STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=B	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and	F 159		4/14/17

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

Electronically Signed | 04/10/2017

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F 159	Continued From page 1 separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview and a review of resident funds account list, the facility failed to allow residents the opportunity to sign a receipt for money transaction from their personal accounts. (Resident #52) The facility failed to notify Residents #38, #27,and #21that received Medicaid benefits when the amount begun to approach the resource limit for eligibility for Medicaid. This was evident in 4 of 5 personal fund accounts reviewed. The findings included:	F 159	Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	

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F 159	Continued From page 2 1. Resident #52 was admitted to the facility on 3/01/2016. Review of the quarterly Minimum Data Set (MDS) dated 1/1/2017 revealed the Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was alert and oriented. . Review of the voucher/receipt for Resident #52 revealed $4.00 on 2/3/17, $ 4.00 on 2/9/17, $4.00 on 2/13/17, $9.00 on 2/17/17 and $15.00 had been provided to the resident. There were 2 signatures of the facility staff. The resident had not signed. Interview on 03/17/2017 at 10:30 AM with Resident #52 who stated she had not signed nor requested by facility staff to sign for her money that she received. Interview on 03/17/2017 at 9 AM with Receptionist (staff who provided personal funds to residents) stated she does not request residents to sign a receipt or voucher when she dispensed personal funds to residents. Continued interview indicated she signed the receipts and had another staff member sign as a witness. Interview on 03/17/2017 at 2:41PM with the Administrator revealed her expectation was to have residents capable of signing for their money be allowed to sign a receipt. 2. Record review revealed there are 47 resident facility trust accounts and 8 residents in which the facility are representative payee. Record review of the trial balance of Medicaid recipients and interview with the Business Office	F 159	Greenhaven Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1) Resident #52 was presented with the receipt vouchers for dates 02/03/17, 02/09/2017, 02/13/2017, and 02/17/17 to be completed by 04/07/2017. The resident signed all of the receipt vouchers for the times identified on 2567. The AR Bookkeeper notified residents #38, #27, and #21 that are receiving Medicaid benefits that they are approaching their resource limit for Medicaid eligibility by 04/09/2017. 2) The AR Bookkeeper audited all resident personal fund receipt vouchers beginning 03/01/17 to 04/04/2017 and offered all affected residents the opportunity to sign receipts for money transactions from their personal funds by 04/12/2017. The AR bookkeeper audited all resident balances receiving Medicaid benefits by 04/10/2017. All affected residents nearing their Medicaid eligibility resource limit were notified by 04/09/2017 by the AR Bookkeeper or Social Worker. 3) The Administrator trained the AR Bookkeeper and receptionist by 4/14/2017	

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F 159	Continued From page 3 Manager (BOM) on 03/17/2017 at 1:47 PM revealed: a. Resident #38 had a balance of $4,245.26. Review of a Social security letter dated 2/22/17 revealed an overpayment had been made from January 2015 through February 2017 in the amount of $2,288.00. With the return of the overpayment there would be $1,957.26 balance. The BOM indicated the responsible party had not been notified. b. Resident #27 had a balance of $1,869.43. The BOM indicated she alerted the facility's social worker on 2/2/17 via email of the balance. c. Resident #21 had a balance of $1,970.95. The responsible party nor the resident was alerted of the balance. Continued interview with the BOM revealed she started employment at the facility on 12/15/16. Interview on 03/17/2017 at 2:32 PM with the Administrator revealed she expected facility staff to monitor the personal fund balances and notify the resident or responsibility party when indicated.	F 159	to ensure all residents have the opportunity to sign receipts for money transactions for personal funds and if the resident refuses to sign to document the residents refusal on the receipt voucher. The Administrator trained the AR Bookkeeper and Social Worker on 04/06/2017 that all residents and or responsible parties are to be notified when the account balance reaches 200 or less than the residents Medicaid Eligibility resource limit. 4) The Administrator and/or AP will audit all resident trust fund vouchers for resident signatures or notation that resident refused to sign vouchers at 100% weekly for 4 weeks, then 50% of all resident trust fund vouchers weekly for 4 weeks to include resident #52 and then 25% of all resident trust fund vouchers weekly to include resident #52 for 4 weeks utilizing the resident fund monitoring tool. The Administrator and/or AP will audit Medicaid recipients account balances for notification of balance when the account balance reaches 200 or less than the residents Medicaid Eligibility resource limit at 100% weekly for 4 weeks, 50% weekly for 4 weeks and 25% weekly for 4 weeks utilizing the resident fund monitoring tool. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	
F 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or	F 160		4/6/17

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F 160	Continued From page 4 death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident's trust fund trial balance report and staff interviews, the facility failed to forward the entire balance of expired resident's personal fund accounts to the Clerk of Court within 30 days, for 3 of 3 expired resident's personal fund accounts reviewed. (Resident #64, Resident #7 and Resident #91). The findings included: 1. Resident #64 expired on 2/07/17. Review of the trust fund trial balance report revealed a $10 balance. 2. Resident #7expired on 12/17/16. Review of the trust fund trial balance report revealed a $10 balance. 3. Resident #91 expired 10/02/16. Review of the trust fund trial balance report revealed a balance of $1,087.54. Interview on 03/17/2017 at 1:47 PM with the Business Office Manager (BOM) indicated she had not forwarded the funds to the Clerk of Superior Court-Estate division but would be sending today (3/17/17). Interview on 03/17/2017 at 2:36 PM with the administrator revealed she expected the balance of expired resident accounts be convey within a	F 160	1) Resident #64, #7, and #91 funds were forwarded to the clerk of court by 03/27/2017 by the AR Bookkeeper. 2) The AR Bookkeeper audited all resident personal fund accounts for residents that have deceased within the 30 days by 3/27/2017. All other affected residents had their conveyances sent to the clerk of court on 3/27/17 by the Business office manager. 3) The Administrator trained the AR Bookkeeper on 04/06/2017 that upon death, residents' personal funds must be conveyed within 30 days. 4) The Administrator, DON, SDC, QI or AP will audit conveyance of deceased resident's personal funds 100% weekly for 4 weeks, 50% weekly for 4 weeks and 25% weekly for 4 weeks utilizing the resident fund monitoring tool. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 160	Continued From page 5 30 day period.	F 160		
F 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 166		4/12/17

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F 166	Continued From page 6	F 166		

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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F 166	Continued From page 7 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s grievance policy failed to include the right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including their name, physical and e-mail business address, and business phone number, and the expected time frame to complete review of the grievance. Findings Included: A review of the facility policy titled "Resident / Family Grievance Policy" dated 2/2009, provided by the Administrator on 3/15/17, revealed "If the resident or family member has a concern, they should report it to a staff member. The staff member will forward the concern to their supervisor, department head or Administrator. The Administrator will direct and oversee the resolution of the grievance process to include investigation, follow up and notification of appropriate persons." A review of the facility policy titled "Grievance Resolution" dated 2/2009, provided by the	F 166	1) The grievance policy was updated on 04/05/2017 to include the right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including their name, physical and email business address and business phone number and the expected time frame to complete review of the grievance. The activities director held a meeting with resident council to discuss the updated grievance policy on 04/06/2017. 2) The Social Worker will audit all grievances within the past 30 days to ensure the residents were offered The right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including their name, physical and email business address and business phone number and the expected time frame to complete review the grievance by 04/12/2017. 3) The Administrator trained department	

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F 166	Continued From page 8 Administrator on 3/17/17, revealed "The Administrator is responsible for investigating grievances in a prompt manner. The Administrator will assure that the resident or family members are notified timely of the results of the investigation and of any corrective measures taken. Residents and their families have the right to present grievances to the State Licensure and Certification Office or any other regulatory agencies without threat of discharge and / or reprisal. The local ombudsman and the state agency are also available to residents for the resolution of grievances. The addresses and phone numbers of these regulatory bodies are posted in the facility and are available in the Resident Services Handbook give to each resident and / or resident ' s representative upon admission to the facility." A review of the "Resident Services Handbook" dated 8/17/15, provided by the Administrator on 3/17/17, revealed a section titled "Resident Care Concerns". This identified that residents and / or family members should use the following procedure for their individual care concerns. "1. The Social Worker or other staff members will offer to complete a care concern form for the residents and family members who register complaints. 2. The facility will make every effort to resolve the concern promptly. 3. The resolution will be shared with the resident or family member who registered the complaint. 4. The facility will maintain the resolution and the resolve the concern promptly. An interview with the Administrator on 3/17/17 at 10:33 am revealed that she oversaw the grievance process. She stated that the facility did not have an updated grievance policy with the	F 166	heads on updated Grievance policy on 04/06/2017 that residents are to be offered the right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including their name, physical and email business address and business phone number and the expected time frame to complete review of the grievance. The DON or SDC will inservice all remaining staff on the updated grievance policy by 04/12/2017. Staff will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. 4) The Administrator, DON, QI, or SDC will monitor all grievances to ensure residents are offered the right to file grievances anonymously, the right to obtain a written response to grievances submitted, the contact information of the grievance official including their name, physical and email business address and business phone number and the expected time frame to complete review of the grievance 50% weekly for 4 weeks, 25% weekly for 4 weeks and 10% weekly for 4 weeks with resident concern tracking form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 166	Continued From page 9 required components effective 3/9/17.	F 166		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 221	1) Resident #29 received a restraint	4/10/17

