STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 03/10/2017

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MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

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F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and staff interviews, the facility failed to maintain a resident ' s dignity when a pancake call light (a call light pad used for those with limited hand function) was not moved with a resident during a room change for 1 of 6 sample residents (Resident #11) reviewed for dignity. The findings included: Resident #11 was admitted to the facility on 2/14/13 from a hospital. The resident ' s cumulative diagnoses included cerebral palsy, contractures, speech disturbance, and dysphonia (difficulty in speaking due to a physical disorder of the mouth, tongue, throat, or vocal cords). A review of Resident #11 ' s annual Minimum Data Set (MDS) dated 1/6/17 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance for bed mobility, dressing, toileting, and personal hygiene. The resident was totally dependent on staff for all of her other Activities of Daily Living (ADLs), including transfers, locomotion, eating, and bathing. Section B of the MDS indicated the resident had unclear speech and was rarely/never understood. Resident #11 was reported as	F 241	The pancake call light was moved to resident #11 new room on 3/10/17 by the licensed nurse. An audit was completed to identify residents that needed a specialized call light on March 21 and 22, 2017 by the Regional Resource Nurse Manager. Sixteen residents were identified using a specialized call light. One of the 16 resident requested her specialized pancake light to be switched to a standard call light. This was completed on March 22, 2017 by the Regional Resource Nurse Manager. An audit was completed on 3/29/17 by the Regional Resource Nurse Manager to ensure that residents' call lights were in reach 4 were found out of reach and placed within reach. Week day and week end nursing staff were inserviced on placement of call lights within reach of resident and ensuring that during a room change a specialized call light is moved with the resident on starting 3/27/17 with completion on 4-4-2017 by Nurse Practice Educator (NPE). The housekeeping staff involved in room changes were inserviced on 3/29/17 by Environmental Director ensuring that	4/4/17

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

Electronically Signed | 03/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 rarely/never having the ability to understand others. However, Section F (Preferences for Customary Routine and Activities) of the MDS assessment was documented as having been completed based on information obtained from the resident. A review of Resident #11 ' s care plans included the following areas of focus: --Resident needs assistance to and from group programs. She is mainly non-verbal and uses gestures and yes/no questions for communication... (Date Initiated: 7/16/14; Revision on: 7/6/16) --Resident has impaired communication as evidenced by impaired ability to make needs known, difficulty making herself understood due to cerebral palsy with dysphonia. (Date Initiated: 6/19/14; Revision on: 1/20/17). An interview was conducted on 3/9/17 at 10:00 AM with Resident #11. The resident was able to answer yes/no questions posed by nodding or shaking her head. At the time of the interview, the resident ' s call light was not within view. Upon inquiry as to where her call light was, the resident appeared to be unable to respond verbally. However, Resident #11 was observed as she slowly pulled her blanket down to reveal a pancake call light (or call light pad) was lying on her chest. When asked, the resident indicated by nodding that she was able to use the call light for staff assistance when needed. Resident #11 was residing on the 2 North Hall at the time of the interview. An observation was made on 3/9/17 at 4:00 PM of Resident #11 sitting in reclined Broda chair by the nursing station on the 2 South Hall. The	F 241	specialized call light are moved with the resident to the new room. The Environmental Director will complete a "Resident Room Transfer Check Off List", with includes special call lights after each room transfer. Administrative nurses, Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and Unit Managers (UM)initiated audit on 3/31/17,and ongoing will complete an audit of call bell placement and the need for specialized call bell of 10 rooms per unit per shift, to include one weekend shift, daily for 5 days. Then 10 rooms per unit on each shift to include one week end shift 3x/week for 3 weeks, then 10 rooms per unit on each shift once a week to include one week end shift for 2 months. The CNE will present trends of call light placement to the Quality Assurance Committee monthly x 3 months. The Environment Director will present any trends for the room transfer check list monthly for 3 months.	

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resident appeared comfortable and smiled when she was greeted.

On 3/10/17 at 7:10 AM, an observation of Resident #11 ' s room on the 2 North Hall revealed the resident had been moved. An interview was conducted on 3/10/17 at 7:10 AM with the Activities Director who was sitting at the 2 North Hall nursing station. Upon inquiry, this staff member reported Resident #11 had been moved to a room on the 2 South Hall after the 3:00 shift change on 3/9/17.

On 3/10/17 at 12:00 PM, an observation and interview was conducted with Resident #11 in her room on the 2 South Hall. During the interview, the resident attempted to verbalize something that could not be understood. When asked if she needed help, the resident nodded to indicate she did. The resident was asked where her call light pad was located. The resident made a slight grimace and then shook her head. At that time, an observation was made of a standard push button call light laying on the night stand next to the bed and out of reach of the resident. Upon exiting the room, the resident was told staff would be alerted to her need for assistance.

On 3/10/17 at 12:02 PM, an interview was conducted with Nurse #1. Nurse #1 was at the nursing station and assigned to the 2 South Hall. At that time, the nurse was alerted Resident #11 was needing assistance with something that she could not verbalize; and, she did not have the call light pad to request help. The nurse responded by saying she was just about to go and get the call light pad for the resident from the other hallway. Nurse #1 reported the call light pad did not come over with the resident when she was

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moved to this hall (around 3:00 PM on 3/9/17) from the 2 North Hall.

On 3/10/17 at 12:03 PM, Nurse #1 was observed as she went into the resident ' s room and picked up the standard push button call light placed on the resident ' s nightstand. The nurse reported she was going to go over to the other hall and get the call light pad for Resident #11.

An interview was conducted on 3/10/17 at 1:20 PM with Resident #11. Upon entry to Resident #11 ' s room, the call light pad was observed to be laying on the resident ' s bed near the right side of her body. The call light pad was within reach of the resident. When Resident #11 was asked if she had been without the call light pad since moving to this room the day before, the resident indicated by nodding that she had. The resident was then asked if she was without the call light pad all night, and she nodded that she had. Upon inquiry as to how she felt without having access to the call light, the resident grimaced and shook her head. When asked if she was worried because she could not call for staff assistance, the resident nodded her head. The resident was asked if she felt better now, and she nodded her head again. When getting ready to exit the room, the resident had a smile on her face and clearly stated the word, "Bye."

An interview was conducted on 3/10/17 at 3:30 PM with the facility ' s Director of Nursing (DON) in regards to Resident #11 ' s call light. Based on the reported time of the room transfer, Resident #11 was without a means to request assistance from staff for approximately 21 hours. When asked, the DON reported Resident #11 was reliable in providing yes/no answers to questions

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F 241	Continued From page 4 posed by nodding (to indicate ' yes ') or shaking her head (to indicate ' no '). The DON stated she would have expected the call light pad for Resident #11 to have been moved with her when she changed rooms on 3/9/17.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to ensure a pancake call light (a call light pad used for those with limited hand function) was available to allow a resident to request staff assistance if needed. This occurred after a room change for 1 of 4 sample residents (Resident #11) reviewed for accommodation of needs. The findings included: Resident #11 was admitted to the facility on 2/14/13 from a hospital. The resident ' s cumulative diagnoses included cerebral palsy, contractures, speech disturbance, and dysphonia (difficulty in speaking due to a physical disorder of the mouth, tongue, throat, or vocal cords). A review of Resident #11 ' s annual Minimum	F 246	The pancake call light was moved to resident #11 new room on 3/10/17 by the licensed nurse. An audit was completed to identify residents that needed a specialized call light on March 21 and 22, 2017 by the Regional Resource Nurse Manager. Sixteen residents were identified using a specialized call light. One of the 16 resident requested her specialized pancake light to be switched to a standard call light. This was completed on March 22,2017 by the Regional Resource Nurse Manager. An audit was completed on 3/29/17 by the Regional Resource Nurse Manager to ensure that residents' call lights were in reach. Four were found out of reach and placed within reach.	4/4/17

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F 246	Continued From page 5 Data Set (MDS) dated 1/6/17 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance for bed mobility, dressing, toileting, and personal hygiene. The resident was totally dependent on staff for all of her other Activities of Daily Living (ADLs), including transfers, locomotion, eating, and bathing. A review of Section G of the MDS assessment revealed the resident had functional limitations in range of motion in her upper extremities (both sides). A review of Resident #11 ' s care plans included the following areas of focus: --Resident is dependent for ADL care in bathing, grooming, dressing, eating (tube feed), bed mobility, transfer, locomotion, toileting due to cerebral palsy, multiple contractures ... (Date Initiated: 6/19/14; Revision on: 1/20/17). The interventions for this care area included, in part: "Uses pressure call bell." (Date Initiated: 6/19/14; Revision on 6/9/16). --Resident is at risk for falls: poor coordination, poor trunk control, unable to move independently, spastic movements related to cerebral palsy (Date Initiated: 6/19/14; Revision on 1/20/17). Intervention noted for this care area included, "Place call light within reach at all times." An interview was conducted on 3/9/17 at 10:00 AM with Resident #11. The resident was able to answer yes/no questions posed by nodding or shaking her head. At the time of the interview, the resident ' s call light was not within view. Upon inquiry as to where her call light was, the resident appeared to be unable to respond verbally. However, Resident #11 was observed	F 246	Week day and week end nursing staff were inserviced on placement of call lights within reach of resident and ensuring that during a room change a specialized call light is moved with the resident on 3/27/17 and completed on 4/4/1/ by the Nurse Practice Educator. The housekeeping staff involved in room changes were inserviced on 3/29/17 ensuring that specialized call light are moved with the resident to the new room. The Environmental Director will complete a "Resident Room Transfer Check Off List" to include any specialized call light after each room transfer. Administrative nurses, Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and Unit Managers (UM) initiated on 3/31/17 and will complete an audit for call light place and need of specialized call light of 10 rooms per unit per shift daily for 5 days on each shift to include one week end shift, the 10 rooms per unit on each shift to include one week end shift 3x/week for 3 weeks, then 10 rooms per unit on each shift once a week to include one week end shift for 2 months. The CNE will present trends of call light placement to the Quality Assurance Committee monthly x 3 months. The Environment Director will present any trends for the room transfer check list monthly for 3 months.	

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as she slowly pulled her blanket down to reveal a pancake call light (or call light pad) was lying on her chest. The resident indicated by nodding that she was able to use the call light for assistance when needed. Resident #11 was residing on the 2 North Hall at the time of the interview.

An observation was made on 3/9/17 at 4:00 PM of Resident #11 sitting in reclined Broda chair by the nursing station on the 2 South Hall. The resident appeared comfortable and smiled when she was greeted.

On 3/10/17 at 7:10 AM, an observation of Resident #11 ' s room on the 2 North Hall revealed the resident had been moved. An interview was conducted on 3/10/17 at 7:10 AM with the Activities Director who was sitting at the 2 North Hall nursing station. Upon inquiry, this staff member reported Resident #11 had been moved to a room on the 2 South Hall after the 3:00 shift change on 3/9/17.

On 3/10/17 at 12:00 PM, an observation and interview was conducted with Resident #11 in her room on the 2 South Hall. During the interview, the resident attempted to verbalize something that could not be understood. When asked if she needed help, the resident nodded to indicate she did. The resident was asked where her call light pad was located. The resident made a slight grimace and then shook her head. At that time, an observation was made of a standard push button call light laying on the night stand next to the bed and out of reach of the resident. Upon exiting the room, the resident was told staff would be alerted to her need for assistance.

On 3/10/17 at 12:02 PM, an interview was

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conducted with Nurse #1. Nurse #1 was at the nursing station and assigned to the 2 South Hall. At that time, the nurse was alerted Resident #11 needed assistance with something that she could not verbalize; and, she did not have the call light pad to request help. The nurse responded by saying she was just about to go and get the call light pad for the resident from the other hallway. Nurse #1 reported the call light pad did not come over with the resident when she was moved to this hall around 3:00 PM on 3/9/17 from the 2 North Hall.

On 3/10/17 at 12:03 PM, Nurse #1 was observed as she went into the resident ' s room and picked up the standard push button call light placed on the resident ' s nightstand. The nurse reported she was going to go over to the other hall and get the call light pad for Resident #11.

An interview was conducted on 3/10/17 at 1:20 PM with Resident #11. Upon entry to Resident #11 ' s room, the call light pad was observed to be laying on her bed near the right side of the resident ' s body. The call light pad was within reach of the resident. When Resident #11 was asked if she had been without the call light pad since moving to this room the day before, the resident indicated by nodding that she had. The resident was then asked if she was without the call light pad all night, and she nodded that she had.

