STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(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 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 164		9/15/17

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

Electronically Signed | 09/08/2017

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F 164	Continued From page 1 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to maintain confidentiality of the MAR for Resident #173. The findings included: During an observation o 08/16/17 at 9:00 AM the medication cart with the resident's MAR was observed to be parked just outside Resident #173's room, and the resident's personal and medical information was left exposed and unattended. An interview was conducted on 08/16/17 at 9:05 AM with Nurse #10 who stated that she had just stepped away from her cart doing medication administration and that she usually would close the MAR, but did not this time. She reported she should have closed tje MAR when she stepped away from the cart. An interview was conducted on 08/16/17 at 9:30 AM with the Director of Nursing (DON). The DON stated the MAR's should be closed or covered at all times when the nurse was not at the cart.	F 164	F164 1. The EMAR for resident #173 was closed immediately by the Director of Nursing. Nurse #10 was terminated. 2. Current residents are at risk for the same alleged deficient practice. The Director of Nursing (DON) and/or designee conducted an audit of all computers to ensure that if unattended the computer was closed and no personal health information was visible on 8/16/17 and 8/17/17. 3. Systemic measures to be implemented to prevent the same alleged deficient practice are: Current Licensed Nurses and Certified Medication Aides will be re-educated on privacy/confidentiality to include closing of the EMAR when left unattended. New Hires will be trained during the orientation process. The Director of Nursing and/or designee will conduct daily audits for 1 week to ensure the EMARs are closed when left unattended and there is no personal health information visible. Negative findings will be addressed if noted. The results of the daily audits will be reviewed during the Interdisciplinary Team meeting Monday through Friday. The Director of Nursing or designee will continue to conduct weekly audits for 3 weeks and monthly audits for 2 months to ensure the EMARs are closed when unattended.	

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F 164	Continued From page 2	F 164	4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 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. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility neglected 3 of 6 sampled residents (Resident #28, #90 and #155), who complained about care during the intial tour of the facility, by leaving residents in	F 224	F224 1. Resident #28 was bathed dressed and assisted out of bed. #155 received incontinent care and was assisted out of bed. #90 received personal care and was	9/15/17

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F 224	Continued From page 3 bed without bathing, changing, and/or repositioning them over multiple shifts. Findings included: 1. Resident #28 was admitted to the facility on 03/22/15. The resident's documented diagnoses included chronic kidney disease stage III, diabetes, osteoarthritis, bladder dysfunction, cardiac arrhythmias, and chronic obstructive pulmonary disease. The resident's 08/04/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, except for eating she required extensive assistance to being totally dependent on two staff members for her activities of daily living (ADLs), she was always incontinent of bowel and bladder, and she had no pressure ulcers. The resident's care plan, last updated on 08/04/17, identified bowel and bladder incontinence and ADL self-care deficit as problems. A goal for the incontinence was to keep the resident clean and dry with provision of timely incontinent care by the staff, and a goal for ADL deficit was staff assistance to turn and reposition in bed. The care plan also documented Resident #28 had to be transferred via lift and two-person staff assist. At 2:50 PM on 08/14/17 Resident #28 was in bed in her gown. She stated she missed her therapy appointment today because there was not enough staff to get her out of bed, bathed, and dressed. She also reported she was wet, and needed to be changed. At 8:33 PM on 08/15/17 Resident #28 stated she	F 224	assisted out of bed. 2. Current residents who require assistance with activities of daily living and/or mobility are at risk for the same alleged deficient practice. Nursing Administration assisted with providing personal care for those residents on 8/14/17. 3. Systemic Measures Implemented to ensure the same alleged deficient practice does not recur is as follows: Current staff will be educated on Mistreatment/Neglect by the Director of Nursing and/or designee. Additional short and long term agency Licensed Nurses and Certified Nurse Aides have been contracted to provide additional staffing coverage. The Director of Nursing/designee will conduct personal care audits and resident interviews weekly times 4 and then monthly times 2 to ensure care needs are being met. Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17. She commented she stayed wet from the early morning hours of 08/14/17 until she was changed, and received a quick bed bath later that same evening at 7:00 PM. The resident reported she was "sopping wet" by the time she was changed. According to the resident, her nursing assistants (NAs) told her they would get to her when they could, but they were extremely short staffed. The resident stated she used the clock on the wall across from her bed to gauge the time. She commented she rang the call bell once when she was first wet, but had to wait so long she eventually fell asleep, and when she awoke someone had cut the call light out. She explained she did not ring the call bell again because either it would be ignored or turned off by staff with promises to return later because they were too under-staffed to get to her right then. The resident commented that this was the type of culture that had developed in the facility over the last couple of months. Resident #28 stated she did not like to be wet, but there was not much she could do about it. She stated there were multiple days when therapy would come to get her, and she was not out of bed, bathed, and dressed. She commented that it was frustrating for herself and the therapists to keep making repeated attempts to get her into the therapy gym. She also reported she missed Bible study multiple times because staff had not gotten her out of bed, and finally her pastor went to the Director of Nursing (DON) about the problem which resulted in staff getting written up.