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F 221	Continued From page 10 interviews the facility failed to provide a medical diagnosis to justify the use of a winged mattress ...for 1 of 1 residents who had a winged mattress applied to her bed (Resident #29). Findings Included: Resident #29 was admitted to the facility on 7/15/16 and diagnoses included dementia, osteoarthritis, abnormal posture and muscle weakness. A quarterly minimum data set (MDS) dated 1/2/17 for Resident #29 revealed she did not have any physical restraints, was non-ambulatory, required extensive assistance with activities of daily living (ADL ' s) and had impaired memory. A review of the care plan for Resident #29 dated 1/9/17 revealed she was at risk for falls characterized by history of falls, actual falls, injury, multiple risk factors including impaired cognition. There was no plan of care in place that identified the use of a winged mattress and how Resident #29 would be evaluated to ensure she had the least restrictive restraint. An observation on 3/15/17 at 4:19 pm of Resident #29 ' s room revealed a winged mattress was present on her bed. She was not present in the room. A review of the medical record for Resident #29 revealed that there was not a specific diagnosis identified for the use of the winged mattress. A restraint evaluation was not completed and there was not a plan in place to evaluate the ongoing use of the restraint.	F 221	evaluation on 04/07/2017 by the DON. The winged mattress was discontinued on resident #29 as a fall intervention on 04/07/2017. 2) All residents with restraints received a restraint evaluation by 04/10/2017 by the DON. All residents with restraints were evaluated for the proper diagnosis for use of a restraint by 04/10/17. All residents with restraints were care planned for the use of a restraint by 04/10/2017 by the DON or MDS Coordinator. 3) The DON in serviced the MDS Coordinator on evaluation of restraint, necessary medical diagnosis and care planning for use of restraints as an intervention on 04/04/17. 4) The Administrator, DON, SDC or QI will monitor residents on a restraint to ensure proper diagnosis at 100% weekly for 4 weeks, then 50% weekly for 4 weeks and 25% weekly for 4 weeks will monitor using the MDS tracking form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 221	Continued From page 11 An observation on 3/16/17 at 9:18 am of Resident #29 revealed she was lying in bed asleep. She was lying on a winged mattress and her bed was in a low position. An interview on 3/16/17 at 9:20 am with Nurse #1 revealed that Resident #29 had a winged mattress on her bed to help prevent her from falling. She stated Resident #29 had confusion and she would attempt to get up on her own. An interview on 3/16/17 at 9:31 am with the MDS nurse revealed that the winged mattress had been applied to Resident #29 ' s bed on 1/4/17. She stated that a restraint evaluation was not completed for the use of the winged mattress because they had not considered it as a restraint. She stated that it was being used as a fall intervention and to define the resident ' s parameters in bed. An interview on 3/16/17 at 10:30 am with Med Aide #1 revealed that Resident #29 could not walk or get out of bed on her own. She stated that she had a winged mattress on her bed to prevent her from getting out of bed unassisted. An interview on 3/16/17 at 4:08 pm with the Director of Nursing (DON) revealed they had placed a winged mattress on Resident #29 ' s bed as a fall intervention. She stated that she did not consider the winged mattress a restraint because Resident #29 had still made attempts to flip her feet over the side of the mattress.	F 221		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities,	F 242		4/12/17

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F 242	Continued From page 12 schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to honor a resident's preference to be out of bed per request for 1 of 10 residents reviewed for Activities of Daily Living (Resident #5). Resident #5 was admitted on 12/31/13 with the diagnoses of cellulitis, and depression. Resident #5 quarterly Minimum Data Set (MDS) dated 1/9/17, revealed the resident was cognitively intact and did not reject care. The MDS indicated the resident required two-person physical assistance for transfers and that this resident was transferred only once or twice during the 7-day assessment period. The resident had a care plan last updated on 1/17/17 for transferring. The goal stated the resident would receive the necessary physical assistance to transfer thru next review. Interventions included using the mechanical lift with 2 person physical assistance.	F 242	1) Resident #5 was out of bed per preference on 3/16/2017. The resident care guide was updated to reflect the resident choice of when to be out of bed. In-service was completed on 3/17/17 by the DON with the staff caring for resident #5 regarding ensuring resident choices are followed. 2) All residents will be interviewed by Medical Records and Admission Coordinator about personal preference to be out of bed by 04/12/2017. All preferences will be included on the residents care plan and care guides on 04/12/2017 by MDS Coordinator or DON. 3) The DON or SDC will complete in-servicing of all nursing staff on following the care guides, to include resident #5, by 04/12/2017. Nursing staff will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. 4) The Administrator, DON, SDC or QI	

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F 242	Continued From page 13 The physician's order sheet dated 3/1/17 through 3/31/17 revealed the resident was to be out of the bed 3 days per week for 1 to 3 hours as tolerated. Activities of Daily Living (ADL's) log was reviewed for the last month from 2/16/17 through 3/16/17 and revealed the resident had only been transferred 6 time in the last month on the following dates: 2/16/17, 2/23/17, 3/1/17, 3/9/17, 3/10/17 and 3/14/17. Nursing notes were reviewed from 2/23/17 to 3/15/17. There were no notes that revealed the resident was transferred out of the bed or that the resident refused care. The resident was interviewed on 3/13/17 at 12:31 PM. Resident #5 stated he wanted to get up to the wheelchair but staff would not get him up when he requested. He stated he had told the social worker and the nurses that he wanted to get up. He stated he liked to play Bingo and it had been 2.5 weeks since he had been up because they wouldn't get him up. He stated the only time that he did not like to get up was on the weekends. The Activities Director was interviewed on 3/15/17 at 3:42 PM. She stated the resident enjoyed getting up, playing BINGO and doing the velvet art. The resident did a lot of in room activities and they discussed in the care plan meeting about the resident getting up for activities. She saw the resident for 1:1 activities in his room. The resident preferred to be active. The resident wanted to get up Monday through Friday and she knew the resident had requested to get up. The resident had not always wanted to get up but did	F 242	will monitor resident care guides are being followed for residents at 50% weekly for 4 weeks, then 25% weekly for 4 weeks and 10% weekly for 4 weeks will be monitored using the MDS Tracking Form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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now.

Nursing assistant #4 was interviewed on 3/15/17 at 4:15 PM. She stated the resident required the assistance of 2 people and the lift to get to the chair. The resident liked to get up after breakfast and before lunch. She stated that was the busiest time and everyone wanted to get up then. She stated after lunch the resident wanted to get up too but lunch trays were delivered and then she went to lunch herself. When 2nd shift staff came in, the resident would refuse to get up. She stated she usually worked 1st shift and the resident had not been neglected but they just didn't have the man power. She stated if she used the lift with just 1 person then she would get in trouble. She wanted to get the resident up but just couldn't find staff to help. She stated it was not that she didn't care but they just didn't have the man power to get these people up. She stated that there were 3 nursing assistants for the whole facility plus the restorative aids.
The resident was interviewed again on 3/16/17 at 2:05 PM. He stated he liked to get up in the morning and asked the nursing assistant multiple times today to get him up. He stated he asked the nursing assistant who provided morning care to him (nursing assistant #2). He stated around 9:00 AM, he told the nursing assistant he wanted to get up right after breakfast and she said "ok". He stated they didn't get him up this morning.

Nursing Assistant #4 was interviewed again on 3/16/17 at 2:10 PM. She stated the resident told her that he wanted to get up around 8:00 AM when she gave him the breakfast tray. However, she had to feed residents and went back just a few minutes ago around 2:00 PM and the resident then refused to get up. She stated that

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she couldn't get the resident up before lunch because she had to feed multiple residents and was then called to the dining room but went back after lunch to see if Resident #5 wanted to get up.