An interview was conducted on 3/10/17 at 3:30 PM with the facility ' s Director of Nursing (DON) in regards to Resident #11 ' s call light. Based on the reported time of the room transfer, Resident #11 was without a means to request assistance from staff for approximately 21 hours. When

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F 246	Continued From page 8 asked, the DON reported Resident #11 was reliable in providing yes/no answers to questions posed by nodding (to indicate ' yes ') or shaking her head (to indicate ' no '). The DON stated she would have expected the call light pad for Resident #11 to have been moved with her when she changed rooms on 3/9/17.	F 246		
F 250 SS=G	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews, dermatology office staff and Medical Director interviews, and record reviews, the facility failed to arrange a dermatology consultation (a specialty branch of medicine that deals with the diagnosis and treatment of diseases that involve the skin) as ordered by the physician for 1 of 1 resident (Resident #2) reviewed for the provision of medically-related Social Services. The findings included: Resident #2 was admitted to the facility on 11/10/15 from the community. His cumulative diagnosis included Alzheimer ' s disease. A review of Resident #2 ' s quarterly Minimum Data Set (MDS) assessment dated 2/3/17 revealed the resident had severely impaired cognitive skills for daily decision making. Resident #2 was independent for transfers, walking in his room and corridor, locomotion off	F 250	Resident #2 was seen by Dermatology on 12/7/16, new orders received and implemented. Skin assessment was completed on resident #2 on 3/27/17 by licensed nurse and was negative. CNE, ACNE and Regional Resource Nurse Manager completed on 3/14/2015 and 3/15/2015 an audit of physician orders and consultant reports for January, February and March of 2017 for appointments. No missing appointments were found. CNE, ACNE will bring MD orders for consultations will be brought to stand-up every morning for review of all appointments which will be compared to the schedule in the computer, which is entered into the calendar by the nursing secretary. Nursing secretary will attend stand-up meeting and bring weekly schedule of appointments to review and	4/4/17

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F 250	Continued From page 9 the unit, and eating. He required supervision for all of his other Activities of Daily Living (ADLs). On 10/2/16, a "Change in Condition-Skin" form indicated Resident #2 had a rash/dermatological disorder. Notes indicated he had a skin rash to his entire back, with redness and raised areas. A Nursing Communication form dated 10/2/16 also noted the problem was observed, reporting the resident ' s entire back and surrounding skin areas were reddened and had some sort of rash or break out. The form indicated Resident #2 complained of itching. He was given 25 milligrams (mg) of diphenhydramine (an antihistamine) with relief of itching. However, the rash remained. A handwritten note on the Nursing Communication form dated 10/5/16 read, "(name of Medical Doctor or MD) Assessed 10/3/16." Further review of the resident ' s medical record revealed a Physician Order was written on 10/3/16 for 1% hydrocortisone cream (a topical steroid medication) with instructions to apply the medication to the resident ' s back and affected areas topically every day and evening shift for the rash to his back for 7 days. An order was also written for 100 mg doxycycline (an antibiotic) to be given by mouth twice daily for 14 days due to a rash. On 10/17/16, a Nurse Practitioner (NP) progress note revealed the resident was seen for evaluation of a rash which had been a problem for the past 2 weeks. The plan of care included the use of hydrocortisone cream to be applied to the affected areas twice daily; and, a request for a dermatology consult.	F 250	any cancellations. Follow-up appointment information will be given to the CNE and ACNE by the van driver following any appointments. Inservice was given on 3/15/17 by CNE to van drivers on making copies of follow-up information and providing copies to the nursing secretary, CNE and ACNE. A weekly meeting will be held with nursing secretary, CNE and ACNE to ensure all appointments were kept, and recommendations were addressed, family cancelled or resident refused and Medical Director was notified. All findings from weekly meetings will be brought to monthly Quality Assurance Committee x 3 months..	

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A review of Resident #2 ' s medical record revealed a Physician Order was received on 10/17/16 to initiate 1% hydrocortisone cream applied to affected areas topically every day and evening shift for "rash" dermatitis.
The Physician Order also requested a dermatology consult be made for the resident due to dermatitis. Nurse #2 ' s signature on the form indicated she was the nurse who received the Physician Orders on 10/17/16.

On 10/28/16, Resident #2 was seen again by the NP. The NP progress notes indicated the chief complaint was dermatitis. The NP notes indicated the resident had an appointment scheduled with dermatology. New orders included 40 mg prednisone for 10 days for a primary diagnosis of dermatitis, unspecified.

Resident #2 ' s medical record included a "Report of Consultation with Dermatologist" dated 12/6/16. The dermatologist indicated the resident had "Crusted Scabies" and initiated 3 medications. The medications included: 3 mg Ivermectin (a medication used to treat parasitic infestations) to be given as 6 tablets by mouth at once on days 1, 2, 8, and 9; 5% Elimite (a topical anti-parasitic medication) with instructions to apply the topical cream to the entire body (neck down) on days 1 and 8; and, 0.1% triamcinolone acetonide cream (a topical steroidal cream) with instructions to apply the cream topically twice daily to the affected areas as needed for itching.

A telephone interview was conducted on 3/8/17 at 2:22 PM with a staff member of the Dermatology office where Resident #2 had been seen for treatment on 12/6/16. The Dermatology office

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confirmed the resident was seen for an appointment once on 12/6/16. The records at their office revealed this appointment was arranged by the facility on 11/17/16 and scheduled for 12/6/16 at that time.

An interview was conducted on 3/9/17 at 12:28 PM with Nurse #2. During the interview, Nurse #2 confirmed she had verified the order for the dermatology consult written on 10/17/17. Upon inquiry, Nurse #2 reported that after verifying the order, she would have called "the scheduler" for the facility and informed her of the need to arrange the dermatology consult.

An interview was conducted on 3/9/17 at 12:55 PM with the facility ' s Unit Secretary. The Unit Secretary reported she was the scheduler for outside appointments and consultations. Upon inquiry, she reported that she was notified of requests for outside consults from the physician, the hall nurse, or upon receipt of a copy of the computer Order Entry or physician order. Once received, the Unit Secretary stated she would gather the paper work needed and fax it to the consulting office. She reported after the paper work was completed, she would telephone the consulting office and ask for the first available appointment. When asked how long it would take to begin this process once the consultation order was received, the Unit Secretary reported the process would be initiated by the next business day. During the interview, Resident #2 ' s referral for a dermatology appointment was discussed. The Unit Secretary was asked why it took one month from when the order was written (on 10/17/16) until 11/17/16 to arrange the dermatology appointment (scheduled for 12/6/16). The Unit Secretary reported she would

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need to look back at a few records to answer the question appropriately.

A follow-up interview was conducted on 3/9/17 at 3:00 PM with the Unit Secretary. During the interview, the Unit Secretary stated she confirmed with the dermatology office that the appointment made for Resident #2 on 12/6/16 was arranged on 11/17/16. Upon further reflection, the secretary reported she was not certain when or how she had been notified of the resident ' s need for a dermatology consult ordered for him on 10/17/16. She recalled there was a need for additional information to be sent to the dermatology office regarding the resident ' s insurance. When asked how long this may have taken, she stated, "probably not more than a couple of days." The Unit Secretary reported she thought a "communication issue" was likely the cause of the delay between when the order was written for a dermatology consult on 10/17/16 until the appointment was arranged on 11/17/16.

A telephone interview was conducted on 3/10/17 at 3:10 PM with the facility ' s Medical Director. During the interview, concerns were discussed regarding the one month delay between when the order for a dermatology consult was written and when the appointment was arranged for Resident #2. When the Medical Director was asked what his thoughts were about this delay, he stated, "We write the order, we expect it to be carried out."

An interview was conducted on 3/10/17 at 3:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns were discussed in regards to the delay in arranging a dermatology consult for Resident #2. Upon inquiry, the DON

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F 250	Continued From page 13 stated her expectation would be for the consultation order to be given to the Unit Secretary when it ' s ordered, and for the Unit Secretary to arrange the appointment either the day the order was written or the next business day.	F 250		
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to maintain cleanliness of resident equipment, and failed to maintain three of five resident common areas in a clean and orderly manner for three of the five resident halls. The findings included: An initial tour was made of the 2nd floor resident halls and common areas on 3/8/17 beginning at 5:22 AM to 6:00 AM. During the tour, the following was observed: 1. Resident lounge area across from Room 210 (2 South Hall) was observed to have an empty soda bottle on the floor next to the love seat. A plastic bag (contents unknown) and a blue cloth tote bag were sitting on the floor. A wrapped pastry food item was laying on the floor behind the bag. Interview with the Environmental Director on 3/10/17 at 10:27 AM revealed facility staff should not have personal items in the residents' lounge areas. Employees had lockers and should store their personal items in them. Any employee food should be kept in the employee refrigerator and not on the floor or residents' areas.	F 253	Personal items were removed for 2 South Hall on 3/9/2017 by licensed nurse. Personal items on the furniture in resident lounge-type areas was removed on 3/9/17 by Certified Nursing Assistants (CNA) and Assistant Administrator. The stack of cup lids in plastic sleeves and stack of Styrofoam cups in the 2 North Hall lounge area was removed by licensed nurse on 3/9/17. The wheelchair for room 114 was cleaned on 3/9/17 by housekeeping staff. Intravenous pole in room 238 was cleaned by housekeeping staff on 3/9/17. Total lift and sit to stand lift in hallway between 1 South rooms were cleaned by housekeeping staff on 3/9/17. Bed frame in room 109 was cleaned by the housekeeping staff on 3/9/2017. An audit for soiled wheelchairs, IV poles, mechanical lifts, beds and personal care items in resident care areas was completed by management staff. The four wheelchairs on 1 South and 2 North that	4/4/17

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F 253	Continued From page 14 2. The Homestead unit was noted with items on the furniture in a resident lounge-type area. A bag was on a chair, with a blanket laying over the top of it. A second bag was an open-top tote which contained 3 standard-sized bottles, which included a bottle of shampoo, conditioner, and lotion. Interview with the Environmental Director on 3/10/17 at 10:27 AM revealed facility staff should not have personal items in the residents' lounge areas. Employees had lockers and should store their personal items in them. Any employee food should be kept in the employee refrigerator and not on the floor or residents' areas. An interview was conducted with NA #3 on 3/8/17 at 5:45 AM. During the interview, the NA confirmed these were her personal items. Upon inquiry, the NA reported she went to the gym and brought these belongings in to work with her. 3. The resident lounge area near the 2 North Hall Nursing Station revealed a stack of cup lids in a plastic sleeve were sitting on the heating/air wall unit and a stack of Styrofoam cups in a plastic sleeve were sitting on the floor. The cups were individually labeled with room numbers. At the time of the observation, interview with on 3/8/17 at 5:22 AM Nurse #3 reported that staff were numbering the cups for later use. A crate was also noted to be sitting on the floor next to two cushioned chairs by the Nursing Station. The crate contained an unfolded towel, an apparently used and crumpled paper towel, and what appeared to be a sheet (unfolded and crumpled in the crate). The two chairs each had a sheet placed on top of their cushions. Nurse #3 reported the residents that sit on the chairs tend to spill and the sheet prevented the chairs from	F 253	were found dirty on 3/9/17 were brought to Environment Director and were cleaned. Environment Director has implemented cleaning schedules/sign-off sheets, to include wheelchairs and beds, on a monthly schedule and as needed. IV poles and mechanical lifts are cleaned daily. Housekeeper to sign and date when cleaning is complete. Inservice for housekeeping staff on cleaning schedules will be completed by 3/25/17 by Environment Director. Staff were inserviced on keeping personal items in either the employee lounge, the lockers or their cars, not in any resident care areas by the week of 3/26/17, completed by the Environment Director, Nurse Practice Educator (NPE), Assistant Administrator and Executive Chef (EC). Management team will complete audit of wheelchairs, IV poles, beds and personal items being left in resident areas daily x 1 week, 2 times/week x 4 weeks, 1 time/week x 2 months. Environment Director will be notified of any areas that need to be cleaned based on audits. All findings from audits will be brought to monthly Quality Assurance Committee.	

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being soiled.

The following equipment used by residents was observed with dried spills:

4. Observation on 3/8/17 at 8:35 AM revealed the wheelchair by room 114 had dried spills and crumbs on the inside of the chair.

Observation on 3/9/17 at 12:30 PM revealed the wheelchair remained unclean.

