic pain syndrome. The most recent Minimum Data Set (MDS) assessment dated 3/17/16 revealed Resident #25 required supervision in the area of bathing. The MDS further revealed Resident #25 was cognitively intact as evidenced by The Brief Interview of Mental Status (BIMS) score of 15. Interview with Resident #25 was conducted on 5/18/16 at 11:29am. Resident #25 indicated showers were an issue that continued to come up as a grievance at resident council meetings. She further indicated the issue was reoccurring and no resolution had occurred in regards to the complaint. She indicated that on her shower day staff would indicate it wasn ' t their shift to provide showers. Resident #25 further indicated staff would tell the residents that they don ' t have time. Resident #25 stated she had not had a shower in a week and was providing herself bird baths. Resident #25 revealed the facility had not communicated how they were going to fix the concern regarding showers. Resident #16 was admitted to the facility on 5/8/15 with diagnoses of difficulty walking, anxiety disorder, pain in joint, and peripheral vascular disease. The most recent MDS assessment	F 244	Regional Vice President of Operations on conducting Resident Council and resolving grievances/Grievance Policy and Procedures on 6/8/16. The Interdisciplinary Team, Certified Nurse Assistants, Licensed Nurses, Dietary and Housekeeping were in serviced 6/13/16-6/17/16 on taking resident/family grievances and timely resolutions by the Director of Clinical Services and/or Nursing Supervisor. The Activities Director and/or Social Services Director will have weekly Resident Council meetings to allow residents to voice concerns 1 time a week for 4 weeks, every other week for 2 months and monthly thereafter. Grievances are brought to Stand up Meeting for follow up. The Executive Director will perform Quality Improvement monitoring of grievances resolutions and 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 8 weeks and/quarterly thereafter. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not	

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F 244	Continued From page 6 dated 4/18/16 indicated Resident # 16 required total assistance in the area of bathing. The MDS assessment further indicated Resident #16 was cognitively intact as evidenced by a BIMs score of 15. Interview with Resident # 16 on 5/18/16 at 11:50am revealed she had not received a shower on Monday. She identified her shower days as Monday and Thursdays. She revealed the resident council had made the complaint about the missing showers several times in resident council meetings. Resident #16 indicated that usually on the day of her shower the NAs would communicate they were not scheduled to do showers for that day or the person who was giving showers had already left. She identified missing showers as an ongoing issue at the facility. Interview with NA #10 on 5/19/16 at 11:16am revealed residents had a bath schedule that the staff followed. She revealed the facility had a shower team that got taken away. After the shower team was removed the NAs were responsible for showering the residents on their assignment. NA #10 revealed she had not had any residents on her assignment to complain but was aware of residents that did complain about not receiving a shower on 2nd shift. The 2nd shift staff were to complete bed B showers. In the instance the 2nd shift staff didn ' t get to the 2nd bed (bed B), the 1st shift staff had to complete showers for residents in the 2nd bed as well. The NA indicated if she couldn ' t get to all of her assignments before her shift ended the residents would have to wait until the next day. She revealed she made her residents aware when she was unable to provide them with a shower	F 244	limited to the Executive Director, Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 244	Continued From page 7	F 244		

and notified the nurse. She indicated the 2nd shift staff should pick the residents up for showers but they did not and the resident would have to wait until 1st shift returned.

Resident #28 was admitted to the facility on 3/22/10 with diagnoses of obesity, type 2 diabetes, rheumatoid arthritis, and major depressive disorder. The most recent MDS assessment dated 3/15/16 revealed Resident #28 required supervision in the area of bathing. The MDS further revealed Resident #28 was cognitively intact as evidenced by a BIMS score of 15.
Interview with Resident # 28 on 5/19/16 at 12:13pm revealed she attended Resident council meetings regularly. She indicated the showers were still an issue that came up at meetings. Resident #28 indicted she had not gotten a shower for the week as of yet. She revealed her shower days were Monday and Thursday in the afternoon. This morning she was told there was no one on the afternoon shift that was able to give her one. She revealed that happened a lot. She indicated the facility was aware that residents had complained about not receiving enough showers. She revealed residents complained that they had gone up to 2 weeks without receiving a bath or a shower. She revealed she provided herself a bed bath in her room.

Interview with the Activity Coordinator on 5/19/16 at 12:30pm revealed she held the resident council meetings for the resident council and recorded the minutes. She stated that the resident council members had complained about not getting baths or showers on days they were scheduled. She indicated the residents felt the showers were getting better during the March 2016 resident

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council meeting. She revealed that the residents were complaining that they were getting only one shower a week. The residents communicated they were getting the first shower of the week but typically missed the second shower or bath during the week.

Resident #22 was admitted to the facility on 1/11/16 with diagnoses that included Parkinson ' s, lack of coordination, abnormalities of gait and mobility, and cellulitis of right upper limb. The most recent MDS assessment dated 4/15/16 indicated Resident #22 required supervision in the area of bathing. The MDS further revealed Resident #22 was cognitively intact as evidenced by a BIMS score of 14.

Interview with Resident # 22 on 5/19/16 at 3:25pm revealed her shower days were Tuesday and Friday. She revealed the resident council had continued to complain in regards to not receiving showers and not being offered showers. She said occasionally on her shower days the NAs would communicate if they gave her a shower there wouldn ' t be any NAs on the hall.

Interview with the Director of Nursing (DON) on 5/19/16 at 2:38pm revealed the facility attempted to resolve grievances within 24 to 48 hours. She revealed in January 2016 the NAs wanted to try to complete their own showers and to remove the shower team. The NAs voted and the facility implemented showers without the use of a shower team. She indicated the facility went without the shower team for 4 to 6 weeks which resulted in more complaints. She revealed that at the end of March 2016 the facility re-implemented the shower team and things got better. In April 2016 the main shower team staff went light duty

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F 244	Continued From page 9 and one resigned. The facility had challenges ensuring there were enough NAs on the hall to take care of the residents and answer call lights. She indicated the facility was currently hiring additional staff so that a shower team could be re-implemented	F 244		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272		6/27/16

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F 272	Continued From page 10 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code sections A1500, A1510 and A1550 of the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination of 1 of 34 residents reviewed as Level II PASRR residents (Resident #55). The findings included: Resident # 55 was admitted to the facility on 11/17/2014 with diagnoses of anxiety and major depression. A review of Resident # 55 ' s admission MDS section A1500 dated 11/24/2014 revealed the MDS was not coded as having a Level II PASRR. A review of Resident # 55 ' s annual MDS dated 11/15/2015 revealed that sections A1500, A1510 and A1550 were not coded as having a Level II PASRR. There was no documentation in the medical record of Resident # 55 to indicate a Level II PASRR was done. The review of this screening is used to determine care needs, appropriate care setting to meet those needs and a set of recommendations for services to help develop an individual ' s plan of care. On 05/17/2016 at 1:12 PM an interview was conducted with the Social Worker and the Admission Coordinator and the medical record for Resident #55 was reviewed. Neither the Social	F 272	1. Previously submitted comprehensive assessments for resident #55 were modified by the Minimum Data Assessment Nurse 6/10/16 to reflect resident residents level 2 PASARR. 2. An audit of current residents with level 2 PASARR's was completed on 6/9/16 by the Minimum Data Assessment Nurse for accurate coding. Follow up based on findings. 3. The Regional Case Mix/Minimum Data Assessment Coordinator in serviced the Minimum Data Assessment Nurse on 6/10/16 coding the MDS accurately. The Executive Director will conduct Quality Improvement Monitoring of accuracy of the MDS for residents with a level 2 PASARR 2 times a week for 8 weeks, 1 time a week for 12 weeks and quarterly thereafter. 4. The Executive Director introduced the Plan of Correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of these audits will be reported to the Quality	