Nurse #4 was interviewed on 3/16/17 at 3:48 PM. She stated the resident could tell staff what he needed and could call if he needed help. The resident was usually supposed to get up on first shift and then put to bed on 2nd shift. She stated the resident got up one day last week. The week before that, she thought she saw the resident up one day. The resident really liked to be up during first shift. The resident would request to get up at 10:00 AM but sometimes it was passed on to her that the resident was not gotten up on first shift and wanted to get up. She knew the resident was supposed to be up 3 days a week per shift report.

The Director of Nursing was interviewed on 3/17/17 at 1:47 PM. She stated the resident was getting up to BINGO two to three times a week in February. He stated he told staff in the last couple months that he wanted to get up more often. She had spoken to the Nursing Assistant about offering to get the resident up. Toward the end of January and February, the resident had been getting up two times a week. In the last couple weeks, she had only seen the resident up for BINGO once since the first of the month. She had not known of any refusals from the resident about getting up. She stated she made rounds every morning with the residents regarding any issues they had. She stated the resident was very alert and would let her know if there was an issue. If a nursing assistant got the resident up to the chair or wheelchair, it would be documented under transfers on the ADL log along with the amount of assistance it took. She stated she had not heard

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F 242	Continued From page 16 of any concerns about the staff not being able to get the resident up. The DON reviewed the resident's documentation and stated that from 2/14/16 to 3/1/16, the resident got up only 3 times per documentation. She would expect for residents to get up when they requested and any refusals to be document and communicated to the next shift.	F 242		
F 253 SS=E	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 observation, record reviews and staff interviews the facility failed to maintain housekeeping and maintenance services to provide clean resident's rooms and clean toilets in resident's bathrooms and provide a maintained, safe and comfortable interior on 2 of 3 resident halls. (Hall 100 and Hall 200) Findings included: 100 Hall On 3/14/2017 at 12:54 PM an observation of room 102-A revealed an odor of urine in the bathroom and unfinished exposed plaster on the wall behind resident's bed. On 3/14/2017 at 2; 10 PM an observation of room 104 revealed an observation of resident's bathroom door has missing paint and jagged edged that were rough to the touch.	F 253	1) The bathroom in 102A was cleaned on 3/15/17 by housekeeper. The wall in 102A was repaired and painted on 04/06/2017 by Maintenance Director. The bathroom door in 104 was repaired and painted on 04/06/2017 by Corporate Support Team . The filters in the heat/air condition unit in room 105 were cleaned on 04/06/2017 by Maintenance Director. The wall in room 109 was repaired and painted on 04/06/2017 by Maintenance Director. The wall in room 109 was repaired and painted on 04/06/2017 by Maintenance Director. The bathroom door in room 110 was repaired and painted on 04/06/2017 by Maintenance Director. The brown colored substance around the toilet in room 113 was caulked on 03/15/2017 by Maintenance Director. The bathroom in 113 was cleaned on 03/15/2017 by facility housekeeper. The door in room 114 was repaired and painted on 04/06/2017 by	4/14/17

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F 253	Continued From page 17 On 3/14/2017 at 2; 38 PM an observation of room 105 revealed dirty filters in the heating/ air conditioning units. On 3/14/2017 at 2:40 PM an observation of room 109 revealed that behind resident's bed had missing paint on the wall and was in need of repairs. On 3/14/2017 at 2:45 PM an observation of room 110 revealed the door to the resident's bathroom door had missing paint and was in need of repairs. On 3/14/2017 at 2:04 PM an observation of room 113 revealed a brown color substance around the resident's toilet in the bathroom with and odor. On 3/15/2017 at 11:00 AM an observation of room 114 revealed that the door to resident's bathroom had missing paint and rough to touch and was in need of repairs. On 3/15/2017 at 11:07 AM an observation of room 115 revealed that the door to resident's bathroom had missing paint and jagged edges that were rough to touch and was in need of repairs. On 3/15/2017 at 11:16 AM an observation of room 116 revealed that the door to resident's bathroom had missing paint and jagged edges that were rough to touch. 200 Hall On 3/14/2017 at 10:57 AM an observation of room 201 revealed that the resident's bathroom door had missing paint and a hole in the wall.	F 253	corporate support team. The door in room 115 was repaired and painted on 04/06/2017 by corporate support team. The door in room 116 was repaired and painted on 04/06/2017 by corporate support team. The door in room 201 was repaired and painted on 04/06/2017 by corporate support team. The hole in the wall in room 201 was repaired and painted on 04/06/2017 by Maintenance Director. The wall in room 205 was painted on 04/06/2017 by Maintenance Director. The door in room 207 was repaired and painted on 04/06/2017 by corporate support team. The bathroom floor tile under the toilet in room 209 was replaced on 04/06/2017 by Maintenance Director. The brown colored substance around the toilet in room 210 was caulked on 03/15/2017 by Maintenance Director. The wall in room 212 was repaired and painted on 04/06/2017 by Maintenance Director. The night stand and basin in room 212 was cleaned on 03/15/2017 by housekeeping supervisor. The wall in room 214 was repaired and painted on 04/06/2017 by Maintenance Director. The bed table in room 217 was removed and replaced on 04/06/2017 by Housekeeping Supervisor. 2) All resident rooms will be audited by housekeeping supervisor on 04/10/2017 for brown substance around bathroom toilets, holes/ damages in need of repair to walls, missing paint, brown substances on nightstands and night stand basins, damage to bedside tables, damage to bathroom doors, missing paint to bathroom doors, an odor of urine in the	

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F 253	Continued From page 18 On 3/14/2017 at 10:50 AM an observation of room 205 revealed that the resident's wall had missing paint. On 3/13/2017 at 1:15PM an observation of room 207 revealed that the resident's bathroom door had damage. On 3/14/2017 at 8:34 AM an observation of room 209 revealed the bathroom floor tiles under toilet are missing and the concrete exposed. On 3/14/2017 at 9:06 AM an observation of room 210 revealed a brown color substance around the resident's toilet in the bathroom. On 3/13/2017 at 2:37 PM an observation of room 212 revealed the wall behind Bed B was damage and the bedside table, night stand was dirty with brown substance on both and basin on nightstand unclean. On 3/14/2017 at 9:18 AM an observation of room 214 revealed missing paint and damage to the wall in room in need of repairs. On 3/15/2017 at 9:30 AM an observation of room 217 revealed over the bed table the top surface was partially removed and peeling. Interview with Maintenance Director on 3/15/2017 at 11 AM indicated he was from a sister facility revealed that he was just helping out until a Maintenance Director was hired. MD revealed that facility work order at each Nurse Station and staff knew how to fill out each order for issues in the Resident's room. Review of Facility work order dated back to	F 253	bathroom and dirty filters in the heating/air conditioning units. 3) The Administrator will train the maintenance supervisor, housekeeping supervisor and housekeeping staff on the need to maintain a sanitary, orderly and comfortable environment by 04/10/2017. Maintenance supervisor, housekeeping supervisor or housekeeping staff will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. All staff were in-serviced by the DON and/or SDC regarding the location and completion of work orders for broken and/or damaged items starting 4/13/17. No staff will be allowed to complete a shift without training being completed. All newly hired staff will be in serviced regarding the location and completion of work orders for broken and/or damaged items during orientation. 4) The Administrator, DON, SDC, QI, or Housekeeping Supervisor will monitor resident bathrooms for an odor of urine, broken tile under toilet, brown substances around toilet, holes in walls and jagged edges and missing paint on bathroom doors, missing paint and holes/damage to walls in rooms and damage to bedside tables and brown substances on nightstand or nightstand basin 50% weekly for 4 weeks, 25% weekly for 4 weeks and 10% weekly for 4 weeks will monitor with the maintenance monitoring form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 253	Continued From page 19 December 2016 until present revealed no issues or concerns with the issues that were observed during stage 1 and Stage 11. Tour and observation with the MD on 3/16/2017 from 10:45 AM until 11:15 AM tour on the 100 Hall, 200 Hall and 400 Hall, revealed the missing paint, jagged edges, stains around the resident toilet and missing paint on the wall in resident's room. During an interview with MD on 3/16/2017 at 11:30 AM revealed that his expectation would be that once staff fined an issues it needs to be report to him or who working this building and that he would begin on the issues and repairs today. MD also indicated that the stains in the resident's bathroom had been cleaned yesterday and the issues with the call bell her repairs that on March 15, 2017. During an interview with Housekeeping Supervisor on 3/16/2017 at 12:10 PM, he indicated that staff clean rooms on a daily bases and the deep clean of rooms are done once a resident is discharged and admitted to the facility. Interview with the Administrator on 3/16/2017 at 12:30 PM indicated that her expectation as the Administrator would be that the facility provide a safe and sanitary environment for residents, staff and the public one that was clean and comfortable.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		4/12/17