Interview with the Environmental Director on 3/10/17 at 10:00 AM indicated the wheelchairs were cleaned on a scheduled basis by housekeeping. The wheelchair for room 114 was last cleaned on 2/24/17. If the wheelchairs needed cleaning between the scheduled cleanings, the housekeeping staff would be responsible for the cleaning.

5. Observation on 1 South on 3/8/17 at 8:37 AM revealed the coverings on the clean linen carts had dried spills and crumbs on the top and sides of the coverings.

Observation on 3/9/17 at 12:55 PM revealed the clean linen cart coverings had dried spills on the top and sides.

Interview with the Environmental Director on 3/10/17 at 10:10 AM revealed she had ordered new coverings for the clean linen carts. The dried spills were stains that would not come out.

6. Observation on 3/8/17 at 8:40 AM revealed a total lift and a sit to stand lift were in the hallway on 1 South between resident rooms. The lifts were observed to have dried spills on the base of

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the lifts.

Observation on 3/10/17 on rounds with the Environmental Director at 10:00 AM revealed the lift bases had the dried spills. Interview with the Environmental Director at that time revealed the equipment should be cleaned daily or as needed.

7. Observation of room 238 on 3/10/17 at 9:15 AM revealed the base of the intravenous pole (IV pole) used to hang the resident's tube feeding formulation had several tan/light brown spots on it.

Accompanied by the Environmental Director, another observation was made of the IV pole in room 238 on 3/10/17 at 1:20 PM which revealed the base of the pole had several tan/brown dried spots on it. Upon seeing the IV pole, the Environmental Director stated, "That's not good." The Environmental Director reported she would have housekeeping staff scrape the tan/brown substance off of the base.

8. Observation of the bed frame in room 109, by the window, on 3/8/17 at 9:45 AM revealed dried yellow substance was observed on the sides of the bed frame.

Observation on 3/10/17 at 10:00 AM revealed the bed frame had the dried yellow substance on it.

Interview with the Environmental Director on 3/10/17 at 10:00 AM revealed the bed frame in room 109 should be cleaned. The last deep cleaning that was completed for that room was on 2/15/17.

An interview was conducted on 3/10/17 at 3:30

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F 253	Continued From page 17 PM with the facility's Director of Nursing. During the interview, the DON stated her expectations for findings upon entry was for the facility to be a clean and homelike environment. She reported the staff knew they were to keep personal belongings in the employee lounge. The DON also stated that staff had lockers in the Homestead unit. She reported that personal items were not supposed to be in residents' rooms or common areas on any of the halls. Upon inquiry regarding her expectation Resident #11's IV pole observed to have dried tan/light brown spots on its base, the DON stated she would expect the pole to be cleaned daily and as needed.	F 253		
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to follow the care plan for interventions to prevent weight loss for three of six sampled residents on supplements (Residents #9, #7 and # 10.) The findings included: 1. Resident #9 was admitted to the facility on 1/23/17 with diagnoses including amputation of	F 282	Resident #9, #7 and #10 have received the prescribed supplements as per care plan interventions. Audit was completed by the Registered Dietitian (RD) to identify residents on supplements on 3/10/17. Twenty-two residents were identified as having orders for supplements. RD, CNE and ACNE audited nutritional care plans for interventions to prevent weight loss on	4/4/17

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F 282	Continued From page 18 the left leg above the knee (AKA), diabetes, kidney failure, right foot transmetatarsal amputation (amputation of the toes), Clostridium Difficile (intestinal infection) and dysphagia (difficulty swallowing). Review of the physician orders dated 1/27/17 included house supplement three times a day for inadequate oral intake. The Admission Minimum Data Set (MDS) dated 1/31/17 indicated Resident #9 had long and short memory problems, required meal set up and was independent with eating. The resident's weight was 85 pounds and no weight loss had occurred. Review of the care plan dated 2/1/17 included a problem of nutritional concern related to her diagnoses, and a Body Mass Index (BMI) that was less than 19. (This indicated a nutritional risk for malnutrition) The stated goal indicated the resident would consume of at least 75% of most meals, increase protein intake with current diet order and she would maintain a stabilized weight with no significant changes through next review. The interventions were as follows: evaluate for proper consistency of diet, offer/encourage fluids of choice, weight per policy and alert dietitian and physician to any significant loss or gain, monitor for changes in nutritional status (changes in intake, unplanned weight loss/gain) and report to food and nutrition/physician as indicated, provide diet as ordered, house supplement as ordered and offer alternate food choices if less than 50% consumed at mealtime. Observation upon entry on 3/8/17 at 5:15 AM revealed a tray of supplements for residents was sitting on the conference room table. The	F 282	3/28/17. Residents' care plans were reviewed to identify residents that have interventions for supplementation to prevent weight loss. Twenty-two residents were identified. Supplement delivery process was changed for licensed staff to deliver supplements and document consumption on Medication Administration Record (MAR). Licensed nurses, including part time and weekend nurses, were inserviced on delivering the supplements to their assigned residents and documenting consumption on the MAR. If the resident refuses five times in a one week period, the RD will be notified by completing a diet order and communication form. CNE, ACNE and UM will complete audit supplement delivery and compare documentation of consumption for two residents per unit, alternating delivery times 5 times x 1 week (including 1 weekend day), 2 times/week x 3 weeks (including 1 weekend day), 1 time/week x 2 months (including 1 weekend day). All findings from audits will be brought to monthly Quality Assurance Committee.	

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supplements were warm to touch and included Resident #9 for the dates of 3/5/17 and 3/6/17. There were two cartons dated 3/5/17 and three cartons for 3/6/17. The Director of Nursing was observed removing the tray and taking it to the kitchen on 3/8/17 at 5:44 AM.
Review of Resident #9's Kardex information dated 3/8/17 included the aides were to provide diet and house supplements as ordered.

Interview on 3/9/17 at 9:31 AM with the Dietary Manager indicated supplements were placed on trays labeled 1, 2, & 3 and then delivered from the kitchen to 4-nourishment room refrigerators by 10:00 AM and 2:00 PM. The supplements placed in nourishment rooms at approximately 9:00 AM. The 8:00 PM supplements were placed in the nourishment rooms between 1:00 and 2:00 PM.

Interview with Resident #9 on 3/9/17 at 9:54 AM revealed she didn't like eggs and had refused them. The tray ticket indicated the eggs were a double portion provided for protein. Further interview revealed she didn't like the house supplement and indicated she did not like the vanilla flavored supplement. During the interview, Resident #9 explained she had not been asked if she would prefer a different flavor. If she could have something different, she would like strawberry.

Interview with Nursing Assistant #4 on 3/9/17 at 9:55 AM revealed Resident #9 had refused the eggs and asked him to remove them. A substitute was not offered in exchange for the double portion eggs for protein.

Interview with Nurse #4 on 3/9/17 at 12:00 PM revealed she worked on 3/6/17 day shift. The

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documentation of the supplement would have been from the aide's report to her. When explained the supplements were found on 3/8/17 at 5:30 AM in the conference room, on a tray, unopened, she replied "in the conference room." No explanation could be provided as to why the supplements had not been provided.

Interview with the unit manager on 3/9/17 at 4:01 pm revealed the house supplements would be ordered by the physician. Dietary would be sent the supplements for the time it was ordered. The aide usually passed the snack/supplement. For the supplement it would be documented on the Medication Administration Record (MAR) by the nurse. The nurse would document the percentage consumed by the resident. It was not the expectation the nurse would give the supplement. If a resident did not like it/refused it, the nurse should notify the unit manager or dietician of the refusal or dislike. No one had informed her she did not like the supplement and/or refused it. Either the aides were not reporting it or the nurses were not asking the aides about amount consumed.

Interview with the DON on 3/9/17 at 4:49 PM revealed her expectation of nursing to provide supplements would be for the staff to provide them to the resident, and the nurse would document the percentage after it had been consumed. The DON did not know why the tray of supplements had been in the conference room or why they were not given to the residents. The DON explained a weight should have been obtained on 3/6/17 and it was not obtained. She further explained the same staff was not obtaining the weights and errors had occurred.

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2. Resident #7 was admitted to the facility on 11/23/16 with diagnoses including diabetes, protein-calorie malnutrition, chronic kidney disease, dementia, and dysphagia. The resident's weight on admission was 108 pounds.

Review of the care plan dated 11/28/16 included problems of requiring assistance/dependent for activities of daily living. The interventions for the problem included to provide the resident with one person extensive assistance for eating. The care plan identified a problem for nutritional risk related to his diseases and a pressure ulcer. The stated goals indicated Resident #7 would maintain a stabilized weight with no significant changes and consume at least 75% of most meals daily through next review. The interventions included diet as ordered, a dysphagia pureed with nectar-like liquids, house supplement as ordered, weigh per policy and alert dietitian and physician to any significant loss or gain, monitor for changes in nutritional status, changes in intake, ability to feed self, unplanned weight loss/gain, or abnormal labs and report to nutrition/physician as indicated.

Review of the physician orders dated 12/1/16 revealed an order for house supplement three times a day.

Review of a Significant Change Minimum Data Set (MDS) dated 12/15/17 indicated Resident #7 had short and long term memory impairment, required extensive assistance of one person for eating and he was receiving hospice services. The MDS assessed his weight as 110 pounds with no significant weight change.

Review of a nurse's note dated 3/6/17 at 12:55 by

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nurse #5 revealed " ... no refusals. House Supplement three times a day for Body Mass Index (BMI) <19."

Review of the March Medication Administration Record (MAR) for Resident #7 revealed documentation by the nurse the house supplement was given three times a day at 10:00 AM, 2:00 PM and 8:00 PM on 3/5/17 and 3/6/17. The supplement was documented as 100% for 3/9/17 at 10:00 AM.

Observations upon entry on 3/8/17 at 5:15 AM revealed a tray of supplements for residents was sitting on the conference room table and included Resident #7 for the dates of 3/5/17 and 3/6/17. There were two cartons dated 3/5/17 and three cartons for 3/6/17. The Director of Nursing was observed removing the tray and taking it to the unclean side of the kitchen on 3/8/17 at 5:44 AM.

Interview on 3/9/17 at 9:31AM with the Dietary Manager indicated supplements were placed on trays labeled 1, 2, & 3 and then delivered from the kitchen to 4-nourishment room refrigerators by 10:00 AM and 2:00 PM supplements placed in nourishment rooms at approximately 9:00 AM. The 8:00 PM supplements were placed in the nourishment rooms between 1-2:00 PM.

Observation of the supplement for Resident #7 on 3/9/17 at 11:30 AM revealed the shake was in the trash with the name of the resident and the date of 3/9/17 and snack 1 (10:00 AM snack). The carton was half full.

Interview on 3/9/17 at 11:45 AM with nurse #5 revealed she did not give the supplement to Resident #7. The nursing assistant #6 gave it to

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the resident. She further explained, to document 100% consumed the carton would have been completely empty. She explained the carton for 10:00 AM was not empty and would not be 100%. The nursing assistants would inform her of the percentage after giving it to the resident. She could not remember who told her it was 100%.

Interview with the nursing assistant #6 on 3/9/17 at 11:50 AM revealed she had not given the supplement to the resident. Nursing assistant #6 stated it must have been the hospice aide/nurse.

Interview with the unit manager on 3/9/17 at 4:01 pm revealed the house supplements would be ordered by the physician. Dietary would be send the supplements for the time it was ordered. The aide usually passed the snack/supplement. For the supplement it would be documented on the Medication Administration Record (MAR) by the nurse. The nurse would document the percentage consumed by the resident. It is not the expectation the nurse would give the supplement. If a resident did not like it/refused it, the nurse should notify the unit manager or dietician of the refusal or dislike. No one has informed her she did not like the supplement and/or refused it. Either the aides are not telling or the nurses are not asking.

Interview with the DON on 3/9/17 at 4:49 PM revealed her expectation of nursing to provide supplements would be for the staff to provide them to the resident, and the nurse would document the percentage after it had been consumed. The DON did not know why the tray of supplements had been in the conference room or why they were not given to the residents.

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3. Resident # 10 was admitted to the facility on 12/12/08 with diagnoses including stroke, dysphagia, and hemiplegia non dominant side.

Review of the Quarterly Minimum Data Set (MDS) dated 1/6/17 revealed Resident #10 had short and long term memory impairment and required set up and supervision of one staff for eating. His weight was 100 pounds with no loss in the past 30 days.