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F 272	Continued From page 11 Worker nor the Admissions Coordinator were able to locate documentation in the medical record of Resident # 55 indicating a Level II PASRR number. The Admission Coordinator stated that Resident # 55 had been admitted from the hospital with a Level II PASRR and produced a facility admission notice dated 11/17/2014 which had been provided to all department managers and indicated that Resident # 55 was admitted with a Level II PASRR status. The Social Worker acknowledged that both the Admission Coordinator and Social Worker maintained a record of Level II PASRR residents which included the expiration date or need to obtain an updated Level II PASRR confirmation status. The Admission Coordinator revealed that she would provide the MDS Coordinator a list of residents with a Level II PASRR each time there was a status change in resident PASRR status. The Admission Coordinator revealed that she included PASRR status on all of the facility ' s admission notices and a copy was also provided to the MDS Coordinator. The Admission Coordinator stated that Resident # 55 had a permanent Level II PASRR. The Admission Coordinator indicated that she was responsible for updating resident ' s Level II PASRR status. An interview on 05/17/2016 at 1:52 PM with the MDS Coordinator revealed that the Level II PASRR status of each resident was indicated on each facility admission notice received from the Admission Coordinator and that the Admission Coordinator also provided the MDS Coordinator with an updated list of residents with a Level II PASRR status. A review of the most recent Level II PASRR list that the MDS Coordinator had in her possession did include Resident #55 as having a Level II PASRR. The MDS Coordinator also stated that it was her responsibility to code	F 272	Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and/ quarterly thereafter. The Quality Assurance Performance Improvement committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 272	Continued From page 12 section A1500, A1510 and A1550 on the comprehensive MDS for any resident with a Level II PASRR. The MDS Coordinator reviewed all of the comprehensive MDSs for Resident #55 and revealed that Resident #55 had never been coded with a Level II PASRR at A1500. The MDS Coordinator stated that she would confirm the PASRR status of all residents on the list with the Admissions Coordinator prior to the completion of MDS section A1500 to make certain that it was coded correctly.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		6/27/16

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F 280	Continued From page 13 Based on observations, staff interview and record review the facility failed to update one of 3 care plans for residents to reflect a change in a resident ' s eating ability (Resident #13). The findings included: Resident #13 was admitted to the facility on 11/30/13 with diagnoses of dementia and Parkinson ' s disease. A quarterly Minimum Data Set (MDS), dated 3/17/16, indicated Resident #13 had short and long term memory impairment and required extensive assistance for eating. The care plan dated 4/14/16, included a problem with activities of daily living. This problem included approaches for eating with use of a divided plate with weighted spoon and regular spoon, allowing the resident time to eat, opening and setting up items, assisting with meals and attending restorative dining. Observations on 05/18/2016 at 8:42 AM revealed Resident #13 was fed by staff, had a regular plate and utensils. The resident did not attend restorative dining during the meal. Review of the tray ticket did not include a divided plate or weighted spoon to be provided at meals. Interview with the MDS nurse on 05/18/2016 at 11:26 AM revealed Resident #13 had a divided plate when she was able to feed herself. Continued interview indicated Resident #13 had declined and required to be fed. The MDS nurse explained she was not sure when Resident #13 became totally dependent on staff for eating. Interview with the Director of Nursing (DON) on 05/18/2016 at 12:17 PM revealed the order for the adaptive equipment had been discontinued on 6/8/2015. Further explanation provided by the	F 280	1. Resident #13 has had care plans reviewed and updated as needed to reflect individualized care . 2. Current residents care plans were review and/or updated to reflect the residents' current eating ability by the Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Dietician, Minimum Data Assessment Nurse 6/10/16-6/24/16. 3. The Regional Director of Clinical Services in serviced the Interdisciplinary Team (Director of Clinical Services, Social Services Director, Activities, Dietary, Minimum Data Assessment Nurse) on updating residents care plan with any change in residents eating ability on 6/9/16. The Director of Clinical Services and/or Nursing Supervisor will perform quality improvement monitoring of resident care plans for revision when a residents eating ability changes 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1time a week for 8 weeks and/ quarterly thereafter. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement committee on 6/21/16. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director,	

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F 280	Continued From page 14 DON included Resident #13 had been evaluated by Occupational Therapy on 5/2015 with the recommendation staff or family was to feed the resident. The order should have been discontinued on the monthly orders and had been missed. The MDS nurse should have updated the care plan to reflect current orders and treatment.	F 280	Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record reviews the facility failed to provide showers for two of ten residents that required extensive assistance by staff for bathing (Resident #149 and #36). The findings included: 1. Resident #149 was admitted to the facility on 3/12/15 with diagnosis of history of motor vehicle accident, anxiety and depression. The Quarterly Minimum Data Set (MDS) dated 3/17/16 indicated Resident #149 was cognitively intact and had a Brief Interview for Mental Status (BIMS) of 15. Resident #149 required limited assistance for transfer, dressing and extensive assist for bathing with	F 312	1. Resident #149 was interviewed 6/6/16 on choice of bathing type and frequency by the Nurse Supervisor and resident receives per choice. Resident #36 no longer resides at the facility. 2. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) interviewed residents and/or their responsible parties for bathing type and frequency preferences 06/06/16-6/09/16. Care Plans and Kardexes updated to reflect choices. ADL sheets were reviewed for residents receiving baths as scheduled, follow up with bathing conducted based on findings.	6/27/16

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F 312	Continued From page 15 assistance of one staff. The care plan dated 4/16/16 included a problem with activities of daily living. Approaches for this problem included staff to provide set up for bathing. Interview with the MDS nurse on 05/19/2016 at 10:24 AM revealed Resident #149 would require extensive assistance by one staff for bathing. Interview with Resident #149 on 5/16/16 at 8:50 AM revealed she " had not had a shower in a month, they (staff) had cut back on them. " The type of bath provided was a pan bath at bedside. Review of the nurse aide's (NA) documentation for the date range of 4/16/16 to 5/17/16 revealed Resident #149 had not received a shower. During this timeframe there were five bed baths documented for Resident #149. Review of a "Kardex" that was not dated, for Resident #149 revealed the area of bathing was not completed for a type of bath, days bath to be provided or how much assistance would be required by staff. Interview with NA #1 on 05/18/2016 at 9:19 AM revealed she had provided care for this resident. NA#1 explained the residents in the second bed (next to the window) were assigned to the 3-11 shift. She worked on the 7-3 shift and would provide showers for residents in the first bed on her assignment. During interview NA#1 was asked how she would know which residents would receive a shower on her assignment. NA#1 explained " they (nursing administration) were working on a shower schedule. " She	F 312	3.Certified Nurse Assistants, Licensed Nurses were in serviced by the Director of Clinical Services and/or Nursing Supervisor on providing showers/bed baths per resident preference of days and frequency 6/13/16-6/17/16. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 15 residents receiving showers and/or bed baths for honoring of preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and /quarterly thereafter. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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continued to explain a shower aide had been assigned to showers, but had quit. She did her own schedule for the residents in the first bed. " It (shower schedule) had been up in the air for about the past week. " NA#1 explained the Kardex was used by the aides for information regarding provision of care for residents.

Interview with NA#2 on 05/18/2016 at 3:36:46 PM indicated she did not work last evening. NA#2 explained the list/schedule for showers was on the shower door.

Review of the list in the shower room indicated Resident #149 was scheduled to receive showers on Tuesday and Thursday, on the 3-11 shift.

Interview with the Nurse #1 on 05/18/2016 at 3:51 PM revealed she worked on 3-11 and was responsible for Resident #149 ' s care. During the interview Nurse #1 indicated she was not aware the resident had not had a shower in a month. She explained the aides do the showers, the 2nd bed is a 2nd shift shower. Nurse #1 indicated she had not been informed of any refusals or that Resident #149 had not had showers as scheduled. There were shower sheets in the shower room, but the sheets had not been turned in to the nurse. She gives her meds, and the aides are to inform her if a shower was not given. Nurse #1 explained a male aide had the resident last evening when her shower was due. Resident #149 does not allow male aides to give a shower. NA #3 (female NA) came on duty at 7 pm and would have given her a shower.

Interview with NA#3 on 05/19/2016 at 6:13 AM indicated she came in extra on 3-11 at 7 pm. NA#3 explained she was not told to do any

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showers last evening and had not given any showers. NA#3 further explained showers are not given on 11-7 shift.

Interview with Resident #149 on 05/19/2016 at 10:06 AM revealed she did not get her shower on Tuesday evening. She further indicated someone had talked to her about getting showers on Tuesday and Thursday, but she had not received a shower yet. She continued with "I hope I get one today."

NA#5 was interviewed on 05/19/2016 at 10:55 AM. This interview revealed the showers were not provided due to not having time and there was not enough staff.

Interview with NA#4 on 05/19/2016 at10:56 AM she was assigned to Resident #149 on Tuesday, 05/17/16 on the 3-11 shift. NA#4 indicated she had not provided a shower to Resident #149 on that date. NA#4 did not give a reason as to why the sower was not provided.