At 3:04 PM on 08/17/17 Resident #28's certified occupational therapy assistant (COTA) #1 stated she provided electrical stimulation (e-stim) to the

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resident in her room on 08/14/17 because the resident was unable to complete range of motion and strengthening exercises in the gym. She reported she heard there were not enough staff to get the resident out of bed and bathed.

At 3:38 PM on 08/17/17 Therapy Assistant #4, who brought residents to the therapy department from their rooms, stated there were multiple days when he had to visit Resident #28's room several times before staff had the resident up out of bed, bathed, and dressed so he could take her to the therapy gym.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #28 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents. They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get some residents out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents. They explained that those residents who suffered the most were those like Resident #28 who had to be transferred via lift because it was almost impossible to come up with a second NA to help operate the lift safely. According to the NAs, even though they realized most all residents preferred to be up and out of bed on first shift and preferred to be clean and dry, many times they had to leave residents in

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bed and wet and/or soiled and hope that second shift would be more heavily staffed.

At 3:35 PM on 08/18/17 the DON stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be repositioned frequently to help with pain control and reduction of pressure ulcer formation.

2. Resident #155 was admitted to the facility on 07/13/15. The resident's documented diagnoses included Parkinson's disease, rheumatoid arthritis, chronic pain, anxiety, and depression.

The resident's 05/17/17 annual minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, except for eating she required extensive assistance to being totally dependent on a staff member for her activities of daily living (ADLs), she was occasionally incontinent of urine but always continent of bowel, and she had a stage III pressure ulcer (sacral ulcer since healed).

The resident's care plan, last updated on 08/13/17, identified risk for and existence of a pressure ulcer as a problem with interventions that included "offer to turn and reposition frequently" and "provide incontinent care as indicated." The care plan also documented Resident #155 required assistance from staff with transfers. The resident's care plan also addressed the provision of appropriate activities, with Bingo identified as a preferred activity. Interventions included "invite the resident to

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scheduled activities of interest."

At 2:56 PM on 08/14/17 Resident #155 stated she would like to be changed since she had been wet since 12 noon. She reported she asked about an hour earlier to be changed, but the nursing assistant (NA) told her she could not get to her yet because the hall was short of staff. She commented that the inability to get timely care was a reoccurring problem over the last couple of months.

At 8:42 PM on 08/15/17 Resident #155 stated last month a NA got her up at 5:30 AM, providing her with a quick partial bed bath to her upper extremities and slipping a T-shirt over her head to wear. She reported the NA told her she would have to stay in bed all day because there was not enough staff to get her up. She commented she also remained wet and soiled before lunch until 8:00 PM that same evening when she was finally changed. According to the resident, she rang the call bell to be changed once on first shift and once on second shift, but both times staff informed her she would have to wait to be changed. She stated the facility had worked diligently to heal her sacral pressure ulcer, and she sure did not want that wound to re-open. She remarked she did not like to be wet and soiled, but it was getting to be a common occurrence in the facility so she did not have much choice but to deal with it. Resident #155 stated she loved to play Bingo, and she had missed the activity several times because staff did not have her up out of bed. She also reported it was a challenge to get to therapy, and once recently the therapist had to change her so she could get to the gym to participate.