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F 278	Continued From page 20 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to accurately code Hospice services on the the Minimum Data Set (MDS) for Resident #74. The facility failed to accurately code the oral status of Resident #36: This was evident in 1 of 1 resident reviewed for	F 278	1. Resident #74 admission MDS was modified to code for hospice services on 03/15/2017 by MDS Coordinator. Resident #36's annual MDS dated 1/4/17 was modified under the oral/dental section to include edentulous on 3/15/17 by the	

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F 278	Continued From page 21 Hospice services and 1 of --- residents reviewed for dental services The findings included: 1.Resident #74 was admitted to the facility on 12/19/16 and diagnoses included chronic kidney disease and Alzheimer ' s disease. A review of the admission minimum data set (MDS) dated 12/30/16 for Resident #74 revealed he did not receive hospice services. A review of the medical record for Resident #74 revealed he began hospice services on 11/15/16 and his hospice benefit services were through 2/12/17. An interview on 3/15/17 at 12:26 pm with Nurse #3 revealed that Resident #74 was admitted to the facility on hospice. An interview on 3/15/17 at 2:47 pm with the MDS nurse revealed that Resident #74 was admitted to the facility on hospice services and that his admission MDS dated 12/30/17 was coded incorrectly. An interview on 3/16/17 at 3:18 pm with the Director of Nursing (DON) revealed that it was her expectation that residents were assessed and that their assessments coded correctly. She stated that Resident #74 should have been coded for hospice on his admission MDS dated 12/30/17. 2.Review of Resident #36's annual Minimum Data Set (MDS) dated 1/4/17 revealed under the oral/dental section edentulous (no natural teeth) was not checked.	F 278	MDS Coordinator. 2. The MDS Coordinator will audit all residents on hospice services to ensure correct coding by 04/07/2017. The MDS Coordinator will audit all residents with dentures last assessment to ensure oral/dental section is coded as edentulous by 04/12/2017. Assessments were modified as needed. For Additional MDS audits please refer to tags 279 and 312 3. The DON will in-service the MDS Coordinator on the coding of hospice services and the oral/dental section coding on 04/07/2017. 4. The DON, QI or SDC will monitor correct MDS coding on all residents receiving hospice services and all residents that have edentulous 50% weekly for 4 weeks, 25% weekly for 4 weeks and 10% weekly for 4 weeks will be monitored on the MDS Tracking Form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 278	Continued From page 22 Observation with the MDS coordinator on 03/15/2017 at 11:40 AM of Resident #36's dental status revealed resident was edentulous. Interview on 03/15/2017 at 11:54AM with the MDS coordinator revealed she read and interpreted the question wrong. The MDS coordinator indicated she should have coded the MDS to indicate the absence of natural teeth. Interview on 03/16/2017 at 2:30 PM with the Director of Nurses revealed she expected the MDS assessment be coded correctly.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 279		4/4/17

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F 279	Continued From page 23 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for 1 of 1 resident who was reviewed for dialysis (Resident #76).	F 279	1) Resident #76's care plan was reviewed and updated to include a plan of care for their dialysis treatment on 03/15/2017 by the MDS Coordinator.	

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F 279	Continued From page 24 Findings Included: Resident #76 was admitted to the facility on 11/11/16 and diagnoses included end stage renal disease. A review of the quarterly minimum data set (MDS) dated 2/15/17 for Resident #76 revealed she had a diagnosis of chronic renal disease, received dialysis treatment and was on a therapeutic diet. A review of the care plan dated 2/15/17 for Resident #76 revealed there was no plan of care for her end stage renal disease or her dialysis treatment. An interview on 3/16/17 at 11:38 am with Nursing Assistant #2 revealed that Resident #76 went to dialysis on Mondays, Wednesdays and Fridays. An interview on 3/16/17 at 12:02 pm with Nurse #3 revealed that Resident #76 went to dialysis on Mondays, Wednesdays and Fridays. She stated that her brother took her to dialysis and that she was supposed to be on a fluid restriction. An interview on 3/16/17 at 11:48 am with the MDS nurse revealed that Resident #76 was on dialysis. She stated that she should have had a care plan for her dialysis treatment and she would complete one. An interview with the Director of Nursing (DON) on 3/16/17 at 3:20 pm revealed that it was her expectation that residents receiving dialysis would have a care plan that included care interventions.	F 279	2) The MDS coordinator will audit all residents on dialysis services care plans to ensure they have a plan of care for dialysis treatment on 03/15/2017. 3) The DON / SDC in-serviced the MDS coordinator on care planning dialysis treatment on 04/04/2017. 4) The Administrator, DON, QI or SDC will audit all residents receiving dialysis treatment for a plan of care on their care plan for 100% weekly for 4 weeks, 50% weekly for 4 weeks and 25% weekly for 4 weeks will be monitored on the MDS Tracking form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	
F 311	483.24(a)(1) TREATMENT/SERVICES TO	F 311		4/14/17

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F 311 SS=E	Continued From page 25 IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide restorative services for Resident #36. This was evident in 1 of 1 resident sampled to participate in a restorative program. The findings included: Record review revealed the facility had 29 residents on a restorative program during the recertification and complaint survey. Resident #36 was admitted to the facility on 1/30/16 with cumulative diagnosis which included Alzheimer's disease. Review of the annual Minimum Data Set (MDS) dated 1/4/17 revealed Resident #36 was unsteady walking and moving from a seated position without the stabilization of human assistance. Record review of the physical therapy progress and discharge summary revealed Resident #36 participated in therapy from 12/27/16 through 1/25/17 for gait training with wheeled walker and increase the strength of the knees. Review of the restorative nursing referral from the therapy department indicate restorative care to begin on 1/26/17. The issues to be addressed were ambulation with a roller walker 100-200 feet or as tolerated and active range of motion	F 311	1) Resident #36 documentation was reviewed by DON on 04/10/2017 to ensure participation was recorded for 6 restorative visits by restorative aides for the week of 04/03/17. The Administrator and DON in-serviced the restorative aide caring for resident #36 on 3/17/17 regarding informing administrator and/or DON regarding not being able to complete restorative programs for residents requiring restorative needs. 2) The DON or MDS Coordinator will review all restorative nursing documentation for blank spaces and or no initials to determine resident participation or was provided restorative therapy within the past 30 days by 04/12/2017. Any residents requiring additional services will be referred to therapy for evaluation by DON or MDS by 04/12/2017. 3) The DON or SDC in serviced all restorative aides on restorative nursing documentation on 03/21/2017. The DON started in-services for the restorative aides on 4/13/17 regarding informing the administrator and/or DON about not being able to complete restorative programs for residents requiring restorative needs. For additional training see tag 353. 4) The Administrator, DON, SDC or QI	

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F 311	Continued From page 26 exercises six (6) times a week for 12 weeks. Review of the Resident Care Guide located inside the closet and used by the nursing assistant revealed restorative nursing was part of the resident's care. Review of the restorative nursing documentation indicated blank spaces and no initials to indicate the resident participated or was provided restorative therapy 6 times each week as noted below: Week of 1/30/17 Restorative therapy only 3 times. Week of 2/6/17 Restorative therapy only 3 times. Week of 2/13/17 Restorative therapy only 4 times. Week of 2/20/17 Restorative therapy only 3 times. Week of 2/27/17 Restorative therapy only 1 time. Week of 3/6/17 Restorative therapy only 4 times. Review of the daily assignment sheets provided by the Administrator and Nursing Scheduler indicated there were 3 Restorative Aides (RA) in the facility but were not available or assigned to perform restorative duties on 1/29/17 through 1/31/17, 2/4/17, 2/5/17, 2/9/17 through 2/12/17, 2/18/17, 2/19/17, and 2/25/17 through 3/14/17. Continued review of the assignment sheets indicated RA #1 was assigned to work on the unit as a Nursing Assistant (NA) and RA #2 was assigned as a medication aide. Interview on 03/16/2017 at 10:23 AM with RA #1 revealed about a month or more that RA #3 and myself were pulled to the unit and no one assigned for restorative care. Continued interview revealed "Today I am pulled to the unit until 11 AM."	F 311	will audit the restorative nursing documentation to determine resident participation was documented for residents at 50% weekly for 4 weeks, 25% weekly for 4 weeks and 10% weekly for 4 weeks will be monitored on the MDS Tracking Form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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F 311	Continued From page 27 Interview on 03/16/2017 at 10:48 AM with NA #6 indicated that she does not perform restorative care for residents. Interview on 03/16/2017 at10:51AM with NA #7 revealed she does not perform any restorative care when the Restorative staff are pulled to the unit. Interview on 03/16/2017 at 2:51 PM with the Director of Nurses (DON) revealed has been a challenge for last month to have Restorative Aides assigned to restorative duties because of the need to pull restorative aides to work on the unit. The DON stated she expected the restorative aide to be creative to get the restorative care completed even when on the unit working as a NA. Interview on 03/17/2017 at 2:48PM with the physical therapist revealed the resident met her goals and was referred to restorative for gait assistance and balance exercise. He stated the resident needed transfer and balance exercises to prevent a decline in function and maintain independent. Resident #36 needed encouragement but would participate in therapy.	F 311		
F 312 SS=E	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: Based on observations, record review, staff and	F 312	Resident #8 received appropriate	4/14/17