Observations of Resident #149 on 05/19/16 at 10:59 AM revealed the NA was getting a basin and setting the resident up for a pan bath at her bedside.

Interview with the Director of Nursing on 05/19/2016 at 2:24 PM indicated her expectation would be for the staff to provide the showers. The facility had a shower team. One aide was on light duty and the second aide had quit. The nursing staff had received in-services regarding provision of showers in the past month. Further interview revealed she was not aware the showers had not been provided. The Director of Nursing explained the nurses were to do the "

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skin sweeps " on the residents ' shower day. That was a check for the nurses to know a shower was given.

2. Resident #36 was admitted to facility on 2/22/16 with diagnoses of congestive heart failure and pneumonia.

The admission Minimum Data Set (MDS) dated 2/29/16 indicated Resident #36 had mild impairment with long term memory and no impairment with short term memory. The MDS assessed the resident as requiring extensive assistance with personal hygiene and bathing.

The care plan dated 4/1/16 indicated a problem with activities of daily living (ADLs) due to a self -care deficit, limited mobility and disease process. For bathing, the care plan gave approaches for staff to assist the resident with ADL's as needed, resident had varied participation of limited, extensive to total assist for ADLs.

An attempt to interview Resident #36 on 5/17/2016 at 1:00 pm revealed he was not able to answer questions appropriately, was not oriented to place or time. A family member was present during the interview and explained Resident #36 was more confused than when he was first admitted. The family member indicated a shampoo had not been provided for the resident and she attempted to remove crusty areas from his scalp when she visited.

Interview with the MDS nurse on 05/17/2016 at 4:06 PM revealed a total lift was used for transfers. Resident #36 had a spell of illness of pneumonia according to the MDS completed 3/29/16. The MDS nurse explained Resident

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#36 had become a " little confused and agitated. " She was not aware of any refusals in care.

Interview on 05/18/2016 at 9:04 AM with Nurse Aide (NA) #6 revealed Resident #36 had been provided a bed bath for several weeks due to his refusing to get out of bed. NA #6 explained she provided a bed bath and washed his hair with periwash. NA #6 explained she used a wet washcloth and sprayed periwash on the washcloth and rubbed his hair to provide a shampoo. This NA did not know if there was a type of dry shampoo that could be used instead of what was used for incontinence care.

Interview with Nurse #3 on 05/18/2016 at 1:29 PM revealed she was not aware Resident #36 had refusals of showers and that he had not had a shower in the past month. She explained he would refuse to get up at times. Nurse #3 was not aware the aide was using periwash to wash his hair. The nurse stated she would investigate this further.

Interview with NA#7 on 05/19/2016 at 9:51 AM revealed she works part time, and had not worked with the resident on his shower day. The schedule was posted on the back of the door in the shower room. If a shower was done, it would be documented in the Kiosk by the aide.

Review of the shower schedule posted in the shower room, indicated Resident #36 should have showers on Tuesdays and Fridays. Review of the daily shower sheets for March revealed Resident #36 ' s last shower was on 3/16/16 and refused a shower on 3/30/16.

Review of the NA ' s documentation for the

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F 312	Continued From page 20 timeframe from 4/15/16 to 5/15/16 indicated Resident #36 had not received a shower and had 11 bed baths. Interview with the Director of Nursing (DON) on 05/19/2016 at 2:24 PM revealed dry shampoo that would be used for washing a resident's hair if a bed bath was given was available in the supply room. The DON did not know why the NA used periwash. Her expectations would have been for the resident to have a shower and his hair washed with dry shampoo.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to supervise 1 of 3 Residents (Resident #15) who was evaluated as an unsafe smoker. The Findings included: The facilities policy and procedures for smoking was reviewed. The policy stated the center was an established non -smoking facility, unless allowed by state and local regulations. Residents are notified on admission that the facility is a non-smoking facility or allowed to smoke only in designated areas, and that they must adhere to	F 323	1. Resident #15 no longer resides at the facility. 2. Current residents that smoke were reassessed for safe smoking, completed 6/8/16- 6/10/16 by the Social Service Director and Care Plans and Kardexes updated based on findings. 3. The Director of Clinical Services in serviced Certified Nursing Assistants , Licensed Nurses and Social Services on	6/27/16

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F 323	Continued From page 21 the smoking policy. Each resident will be assessed on admission and quarterly to determine if the resident is a safe smoker. The procedures included 3) the facility shall establish and post designated resident smoking times, 5) smoking materials will be retained, and stored by the nursing staff for all residents who have been granted smoking privileges, 6) no fire igniting materials (matches/lighters) will be in the residents possession at any time and is strictly prohibited, 7) designated staff will supervise residents during assigned smoking times. The posted smoking schedule stated in order to ensure resident safety, THS has implemented scheduled smoking times. Please know that in order to ensure safety, all smoking materials must be returned to locked cart at end of each smoking session. The posted times were 9:30am to 9:45am, 11:30am to 11:45am, 1:30pm to 1:45pm, 3:30pm to 3:45pm, 5:30pm to 5:45pm and 7:30pm to 7:45pm. Resident #15 was admitted to the facility on 4/29/16 with a diagnosis that included glaucoma, difficulty walking, ataxia, congestive heart failure, and muscle weakness. The most recent Minimum Data Set (MDS) assessment dated 5/6/16 revealed Resident #15 had no impairments of the upper or lower extremities. The MDS further indicated Resident #15 was cognitively intact as evidenced by a brief interview for mental status (BIMS) of 14. Review of Resident #15 ' s smoking assessment dated 4/29/16 revealed he was not a safe smoker. The assessment indicated Resident #15 was alert and oriented, able to hold cigarettes safely but allowed ashes to fall on himself/clothing. Resident #15 was able to light cigarettes properly and Resident needed to be monitored.	F 323	supervising residents who smoke 6/13/16-6/17/16. The Executive Director and/or Director of Clinical Services will perform Quality Improvement monitoring of residents being supervised while smoking 5 times a week for 4 weeks, 3 times a week for 8 weeks,2 times a week for 8 weeks and 1 time a week for 4 weeks and quarterly thereafter. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Service Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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Resident #15 care plan dated 5/5/16 revealed a " focus " of safety for smoking. The goal stated Resident #15 would comply with facility smoking protocol ' s The interventions included keep smoking materials locked at nurses station, instruct resident on smoking protocol, safe smoking assessment on admission and quarterly, monitor for continued safe smoking, redirect resident during non-smoking times and provide smoking apron (as resident would wear).

Observation on 5/15/16 at 10:14am revealed Resident #15 to be outside smoking without supervision. Resident was observed 10:26am to pull a lighter out of his front pocket and light other resident ' s cigarettes. It was not observed where resident #15 retrieved the cigarette from. The sign on the exit door to the smoking area was unlocked and had posted smoking schedule for residents. At 10:33am the Resident was observed to be escorted in the facility by Nurse #2 who monitored the residents outside until they finished his cigarette.

Interview with Resident #15 on 5/16/16 at 8:00am revealed the facility did not allow him to have cigarettes or a lighter. He indicated the nurses kept his smoking supplies. During the interview Resident #15 was unware of the residents names he was smoking with the morning of 5/15/16. He further indicated he did not have a lighter or light anyone ' s cigarettes.
Interview with Nurse #1 on 5/16/16 at 2:23pm revealed the residents smoked at designated times throughout the day. Staff take the residents out to smoke at designated times that are posted. The resident cigarettes are kept at the 400 hall nursing station. Resident in the building are not supposed to have smoking materials on their

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person. She revealed she had not observed any residents outside smoking independently. Interview the Dietary Manager on 5/16/16 at 2:42pm revealed he assisted with resident smoke breaks when the facility needed help supervising the residents. He indicated the smoking material was kept at the nursing station on the 400 hall. The crate was kept by the filing cabinet. The cigarettes were supposed to be handed out, lit and the resident should be monitored to ensure they don ' t get ashes on themselves. He further revealed he was not kept abreast of who was assessed as a safe smoker and who is not considered a safe smoker.

Interview with Nurse #2 on 5/16/16 at 2:50pm revealed Residents were supposed to be supervised on the morning of 5/15/16. She was unaware of why Resident #15 was not supervised or how be obtained smoking materials. Nurse #2 revealed the smoking materials were kept in an unlocked basket at the nursing station. She state she had inquired about where the resident got the smoking paraphernalia from. Nurse #2 indicated she educated Resident #15 on the smoking times and rules. She further revealed she notified the social worker that the resident #15 was outside smoking.