The care plan dated 1/20/17 for a problem of nutritional concern related to history of weight loss, cognitive impairment, difficulty in chewing/swallowing and refuses weights at times. The stated goal included Resident #10 would maintain weight with no significant weight changes through next review. The interventions included for staff to encourage him to consume all fluids during meals, provide diet as ordered, supervise and cue or assist as needed with meals.

Review of the diet order dated 1/20/16 indicated the diet was a regular/liberalized diet, dysphagia puree texture, thickened liquids of nectar consistency.

Review of the dietician note of 2/22/17 revealed she added double portions to the diet order and also nectar thick milk with meals in order to increase caloric intake.

Observation of Resident #7's tray on 3/10/17 at 9:20 AM revealed he had orange juice to drink and no milk.

Interview with nursing assistant #6 on 3/10/17 at 9:36 AM revealed he delivered the tray, but did

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F 282	Continued From page 25 not set up the tray with the drinks. NA #6 stated the nursing assistants worked together to set up trays, and one of the other aides set up the drinks. Nursing assistant #6 explained there was thickened orange juice on the tray, but there was no milk. Interview with nursing assistant #7 on 3/10/17 at 9:42 AM revealed she followed the tray ticket to add the drinks to the tray. The tray ticket was reviewed with the nursing assistant #7 and she explained the "thickened milk" on the right side of the tray ticket let them know he would receive thickened milk when provided. This nursing assistant further explained, she would know if he was to have something at each meal, by the middle section of the tray ticket. If Resident #10 was to have milk at each meal, it would be in the middle section and say "at each meal." Interview with the Dietary Manager on 3/10/17 at 9:53 AM revealed the drinks that should be provided at each meal are under the notes on the right side of the tray ticket. The nectar thick milk should be provided at each meal. The other section (middle section) was for dislikes. He was not aware the nursing assistants did not know how to read the tray ticket correctly.	F 282		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		4/4/17

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F 309	Continued From page 26 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews, dermatology office staff and Medical Director interviews, and record reviews, the facility failed to evaluate and effectively treat a resident's itching skin condition due to a delay in the scheduling of a dermatology consultation (a specialty branch of medicine that deals with the diagnosis and treatment of diseases that involve the skin) ordered by the physician for 1 of 4 sample residents (Resident #2) reviewed for the provision of care to maintain	F 309	Resident #2 was seen by Dermatology on 12/7/16, new orders received and implemented. Skin assessment was completed on resident #2 on 3/27/17 by licensed nurse and was negative. CNE, ACNE and Regional Resource Nurse Manager completed an audit of physician orders and consultant reports for January, February and March of 2017	

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well-being. This resulted in delayed treatment and prolonged discomfort for the resident.

The findings included:

Resident #2 was admitted to the facility on 11/10/15 from the community. His cumulative diagnosis included Alzheimer ' s disease.

A review of Resident #2 ' s quarterly Minimum Data Set (MDS) assessment dated 2/3/17 revealed the resident had severely impaired cognitive skills for daily decision making. Resident #2 was independent for transfers, walking in his room and corridor, locomotion off the unit, and eating. He required supervision for all of his other Activities of Daily Living (ADLs).

On 10/2/16, a "Change in Condition-Skin" form indicated Resident #2 had a rash/dermatological disorder. Notes indicated he had a skin rash to his entire back, with redness and raised areas.

A Nursing Communication form dated 10/2/16 also noted the problem was observed, reporting the resident ' s entire back and surrounding skin areas were reddened and had some sort of rash or break out. The form indicated Resident #2 complained of itching. He was given 25 milligrams (mg) of diphenhydramine (an antihistamine) with relief of itching. However, the rash remained. A handwritten note on the Nursing Communication form dated 10/5/16 read, "(name of Medical Doctor or MD) Assessed 10/3/16."

Further review of the resident ' s medical record revealed a Physician Order was written on 10/3/16 for 1% hydrocortisone cream (a topical

for appointments on 3/14/2017 and 3/15/2017. No missing appointments were found.

CNE , ACNE will bring the MD orders for consultations will be brought to stand-up every morning for review of all appointments which will be compared to the schedule in the computer, which is entered into the calendar by the nursing secretary. Nursing secretary will attend stand-up meeting and bring weekly schedule of appointments to review and any cancellations. Follow-up appointment information will be given to the CNE and ACNE. Inservice was given to van drivers 3/15/17 by the CNE on making copies of follow-up information and providing copies to the nursing secretary, CNE and ACNE. A weekly meeting will be held with nursing secretary, CNE and ACNE to ensure all appointments were kept, and recommendations were addressed, family cancelled or resident refused and Medical Director was notified.

All findings from weekly meetings will be brought to monthly Quality Assurance Committee for 3 months.

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steroid medication) with instructions to apply the medication to the resident ' s back and affected areas topically every day and evening shift for the rash to his back for 7 days. An order was also written for 100 mg doxycycline (an antibiotic) to be given by mouth twice daily for 14 days due to a rash.

Resident #2 ' s medical record included additional "Change in Condition-Skin Follow-up" forms dated 10/4/16 and 10/5/16. The rash continued to be present.

A Physician Order was also received on 10/5/16 for initiation of 40 mg prednisone (an oral steroid medication) to be given as one tablet by mouth every day for 10 days for dermatitis.

The resident ' s medical record included an additional "Change in Condition Follow-up" form completed on 10/6/16. The rash was reported to be present at the time of the assessment.

A "Skin Check" form was completed on 10/17/16. The rash was reported to be present at the time of this skin check.

On 10/17/16, a Nurse Practitioner (NP) progress note revealed the resident was seen for the evaluation of a rash which had been a problem for the past 2 weeks. The resident was reported to describe the rash as moderately pruritic (itchy). The resident ' s history was negative for the addition of a new medication or use of a new detergent (which indicated these were not likely causes for the rash). The NP notes reported the resident had dermatitis with a red raised diffuse rash on his back. The plan of care included the use of hydrocortisone cream to be applied to the

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affected areas twice daily; and, a request for a dermatology consult.

A review of Resident #2 ' s medical record revealed a Physician Order was received on 10/17/16 to initiate 1% hydrocortisone cream applied to affected areas topically every day and evening shift for "rash" dermatitis. The Physician Order also requested a dermatology consult be made for the resident due to dermatitis. Nurse #2 ' s signature on the order form indicated she was the nurse who received the Physician Orders on 10/17/16.

The resident ' s medical record revealed a "Skin Check" form was completed on 10/24/16. No skin injuries/wounds were noted. The presence of a rash was not reported on the skin check.

On 10/28/16, Resident #2 was seen again by the NP. The NP noted, " ...He presents with dermatitis ...I am seeing this patient for a sick visit at the request of the patient." Notations from the visit also included the following: " ...He is complaining of itching to his back. The patient has diffuse dermatitis to his back, hydrocortisone cream has provided some relief of the itching, but symptoms still persist. (Resident #2) has an appointment scheduled with dermatology ..." New orders included 40 mg prednisone for 10 days for a primary diagnosis of dermatitis, unspecified.

A review of the resident ' s medical record included a Nursing Note dated 10/31/16 at 5:52 AM. The note indicated a skin check was performed. A description of the rash reported: "Back rash for entire back and near shoulders and upper arm area. Treatment in place.

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Dermatologist consult."

Resident #2 ' s medical record included a "Skin Check" form completed on 11/14/16. The presence of a rash previously reported was noted on this skin check. A review of another "Skin Check" form dated 11/21/16 revealed the form was blank; no information was provided on the form.

Resident #2 ' s medical record included documentation of the dermatology consultation visit on 12/6/16. Information on the visit report noted the resident ' s symptoms as "itch" with "moderate" severity. A "Report of Consultation with Dermatologist" dated 12/6/16 was also reviewed. The report indicated Resident #2 had a "very itchy rash all over." The rash was noted as widespread, with burrows in between fingers and on his trunk. Testing indicated live mites and eggs were present, and the dermatologist noted the resident had "Crusted Scabies." Three medications were initiated and included: 3 mg Ivermectin (a medication used to treat parasitic infestations) to be given as 6 tablets by mouth at once on days 1, 2, 8, and 9; 5% Elimite (a topical anti-parasitic medication) with instructions to apply the topical cream to the entire body (neck down) on days 1 and 8; and, 0.1% triamcinolone acetonide cream (a topical steroidal cream) with instructions to apply the cream topically twice daily to the affected areas as needed for itching.

Further review of the resident ' s medical record included a Nursing Note dated 12/7/16 at 11:06 PM. The nursing note indicated Resident #2 ' s rash was on his back/bilateral arms with increased itchy skin; now being treated by dermatology.

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Resident #2 ' s medical record included nursing notes dated 12/9/16 and 12/10/16 which reported the status of the resident ' s condition as improved. A nursing note dated 12/10/16 at 1:41 AM revealed the resident had no complaints of itching.

A telephone interview was conducted on 3/8/17 at 2:22 PM with a staff member of the Dermatology office where Resident #2 had been seen for treatment on 12/6/16. The Dermatology office confirmed the resident was seen for an appointment once on 12/6/16. The records at their office revealed this appointment was arranged by the facility on 11/17/16 and scheduled for 12/6/16 at that time.

An interview was conducted on 3/9/17 at 12:28 PM with Nurse #2. During the interview, Nurse #2 confirmed she had verified the order for the dermatology consult written on 10/17/17. Upon inquiry, Nurse #2 reported that after verifying the order, she would have called "the scheduler" for the facility and informed her of the need to arrange the dermatology consult.

An interview was conducted on 3/9/17 at 12:55 PM with the facility ' s Unit Secretary. The Unit Secretary reported she was the scheduler for outside appointments and consultations. Upon inquiry, she reported that she was notified of requests for outside consults from the physician, the hall nurse, or upon receipt of a copy of the computer Order Entry or physician order.

A follow-up interview was conducted on 3/9/17 at 3:00 PM with the Unit Secretary. During the interview, the Unit Secretary stated she confirmed

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F 309	Continued From page 32 with the dermatology office that the appointment made for Resident #2 on 12/6/16 was arranged on 11/17/16. The Unit Secretary reported she thought a "communication issue" was likely the cause of the delay between when the order was written for a dermatology consult on 10/17/16 until the appointment was arranged on 11/17/16. A telephone interview was conducted on 3/10/17 at 3:10 PM with the facility ' s Medical Director. During the interview, concerns were discussed regarding the one month delay between when the order for a dermatology consult was written and when the appointment was arranged for Resident #2. When asked what the Medical Director ' s thoughts were about this delay, he stated, "We write the order, we expect it to be carried out." An interview was conducted on 3/10/17 at 3:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns were discussed in regards to the delay in arranging a dermatology consult for Resident #2. Upon inquiry, the DON stated her expectation would be for the consultation order to be given to the Unit Secretary when it ' s ordered, and for the Unit Secretary to arrange the appointment either the day the order was written or the next business day.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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:	F 312		4/4/17

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F 312	Continued From page 33 Based on observations, resident interviews, and staff interviews, the facility failed to provide grooming services for a dependent resident as evidenced by not trimming toe nails or shaving facial hair for 1 of 5 sampled residents (Resident #11) reviewed for the provision of Activities of Daily Living (ADL) care. The findings included: Resident #11 was admitted to the facility on 2/14/13 from a hospital. The resident ' s cumulative diagnoses included cerebral palsy, contractures, speech disturbance, and dysphonia (difficulty in speaking due to a physical disorder of the mouth, tongue, throat, or vocal cords). A review of Resident #11 ' s annual Minimum Data Set (MDS) dated 1/6/17 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance for bed mobility, dressing, toileting, and personal hygiene. The resident was totally dependent on staff for all of her other Activities of Daily Living (ADLs), including transfers, locomotion, eating, and bathing. A review of Resident #11 ' s care plans included the following areas of focus: --Resident needs assistance to and from group programs. She is mainly non-verbal and uses gestures and yes/no questions for communication... (Revision on: 7/6/16) --Resident is dependent for ADL care in bathing, grooming, dressing, eating (tube feed), bed mobility, transfer, locomotion, toileting due to cerebral palsy, multiple contractures ... (Revision on: 1/20/17).	F 312	Resident #11 toenails were trimmed on 3/10/17 by licensed nurse. Resident #11's facial hair was removed on 3/10/17 by nursing assistant. Audit of in house residents' toenails was completed during the week of 3/20/17 by licensed nurses. Five resident's toenails were trimmed by Regional Resource Nurse Manager, twenty-five residents are diabetic or have circulation problems were placed on the podiatry list to see on 4/4/17, 4/18/17 and 4/19/17. Audit was completed for facial hair for female residents during the week of 3/20/17 by licensed nurses. One resident was identified as needing facial hair removed and the facial hair was removed on 3/20/17 by nursing assistant. Nursing staff, including licensed nurses and nursing assistant were inserviced on providing nail care and removing facial hair during care by NPE starting on 3/21/17 and completed on 4/4/17. Stop and Watch form was updated to include nail assessment and facial hair. Nursing staff was inserviced during starting on 3/21/17 and completed on 4/4/17. The updated Stop and Watch form to identify if toenails need to be trimmed. The form then goes to the licensed nurse for follow-up. Nursing administration, CNE, ACNE and UM, to complete audit starting on 3/31/17 for facial hair and nails of 10 residents per day on each unit for 5 days x 1 week, then 3x weekly for 3 weeks, then weekly for 2 months to monitor toenail care and facial hair	