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F 312	Continued From page 28 resident interviews the facility failed to provide appropriate cleansing of the genitals, wash the skin on the left leg and thoroughly rinse the body soap off the skin of Resident #8. The facility failed to clean the finger nails of dependent Residents #36, #22 and #51. The facility failed to remove the hair from Resident #52's chin. The facility failed to comb the hair of Resident #51 who was dependent on staff for care. The facility failed to transfer Resident #5 out of bed per the physician order and resident choice.This was evident in 6 of 10 dependent residents in the sample reviewed for activities for daily living. The findings included: 1. Review of the manufacturer's instructions revealed the bath soap used on Resident #8 should be thoroughly rinsed off the body. Resident #8 was readmitted to the facility on 3/13/2017 with cumulative diagnoses which included right below the knee amputation, diabetes, cellulitis, neuropathy, and an indwelling urinary catheter due to a neurogenic bladder. Medical record review revealed the Minimum Data Set (MDS) was not completed. Review of the Resident Care Guide located inside the closet and used by the nursing assistant indicated Resident #8 was dependent on staff for care. Observation of the activity of daily living (ADL) care on 03/16/2017 at 11:29 AM performed by Nursing Assistant #4 (NA) was conducted. NA #4 repeatly cleansed the genitals and around the catheter from a back to front motion then back and forth on both side of the groin. Resident	F 312	cleansing of the genitals, washing of the skin on the left leg and the soap rinsed off of the skin on 03/20/2017 by CNA. Resident #36, #22, and #51 received nail care to clean nails on 03/15/2017 by CNA. Resident #52 chin was shaved on 03/15/2017 by CNA. Resident #5 was up out of bed on 3/16/17 by CNA. Resident #51 hair was combed on 03/15/2017 by CNA. The DON in-serviced all of the staff caring for residents #36,#22,#51,#52, and #5 on 3/15 - 17/17 regarding on proper cleanliness of residents to include: genitals, skin and nails, and honoring resident preferences on shaving, hair combing and being out of bed. 2) The DON, SDC or QI nurse will audit all residents' skin for proper cleanliness to include: genitals, skin, and nails by 04/12/2017. The DON, SDC,QI, Medical Records or Admissions Coordinator will audit all residents for preference on shaving, combing hair and being out of bed by 04/12/2017 All results will be added to the residents' care guide by 04/12/2017 by the MDS Coordinator. 3) The DON, SDC, QI will in-service all CNAs and Nurses on proper cleanliness of residents to include: genitals, skin and nails by 04/12/2017. The DON, SDC, QI will in-service all CNAs and Nurses on honoring resident preferences on shaving, hair combing and being out of bed by 04/12/2017. Nursing staff will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. 4) The Administrator, DON, SDC or QI will audit the care guide against care	

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F 312	Continued From page 29 #8's buttocks were then cleansed and the groin and buttocks were noted to be reddened and excoriated. A barrier ointment was applied. The water in the basin was sudsy and the soap was not rinsed off the skin. Resident # 8's left leg had a white sock on at the beginning of the bath and no attempt was made to remove the sock to wash her leg. Interview on 03/16/2017 at 11:47 AM with NA #4 revealed she washed around the catheter and would have washed the genitals in a front to back motion if Resident #8 did not have barrier cream on her body. Further interview with NA #4 revealed Resident #8 does not want you to touch her leg. NA #4 stated she had a second wet washcloth to rinse the soap off the body. Interview on 03/16/2017 at 11:52 AM with Nurse #3 revealed when perineal care is provided the genitals should be cleansed from a front to back motion. Interview on 03/16/2017 at 2:51 PM with the Director of Nurses (DON) revealed she expected staff to cleanse the resident's genitals in a front to back motion and to wash the leg. 2. Resident #36 was admitted to the facility on 1/30/16 with cumulative diagnosis which included Alzheimer's disease. Review of the annual Minimum Data Set (MDS) dated 1/4/17 revealed Resident #36 required extensive assistance for personal hygiene and total dependence on staff for bathing. Her cognition was coded as impaired. Review of the Care Area Assessment (CAA) revealed activities of daily living (ADL) did not trigger to develop a care plan.	F 312	given for proper cleanliness of residents' skin, nails and genitals. The Administrator, DON, SDC or QI will audit the care guide against given for resident preference of shaving, hair combing and being out of bed. 50% weekly for 4 weeks, 25% weekly for 4 weeks and 10% weekly for 4 weeks will be monitored on the nursing care tracking form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance may result in continued monitoring.	

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An attempt to interview Resident #36 was unsuccessful due to impaired cognition.
Review of the Resident Care Guide located inside the closet and used by the nursing assistant revealed staff to provide extensive to total care for personal hygiene and bathing.
Observation on 3/14/2017 at 2 PM revealed Resident #36 had an accumulation of a brown colored substance under the finger nails on both hands.
Observation with the MDS coordinator on 03/15/2017 at 11:40 AM revealed both hands continued to have an accumulation of a brown colored substance under her finger nails.
Observation on 03/15/2017 at 12 noon revealed the accumulation of a brown colored substance remained under her finger nails.
Observation on 3/15/2017 at 12:30 PM revealed Resident #36's fingernails remained with an accumulation of a brown colored substance.
Interview on 03/16/2017 at 2:28 PM with the Director of Nurses (DON) revealed her expectation was for residents to have clean fingernails.
Interview on 03/17/2017 at 11:41 AM with the MDS coordinator revealed Resident #36 was not capable of providing nail care for herself
Interview on 03/17/2017 at 12:37 PM with Nursing Assistant #2 (NA) revealed she normally scheduled to work the 200 hall (201-208) and when NA #5 left early on 3/15/17 her assignment was changed. Continued interview with NA #2 revealed she bathed Resident #36 the morning of 3/15/17. NA #2 stated there was not enough staff to complete the assignments.

3. Resident #22 was admitted to the facility on 10/23/2013 with cumulative diagnoses which included dementia.

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Review of the annual Minimum Data Set (MDS) dated 1/2/2017 revealed the Brief Interview for Mental Status (BIMS) score of 7 which indicated impaired cognition. The MDS assessment indicated Resident #22 required total assistance of 1 staff for bathing and extensive assistance of 1 staff member for washing and drying his face and hands.

Observation on 3/14/2017 at 2:11 PM revealed the fingernails on both hands extended approximately1/4 Inch from the nail beds. There was an accumulation of a brown colored substance under the nails on both hands.

Observation on 3/15/2017 at 12:40 PM revealed an accumulation of a brown colored substance remained under the resident's nails on both hands.

Observation on 3/15/2017 at 3:40 PM revealed the accumulation of a brown colored substance remained under the resident's fingernails on both hands.

Observation on 03/16/2017 at 10:05 AM revealed the resident's fingernails continued to have a brown colored substance under the fingernails.

Interview on 03/16/2017 at 10:23 AM with Restorative Aide #1(RA) revealed on 3/15/2017 Resident #22 was showered but she had not cleaned his fingernails.
Interview on 03/16/2017 at 2:28 PM with the Director of Nurses (DON) revealed her expectation was for residents to have clean fingernails.
Interview on 3/17/17 at 2:49 PM revealed she

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expected resident nails to be clean.