Interview with social worker on 5/16/16 at 3:00p revealed she completed the smoking assessment on residents upon admission, quarterly or in the instance there was a change in the resident ' s condition. She indicated residents were to go out with nursing staff or a family member. She revealed she was notified by nurse #2 that Resident #15 was outside smoking without supervision. She indicated that she believed Resident #15 went out with family and came in

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F 323	Continued From page 24 with cigarettes that Resident #15 did not turn over to us to keep. Following a consented search of residents no cigarettes or lighters were found. Interview with the DON on 5/19/16 at 2:38pm revealed the facility had posted signs as to when the designated smoking times were. The DON revealed the problem was that sometimes the residents wanted to be out there when and it wasn ' t a designated smoking time. A staff is to be outside supervising the Resident #15 when he is smoking. She was unware of how Resident #15 came in possession of the smoking material.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and physician interview the facility failed to monitor and identify one of one resident (Resident #146) who had significant weight loss of 14% in a quarter. The findings included: Resident #146 was admitted to the facility on	F 325	1. Resident #146 was assessed by the physician on 5/19/2016, with new orders received. Resident is an assisted diner and receives required assistance with eating. Resident #146 care plan was reviewed/updated on 6/8/2016,by the Director of Clinical services and/or	6/27/16

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F 325	Continued From page 25 12/2/14 with a diagnosis that included hypertension, depression, right hip pain, deep vein thrombosis (DVT), coronary heart disease, acute right sided middle cerebral artery CVA, secondary stroke prophylaxis and dysphagia. The most recent minimum data set (MDS) assessment dated 4/28/16 indicated Resident #146 required supervision to include encouragement/cueing and set up only for dining. The MDS further indicated Resident #146 required extensive assistance to complete activities of daily living. Section K of the MDS assessment revealed Resident #146 weight was 133lbs. Resident #146 was cognitively impaired as evidenced by a brief interview for mental status (BIMs) score of 10. Review of Resident #146 care plan revealed a goal that stated Resident #146 would receive appropriate staff support with bed mobility, transfers, and eating. The approaches included; allow resident time to eat, no straws, clear cup with 2 handles at meals, encourage resident to eat, keep needed items in easy reach at right side, monitor and report decline in abilities, open and set up items and resident required supervision of 1 staff person for eating at times. Review of Resident #146 physician progress note dated 1/7/16 indicated Resident #146 had recent history of cerebrovascular accident (CVA) with dysphagia and s/p percutaneous endoscopic gastrostomy (PEG tube is passed into a the stomach or abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) placement. Patient is eating well and PEG had been unused. The assessment indicated a diagnosis of dysphagia with a plan to consult Gastroenterologist (GI) for PEG removal since patient was on Eliquis (an anticoagulant medication).	F 325	Nursing Supervisor. 2. Current residents were reweighed by Certified Nurse Assistant, on 5/19/2016-5/20/2016, to reestablish a baseline weight. A review of residents currently receiving dietary supplements were completed on 6/8/2016-6/15/16 by the Director of Clinical Services and/or Nursing Supervisor and follow up conducted based on review findings. The Interdisciplinary Team will meet weekly to discuss residents with significant weight loss and update residents' dietary interventions as indicated. The Registered Dietician will meet with the Director of Clinical Services and/or Nursing Supervisor after each visit to review residents with significant weight loss. 3.The Dietary Manager was in-serviced on proper identification of significant weight loss, providing supplements as ordered and following meal tickets by the District Manager of Nutritional Services on 6/8/2016. Dietary Aides and Cooks were in-serviced 6/13/2016-6/17/2016 by the Dietary Manager on providing supplements on resident's trays when ordered. The Regional Director of Clinical Services in-serviced the Interdisciplinary Team (Director of Clinical Services, Social Services, Activities, Dietary Manager and Minimum Data Assessment Nurse) on weight meeting procedure, obtaining weights and intervening with identified significant weight loss on 6/9/2016.	

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F 325	Continued From page 26 Review of Resident #146 ' s physician progress note dated 1/11/16 indicated the resident had a history of CVA. Resident #146 Labs showed low albumin of 2.7. The assessment stated malnutrition with a plan to add prostat 30cc 3 times a daily (tid). Review of physician order dated 1/19/16 revealed speech therapy recommendations for Resident #146 to receive puree foods and thin liquids with no straws. Review of Resident #146 Kardex (nursing assistant care guide) updated 2/23/16 revealed Resident #146 had a regular diet with a frozen treat with meals. The care guide also indicated the resident was dependent on staff for feeding. Review of weight taken 3/16 (no day of the week provided) indicated Resident #146 weight was 133lbs. Review of Resident #146 consultation report from the Gastroenterologist dated 3/7/16 revealed a diagnosis of dysphagia due to acute CVA and a resolved PEG tube. The findings included PEG tube removed in office. Physician progress note dated 3/8/16 revealed Resident #146 had a history of dysphagia and had been taking food well by mouth. The note continued with Resident #146 was sent to GI and her PEG was removed without problems. The assessment stated dysphagia resolved with a plan to monitor intake. Review of Resident #146 ' s meals and fluids detailed entry report for the month of March 2016 revealed documented consumption for 20 of 93 meals with consumption at or below 50% documented for 3 meals and consumption between 50-75% for five meals. This report only contained documentation that a supplement was offered and accepted one of the eight meals where intake was at or below 75%.	F 325	Current residents with significant weight loss will be weighed weekly until stable then monthly thereafter by Certified Nurse Assistant. Care Plans and Kardex will be reviewed and updated with interventions indicated. The Dietary Manager and/or Executive Director will do Quality Improvement Monitoring 5 times a week for 4 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks, and quarterly thereafter of meal trays of residents with physician orders for supplements on meal tray verifying that supplements are provided as ordered. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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Review of Resident #146 Occupational Therapy (OT) treatment encounter note dated 4/11/16 revealed interventions that included establishing and maintaining safe posture during feeding and task modification to improve performance and safety in feeding. The note stated, " Patient seen at breakfast, in bed with head of bed partially elevated, food dropped on chest " . The OT treatment encounter note was signed by OT#1.
Review of Resident #146 OT treatment encounter note dated 4/12/16 revealed skilled interventions that included; positioning techniques to facilitate safe swallowing skills, facilitate upright posture and proper body alignment to increase socialization and to enhance participation in ADL tasks. The note continued with Resident #146 was educated on proper positioning for posture, self feeding and pain management with little to no carryover. Resident #146 required repositioning frequently throughout the day. The OT treatment encounter note was signed by OT#1.
Review of Physician progress note dated 4/23/16 indicated Resident #146 was seen for a monthly visit. Past 30 days no acute events noted. The assessment indicated resident #146 congestive heart failure (CHF) was stable with a plan to monitor her weight.
Nutritional Review dated 4/28/16 indicated Resident #146 weight was 133lbs. The note revealed Resident #146 weight trend for the past 30, 90, and 180 days was stable. Resident#146 ability to chew/swallow was documented as poor. The resident supplemental intake was left blank. The note indicated Resident #146 had the ability to feed herself.
Review of Resident #146 ' s meal and fluids detailed entry report for the month of April 2016 revealed documented consumption for 10 out of 90 meals with consumption at or below 50%

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documented for 4 meals and consumption between 50-75% for 1 meals. This report contained documentation that a supplement was not offered for the month of April.
Resident #146 was observed on 5/15/16 at 12:42pm to be eating lunch in her bed by herself in her room. Resident #146 had a standard drinking glass. Resident #146 was noted to have a large amount of food on her face and on her personal clothing protector. The resident was observed to have her frozen nutritional treat on her tray.
Review of weight taken 5/16 (no date provide) indicated Resident #146 weight was 117.5 lbs. Dietary note dated 5/16/16 revealed Resident #146 refused April and May weight measurement. The director of nursing services (DON) then requested a weight for May. 117 pounds was reported to the Registered Dietician (RD) by director of nursing services (DON). The dietary note revealed Resident #146 ' s usually body weight was between 130lbs and 135lbs. Resident #146 received a puree diet with a frozen treat with her lunch meal, a Multivitamin and Prostat 30cc 3 x a day (tid) with fortified cream 1 time daily (QAM). The dietary note continued with Resident #146 ' s Albumin was low at 2.67 on 4/11/16. The recommendations revealed continue with Prostat due low albumin, start 60cc med pass 2.0 and add to weekly weight monitoring until sable.
Review of Resident #146 ' s meal and fluid detailed entry report for the month of May revealed documented consumption of 21 out of 42 meals with consumption at or below 50% documented for 12 meals and consumption between 50 - 75% for 1 meal. This report contained documentation that a supplement was offered and accepted 2 of the 13 meals where intake was at or below 75%.