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F 312	Continued From page 34 An observation was made on 3/9/17 at 9:54 AM of Resident #11 lying in her bed with covers on. The resident was observed to have obvious multiple contractures, including her neck, upper extremities, and hands. The resident ' s upper body appeared to be leaning towards the right side of the bed. However, her right foot was exposed and sticking out from under the covers off to the left side of the bed. The resident ' s toe nails on the exposed right foot were approximately ½" long. The toe nails were not trimmed. The right big toe nail had a jagged edge and the remaining toe nails on the right foot appeared to be curled over the tip of the toes. Upon further observation, Resident #11 was noted to have several black, facial hairs approximately ¾" long at each corner of her mouth. An accumulation of a yellow substance was also noted at the corners of the resident ' s mouth (left side more than the right). The resident ' s hair did not appear to be groomed. On 3/9/17 at 10:17 AM, Nursing Assistant (NA) #1 was observed as she prepared to give Resident #11 a bed bath. An interview was conducted on 3/9/17 at 10:18 AM with NA #1. Upon inquiry as to what tasks would be completed along with the bed bath, the NA reported that after she finished bathing the resident, she would put deodorant on and provide mouth care for the resident. An observation was made on 3/9/17 at 12:20 PM of Resident #11 as she was sitting in a reclined Broda chair by the 2 North Hall nursing station. The resident appeared clean and odor free. She was dressed in clean clothes. The resident ' s mouth appeared clean and her hair was combed	F 312	removal. The CNE will assess for trends and present to the Quality Assurance Committee monthly for 3 months.	

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and pulled back into a pony tail. Resident #11 ' s facial hair was not trimmed. The resident was wearing socks so her toe nails were not visible.

An observation was made on 3/9/17 at 4:00 PM of Resident #11 sitting in a reclined Broda chair by the nursing station on the 2 South Hall. The resident was wearing street clothes and socks. Her toe nails were not visible. Resident #11 was noted to have facial hair as previously observed.

An observation was conducted on 3/10/17 at 7:20 AM of Resident #11 lying in her bed. The resident was awake and alert. The resident ' s facial hair at the corners of her mouth was noted as unchanged from previous observations made on 3/9/17. The resident ' s feet were covered by a blanket.

An interview was conducted on 3/10/17 at 9:47 AM with NA #2. NA #2 was assigned to care for the resident. Upon inquiry, the NA was asked when Resident #11 ' s nails were trimmed and facial hair shaved. The NA reported her fingernails were trimmed on shower days and as needed. However, NA #2 reported she herself did not trim the resident ' s toe nails and thought either the nurse or podiatrist did. The NA reported she shaved the resident ' s facial hair on an as needed basis.

Accompanied by NA #2 on 3/10/17 at 9:54 AM, an observation was conducted of the resident in her room. With consent of the resident, the NA was asked to uncover the resident ' s feet for observation. Upon seeing the resident ' s toe nails, NA #2 stated, "These need to be trimmed." The NA confirmed the resident ' s toe nails were at least 1/2" long.

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An interview was conducted on 3/10/17 at 10:04 AM with Nurse #1. Nurse #1 was the hall nurse assigned to care for Resident #11. Upon inquiry, the hall nurse reported that if Resident #11 ' s toe nails needed to be trimmed, the nurse would tell Medical Records and they would put her on a list for a quarterly podiatry visit. The nurse also reported that if her toe nails needed to be trimmed before then, she would trim them herself.

Accompanied by Nurse #1 on 3/10/17 at 10:05 AM, an observation was conducted of the resident in her room. Upon viewing the resident ' s toe nails, the nurse stated, "Oh yeah, that one ' s got to go." The nurse also confirmed the resident ' s other toe nails also needed to be trimmed.

On 3/10/17 at 12:00 PM, an interview was conducted with Resident #11 in her room on the 2 South Hall. At the time of the interview, the resident ' s right foot was sticking out from under the bed covers. Her toe nails were observed to have been trimmed. When the resident was asked if it felt good to have her toe nails trimmed, the resident smiled and nodded. The resident was observed to have several black facial hairs approximately 3/4" long at each corner of her mouth as previously noted. Upon inquiry, the resident indicated by nodding that she did want facial hair shaved off by staff. When asked, the resident shook her head to indicate that she did not like having facial hair. Prior to leaving the room, the resident attempted to verbalize something (not understandable). When asked if she needed help, the resident nodded to indicate she did. Upon exiting the room, the resident was

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F 312	Continued From page 37 told staff would be alerted to her need for assistance. On 3/10/17 at 12:02 PM, an interview was conducted with Nurse #1 at the nursing station. When the nurse looked up, she immediately reported the resident ' s toe nails had been trimmed. At that time, the surveyor alerted this nurse the resident was needing assistance with something that she could not verbalize. On 3/10/17 at 12:03 PM, Nurse #1 was observed as she went into the resident ' s room. At that time, Nurse #1 was asked what her thoughts were about the resident ' s facial hair. The nurse stated that it would be taken care of. An interview was conducted on 3/10/17 at 3:30 PM with the facility ' s Director of Nursing (DON) in regards to the observations made of Resident #11 ' s untrimmed toe nails and facial hair. When asked, the DON reported Resident #11 was reliable in providing yes/no answers to questions posed by nodding (to indicate ' yes ') or shaking her head (to indicate ' no '). The DON stated her expectation would be, "For it (grooming of nails and facial hair) to be done when it ' s needed."	F 312		
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 325		4/4/17

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F 325	Continued From page 38 (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to provide diet interventions for weight loss prevention for 1 of 6 sampled residents (Residents # 9) when house supplements were not provided and failed to review the interventions and make changes in the interventions for 1 of 6 residents (Resident #9) when she refused the supplement and continued to have unintended weight loss. The facility failed to provide diet interventions of supplements to assist in maintaining their weight for 2 of 6 sampled residents (Residents #7 and 10). The findings included: 1. Resident #9 was admitted to the facility on 1/23/17 with diagnoses including amputation of the left leg above the knee (AKA), diabetes, kidney failure, right foot transmetatarsal amputation (amputation of the toes), Clostridium Difficile (intestinal infection resolved) and dysphagia (difficulty swallowing). Review of the admission "Nutritional Assessment" dated 1/25/17 indicated Resident #9 weighed 85.2pounds on admission, and her Body Mass Index (BMI) was 18.1. The prescribed diet was	F 325	The tray of supplements in the Conference Room was taken to the kitchen for disposal on 3/9/17 by the CNE. Resident #9 was interviewed by the RD on 3/10/17 for supplement preference and changed supplement flavor from vanilla to strawberry. The nurse who documented that the supplement was given was inserviced by the CNE on proper documentation. An inservice was given 3/10/17 to nursing assistant on how to read meal tickets and offer alternate if a resident does not like what is being served. RD interviewed the residents who were receiving supplements for their preference on 3/10/17. No other resident was identified as not receiving their preference. The system of passing the supplements has been changed to licensed nurses delivering the supplements to their residents and documenting consumption in the MAR. Licensed nurses were	

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F 325	Continued From page 39 regular/liberalized with a dysphagia puree texture. The "Nutrition History" included in part, the puree diet was due to holding food in her mouth, her intake was fair, she was able to feed herself with set up assistance, was on weekly weights and had an adjusted BMI due to the left AKA. This assessment indicated Resident #9 had increased protein needs required for wound healing due to open area on top of the left thigh, right lower surgical incision and left AKA surgical incision. The interventions included to provide meals and snacks as ordered, staff to encourage good intake with a goal to promote wound healing and maintain weight with no significant changes through next review. Review of the physician orders dated 1/27/17 included house supplement three times a day for inadequate oral intake. A nutrition progress note dated 2/28/17 indicated a wound review was made of an unstageable right heel pressure ulcer. Resident #9 had an oral intake that improved and she was eating 50-100% of meals. Resident #9 was also receiving supplementation: "house shake TID (three times a day) which provides additional 600 kilocalories and 18 grams protein. Currently meeting/exceeding calorie/protein needs in order to promote wound healing ..." The Admission Minimum Data Set (MDS) dated 1/31/17 indicated Resident #9 had long and short memory problems, required meal set up and was independent with eating. The resident ' s weight was 85 pounds and no weight loss had occurred. Review of the care plan dated 2/1/17 included a problem of nutritional concern related to her	F 325	inserviced on the supplement delivery system change on 3/23/17 by the Nurse Practice Educator (NPE). RD completed an audit to identify residents who were on supplementation 3/10/17,two residents were identified of residents supplement on their meal tray. The two residents identified having supplements on their meal tray will have their supplement be given by licensed nurse and consumption entered on the MAR. Nursing education was provided by NPE on 3/23/17 on documenting refusal of supplementation in MAR and notifying the RD after five refusals in a one week period by completing the diet order communication form and placing the form in the RD's box in the back service hallway. CNE, ACNE and UM will complete audit supplement delivery and compare documentation of consumption for 2 residents per unit, alternating delivery times, 5 times x 1 week (including 1 weekend daily), 2 times/week x 3 weeks (including 1 weekend daily), 1 time/week x 2 months (including 1 weekend day). All findings from audits will be brought to monthly Quality Assurance Committee for 3 months.	

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diagnoses, and a BMI that was less than 19. This is an indicator for nutritional risk for malnutrition. The stated goal indicated the resident would consume of at least 75% of most meals, increase protein intake with current diet order and she would maintain a stabilized weight with no significant changes through next review. The interventions were as follows: evaluate for proper consistency of diet, offer/encourage fluids of choice, weight per policy and alert dietitian and physician to any significant loss or gain, monitor for changes in nutritional status (changes in intake, unplanned weight loss/gain) and report to food and nutrition/physician as indicated, provide diet as ordered, house supplement as ordered and offer alternate food choices if less than 50% consumed at mealtime.

Review of the weight for 2/1/17 was 83.6 pounds.

Review of a physician order dated 2/1/17 to increase protein intake to at least 70 grams daily. Add lean meat, eggs, yogurt, beans, low fat dairy or protein shakes.

A nutrition progress note dated 2/28/17 indicated a wound review was made of an unstageable right heel pressure ulcer. Resident #9 had an oral intake that improved and she was eating 50-100% of meals. Resident #9 was also receiving supplementation: "house shake TID (three times a day) which provides additional 600 kilocalories and 18 grams protein. Currently meeting/exceeding calorie/protein needs in order to promote wound healing ..."

Interview with the DON on 3/10/17 at 2:00 PM revealed Resident #9 may have had weight loss from a cast that was removed from her arm. A

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date of 2/13/17 was provided for the removal of the cast.

Review of the 30 day MDS dated 2/18/17 indicated Resident #9 had improvements in her cognition with no long or short term memory problems.

Review of the Medication Administration Record (MAR) for February revealed Resident #9 had refused the house supplement 16 times.
The documented intake varied from 25% to 100% of the house supplement.

Review of the meal intake for the month of February revealed breakfast and lunch was 50% consumed with 14 days not documented, and supper intake was from 25% to 100%.

Review of the weight for 2/20/17 (after the cast was removed) was 85.8 pounds (no documented method for weighing). This indicated Resident #9 had a gain of 0.2 pounds after the cast was removed. The next weight was obtained on 3/3/17 with a weight of 77.8 pounds (use of a wheelchair for weighing). The weight loss for one month was 9.3%.

Review of the March Medication Administration Record (MAR) for Resident #9 revealed the house supplement was documented for the dates of 3/5 and 3/6 as 100% consumed for 10:00 AM, 2:00 PM and 8:00 PM.

Observations upon entry on 3/8/17 at 5:15 AM revealed a tray of supplements for residents was sitting on the conference room table. The supplements included Resident #9 for the dates of 3/5/17 and 3/6/17.There were two cartons

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dated 3/5/17 and three cartons for 3/6/17.