4. Resident #52 was admitted to the facility on 3/01/2016 with cumulative diagnoses which included cerebral vascular disease and diabetes

Review of the quarterly Minimum Data Set (MDS) dated 1/1/2017 revealed the Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was alert and oriented. The MDS assessment indicated total dependence of staff for bathing and limited assistance for personal hygiene.

Review of the Resident Care Guide located inside the closet and used by the nursing assistant revealed resident required staff for bathing and personal hygiene.

Observation and interview with Resident #52 on 3/15/2017 at 12:20 PM revealed white/gray colored facial hair under her chin. A patch of facial hair extended about 1/4 inch from her chin. Interview with the resident revealed she did not like the hair on her chin. Resident # 52 stated the nursing staff have seen the chin hair and had to beg to get the staff to shave the hair. Continued interview with Resident #52 revealed it had been about 3 weeks since her chin hair had been removed by staff.

Observation on 3/15/2017 at 3:30 PM revealed the facial chin hair remained.

Interview on 3/15/2017 at 4:35 PM with Nursing Assistant #4 (NA) stated she would have shave Resident #52 chin hair but she did not had time to do.

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Observation on 03/16/2017 at 10:07 AM revealed the facial chin hair had been removed. Interview on 03/16/2017 at 10:08 AM with Resident #52 revealed a staff member (could not remember name) removed the chin hair yesterday (referring to 3/15/2017).

5. Resident #51 was admitted to the facility on 5/5/2011 with cumulative diagnoses which included Alzheimer's disease.

Review of the quarterly Minimum Data Set (MDS) dated 12/02/2016 revealed the resident was rarely/never understood with memory problems. The MDS indicated the resident was assessed as totally dependent on staff for personal hygiene and bathing.

Review of the care plan revised on 12/20/2016 revealed Resident #51 required assistant by staff with all activities of daily living on a daily and as needed.

Review of the Resident Care Guide used by the nursing assistant revealed Resident #51 was totally dependent on staff for personal hygiene.

Observation on 03/15/2017 at 9:30 AM revealed the braids were not intact with hair separating out of the braids. The hair at the neckline was uncombed.

Observation on 03/15/2017 at 12:28 PM revealed Resident #51's hair remained uncombed with hair separating from the braids.

Observation on 03/15/2017 at 2:20 PM revealed the hair remained uncombed with hair separating from the braids.

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Observation on 3/15/2017 at 3 PM revealed the resident's hair remained uncombed with hair separating from the braids.

Observation on 03/15/2017 at 3:10 PM revealed the resident's hair continued to remain uncombed with hair separating from the braids.

Interview on 3/15/2017 at 4:35 PM with Nursing Assistant #4 (NA) revealed any staff person could do the braiding of the Resident's #51 hair. NA #4 stated she usually will braid the resident's hair but have been unable due to being short staffed with too much work to get done and staff quitting.

Observation on 03/16/2017 at 10:01 AM revealed Resident's #51 hair was combed and the braids were intact. The resident's fingernails had an accumulation of a brown colored substance under and around the nails.

Interview with the Director of Nurses (DON) on 03/16/2017 at 2:41 PM revealed she expected hair care to be done when Resident #51 was out of bed and whenever it was needed. Additionally the DON expected the hair to be maintained throughout the day.
6.) Resident #5 was admitted on 12/31/13 with the diagnoses of cellulitis, and depression.

Resident #5 Quarterly Minimum Data Set (MDS) dated 1/9/17 revealed the resident was cognitively intact and had no rejection of care. Transfers only occurred once or twice and the resident required two person physical assistant. The resident had no mobility devices. The resident was always incontinent of bowel and bladder.

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The resident had a care plan last updated on 1/17/17 for transferring. The goal stated the resident would receive the necessary physical assistance to transfer thru next review. Interventions included using the mechanical lift with 2 person physical assistance.

The physician's order sheet dated 3/1/17 through 3/31/17 revealed the resident was to be out of the bed 3 days per week for 1 to 3 hours as tolerated. The physician's order sheet stated that signature by the physician on one page of physician's order sheet denotes review and renewal of all orders. The physical had signed the orders sheet for March, 2017.

Activities of Daily Living (ADL's) log was reviewed for the last month from 2/16/17 through 3/16/17 and revealed the resident had only been transferred 6 times in the last month on the following dates: 2/16/17, 2/23/17, 3/1/17, 3/9/17, 3/10/17 and 3/14/17.

Nursing notes were reviewed from 2/23/17 to 3/15/17. There was no notes that revealed the resident was transferred out of the bed or that the resident refused care.

Review of the resident's medical record revealed the resident was not currently getting Physical or Occupational therapy.

The resident was interviewed on 3/13/17 at 12:31 PM. Resident #5 stated he wanted to get up to the wheelchair but staff would not get him up when he requested. He stated he had told the social worker and the nurses that he wanted to get up. He stated that he liked to play Bingo and

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it's been 2.5 weeks since he had been up because they wouldn't get him up. He stated the only time that he does not like to get up was on the weekends.

The Activities Director was interviewed on 3/15/17 at 3:42 PM. She stated the resident enjoyed getting up, playing BINGO and doing the velvet art. The resident did a lot of in room activities and they discussed in the care plan meeting about the resident getting up for activities. She saw the resident for 1:1 activities in his room. The resident preferred to be active. The resident wanted to get up Monday through Friday and she knew the resident did request to get up. The resident had not always wanted to get up but did now.

Nursing assistant #4 was interviewed on 3/15/17 at 4:15 PM. She stated the resident required the assistance of 2 people and the lift to get to the chair. The resident liked to get up after breakfast and before lunch. She stated that was the busiest time and everyone wanted to get up then. She stated after lunch the resident wanted to get up too but lunch trays were delivered and then she went to lunch herself. When 2nd shift staff came in, the resident would refuse to get up. She stated she usually worked 1st shift and the resident had not been neglected but they just don't have the man power. She stated if she used the lift with just 1 person then she would get in trouble. She wanted to get the resident up but just couldn't find staff to help. She stated it's not that she doesn't care but they just don't have the man power to get these people up. She stated that there were 3 nursing assistants for the whole facility plus the restorative aids.

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The resident was interviewed again on 3/16/17 at 2:05 PM. He stated he liked to get up in the morning and asked the nursing assistant multiple times today to get him up. He stated he asked the nursing assistant who provided morning care to him (nursing assistant #4). He stated around 9:00 AM, he told the nursing assistant he wanted to get up right after breakfast and she said "ok". He stated they didn't get him up this morning.

Nursing Assistant #4 was interviewed again on 3/16/17 at 2:10 PM. She stated the resident told her that he wanted to get up around 8:00 AM when she gave him the breakfast tray. However, she had to feed residents and went back just a few minutes ago around 2:00 PM and the resident then refused to get up. She stated that she couldn't get the resident up before lunch because she had to feed multiple residents and was then called to the dining room but went back after lunch to see if Resident #5 wanted to get up.

Nurse #4 was interviewed on 3/16/17 at 3:48 PM. She stated the resident could tell staff what he needed and could call if he needed help. The resident was usually supposed to be getting up on first shift and then put to bed on 2nd shift. She stated the resident got up one day last week. The week before that, she thought she saw the resident up one day. The resident never got up on second shift but they would let him stay up till 4:00 PM on second shift if he wanted to. The resident really liked to be up during first shift. The resident had never refused care with her before. The resident would request to get up at 10:00 AM but sometimes it was passed on to her that the resident was not gotten up on first shift and wanted to get up. She knew the resident was supposed to be up 3 days a week per shift report.