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Resident #146 was observed on 5/16/16 at 8:10am eating breakfast alone in her room. The resident ' s meal tray was observed to have a carton of milk, cranberry juice in the original container (small cup with aluminum lid). Resident was observed to have food on her chest and food coming out of the left side of the resident ' s mouth.
Resident #146 was observed on 5/16/16 at 12:56pm eating lunch in her room alone in a Broda chair. The resident was observed to have food on her chest and food that came out of her mouth on the left side. No frozen treat (supplement) was observed on Resident #146 meal tray. Resident #146 meal card identified frozen nutritional treat.
Resident #146 was observed on 5/17/16 at 12:17pm eating lunch in her room in a Broda chair. Resident ' s meal consisted of pureed spaghetti, regular salad and pudding in a cup. The resident had no frozen nutritional treat. The meal card on the resident ' s meal tray identified frozen nutritional treat. Resident #146 was observed to have food coming out of the left side of her mouth and food on her chest.
Observation on 5/18/16 at 12:35pm revealed Resident #146 to be eating lunch in her room. Food was observed to be coming out of the left corner of her mouth. Resident #146 had yellow pudding running down the side of the Broda chair with pudding up turned upside down on the arm of the Broda chair. Resident was observed to have yellow pudding sitting on her chest. The resident was observed to attempt to eat her frozen nutritional treat. Resident #146 exhibited difficulty eating her frozen treat as evidenced by not being able to hold the frozen nutritional treat (left side hemiplegia) and eating with her right hand. The frozen nutritional treat was observe to

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move with the spoon and slide across the bedside table as Resident #146 attempted to scoop the frozen nutritional treat onto her spoon. Staff (unknown) came into the room and stated, " They usually place a towel over her " . The staff member was observed to wipe the food from resident chest and wipe the food spilling from the left side of the resident ' s mouth. The NA was observed to cover the resident with a clean towel to protect her clothing and left the room.
Review of physician progress note dated 5/17/16 revealed Resident #146 had a history of CHF who lost significant weigh past month. The physician noted Resident #146 had no shortness of breath or no pain. The assessment stated weight loss with a plan of med pass 60cc qid.
Interview with the DON on 5/19/16 at 2:38pm revealed the facility conducted daily meetings in which changes of condition were reviewed and physician orders. The orders for the resident nutritional dining needs should be transcribed on the chart and on the medication administration record (MAR) as an fyi to staff. The order should also go to the dietary department where it is placed on the individual resident meal ticket. Her expectation was that staff look at the resident meal tickets to identify the resident is getting what is ordered. The information regarding dining needs should be carried over to the care plan.
The DON further revealed the nursing assistants (NA) used the Kardex that should be updated to match the plan of care. The DON indicated that the NA ' s should be documenting the resident ' s consumption daily in the care tracker. The DON stated that the resident meals and fluids detailed entry report was not reviewed in the morning meetings.

Interview with Dietary Manager on 5/17/16 at

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2:40pm revealed he became aware of resident nutritional dining needs after the physician order was processed. The order would then be written on a nutritional diet slip and the Dietary Manager would place the information in the system. The information regarding a residents nutritional needs would come on the meal card. The dietary department would put the adaptive dining equipment and or nutritional supplement on the resident ' s meal tray according to the dining slip.

Interview with the District Registered Dietician (RD) on 5/18/16 at 1:27 pm revealed she was brought Resident #146 medical chart by the DON on Monday (5/16/16) and was told there was no weight for April 2016 and May 2016. The RD stated she was told the resident refused to be weighted for the Month of April and May. The RD continued with the DON then requested a weight for May. She believed it was May 10, 2016. She further indicated she reacted immediately to the weight of 117lbs in March 2016 when it became available to her. She calculated the residents weight loss over a period of 6 months (November through May) as Resident #146 having a 14.2% weight loss (calculated from November weight of 137 and May weight of 117.5). The RD stated today (5/18/16) she would try discontinue the recommended med pass (nutritional supplement) due to Resident #146 refusal and she would implement house shakes (nutritional supplement) with meals. The RD further indicated she was not responsible for care planning.

Interview with Dietary Manager on 5/18/16 at 3:45 pm revealed he was responsible for the MDS section K. He indicated he received residents weights by nursing or restorative nursing. He stated it varied who took weights. The Dietary

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Manager revealed he looked at the weights and passed them to the RD for review. If the weight looks crazy he requests a re-weight. The Dietary Manager indicated when he completed section K of the MDS assessment dated 4/28/16 he used the weight for March of 133lbs because it was the most recent weight available. He was unaware if Resident #146 refused the weight for April or if it was missed. He further indicated it was the responsibility of the RD to implement interventions in regards to weight loss. He stated he notified the RD of the May 2016 weight of 117lbs on Monday (5/16/16) as soon as he be became aware of Resident #146 weight. He was unsure of the day in May Resident #146 weight was taken.

Interview with the DON on 5/18/16 at 4:13pm revealed Resident #146 weights were running in the 130 ' s and stable until the end of March. The DON stated she assumed they were having problems with the facility scales. On 3/31/16 the facility requested the scales be calibrated by a medical equipment services. It was between 4/4/16 and 4/6/16 the facility scales were fixed. We reweighed Resident #146 in April and got a weight of 119lbs with the newly calibrated scale. OT picked up Resident #146 on 4/11/16 as a response to the weight loss. On Monday (5/13/16) Resident #146 weight was 117lbs. She further revealed she weighed the Resident #146 on a wheelchair scale at 119lbs and the Hoyer lift scale at 117lbs. She indicated she was unaware of why the 119lb weight was not on the April 2016 facility weight sheet. The restorative aide would put the facility weight list in the dietary room for the Dietary Manager. The DON indicated the facility weight sheet was not utilized in morning meetings for monitoring of residents intake.

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Residents should be reweight with any 5% increase or 5% decrease in weight.

Interview with OT #1 on 5/19/16 at 10:48am revealed she assessed Resident #146 for positioning during dining and not weight loss. She revealed that when Resident #146 was in her Broda chair she ate better. The OT stated Resident #146 had a positioning angel issue when she was eating in the bed. Resident #146 had a tendency to wiggle and slide down. Resident #146 had a severe stoke and the OT indicted she believed she had no feeling on the left side. OT #1 revealed she had included in her assessment of Resident #148 dated 4/11/16 that food had dropped on Resident #146 chest. She indicated that it wasn ' t an alarming amount of food on her chest and believed the resident was getting more food in her mouth than on her chest. The OT revealed she used a regular plate when assessing Resident #146 ability to feed herself and had not used any type of bowl. Due to not using a bowl for the assessment she was unaware if resident #146 had difficulty while attempting to scoop. OT#1 stated, " Sometime the pudding is the only thing the resident eats " .

Interview with NA # 1 on 5/19/16 at 10:59am revealed she was familiar with Resident #146. She indicated Resident #146 would normally eat all of her sweets and she was not big on eating her pureed items. She indicated Resident #146 ate a good amount of her breakfast and wasn ' t a big eater at lunch. She stated that she did offer to assist with Resident #146 but Resident #146 would only eat a couple of bites. NA#1 stated she recalled Resident #146 being in restorative dining at one time (NA unaware of date). Resident #146 was taken off restorative dining and put in 2nd

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dining. Resident #146 showed inappropriate behaviors in the dining room to include putting her leg up on the table as she ate and moving about in her chair. Resident#146 no longer ate in the dining room, she ate meals in her room independently. NA#1 indicated she was not told Resident #146 required assistance and was not one of the resident on the hall that was identified for feeding assistance. NA#1 revealed Resident leaned a lot in her chair and would get food on her. NA#1 further stated, " If you can get her to sit up she does better. " Resident #146 wouldn ' t stay seated upright for long. She scoots in her seat. NA #1 indicated Resident #146 had left side weakness. NA#1 stated when she documented Resident #146 consumption she didn ' t include the food remaining on the plate or the food that lands on the resident ' s chest. NA# 1 revealed believed Resident #146 had difficult eating with the use of only her right hand. She further indicated Resident #146 could benefit from an adaptive plate that would assist with keeping food on her plate.