The Director of Nursing was observed removing the tray and taking it to the kitchen on 3/8/17 at 5:44 AM.
Review of Resident #9 ' s Kardex information dated 3/8/17 included the aides were to provide diet and house supplements as ordered.

Observations on 3/9/17 revealed dietary delivered the Snacks/supplements to the floor at 9:47 AM. The supplements were placed in a refrigerator in the nourishment room.

Interview with Resident #9 on 3/9/17 at 9:54 AM revealed she didn ' t like eggs and had refused them. The tray ticket indicated the eggs were a double portion provided for protein. Further interview revealed she didn ' t like the house supplement and indicated she did not like the vanilla flavored supplement. During the interview, Resident #9 explained she had not been asked if she would prefer a different flavor. If she could have something different, she would like strawberry. The tray ticket included dislikes of cottage cheese and yogurt, likes of bacon and scrambled egg, and she was to have double protein. Observations during interview with Resident #2 ' s breakfast tray revealed she ate dry cereal with milk and bacon.

Interview with Nursing Assistant #4 on 3/9/17 at 9:55 AM revealed Resident #9 had refused the eggs and asked him to remove them. A substitute was not offered in exchange for the double portion eggs for protein.

Interview with Nurse #4 on 3/9/17 at 12:00 PM revealed she worked on 3/6/17 day shift. The

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documentation of the supplement would have been from the aides report to her. When explained the supplements were found on 3/8/17 at 5::30 AM in the conference room, on a tray, unopened, she replied "in the conference room." No explanation could be provided as to why the supplements had not been provided.

Interview with Nursing Assistant #4 on 3/9/17 at 1:04 PM revealed he had passed out the supplements to the residents ' rooms that morning. For Resident #9, he attempted to offer the supplement, but she refused. He had not informed the nurse or documented the refusal. Review of the MAR for Resident #9 revealed the house supplement was recorded as 100% at 10:00 AM by Nurse #4.

Interview with the dietician on 3/9/17 at 3:09 PM revealed the process for obtaining weekly weights included the unit manager providing a list on Mondays for the nursing assistants. The aide assigned to that resident would obtain the weight. The unit nurse manager would document the weights in the computer and would let her know about the weights. For new admissions, the weights were obtained weekly for four weeks. If significant weight loss was noted, the weights would continue to be obtained weekly for four more weeks. The re- weights would be obtained if there was a (+ or -) 5 pound difference from the previous weight. The person responsible for reviewing the weights and requesting a re-weight would be the unit nurse manager. The unit nurse managers were responsible for monitoring the weight changes. The dietician further explained information about weight changes would not come to her on a weekly basis. She would review month to month of any changes in weights. She

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had not reviewed March ' s weights yet. If there was a significant weight loss, the unit manager would let her know. The dietician was asked if a resident refused the supplements or meals, would she be made aware. She explained the aides and nurses would tell her and they were good about letting her know the residents ' likes and dislikes. The communication was verbal and not documented. Further interview revealed she would review the nurses ' documentation on the MAR of the intake and percentage of the supplements for residents.

Interview with Resident #9 on 3/9/17 at 9:54 AM revealed she didn ' t like eggs and had refused them. The tray ticket indicated the eggs were a double portion provided for protein. Further interview revealed she didn ' t like the house supplement and indicated she did not like the vanilla flavored supplement. During the interview, Resident #9 explained she had not been asked if she would prefer a different flavor. If she could have something different, she would like strawberry. Interview on 3/9/17 at 4:01 pm with Nurse #5 (unit manager) revealed the nursing assistants were responsible for obtaining the weights on the residents they were assigned to for that day. The weight obtained on 3/3/17 was taken on a Friday. The re-weight was taken on 3/4/17 a Saturday. She worked on Monday, but as a floor nurse and had not reviewed the weights. A re-weigh would have been done on Tuesday if she had been working. Those (re-weights) were done if the weight change was plus or minus 5 pounds from the previous weight. For Resident #9, the nurse manager explained she thought the 3/4/17 weight was incorrect. Further explanation provided indicated she thought the nursing assistant had not subtracted

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the weight of the wheelchair after weighing the resident. The problems with Resident #9 ' s weights had not been discussed with the dietician.

Interview with Nurse #5 on 3/9/17 at 4:05 PM revealed the house supplements were passed by the nursing assistants. The nurse would document the percentage that had been consumed from a verbal report from the nursing assistant. If a resident did not like the supplement, that should be reported to the dietician or unit manager. Further interview revealed she had not been informed Resident #9 did not like the supplement and/or refused it. Nurse #5 further explained "Either the aides are not telling or the nurses are not asking."

Interview on 3/9/17 at 4:30 PM with the Director of Nursing (DON) revealed weights would be reviewed in the daily stand up meeting. The DON was not aware of Resident #9 ' s weight changes on 3/3/17 and again on 3/4/17 with a recorded weight of 114.8 pounds. Interview with the DON revealed a re-weight should have been done and she checked the re-weight sheet for the re-weights. An explanation provided indicated if the unit manager was not available, either she or the Assistant Director of Nursing would review the weights and requested a re-weight. The re-weight would have been done on Monday 3/6/17. Reviewing the re-weight sheet with the DON revealed a weight was not obtained on 3/6/17. The DON requested a re-weight to be obtained for Resident #9 on 3/9/17.

Interview with the DON on 3/9/17 at 4:49 PM revealed Resident #9 was just re- weighed at 4:45 PM on 3/9/17 and was 78.4 pounds. This

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weight indicated Resident #9 had experienced a 7.7% weight loss from 2/20/17 to 3/10/17. Further interview revealed the residents were not weighed by the same person, the same way and errors had occurred. Her expectation of nursing to provide supplements would be for the staff to provide them to the resident, and the nurse would document the percentage after it had been consumed. The DON did not know why the tray of supplements had been in the conference room or why they were not given to the residents.

2. Resident #7 was admitted to the facility on 11/23/16 with diagnoses including diabetes, protein-calorie malnutrition, chronic kidney disease, dementia, and dysphagia. The resident ' s weight on admission was 108 pounds. Review of the care plan dated 11/28/16 included problems of requiring assistance/dependent for activities of daily living. The interventions for the problem included to provide the resident with one person extensive assistance for eating. The care plan identified a problem for nutritional risk related to his diseases and a pressure ulcer. The stated goals indicated Resident #7 would maintain a stabilized weight with no significant changes and consume at least 75% of most meals daily through next review. The interventions which included diet as ordered, a dysphagia pureed with nectar-like liquids, house supplement as ordered, weigh per policy and alert dietitian and physician to any significant loss or gain, monitor for changes in nutritional status, changes in intake, ability to feed self, unplanned weight loss/gain, or abnormal labs and report to nutrition/physician as indicated.

Review of the physician orders dated 12/1/16 revealed an order for house supplement three

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times a day.
Review of a "Nutrition Assessment" dated 12/12/16 indicated Resident5 #7 ' s weight was 109.6 pounds on 12/6/16, his Body Mass Index (BMI was 16.2). Resident #7 ' s diet type was Regular Liberalized, with a texture of dysphagia puree and nectar liquids. A house supplement was provided three times a day. The assessment was completed due to a significant change assessment secondary to receiving hospice/comfort care on 12/2/16. Resident #7 was assessed with good oral intake on the current diet order with an intake of 50-100%. He continued to be dependent on staff for feeding assistance with meals and ate in his room. The house shake provided additional 600 kilocalories (kcal) and 18 grams of protein daily. The resident should be able to meet daily nutritional requirements based on current intake and supplementation.

Review of a Significant Change Minimum Data Set (MDS) dated 12/15/17 indicated Resident #7 had short and long term memory impairment, required extensive assistance of one person for eating and he was receiving hospice services. The MDS assessed his weight as 110 pounds with no significant weight change.

Review of the subsequent monthly weights revealed the following: 12/28/16 105 pounds, 1/3/17 106 pounds, 2/17/17 99.2 pounds, 3/4/17 118.8 pounds and 3/9/17 99 pounds.

A nutrition progress note dated 2/28/17 revealed the resident was seen due to significant weight loss in 30 days and monthly wound care review. His wound was a stage 2 sacral pressure ulcer. He continued to have good intake of 50 to 100%.

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House shake three times a day provided additional 600 kcal and 18 grams of protein. The dietician did not place him on weekly weights due to receiving hospice comfort care.

Review of a nurse ' s note dated 3/6/17 at 12:55 by nurse #5 revealed " ... no refusals. House Supplement three times a day for BMI <19." Review of the March Medication Administration Record (MAR) for Resident #7 revealed documentation by the nurse the house supplement was given three times a day on 3/5/17 and 3/6/17. The supplement was documented as 100% for 3/9/17.
Observations upon entry on 3/8/17 at 5:15 AM revealed a tray of supplements for residents was sitting on the conference room table. The supplements were warm to touch included Resident #7 for the dates of 3/5/17 and 3/6/17.There were two cartons dated 3/5/17 and three cartons for 3/6/17. The Director of Nursing was observed removing the tray and taking it to the unclean side of the kitchen on 3/8/17 at 5:44 AM.

Observation of the supplement for Resident #7 on 3/9/17 at 11:30 AM revealed the shake was in the trash with the name of the resident and the date of 3/9/17 and snack 1 (10:00 AM snack). The carton was half full.

Interview on 3/9/17 at 11:45 AM with nurse #5 revealed she did not give the supplement to Resident #7. The nursing assistant #6 gave it to the resident. She further explained, to document 100% consumed the carton would have been completely empty. She explained the carton for 10:00 AM was not empty and would not be 100%. The nursing assistants would inform her of the

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percentage after giving it to the resident. She could not remember who told her 100%.

Interview with the nursing assistant #6 on 3/9/17 at 11:50 AM revealed she had not given the supplement to the resident. It must have been the hospice aide/nurse.

Interview with nurse #5 on 3/9/17 at 12:00 PM revealed she worked on 3/5/17 and 3/6/17 day shift. The documentation of the supplement would have been from the nursing assistants report to her. The resident does not always drink the supplement, it varies. When explained the supplements were found on 3/8/17 at 5::30 AM in the conference room, on a tray, unopened, she replied "in the conference room." No explanation could be provided as to why the supplements had not been provided and her documentation had a percentage of an amount consumed for those dates.

Interview with the dietician on 3/9/17 at 3:40 PM revealed he received shakes three times a day to provide the additional calories and protein. She did the goal and care plan for Resident #7 ' s nutritional needs. The goal for this resident would not usually be achievable, normally she would put normal weight loss to be expected. When he first came in the facility, he was eating 100% of meals, and the family had him on hospice for a very long time prior to admission to this facility. There had not been communication to her over the past week of any change in his intake or condition.

Interview with the DON on 3/9/17 at 4:49 PM revealed Resident #7 was just re- weighed at 4:45 PM on 3/9/17 and was 99 pounds. Further

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interview revealed the residents were not weighed by the same person, the same way and errors had occurred. The weight of 118 pounds on 3/4/17 was not accurate. Her expectation of nursing to provide supplements would be for the staff to provide them to the resident, and the nurse would document the percentage after it had been consumed. Nurse #5 should have documented the actual percentage, and not what she thought the resident would consume. The DON did not know why the tray of supplements had been in the conference room or why they were not given to the residents.

3. Resident # 10 was admitted to the facility on 12/12/08 with diagnoses including stroke, dysphagia, and hemiplegia non dominant side. Review of the Quarterly Minimum Data Set (MDS) dated 1/6/17 revealed Resident #10 had short and long term memory impairment and required set up and supervision of one staff for eating. His weight was 100 pounds with no loss in the past 30 days.
The care plan dated 1/20/17 for a problem of nutritional concern related to history of weight loss, cognitive impairment, difficulty in chewing/swallowing and refuses weights at times. The stated goal included Resident #10 would maintain weight with no significant weight changes through next review. The interventions included for staff to encourage him to consume all fluids during meals, provide diet as ordered, supervise and cue or assist as needed with meals.

Review of the diet order dated 1/20/16 indicated the diet was a regular/liberalized diet, dysphagia puree texture, thickened liquids of nectar consistency.

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Review of the dietician note of 2/22/17 revealed she added double portions to the diet order and also nectar thick milk with meals in order to increase caloric intake.