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F 312	Continued From page 38 The Director of Nursing was interviewed on 3/17/17 at 1:47 PM. She stated the resident was getting up to BINGO two to three times a week in February. He had told staff in the last couple months that he wanted to get more. She had spoken to the nursing assistant about offering to get the resident up. Toward the end of January and February, the resident had been getting up two times a week. In the last couple weeks, she had only seen the resident up for BINGO once since the first of the month. She had not known of any refusals from the resident about getting up. She stated she made rounds every morning with the residents regarding any issues they had. She stated the resident was very alert and would let her know if there was an issue. If a nursing assistant got the resident up to the chair or wheelchair, it would be documented under transfers on the ADL log along with the amount of assistance it took. She stated she had not heard of any concerns about the staff not being able to get the resident up. The DON reviewed the resident's documentation and stated that from 2/14/16 to 3/1/16, the resident got up only 3 times per documentation. She would expect for residents to get up when they requested and any refusals to be document and communicated to the next shift.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		4/14/17

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F 314	Continued From page 39 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to complete a comprehensive wound assessment for 1 of 4 residents reviewed for pressure ulcers (Resident #8). Findings Included: Resident #8 was readmitted to the facility on 3/13/17 and diagnoses included charcots joint of left foot and ankle (a progressive degenerative disease of the joints caused by nerve damage resulting in the loss of ability to feel pain in the joint and instability of the joint), diabetes and protein calorie malnutrition. The minimum data set (MDS) assessment and care plan for Resident #8 were not completed at the time survey. A review of the hospital discharge summary dated 3/13/17 for Resident #8 identified a Stage 2 pressure ulcer on her left foot. The discharge summary documented that Resident #8 had been treated with a 7 day course of vancomycin and zosyn (both antibiotics) for cellulitis of her left foot	F 314	1) Resident #8 wound assessment was completed on 03/14/2017 by Floor Nurse. During the time of the POC submission, the staff caring for resident #8 was no longer employed. 2) The DON, SDC or QI Nurse will audit all admission wound assessments for the past 30 days. Any changes will be updated in the resident record by 04/10/2017 by the DON or MDS Coordinator. 3) The DON, SDC or QI Nurse will train all nurses on timeliness of wound assessments by 04/12/2017. Nurses will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. 4) The Administrator, DON, SDC, or QI Nurse will monitor the completion of wound assessments upon admission at 100% weekly for 4 weeks, then 50% weekly for 4 weeks and 25% weekly for 4 weeks will be monitored on the nursing documentation tracking form. All finding will be taken to the monthly QI meeting for review. Any incidents of non-compliance	

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and she had an increased risk of this pressure ulcer becoming infected again.

A review of the medical record for Resident #8 revealed a nursing admission assessment dated 3/13/17 had identified a dark area to her outer left foot. A skin check dated 3/13/17 identified the left foot had a discolored area with a foam dressing in place.

An interview with Nurse #2 (the treatment nurse) on 3/17/17 at 12:03 pm revealed she had not completed a wound assessment on Resident #30 since she had been re-admitted, but was working on getting the measurements.

An observation of wound care for Resident #8 was conducted on 3/17/17 at 12:10 pm. The wound care was performed by Nurse #2. Resident #8 was sitting up in her wheelchair. Nurse #2 removed the dressing from her left foot and a small amount of light yellow drainage was present on the dressing. The wound was located on the outer part of her left foot and appeared dry with a section of skin peeling off toward the top part of the wound. Nurse #2 cleaned the wound with wound cleanser. At the request of the surveyor Nurse #2 measured the wound. The wound measurements were 2.5 centimeters (cm) length by 1.2 cm width by 0, 2 cm depth. Nurse #2 applied silver alginate to the wound, covered the silver alginate with a piece of foam and wrapped the wound in gauze.

A comprehensive wound assessment of the left foot for Resident #8 was not completed as of 3/17/17.

An interview with the Director of Nursing (DON)

may result in continued monitoring.

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F 314	Continued From page 41 on 3/17/17 at 1:15 pm revealed that it was her expectation that a complete wound assessment would have been completed for Resident #30.	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		4/14/17

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F 329	Continued From page 42 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess the blood pressure prior to administering blood pressure medication as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #90). Findings Included: Resident #90 was admitted to the facility on 3/1/17 and diagnoses included hypertension, cerebral vascular accident (CVA) and seizure disorder. An admission minimum data set (MDS) dated 3/10/17 for Resident #90 revealed she required extensive assistance with activities of daily living (ADL) and her cognition was intact. A review of the March 2017 physician orders for Resident #90 revealed an order for Hydralazine (a medication used to treat high blood pressure) 50 milligrams (mgs) every 8 hours; hold medication if systolic blood pressure (SBP) was less than 90. A review of the March 2017 medication administration record (MAR) for Resident #90 revealed 50 mg of Hydralazine was administered March 1st through March 15th at 6:00 am, 2:00 pm and 10:00 pm. There were no blood pressure readings documented on the MAR.	F 329	1) Resident #90 blood pressure was taken prior to blood pressure medication administration on 03/15/2017 by floor nurse. The DON on 3/15/15 in serviced the nurses caring for resident #90 on proper monitoring of blood pressures with parameters prior to medication administration 2) The DON, SDC, or QI Nurse will audit all residents required to have a blood pressure check prior to blood pressure medication administration by 04/10/2017. Any missed blood pressures will be reported to the resident physician for any follow up orders by DON,SDC, MDS Coordinator by 04/10/2017. 3) The DON, SDC or QI in-serviced all nurses on blood pressure medications with parameters to obtain blood pressure prior to administration by 04/12/2017. Nurses will not be able to complete a shift without being trained and all new hires will be trained during orientation by the SDC. 4) The Administrator, DON, SDC or QI will monitor the residents with parameters to obtain blood pressure prior to blood pressure medication administration at 100% weekly for 4 weeks, then 50% weekly for 4 weeks and 25% weekly for 4 weeks will be monitored on the Nursing Documentation Tracking Form. All finding will be taken to the monthly QI meeting for	

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F 329	Continued From page 43 An interview on 3/16/17 at 3:03 pm with Nursing Assistant #1 revealed she had taken Resident #90 ' s blood pressure once when she was on her assignment. An interview on 3/16/17 at 3:15 pm with Nurse #2 revealed that she had administered the Hydralazine for Resident #90. She reviewed the MAR for March 2017 and stated that she was used to having a place on the MAR to record the blood pressure if it was supposed to be checked prior to administering a medication. She was not able to produce any blood pressure readings for Resident #90. During an interview with the Director of Nursing (DON) on 3/16/17 at 3:30 pm she provided a weight and vital sign print out for Resident #90; this documented 2 blood pressure readings on 3/1/17 and one blood pressure reading on 3/2/17, 3/7/17 and 3/14/17. She was unable to produce blood pressure readings prior to the administration of the Hydralazine as ordered by the physician. She stated that it was her expectation that Resident #90 ' s blood pressure was checked prior to the administration of the Hydrazine as ordered by her physician. An interview on 3/16/17 at 3:59 pm with the physician for Resident #90 revealed that it was his expectation that the blood pressure was checked prior to administering the medication as ordered.	F 329	review. Any incidents of non-compliance may result in continued monitoring.	
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services	F 353		4/14/17

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F 353	Continued From page 44 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and	F 353		

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F 353	Continued From page 45 described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff, resident and families and observation the facility failed to provide staffing of sufficient quantity and quality to honor a resident's preference, restorative services, appropriate cleaning of the genitals, nail care, com resident hair and pressure sores, for residents who required assistance. This affected 6 out of 40 residents (Resident #5, Resident #8, Resident #22, Resident #36, Resident #51, and Resident #52). This tag is cross referenced to tags F 242, F 311, F 312. And 314 Finding included: F 242: Based on record review, observations and staff and resident interviews, the facility failed to honor a resident's preference to be out of bed per request for 1 of 10 residents reviewed for Activities of Daily Living (Resident #5). F 311: Based on record review and staff interview, the facility failed to provide restorative services for Resident #36. This was evident in 1 of 1 resident sampled to participate in a restorative program. F 312: Based on observations, record review, staff and resident interviews the facility failed to provide appropriate cleansing of the genitals,	F 353	1) Resident #5 was out of bed per preference on 3/16/2017. Resident #36 documentation was reviewed by DON on 04/10/2017 to ensure participation was recorded for 6 restorative visits by restorative aides for the week of 04/03/17. Resident #8 received appropriate cleansing of the genitals, washing of the skin on the left leg and the soap rinsed off of the skin on 03/20/2017 by CNA. Resident #36, #22, and #51 received nail care to clean nails on 03/15/2017 by CNA. Resident #52 chin was shaved on 03/15/2017 by CNA. Resident #51 hair was combed on 03/15/2017 by CNA. Resident #8 wound assessment was completed on 03/14/2017 by hall nurse. 2) The Administrator, DON or SDC will audit all staffing sheets for the last 30 days to ensure adequate staffing was in house. Any staffing issues will be identified for root cause and taken to the QI meeting. 3) The Administrator re-trained the DON and Scheduler on 04/13/2017 regarding: 1) reviewing the staffing sheets to ensure adequate staffing, 2) nursing schedule and assignments are designed based on the needs of the residents, 3) process for calling agency staff, if needs are identified 4) all call offs will go through	