Interview with NA# 10 on 5/19/16 at 11:10am revealed Resident #146 did not require assistance to eat. NA# 10 indicated she had noticed that Resident #146 would get food on her chest while eating. NA#10 stated that if the Resident #146 didn ' t like certain food items she wouldn ' t hold the food in her mouth. She stated that occasionally Resident #146 ' s food would come out the side of her mouth. She stated Resident #146 liked sweets such as her frozen nutritional treat and deserts. Resident #146 did well eating if staff added jelly in her grits. NA# 10 described Resident #146 as having problems manipulating a bowl or had problems with cups like Ice cream. The NA indicated in the instance

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the ice cream wasn ' t soft enough she couldn ' t get it out or the spoon sticks in it. NA #10 stated Resident #146 didn ' t have her other hand to hold a cup steady as she scooped. She indicated in the instance she completed the residents consumption sheet and she identified everything on the plate gone and food on the residents chest she would document the resident ate 95%.

Interview with the facility physician on 5/19/16 at 11:27am revealed it was her expectation to be informed in the instance a resident loses more than 5lbs a month. She indicated she needed to be informed so she could trouble shoot why the weight loss was occurring and implement preventative measures in an attempt to prevent further weight loss. She stated she was unaware of the Resident #146 weight loss. She further revealed had she been aware of the significant weight loss in April 2016 she would have put interventions into place immediately. The physician indicated she would check the residents Pre-albumin levels to determine how poorly resident #146 was malnourished. She further revealed she might have to prescribe Resident #146 a protein supplement and an appetite stimulant.

Interview with Restorative Aide #1 on 5/19/16 at 11:44am revealed she was responsible for taking and recording Resident weights. She revealed that in the instance a residents weight was low or appeared off she would reweight the resident. She indicated that she gave the weights to the Dietary Manager. In the instance the Dietary Manger thought there was a discrepancy in a weight he would request a reweight. She indicated the last weight she recalled seeing was about 117lb or 119lbs. The Restorative Aide

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F 325	Continued From page 36 recalled the mechanical lift was recalibrated sometime in April 2016. She indicated when Resident #146 was on restorative dining she assisted the resident by setting up her meal tray, starting Resident #146 off and watching her eat independently. She did well eating in restorative dining. She revealed after ending restorative dining resident #146 still received assistance in secondary dining. Resident #146 no longer was in secondary dining and ate in her room due to inappropriate behaviors. Resident #146 would occasionally have difficulty holding a cup and scooping and require assistance. Therapy assessed Resident #146 and gave her a cup with handles to see if that would help with drinking. She indicated Resident #146 would have food that would come out of the left side of her mouth when she fed herself. She indicated she did not believe it was an excessive amount. The Restorative Aide stated Resident #146 would keep more food in her mouth when she fed the resident.	F 325		
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:	F 353		6/27/16

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F 353	Continued From page 37 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, interviews with staff, residents and families, and observations the facility failed to provide staffing of sufficient quantity and quality to provide care for residents who required assistance with eating, bathing and choices about their care. This affected 8 out of 34 residents. This tag is cross referenced through the following F242, F 244, F 312, and F323. Findings included: 1. F 242 Based on observations, resident and staff interviews and record review, the facility failed to allow one of one resident a choice in bathing type and frequency (Resident #149). 2. F244 Based on resident interview, staff interview, resident council minutes, and record review the facility failed to respond to Resident Council ' s ongoing grievances of not receiving showers. 3. F312 Based on observations, resident, family and staff interviews and record reviews the facility failed to provide showers for two of ten residents that required extensive assistance by staff for bathing (Resident #149 and #36).	F 353	1. Facility has sufficient staff and provides care to residents requiring assistance with eating , bathing and choices about their care. 2. Current residents that are interviewable were interviewed regarding needed assistance with eating, bathing and choices about their care 6/6/16. Follow up conducted based on findings. 3. Staff re educated on providing assistance to residents as needed 6/13/16-6/20/16. Executive Director and/or Director of Clinical Services will conduct residents rounds to ensure residents receiving care as required 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks then quarterly thereafter. Executive Director to review grievances and resident council meeting minutes for care concerns and unmet assistances needs 3 times a week for 8 weeks, 2 times a week for 8 weeks, and 1 time a week for 8 weeks and quarterly thereafter.	

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F 353	Continued From page 38 4. F323 Based on observation, resident interview, staff interview and record review the facility failed to supervise 1 of 3 Residents (Resident #15) who was evaluated as an unsafe smoker. Interview with nurse aide (NA) #1 on 05/18/2016 at 9:20 AM revealed there had been a shortage of NAs for " awhile " due to some (NAs) quitting. NA#1 and another aide on 300 hall were working their days off. Their nurse was good to help them on the floor to give care to residents. They had nurses working the floor as aides for a while also. She knew the administration was hiring staff. NA#5 was interviewed on 05/19/2016 at 10:55 AM. This interview revealed the showers were not provided due to not having time and there was not enough staff. An interview with nurse #4, on 5/19/2016 at 7:00 AM revealed they used to have 4 nurses on night shift. It was hard with only 2 nurses in the building. Further interview revealed there had been times there were only 2 aides in building. Interview with the Director of Nursing (DON) on 5/19/2016 at 12:17 PM revealed new staff had been hired as nurses and NAs. She had nurses working on the floor as NAs at times, given bonus money for staff working extra shifts and staff not showing up for work had affected the staffing.	F 353	4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369		6/27/16

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F 369	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide adaptive dining equipment for 1 of 2 residents (Resident #8) who required a sectional plate and red foam tubing on eating utensils. The findings included: 1. Resident #8 was admitted to the facility on 4/30/2015 with diagnoses of osteoarthritis, dementia, and muscle weakness. Review of the Occupational Therapy discharge summary dated 1/18/16 indicated Resident #8 received therapy for self-feeding which "had improved with use of adaptive equipment including a sectional plate and red foam tubing on utensils." The Quarterly Minimum Data Set (MDS) dated 4/3/16, indicated Resident #8 had moderate impairment with long and short term memory with a Brief Interview for Mental Status (BIMS) of 5. The MDS assessed Resident #8 with no impairment in functional movement of her upper extremities, required supervision with set up for eating and had not had significant weight loss since the last assessment. The care plan, dated 4/3/16, included a problem in activities of daily living for eating. The approaches included use of assistive devices for eating as indicated to have sectional plate as ordered and foam tubing spoon as ordered.	F 369	1. Resident #8 has been re-evaluated by Therapy and is provided adaptive dining equipment as needed. 2. A review of current residents receiving adaptive dining equipment for meals was completed 6/8/2016-6/17/2016 by the Director of Clinical Services/Nursing Supervisor and/or Dietary Manager. 3. The District Manger of Nutritional Services in-serviced the Dietary Manager on providing adaptive dining equipment as ordered for meals 6/8/2016. The Dietary Manager in-serviced the dietary aides and cooks on following tray cards and putting adaptive dining equipment on the tray as ordered 6/13/2016-6/20/2016. The Dietary Manager and/or Executive Director will do Quality Improvement Monitoring of 5 residents meal trays per meal verifying that adaptive dining equipment is provided as ordered 5 times a week for 4 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks and quarterly thereafter. 4. The Dietary Manager introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/16. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The	