Observations of Resident #7 ' s tray on 3/10/17 at 9:20 AM revealed he had orange juice to drink and no milk.
Interview with nursing assistant #6 on 3/10/17 at 9:36 AM revealed he delivered the tray, but did not set up the tray with the drinks. The nursing assistants work together to set up trays, and one of the other aides set up the drinks. Nursing assistant #6 explained there was thickened orange juice on the tray, but there was no milk.

Interview with nursing assistant #7 on 3/10/17 at 9:42 AM revealed she and nursing assistant #8 usually work on Resident #10 ' s hall. They follow the tray ticket, ask residents before breakfast what they want to drink and give them a choice. Resident #10 receives thickened liquids and would have milk at lunch. She further explained milk was his favorite (beverage). The tray ticket was reviewed with the nursing assistant #7 and she explained the "thickened milk" on the right side of the tray ticket lets them know he would receive thickened milk when provided. He can have milk at breakfast if he wants it. This nursing assistant further explained, she would know if he was to have something at each meal, by the middle section of the tray ticket. If Resident #10 was to have milk at each meal, it would be in the middle section and say "at each meal."

Interview with the Dietary Manager on 3/10/17 at 9:53 AM revealed the drinks that should be provided at each meal are under the notes on the

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F 325	Continued From page 52 right side of the tray ticket. The nectar thick milk should be provided at each meal. The other section (middle section) was for dislikes. He was not aware the nursing assistants did not know how to read the tray ticket correctly.	F 325		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide 1 of 3 sampled residents (Resident #4) the meal	F 363	Resident #4 has received a double meat entr¿e and large portions since 3/10/17.	4/4/17

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F 363	Continued From page 53 portion sizes as prescribed by the Physician; and ensure residents of 2 of 4 dining room services received appropriate portioned sizes as specified by the menus and the meal production worksheets. Findings included: 1. Resident #4 was originally admitted to the facility on 9/22/14 and re-admitted on 11/30/16 with diagnoses which included: cerebrovascular disease and dysphagia. Review of the Physician's Order dated 5/31/16 documented Resident #4 was to receive a regular, liberalized diet consisting of double meat entrée and large portions for the rest of the meal. Review of the quarterly MDS (minimum data set) dated 2/8/17 indicated Resident #4 was cognitively intact, independent with eating, and had no weight loss. The Care Plan revised 2/8/17 revealed Resident #4 was at risk for nutritional concern related to low BMI (body mass index). Interventions included: provide diet as ordered-regular, liberated with double protein and large portions for rest of meal. During an observation and interview on 3/9/17 at 2:07 pm, Resident #4 was in bed eating a meal delivered from the second floor dining room of regular texture consisting of one ham and cheese sandwich, coleslaw and ice cream for lunch. After a several minutes, the resident requested and received from facility staff a bowl of chili (the alternate on the menu) and a soda. The resident	F 363	Meals on the secured dementia unit is now plated in the dietary department and transported to the unit with meal tickets on the tray with the plated food. RD reviewed all diet orders to determine for appropriate double portions/double protein diet orders the week of 3/13/17 with meal tickets updated. Fifteen residents were reassessed and identified not requiring double protein/portions and meal tickets and diet orders were updated the week of 3/26/17. The dietary staff was inserviced on the week of 3/26/17 on portion sizes and diet order types with return demonstration with RD and Executive Chef (EC). The RD observed meat slicing demonstration with cooks and snack aides to ensure correct serving sizes with inservice with return demonstration on week of 3/26/17 for proper portion size. RD/EC will complete audit on portion size 5 times x 4 weeks, 2 times/week x 4 weeks, 1 time/week x 2 months. All findings from audits will be brought to the monthly Quality Assurance committee. RD will present and discuss any issues or trends discovered during monitoring to Quality Assurance Committee for three months.	

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revealed she would sometimes request the regular menu plus the alternate to ensure she received the double protein as ordered by the Physician.

During an interview on 3/9/17 at 2:10 pm, the DM acknowledged a double portion of this day's lunch service would consist of 2-ham and cheese sandwiches instead of one sandwich.

During an interview on 3/9/17 at 3:42 pm, the RD (Registered Dietician) confirmed Resident #4 requested and was to receive double protein and large portion sizes of all other foods during each meal service. The RD indicated this order was placed in May 2016 at her recommendation and the resident's request. She also stated that the resident sometimes requested the main protein entrée and the alternate protein entrée during meals. The RD indicated the resident had no significant weight losses and the resident weight was stable.

2. During an observation of the dining room meal service in the secured, dementia unit on 3/8/17 at 1:07pm, two nursing assistants were preparing and serving plates of meals to residents. There were no meal cards available in the dining room for any of the residents. Standard, plastic household serving utensils without portion sizes were used to place food items on the plates. There was no production worksheet of this day's menu for the nursing assistants to use as guidance for portion sizes required to ensure nutritional adequacy.

During an interview on 3/8/17 at 1:12 pm, the DM revealed the serving utensils used in the

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dementia unit were not issued by the kitchen; but, the kitchen staff were responsible for cleaning them. He revealed the meals were prepared in the kitchen and delivered in bulk via insulated containers to the dementia unit's kitchen. The DM indicated he did not know why portion control was not monitored with use of appropriate serving utensils.

Review of the facility's lunch menu on 3/9/17 read: ham and Swiss cheese on rye, creamy coleslaw or chili con carne, creamy coleslaw, corn muffin, and chocolate ice cream. The Production Worksheets Report of the lunch menu items for 3/9/17 included the following standard portion sizes: 1-slice regular ham and 1-slice cheese; 1 #12-scoop (2 ¾ ounces) of pureed ham and cheese; 1-cup of chili con carne (regular, mashed, pureed); ½ cup of regular coleslaw; 1 #10-scoop (3 ounces) of pureed marinated vegetable; and ½ cup of ice cream. The amounts of pureed ham, pureed coleslaw, regular chili, and pureed chili served were less than the standard portion sizes as reviewed on the Production Worksheet Report on 3/9/17 at 1:40 pm.

On 3/9/17 at 1:35 pm, an observation of the dietary staff plating meals from the meal steamtable in the second floor dining room revealed the following portion sizes of the food items served to each resident receiving foods of regular and textures: 1-slice of ham plus 1-slice of cheese with combined weight of 2.75 ounces; the 4-ounce ladle used yielded ½ cup of coleslaw; 4-ounce container of ice cream yielded ½ cup; and the 4-ounce ladle used yielded ½ cup of chili. The serving utensils used by the dietary staff were tongs and ladles. There were no scoops or

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F 363	Continued From page 56 a copy of the production worksheet noted in the serving area. During an interview on 3/9/17 at 1:40 pm, the DM (Dietary Manager) indicated it was the responsibility of the dietary staff assigned to the second floor dining room to collect all serving utensils needed from the kitchen. He also revealed the dietary staff should have used the production worksheet in determining which type and size serving utensil to use for portion control.	F 363		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide special eating utensils as ordered for 1 of 6 sampled residents (Resident #12) reviewed for ensuring dietary needs were met. Findings included: Resident #12 was admitted on 8/22/13 with diagnoses which included: Alzheimer's disease, dementia with behavioral disturbance, dysphagia, aphasia, muscle weakness, and lack of coordination.	F 369	Resident #12 has received adaptive equipment (built-up spoon and section plate) at meal time. Audit was completed by RD, Center Executive Director, CNE, ACNE and Regional Resource Nurse Manager on 3/28/17 to identify residents that need to use adaptive equipment. Twenty-three residents were identified as needing adaptive equipment. Meal tickets, care plans and residents' Kardex was updated to reflect the use of adaptive equipment by RD on 3/28/2017. Dietary staff was inserviced on reading meal tickets to identify residents that	4/4/17

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F 369	Continued From page 57 Review of the Annual MDS (minimum data set) dated 1/30/17 indicated Resident #12 was severely, cognitively impaired and required supervision with eating. The Nutrition Assessment dated 1/31/17 revealed Resident #12 received a regular, liberalized dysphagia advanced diet with large portion sizes. The assessment also documented the resident was to have the use of adaptive equipment with her meals in order to promote self-feeding; a sectional plate and built-up utensils. The Care Plan dated 2/9/17 documented Resident #12 was a nutritional concern-risk related to mechanically altered diet order due to a history of dysphagia. Interventions included: provide rehabilitative eating devices: a sectional plate and built-up utensils during meals. During a meal observation in the second floor dining room on 3/8/17 at 8:20 am, Resident #12 was feeding herself from a sectional plate, using regular, stainless steel utensils and assisted by facility staff. Review of the resident's meal card which was on the table next to the resident's plate indicated the resident was to receive her meals on sectional plate and have the use of built-up utensils. During an interview on 3/10/17 at 11:45 am, the Rehabilatative Manager indicated Resident #12 was evaluated for occupational therapy on 3/18/16 for self-feeding. She revealed that on 6/16/16 she recommended and an order was written for the resident to have a sectioned plate and built-up utensils for all meals; as of this date the order had not been discontinued.	F 369	require adaptive equipment and bring equipment to each dining room for meal service the week of 3/26/17 by EC. Licensed nurses and nursing assistants were inserviced on reading the meal tickets to identify residents that need adaptive equipment the week of 3/26/17 by NPE. CNE, ACNE, UM will audit 5 residents that receive adaptive equipment for one meal alternating between breakfast, lunch and dinner, 5 days a week including one week end day for one week, then 3x/week, including one week end day, for 3 months, then weekly for 2 months. The results of the observation of the delivery of adaptive equipment will be presented to the Quality Assurance Committee for 3 months by the CNE.	

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F 369	Continued From page 58 During an interview on 3/10/17 at 12:09 pm, the Registered Dietician revealed Resident #12 has had no signs of weight loss and her weight was stable. During an interview on 3/10/17 at 1:09 pm, the DM (Dietary Manager) indicated assistive eating devices were brought from the kitchen to each dining room during meal service. The DM revealed it was the responsibility of the dietary staff serving to ensure each resident received meals and assistive devices as documented on the residents' meal cards. He confirmed Resident #12 did not receive the special built-up utensils as indicated on her meal card, but should have. The DM did not provide any explanation why the dietary staff did not provide the built-up utensils. (The DM revealed he was the Acting DM and at the facility for two months.) On 3/10/17 at 1:45 pm, Resident #12 was observed in the second floor dining room feeding herself ice cream using a stainless steel fork which she dropped then began using a stainless steel spoon. There was no built-up utensil at or near the resident's place setting. The resident was able to use these available utensils without any eating problems. Facility staff were observed supervising and assisting residents with their meals.	F 369		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		4/4/17

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F 371	Continued From page 59 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen and in 4 of 4 dining rooms by not ensuring hair coverings were worn and hands were washed by facility staff when preparing food; by not ensuring food service equipment and food preparation areas were maintained clean, free from debris and free from staff personal items; by not ensuring dishware, cooking pans, and serving utensils were stacked and stored clean and dry. The facility also failed to serve food items at acceptable temperatures during 3 of 4 meal tray line services. Findings included:	F 371	Two male dietary aides were given hairnets for head and chin and were inserviced by the Executive Chef on 3/9/17. The nursing assistants on the dementia unit were given hairnets and inserviced by the EC on 3/16/17. The dietary aide that exited the kitchen, returned scratching the back of his head and continued to work without washing his hands was inserviced by EC and ACED on 3/16/17. The dietary aide who worked in the first floor North dining room was in serviced on the appropriate temperatures of cold beverages by EC on 3/24/17. The dietary aide staff #1 was inserviced on appropriate temperatures for food and beverages and process if food is not at appropriate temperatures by EC on	

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F 371	Continued From page 60 1. During a meal observation on 3/8/17 at 8:45 am in the second floor dining room's food service area, a male dietary staff prepared plated meals for residents without wearing a hairnet and a chin guard (facial hair which was approximately one inch thick). On 3/8/17 at 12:17 pm, one male dietary staff with facial hair (approximately ½ inch to 1 inch in thickness) were observed preparing food and beverages in the food preparation areas of the kitchen. During a meal observation in the dementia unit's dining room on 3/8/17 at 1:11 pm, two nursing assistants prepared plated meals from the bulk food items delivered from the kitchen. The two nursing assistants were not wearing hairnets. On 3/9/17 at 11:19 am, two male dietary staff with facial hair but no chin guards were observed preparing sandwiches and drinks in the kitchen. Also, one male staff exited then returned to kitchen, scratched the back of his head, then began stacking pans of food into one of the insulated delivery carts without washing his hands. During an interview on 3/10/17 at 1:12 pm, the DM (Dietary Manager) revealed the two male dietary staff were aware they were to wear chin guards to cover their facial hair and informed him they forgot to replace the chin guards after their breaks. The DM indicated had been at the facility for only two months and did not know why dietary staff were not serving meals in the dementia unit. He was also unsure if the nursing assistants serving the food had been trained in food service, but acknowledged that he had not provided any in-services on food services with the staff.	F 371	3/16/17. The dementia unit dinig service is not serving family style and are using tray system for meal service as of 3/24/17. The meal tray delivery cart was cleaned on 3/9/17 by dietary aide. The kitchen floor was cleaned on 3/9/17 by dietary staff. The personal beverages in kitchen were thrown away 3/9/17 by EC. The wet and/or dirty pans stacked on the clean storage rack: 3-wet (2") hotel pans; 2- wet (4") pans; 3-wet (6") 1/3 pans; 1-stained (4") 1/3 pan were rewashed and properly dried on 3/16/17 by dietary staff. One utensil drawer was cleaned and 9 dirty scoops were washed and dried appropriately on 3/16/17 by dietary staff. The 9-dinner plates, 1 coffee mug, 2-eight ounce glasses and bowls were rewashed and dried appropriately on 3/16/17 by dietary staff. Registered Dietitian completed kitchen sanitation audit on 3/17/17, issues identified were corrected. Kitchen floor will be deep cleaned by Environmental Director the week of 3/26/17. The executive chef inserviced the dietary staff on 3/16/17 on the kitchen cleaning schedule which includes a detailed list of all kitchen appliances and utensils to be cleaned. The schedule contains a completion sheet to be signed by dietary staff after cleaning assignment is completed daily. An inservice was given to dietary staff on 3/22/17 on safety and sanitation in the kitchen and dietary staff reviewed daily cleaning schedule and correct procedures for cleaning.	