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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F 353	Continued From page 46 wash the skin on the left leg and thoroughly rinse the body soap off the skin of Resident #8. The facility failed to clean the finger nails of dependent Residents #36, #22 and #51. The facility failed to remove the hair from Resident #52's chin. The facility failed to comb the hair of Resident #51 who was dependent on staff for care. The facility failed to transfer Resident #5 out of bed per the physician order and resident choice. This was evident in 6 of 10 dependent residents in the sample reviewed for activities for daily living. F 314: Based on observations, record review and staff interviews the facility failed to complete a comprehensive wound assessment for 1 of 4 residents reviewed for pressure ulcers (Resident #8). Nursing assistant #4 was interviewed on 3/15/17 at 4:15 PM. She stated the resident required the assistance of 2 people and the lift to get to the chair. The resident liked to get up after breakfast and before lunch. She stated that was the busiest time and everyone wanted to get up then. She stated after lunch the resident wanted to get up too but lunch trays were delivered and then she went to lunch herself. When 2nd shift staff came in, the resident would refuse to get up. She stated she usually worked 1st shift and the resident had not been neglected but they just didn't have the man power. She stated if she used the lift with just 1 person then she would get in trouble. She wanted to get the resident up but just couldn't find staff to help. She stated it was not that she didn't care but they just didn't have the man power to get these people up. She stated that there were 3 nursing assistants for the whole facility plus the restorative aids.	F 353	the DON/Scheduler/Administrator so staffing needs may be identified prior to shifts starting, 5) ensuring all residents requiring restorative care needs are being met even during times when assignments are changed. The DON and/or SDC will start training on 4/13/17 to all nursing staff on the proper call off procedure to include: 1) when and whom to call out to, 2) how to request time off, 3) to inform their supervisor when needing additional assistance with resident care, and 4) ensuring administration is aware of residents needed restorative assistance during times of assignment changes. All Nursing staff will be trained by the end of their next scheduled shift by the SDC, DON or Administrator by 04/14/2017. Nursing staff will not be able to complete a shift without being trained and all new hires will be trained during the orientation process by SDC. 4) The DON, Scheduler or SDC will review staffing sheets and nursing schedule to ensure adequate staffing levels. The DON, SDC, or Scheduler will complete the staffing monitoring tool to ensure adequate staff daily x4 weeks, then 5x weekly x4 weeks, then 3x weekly x8 weeks. The completed audit tool will be given to the Administrator for review. The Administrator or DON will take the results to the monthly QI for continued follow up. Any issues of non-compliance may result in continued monitoring.	

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F 353	Continued From page 47 Nursing assistant #6 was interviewed on 3/16/2017 at 3:30 PM She stated that she had worked on the hall several days having 22 residents and it hard to meet the needs of the resident at this facility. NA stated we need help on 2rd shift is bad. NA #6 stated that residents do wait for care because we do not have enough NA on the halls. Interview with Administrator Brittany Robinson on 3/17/2017 at 12:24 PM indicated that her expectation for staffing for her building is that she have enough staff in her building to meet her resident's needs.	F 353		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		4/12/17

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F 520	Continued From page 48 identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on March, 2016. This was for three recited deficiency, which was originally cited in March, 2016 on a recertification survey and on the current recertification survey. The deficiency was in the area of Housekeeping and Maintenance, MDS accuracy and Activities of daily living (ADL's). The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to F253: Based on observation, record reviews and	F 520	1) The bathroom in 102A was cleaned on 3/15/17 by housekeeper. The wall in 102A was repaired and painted on 04/06/2017 by the Maintenance Director. The bathroom door in 104 was repaired and painted on 04/06/2017 by corporate support team. The filters in the heat/air condition unit in room 105 were cleaned on 04/06/2017 by the Maintenance Director. The wall in room 109 was repaired and painted on 04/06/2017 by the Maintenance Director. The wall in room 109 was repaired and painted on 04/06/2017 by the Maintenance Director. The bathroom door in room 110 was repaired and painted on 04/06/2017 by corporate support team. The brown colored substance around the toilet in room 113 was caulked on 03/15/2017 by	

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F 520	Continued From page 49 staff interviews the facility failed to maintain housekeeping and maintenance services to provide clean resident's rooms and clean toilets in resident's bathrooms and provide a maintained, safe and comfortable interior on 2 of 3 resident halls. (Hall 100 and Hall 200) F278: Based on record review, observation and staff interview the facility failed to accurately code Hospice services on the Minimum Data Set (MDS) for Resident #74. The facility failed to accurately code the oral status of Resident #36: This was evident in 1 of 1 resident reviewed for Hospice services and 1 of 3 residents reviewed for dental services F312: Based on observations, record review, staff and resident interviews the facility failed to provide appropriate cleansing of the genitals, wash the skin on the left leg and thoroughly rinse the body soap off the skin of Resident #8. The facility failed to clean the finger nails of dependent Residents #36, #22 and #51. The facility failed to remove the hair from Resident #52's chin. The facility failed to comb the hair of Resident #51 who was dependent on staff for care. The facility failed to transfer Resident #5 out of bed per the physician order and resident choice. This was evident in 6 of 10 dependent residents in the sample reviewed for activities for daily living. This was originally cited in March, 2016 during the recertification survey when the facility failed to maintain housekeeping and maintenance services to provide clean walls and bathroom. The facility failed to code the Minimum Data Set for assessment to reflect the level of activities of daily living (ADL's) for accuracy on the MDS. The facility also failed to clean and trim fingernails as	F 520	the Maintenance Director. The bathroom in 113 was cleaned on 03/15/2017 by housekeeper. The door in room 114 was repaired and painted on 04/06/2017 by corporate support team. The door in room 115 was repaired and painted on 04/06/2017 by corporate support team. The door in room 116 was repaired and painted on 04/06/2017 by corporate support team. The door in room 201 was repaired and painted on 04/06/2017 by corporate support team. The hole in the wall in room 201 was repaired and painted on 04/06/2017 by the Maintenance Director. The wall in room 205 was painted on 04/06/2017 by the Maintenance Director. The door in room 207 was repaired and painted by corporate support team on 04/06/2017.The bathroom floor tile under the toilet in room 209 was replaced on 04/06/2017 by the Maintenance Director. The brown colored substance around the toilet in room 210 was caulked on 03/15/2017 by the Maintenance Director. The wall in room 212 was repaired and painted on 04/06/2017 by the Maintenance Director. The night stand and basin in room 212 was cleaned on 03/15/2017 by the Housekeeping Supervisor. The wall in room 214 was repaired and painted on 04/06/2017 by the Maintenance Director. The bed table in room 217 was removed and replaced on 04/06/2017 by the Housekeeping Supervisor. Resident #74 admission MDS was modified to code for hospice services on 03/15/2017 by the MDS Coordinator. Resident #36□s annual MDS dated 1/4/17	

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F 520	Continued From page 50 needed and clean between toes when providing a bed bath for residents. The Director of Nursing was interviewed on 3/17/17 at 4 PM. She stated that she was action QA person until next week. Her expectation for QA to identify any issues within the building and put a system in place to correct the problem and monitor the problem. DON indicated that the facility has to put new interventions for the areas of recited deficiencies.	F 520	was modified under the oral/dental section to include edentulous on 3/15/17 by the MDS Coordinator. Resident #8 received appropriate cleansing of the genitals, washing of the skin on the left leg and the soap rinsed off of the skin on 03/20/2017 by CNA. Resident #36, #22, and #51 received nail care to clean nails on 03/15/2017 by CNA. Resident #52 chin was shaved on 03/15/2017 by CNA. Resident #5 was up out of bed on 3/16/17 by CNA. Resident #51 hair was combed on 03/15/2017 by CNA. The QA committee meet on 04/07/2017. 2) The Administrator, DON or SDC will audit all QI notes for the last 12 months to ensure completion of monitoring forms and to ensure facility matters are addressed and corrective measures are in place by 04/12/2017. Any Items needing additional monitoring will be taken to facility QI meeting. All newly hired Department managers will be trained to ensure completion of monitoring forms and to ensure facility matters are addressed and corrective measures are in place during orientation. 3) The Administrator will re-train all department level staff on the importance of monitoring issues in the facility to include: completion of monitoring forms and to ensure facility matters are addressed and corrective measures are in place by 04/12/2017. 4) The Administrator, DON, QI or SDC will monitor QA minutes for proper compliance monthly x 6 months with the QI monitoring tool. All findings will be taken to the monthly QI meeting for	

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F 520	Continued From page 51	F 520	review. Any incidents of non-compliance may result in continued monitoring.	