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F 369	Continued From page 40 Review of the tray ticket on 05/16/16 at 8:25 AM, at breakfast, revealed a divided plate and utensil with "red handle" (foam handle) was to be provided for meals for use on the fork/spoon. Observations at this time revealed the foam handle was not provided for the fork/spoon and the divided plate was provided. The French toast was not cut up for the resident. Observations revealed Resident #8 did not eat the French toast. Resident #8 held the regular handled fork loosely in her hand and did not have a grip on the handle. Food spillage was not observed. Resident #8 was not able to cut the French toast and eat it. Observations on 05/17/16 at 12:28 PM revealed Resident #8 did not have the foam handle on the silverware for the lunch meal. Regular silverware was provided. The tray ticket was noted to have the "red handle" fork/spoon marked through with a black marker. The divided plate was provided. The divided plate remained on the tray ticket. Interview with the Occupational therapist (OT) that had worked with Resident #8 was conducted on 05/17/16 at 1:53 PM. The OT indicated the discharge plan included adaptive equipment of a sectional plate and red foam tubing on utensils. This was still in place and had not been changed. She was not aware of any changes in the resident's condition and was not aware the resident was not receiving the adaptive equipment. Observation on 05/18/16 at 8:53 AM revealed Resident #8 did not have the foam handle for the utensil, but did receive the divided plate. Interview with Nurse Aide (NA) #1 on 05/18/16 at	F 369	Quality Assurance Performance Improvement committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 369	Continued From page 41 9:00 AM revealed she did not recall seeing the foam for the fork/spoon. NA#1 indicated she remembered the resident had a divided plate. Interview with the MDS nurse on 05/18/16 at 11:35 AM revealed Resident # 8 should have the foam handle for use on the fork/spoon. The MDS nurse explained the resident did use it. Interview with the Director of Nursing (DON) on 5/18/16 at 2:00 PM revealed Resident #8 was supposed to have foam handle on the fork/spoon. The DON had written a clarification order to ensure it would be included on the monthly orders. An explanation could not be provided as to how the order was not on the monthly orders for the adaptive equipment. Further interview revealed she had talked with the dietary manager and they did not know why it was marked off the tray ticket of the lunch meal on 5/17/16.	F 369		
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, date and store foods in a	F 371	1. Four loaves of bread and one pack of hamburger buns were disposed of on	6/27/16

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F 371	Continued From page 42 sanitary manner, failed to maintain equipment in working condition and store personal items away from foods. The findings included: 1. During initial tour of the dietary department on 05/15/2016 beginning at 10:30 AM the following items were found to be expired and available for use: a. On the bread rack, 4 partially used loaves of bread with a " best if used by date " of 05/13/2016, one pack of hamburger buns with an expiration date of 05/06/2016. Interview with the dietary cook on 05/15/2016 at 10:33 AM revealed the top rack of bread was for use. The walk-in refrigerator had 5 puddings that were undated on a serving tray that was labeled " applesauce " , 8 vanilla health shakes with a 05/09/2016 " use by date " , 1 open, not dated or labeled bag of sliced salami, 1 bag of sliced bologna not labeled or dated, one bag of shredded cheddar cheese not dated when opened and 1 bag of sausage patties that were in a box open to air. b. In the walk-in freezer, a gallon of vanilla ice cream was not dated when opened, 4 individual ice creams had leakage of the ice cream on the outside of the lids and a box of hot dogs were open to air. c. In the dry storage for emergency food supply, there was an opened bag of white rice with an expiration date of 05/06/2015 and 1 dented can of mandarin oranges. In other areas of dry storage the following were opened and not dated: 1 bag of potato pearls and 1 bag of white cake mix. The cake mix was also not labeled. Interview on 05/15/2016 at 10:45 AM with a dietary aide revealed it was white cake mix. d. On top of the microwave was a storage	F 371	5/15/2016 by the Dietary Manager. Five puddings in the walk in refrigerator were disposed of by the Dietary Manager on 5/15/2016. One opened bag of Salami, bologna, one bag of shredded cheddar cheese and one bag of sausage patties were disposed of by the Dietary Manager on 5/15/2016. One gallon of vanilla ice cream and 4 individual ice creams were disposed of by the Dietary Manager on 5/15/2016. One box of hot dogs was dated by the Dietary Manager on 5/15/2016. One bag of rice and one dented can of mandarin oranges were disposed of by the Dietary Manager on 5/15/16. One bag of potato pearls, white cake mix and one container of white granular substance were labeled and dated by the Dietary Manager on 5/15/2016. The reach in refrigerator and walk in freezer had gaskets repaired by 6/24/2016 by the Maintenance Director. The walk in freezer had the ice/icicles removed 6/9/2016 by the Maintenance Director. The wall behind the dish machine was cleaned and repaired on 6/9/2016 by the Maintenance Director. 2. The Executive Director and/or Dietary Manager audited the refrigerator, walk in freezer, cooler, dry storage area and other storage sites for open/unlabeled/undated items on 6/8/2016-6/10/2016. 3. The District Dietary Manager in-serviced the Dietary Manager on proper storage of items in the kitchen and reporting equipment in need of repair 6/8/2016. The Dietary Manager	

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F 371	Continued From page 43 container of a white granular substance not labeled or dated. 2. Continuing with initial observations, staff had a personal drink in the reach-in refrigerator beside food items for residents. The dietary aide removed the drink and set it on a work table beside the serving line. She was preparing the eating utensils for the next meal. Interview with the dietary aide on 05/15/2016 at 10:43 revealed she should not have placed the drink in the reach-in and should have kept it in their break room. The dietary aide removed the drink after the interview. Staff had personal items such as purses laying on top of packaged items in the dry storage area. 3. The following equipment was observed to need repair: a. The reach in refrigerator and the walk-in freezer had worn, ripped and loose gaskets on inside of the doors. b. The walk-in freezer had ice build- up inside the back of the freezer wall, with icicles hanging down approximately 12 inches in length. c. The wall behind the dish machine was bubbled, peeling and black in color as compared to the surrounding white wall. The problems identified on initial tour were reviewed with the Dietary Manager on 05/19/2016 at 07:33 AM. The Dietary Manager (DM) provided the following explanations: the item on top of microwave was probably thickener and was since removed. The dented can and expired rice was removed from the emergency food supply. The emergency food supply was checked about every three months per the DM. The other items found not labeled/dated had been either removed	F 371	in-serviced the dietary aides, cooks on proper labeling/dating of food items and not housing personal items in the food prep area 6/13/2016-6/17/2016. The Dietary Manager/Executive Director will do Quality Improvement monitoring of the Dietary Department for unlabeled/undated items and personal items in the food prep area 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks then 1 time a week for 4 weeks and quarterly thereafter. 4. The Dietary Manager introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 371	Continued From page 44 or dated in the walk- in refrigerator. Further interview with the DM revealed staff were allowed personal items in dry storage, but were to be placed on hooks on wall. The DM explained the ice cream came with ice cream on the outside of the lids. There was no explanation as to why it occurred or what he would do about it. The DM explained gaskets were replaced not long ago by maintenance and may not have been replaced correctly. The condensation had been removed in the walk in freezer. He stated that was an on-going problem. Interview with both maintenance staff members on 05/19/2016 at 12:07 PM revealed they were not aware of any problems with the gaskets on the doors in dietary, the peeling wall behind the dish machine or condensation inside the freezer.	F 371		
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	F 441		6/27/16

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F 441	Continued From page 45 (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 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to post a contact isolation sign for a resident that was positive for MRSA (Methicillin Resistant Staph Aureus) for 1 (Resident #19) of 4 residents reviewed. The findings included: Resident #19 was admitted to the facility on 1/26/15 with diagnosis of above the knee amputation and peripheral vascular disease. A medical record review completed on 05/17/2016 at 8:30 AM revealed that Resident #19 had a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) of the wound on her left thigh. A review of physician note and the laboratory results dated 05/06/2016 revealed that the wound culture and sensitivity results of the left thigh wound of Resident # 19 received by the	F 441	1.Resident has appropriate isolation signage posted and PPE. 2. Observations of current residents rooms that are on isolation were checked for posting of signs and PPE by the Director of Clinical Services and/or Nursing Supervisor on 6/10/2016. Appropriate follow up conducted based on findings. 3. Certified Nurse Assistants and Licensed Nurses were in-serviced by the Director of Clinical Services and/or Nursing Supervisor on isolation procedure 6/13/2016-6/17/2016. The Director of Clinical Services will perform Quality	

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	345258	A. BUILDING _____ B. WING _____	C 05/19/2016