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F 371	Continued From page 61 2. A meal service observation on 3/8/17 at 8:50 am in the first floor North dining room revealed a bin of water containing multiple eight ounce cartons of milk ready for usage. The temperature of one of the milk cartons was 42 degrees Fahrenheit. After reading the temperature, the dietary staff did not remove the milk from service. Further observation revealed staff did not obtain any more of the milk in the bin to serve to residents. On 3/8/17 at 12:30 pm in the first floor South dining room, food temperatures were taken at the steamtable serving line by dietary staff. During the observation, Dietary Staff #1 revealed that any foods with temperatures less than 145 degrees Fahrenheit must be returned to the kitchen to be reheated. The following food items had temperatures below 135 degrees Fahrenheit: pureed bread had a temperature of 130 degrees Fahrenheit; a slice of regular pizza had a temperature of 115 degrees Fahrenheit; and, pureed pizza had a temperature of 130 degrees Fahrenheit. The first prepared plate contained pureed pizza, pureed bread and pureed soup. When Dietary Staff #1 presented the prepared plated meal to staff to be served to a resident, the process was stopped and all of the food items with temperatures below 135 degrees Fahrenheit were removed from the steamtable and returned to the kitchen. During a meal observation of the dining room in the dementia unit on 3/8/17 at 1:07 pm, stainless steel pans of food items were haphazardly on counter tops and on a stove which was not heating any of the foods. There were also bowls of food items observed covered with napkins. The	F 371	Registered dietitian/executive chef complete sanitation audit to include hair restraints, proper hand washing, pot and pan cleaning procedure, proper storage of personal items, dishes stacked/stored clean and dry, for 5 days a week and one weekend day for 1 month, 2 times/week x 4 weeks, and weekly x 4 weeks. Any issues from sanitation audit will be corrected immediately and attached to audit. Management team will audit 3 breakfast, 3 lunch, and 3 dinner temperature logs x 4 weeks, 2 breakfast, 2 lunch, 2 dinner temperature logs x 4 weeks, and 1 breakfast, 1 lunch, 1 dinner x 4 weeks. Weekend Management will monitor I breakfast and 1 lunch temperature logs for 3 months. Any issues will be reported to EC and RD. All findings from audits will be brought to monthly QA. RD will present and discuss any issues or trends discovered during audits and monitoring to QA committee for review at monthly QA meetings for three months.	

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food temperatures were: the soup was 108 degrees Fahrenheit; chicken and rice casserole was 138 degrees Fahrenheit; pizza was 117 degrees Fahrenheit; pureed soup was 121.1 degrees Fahrenheit; and the pureed pizza was 84.7 degrees Fahrenheit. NA#9 and NA#10 (nursing assistant) who prepared and served the plated meals revealed they had never taken food temperatures before plating and serving the food items delivered in the insulated containers from the kitchen. On 3/8/17 at 1:12 pm, the DM (Dietary Manager) acknowledged the food temperatures were not maintained throughout the meal service and should have been. The DM indicated he did not know why dietary staff were not serving meals in the dementia unit or why food temperatures were not maintained.

During an observation in the kitchen on 3/9/17 at 12:40 pm, dietary staff were preparing meal items in bulk to be transported to the four dining rooms. The food temperature of the pan of coleslaw prepared for the second floor dining room was 48 degrees Fahrenheit and the pan of chilled marinated vegetables was 75 degrees Fahrenheit. When Dietary Staff#1 indicated the insulated delivery container consisting of these food items was ready for delivery, the container was stopped and the coleslaw and the marinated vegetables were returned to the walk-in refrigerator due to the unsafe temperature of the coleslaw which was above 41 degrees Fahrenheit. Dietary Staff#1 stated she never took food temperatures of the prepared foods in the kitchen before she delivered them to the dining rooms' steam tables.

3. During an observation on 3/8/17 at 8:50 am of

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F 371	Continued From page 63 the first floor North dining room, the meal tray delivery carts had dried and wet food spills on the shelves, along with paper debris. During a visit to the kitchen on 3/9/17 at 11:19 am, the following unsanitary conditions were observed: employee jackets were stored in the kitchen preparation area on the storage rack with a case of bananas and a case of potatoes; the kitchen floor was dirty with a gray, greasy film and littered with small pieces of paper and food, especially beneath preparation tables; and, one female staff was observed drinking from a Styrofoam cup and replacing it on the bottom shelf of one of the food preparation tables. There were wet and/or dirty pans stacked on the clean storage rack: 3-wet (2") hotel pans; 2-wet (4") ½ pans; 3-wet (6") ½ pans; 1-dented (6") ¼ pan; 3-stained and wet (6") 1/3 pans; 1-stained (4") 1/3 pan. One of two utensil drawers contained 9-dirty scoops with white and brown dried debris. Also, 9-dinner plates, 1-coffee mug, 2-eight ounce glasses were stacked wet and 2-bowls containing dried brown debris were stacked in a large, plastic bin to be transported to the dementia unit for use during lunch. The Dietary Manager acknowledged these observations and had dietary staff remove personal items, rewash dishware, pans and utensils, and clean the kitchen floor. He also revealed that he had repeatedly instructed staff not to store personal items in the kitchen.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		4/4/17

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and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 441	Continued From page 65 (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow their infection control policy entitled "Contact Precautions" for one of three sampled residents with infections (Resident #6) and failed to complete surveillance of one of three residents with infections (Resident #2) with scabies for tracking and trending of infections. The findings included: Policy for Contact Precautions with a revised date of 11/28/16 included in part "In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient ' s environment." The process indicated "3. Instruct	F 441	Resident #6's contact isolation was discontinued on March 10, 2017 by ACNE. ACNE amended the December 2016 infection control line listing to include resident #2 that presented with scabies. There are no other residents requiring any type of isolation. A skin assessment was complete on residents the week of March 20 and March 26, 2017 by licensed nurses. No evidence of scabies were found. The ACNE was in-serviced on completing the infection control line listing and what to	

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F 441	Continued From page 66 staff, patient, and visitors regarding precautions and the use of personal protective equipment (PPE). 4. Staff must use barrier precautions when entering the room. Wear gown and gloves. Wear eye protection if splashing of infectious material is likely ...." 1. Resident #6 was admitted to the facility on 1/27/17 with diagnoses on the hospital discharge summary included an Active Problem Clostridium difficile (C. diff). Observations on 3/8/17 at 5:30 AM revealed a cart with personal protective equipment (PPE) with a sign posted on the cart "Contact Precautions" was outside Resident #6 ' s door. Observations on 3/8/17 at 6:20 AM revealed the Nursing Assistant #9 entered the resident ' s room and emptied the colostomy bag without use of a gown. The stool in the colostomy bag was liquid in consistency. Interview with Nurse #6 on 3/8/17 at 6:30 AM revealed Resident #6 had C. diff. When Nurse #6 was asked what should be worn when providing care she explained, a gown, but it was precautionary for C. Diff. Interview with Nursing Assistant #9 on 3/9/17 at 4:55 PM revealed he should have put a gown on before emptying the colostomy bag. He explained he forgot to wear it. Interview with the Assistant Director of Nursing revealed the nurses did not obtained orders for isolation precautions. She further explained Resident #6 did not need to be on contact precautions since he was no longer treated for C. diff. Interview on 3/10/17 at 3:00 PM with the Medical Director revealed C. diff was usually treated with 14 days of oral Vancomycin and contact precautions would be used.	F 441	include by Regional Resource Nurse Manager on 3/28/17. Full time, part time, and weekend nursing staff including licensed nurses and nursing assistants were in-service on use of personal protective equipment by the Regional Clinical Educational Specialist during the week of 3/26/17. Housekeeping staff was in-service by the Environmental Director on the use of personal protective equipment during the week of 3/26/17. ACNE/Infection Control nurse will review residents with infections to determine if the resident needs to be placed on any type of isolation. For future cases of isolation, the infection control nurse will observed to ensure that staff are using personal protective equipment. New Cases of isolation will be reviewed during daily stand up meetings and infection control nurse will monitor for proper isolation procedures and use of personal protective equipment. This will be done as new cases requiring isolation occur. Once a resident has been determined to need isolation the ACNE/Isolation Control Nurse will have the isolations cart placed outside the residents room and she review and educate the nurse and staff on Personal Protective equipment needed. Random checks will be completed on staff that have direct contact with residents requiring isolation. While residents are on isolation they will be reviewed 5xweek during the clinical stand up (CNE, ACNE/Isolation Nurse, and Unit Managers). ACNE to determine if the isolation is still necessary. All orders are reviewed in daily stand up meeting, where	

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F 441	Continued From page 67 2. Resident #2 had a "Change in Condition-Skin" form dated 10/2/16 which indicated Resident #2 had a rash/dermatological disorder. Notes indicated he had a skin rash to his entire back, with redness and raised areas. Resident #2's medical record included documentation of the dermatology consultation visit on 12/6/16. Information on the visit report noted the resident's symptoms as "itch" with "moderate" severity. A "Report of Consultation with Dermatologist" dated 12/6/16 was also reviewed. The report indicated Resident #2 had a "very itchy rash all over." The rash was noted as widespread, with burrows in between fingers and on his trunk. Testing indicated live mites and eggs were present, and the dermatologist noted the resident had "Crusted Scabies." Three medications were initiated and included: 3 mg Ivermectin (a medication used to treat parasitic infestations) to be given as 6 tablets by mouth at once on days 1, 2, 8, and 9; 5% Elimite (a topical anti-parasitic medication) with instructions to apply the topical cream to the entire body (neck down) on days 1 and 8; and, 0.1% triamcinolone acetonide cream (a topical steroidal cream) with instructions to apply the cream topically twice daily to the affected areas as needed for itching. Review of the Infection Control line listing for the month of December 2016 indicated Resident #2 was not followed for his infection for tracking and trending infections. Interview with the Assistant Director of Nursing (ADON) on 3/8/17 at 12:12 PM revealed she was responsible for the Infection Control Program since October 2016. Part of her duties included	F 441	the infection control nurse will track and trend all infections including scabies on the infection control line listing. Tracking and trending of infections will be reviewed at monthly QA meetings times three months.	

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F 441	Continued From page 68 completing the "Infection Control Monthly Line Listing" of infections. She explained the process for reviewing infections included checking physician orders each day, review of the shift to shift report, review of new admissions information and review of the reports in the electronic charting system. The line listing was completed each month to track and trend for infection control problems. The ADON explained there had not been any cases of scabies since she began as infection control nurse. Interview with the Director of Nursing on 3/8/17 at 1:56 PM revealed they missed tracking and trending for Resident #2 for the scabies infection. The resident was treated, his roommate and another resident were treated. Resident #2 was the only resident with symptoms and the actual infection in the facility.	F 441		