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F 441	Continued From page 46 laboratory on 04/26/2016, had a heavy growth of MRSA which was vancomycin susceptible and required Contact Isolation. On 5/6/16, the physician ordered Resident # 19 to be placed on Contact Isolation and to begin vancomycin 1 gram intravenously (IV) every 12 hours for two weeks and that the pharmacist was to dose according to vancomycin trough (a laboratory test to determine serum vancomycin concentrations in the blood) levels. An observation on 05/16/2016 at 12:38 PM revealed Personal Protective Equipment (PPE) hanging on the door of Resident #19 ' s room. No sign was posted to indicate the type of isolation precautions that were to be taken by staff or visitors. On 05/17/2016 at 9:14 AM PPE remained hanging on the outside of the door to the room for Resident #19, and there was no isolation sign posted. On 05/18/2016 at 2:22 PM the PPE remained hanging on the outside of the door of Resident # 19 ' s room and there was no posted sign to indicate the type of precautions to be used by staff or visitors. An interview with the Director of Nurses (DON) on 05/19/2016 at 8:54 AM revealed she was also the Infection Control Nurse and was responsible for placing isolation signs and obtaining PPE equipment for all residents on isolation. The DON stated that she was not aware that there was not a Contact Isolation sign on the outside of the door for Resident #19. Continued interview revealed the DON was certain she had placed a sign on the door, but also was certain that she had not removed it as she did not recall a physician order to discontinue isolation precautions when reviewing physician orders daily. The DON stated that she would need to review the medical record for Resident # 19 to clarify if the physician had discontinued the isolation or not. The DON stated	F 441	Improvement monitoring of residents on isolation signage and PPE are present 3 times a week for 8 weeks,2 times a week for 8 weeks, 1 time a week for 8 weeks and quarterly thereafter. 4.The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 441	Continued From page 47 that only the physician could order isolation precautions and that a physician order was needed to discontinue isolation precautions. On 05/19/2016 at 9:00 AM the DON was observed hanging a Contact Isolation sign on the door of Resident #19 next to the PPE equipment. An interview conducted with Licensed Nurse #2 on 05/19/2016 at 9:44 AM revealed that he and other staff members were aware that Resident #19 was on Contact Isolation Precautions, but was not able to explain why there was no Contact Isolation sign on the room door, but the PPE was hanging on the door and used by all persons entering the room of Resident #19. A review of the Medication Administration Record (MAR) dated for May, 2016 revealed that Resident #19 was to be on Contact Isolation as " For your information " (FYI) for the nurse on each shift. An interview with the Wound Care nurse on 05/19/2016 at 10:25 AM revealed that she was aware of Resident #19 being on Contact Isolation Precautions, but had not noticed that a sign was not posted on the outside of the door. The nurse also stated that she always wore the PPE because she knew about the wound infection and the PPEs were hanging on the door.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463		6/27/16

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F 463	Continued From page 48 Based on observation, record review, and staff interviews the facility failed to maintain a functioning call light system for 1 of 34 residents (Resident #96). The findings included: Resident #96 was admitted to the facility on 10/1/2013 with a diagnosis of dementia. The Minimum Data Set (MDS) quarterly assessment dated 2/24/2016 revealed that the resident has difficulty communicating and is rarely understood. On 5/16/2016 at 12:56 pm the call light for Resident #96 was checked. The call light would not activate. The test was repeated and on the sixth try the light activated. The call light was canceled. On 5/18/2016 at 2:11 pm the call light was activated by Resident #96. Nurse Aide #8 responded. She was observed attempting to cut the call light off by hitting the cancel switch on the wall unit. The light did not turn off. She was seen unplugging and plugging the cords to the call light. The light did not turn off. This was repeated several times before the light was turned off. Nurse Aide #8 was interviewed on 5/19/2016 at 11:06 am. She explained that if call bells don ' t work we would call maintenance. After hours we would try to find someone in the building who could fix the lights, if not we can call maintenance in to fix it. Nurse Aide #9 was interviewed on 5/19/2016 at 12:40 pm. She explained when call lights don ' t work we post it on the board to let maintenance know. She indicated that she knew that the call light for Resident #96 was not cancelling yesterday, but didn ' t report it because it did eventually turn off. On 5/19/2016 at 12:43 pm Maintenance Staff #1	F 463	1. The Maintenance Director repaired the call light in resident #96 room on 5/19/2016. 2. Call bells in residents rooms were checked for proper functioning by the Maintenance Director and/or Maintenance Assistant 6/8/2016-6/10/2016. No issues identified. 3. The Director of Clinical Services and/or Nursing Supervisor in-serviced Certified Nurse Assistants, Licensed Nurses and Housekeeping on reporting any issues using the maintenance log that are observed with residents call bells 6/13/2016-6/17/2016. The Maintenance Director and/or Maintenance Assistant to complete weekly audits times 4 weeks then monthly, for call lights being able to be activated in resident rooms properly. Report findings to Quality Assurance Performance Improvement Committee meeting. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services,	

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F 463	Continued From page 49 was interviewed. He indicated that he was not aware of the call light in Resident #96 ' s room not working until today. He explained that staff should have filled out a maintenance request if it wasn ' t working. He explained that several requests had come in and that they had even brought in an outside electric service to help them fix the problems. He indicated that he had fixed the lights and that they were working properly. The maintenance requests related to calls lights were reviewed for the past three months. Six rooms had maintenance requests for call lights not functioning. All these were checked and were found to be functioning properly. On 5/19/2016 at 12:47 pm Nurse #4 was interviewed. She explained that if the call lights are not working the Nurse Aides should report it. The Nurse Aides who had difficulty cancelling the lights should have reported it yesterday. One 5/19/2016 at 1:38 pm the DON was interviewed. She indicated that she expected staff to report to maintenance any call lights that are not functioning properly. She explained that maintenance had reported to her that the call lights had been fixed and are working fine at present.	F 463	Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		6/27/16

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F 520	Continued From page 50 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 observations, record reviews, and staff and resident interviews, the facility ' s Quality Assessment and Assurance Committee failed to implement, monitor and revise, as needed, the action plan developed for the recertification and complaint survey dated 06/12/2015 in order to achieve and sustain compliance. The facility had repeat deficiencies in two areas. The first area was associated with the resident has the right to participate in planning care and treatment or changes in care and treatment (F 280) and the second area was associated with the facility must ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents (F 323). These deficiencies were cited on the complaint and recertification survey of 06/12/2015 and again on the current recertification and complaint survey.	F 520	1. Facility has Quality Assurance Performance Improvement Committee in place and implements plans for improvement and monitors and revises as needed through the Quality Assurance Performance Improvement process. 2. The Regional Director Of Clinical Services re-educated the Interdisciplinary Team members on regulation 520 and the facility's policy and procedures for Quality Assurance Performance Improvement on 6/17/16. Current resident care plans were reviewed and/or updated to reflect the residents current eating ability by the Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Dietician, and Minimum Data Assessment Nurse 6/10/2016-6/17/2016. Current residents that smoke had a smoking	

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F 520	Continued From page 51 Findings included: This tag is cross referenced to F 280. The facility failed to have audit tools in place to audit for care plan accuracy. An interview was conducted on 05/19/2016 at 4:11 PM with the facility ' s Administrator revealed that she was the contact person for the Quality Assessment and Assurance Committee (QA and A) and that the facility had audit tools in place for the accurate coding of the Minimum Data Set (MDS) but not for following the care plan or for auditing the accuracy of the care plans. The Administrator explained that the QA and A Committee would need to implement changes to audit for resident care plan accuracy. This tag is cross referenced to F 323. The facility failed to monitor residents for safety practices and failed to provide staff supervision for residents while residents were smoking. An interview was conducted on 05/19/2016 at 4:11 PM with the facility ' s Administrator. She was the contact person for the Quality Assessment and Assurance Committee. She said the facility had no action plan or audit in place to monitor resident safety while they were smoking. The Administrator stated that the facility had not had concerns related to safe smoking procedures for residents that were smoking. The Administrator explained that the QA and A Committee would need to implement changes to audit for resident safety and provide supervision while residents were smoking.	F 520	assessment completed 6/8/2016-6/10/2016 by the Social Services Director. The review of the 6/12/2015 plan of correction was completed by the Interdisciplinary Team at the 6/21/2016 Quality Assurance Performance Improvement Meeting and based on findings follow up implemented with performance improvement plans and monitoring put back into play. 3. The Regional Director of Clinical Services in-serviced the Interdisciplinary Team, (Director of Clinical Services, Social Services Director, Activities Director, Dietary Manager, Minimum Data Assessment Nurse)on updating residents care plans with any change in resident eating ability on 6/9/2016. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of residents care plans for revision when a residents eating ability changes 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. The Director of Clinical Services in-serviced Certified Nurse Assistants, Licensed Nurses and Social Services on supervising residents who smoke 6/13/2016-6/17/2016. The Executive Director and/or Director of Clinical Services will perform Quality Improvement monitoring of residents being supervised while smoking 5 times a week for 4 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks and quarterly thereafter.	

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F 520	Continued From page 52	F 520	The Regional Vice President of Operations and/or Regional Director of Clinical Services will conduct Quality Improvement monitoring of the facility's Quality Assurance Performance Improvement process in monitoring of cited deficiencies to ensure that cited deficiencies identified through the survey process attain and maintain compliance. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 6/21/2016. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and quarterly thereafter. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	