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At 3:38 PM on 08/17/17 Therapy Assistant #4, who brought residents to the therapy department from their rooms, stated there were multiple days when he had to visit resident rooms several times before staff had the residents up out of bed, bathed, and dressed so he could take them to the therapy gym.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #155 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents (Resident #155 resided on one of these halls). They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get some residents out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents. According to the NAs, even though they realized most all residents preferred to be up and out of bed on first shift and preferred to be clean and dry, many times they had to leave residents in bed and wet and/or soiled and hope that second shift would be more heavily staffed.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be

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repositioned frequently to help with pain control and reduction of pressure ulcer formation.

3. Resident #90 was admitted to the facility on 05/08/15. Her documented diagnoses included restless leg syndrome, right foot drop, and osteoarthritis.

The resident's 06/16/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, except for eating she required extensive assistance to being totally dependent on one or two staff members for her activities of daily living (ADLs), and she had no pressure ulcers.

The resident's care plan, last updated on 08/09/17, documented the resident had arthritis in her bilateral shoulders and lower extremities. The goal for the management of this arthritis pain was to remain free of complications related to arthritis, contractures, joint stiffness, swelling, and decline in mobility. Interventions for the problem included "turn and reposition frequently" and "report to MD (physician) signs and symptoms of complications related to arthritis." The care plan also documented Resident #90 had a "personal preference to be out of bed early."

At 3:25 PM on 08/14/17 Resident #90 stated she was in discomfort due to stiffness, cramping, and muscle spasms in her legs and feet. She reported she had been in the bed, without being turned and repositioned, since about 10:00 PM the previous night. According to the resident, she had asked to get up out of bed twice so far today, but was told that there was not enough staff to do so. However, she commented she had not told staff about the discomfort that she was

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F 224	Continued From page 10 experiencing. After surveyor intervention, a NA got Resident #90 out of bed. At 10:33 AM on 08/18/17 Nurse #12 stated Resident #90 was interviewable and reliable. At 2:40 PM on 08/18/17 three nursing assistants (NAs), #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents (Resident #90 resided on one of these halls). They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get residents who required lift transfers out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents. At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be repositioned frequently to help with pain control and reduction of pressure ulcer formation.	F 224		
F 242 SS=E	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services	F 242		9/15/17

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F 242	Continued From page 11 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 observation, resident interview, staff interview, and record review the facility failed to honor preferences regarding bathing and getting out of bed in the mornings for 4 of 6 sampled residents (Resident #28, #90, #155, and #181) who expressed care concerns during intial tour of the facility. Findings included: 1. Resident #155 was admitted to the facility on 07/13/15. The resident's documented diagnoses included Parkinson's disease, rheumatoid arthritis, chronic pain, anxiety, and depression. The resident's 05/17/17 annual minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, and except for eating she required extensive assistance to being totally dependent on a staff member for her activities of daily living (ADLs). At 8:42 PM on 08/15/17 Resident #155 stated staff got her out of bed today at about 10:00 AM, but therapy had been to her room a couple times before then to check and see if she was ready to	F 242	F242 1. Resident #155, #28, #90 and #181 have been evaluated for their personal preferences and their preferences have been honored and plan of care has been updated. 2. Current residents are at risk to be affected by the same alleged deficient practice. Residents who are capable of making needs known have been interviewed by the Director of Nursing and/or designee regarding personal preferences. Their preferences have been honored and the plans of care updated accordingly. 3. Systemic Measures Implemented to ensure the same alleged deficient practice does not recur are as follows: Licensed Nurses and Certified Nurse Aides will be re-educated regarding resident rights related to personal preferences and resident choice. The Director of Nursing/designee will conduct audits and resident interviews weekly times 4 and then monthly times 2 to ensure	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 12 go to the therapy gym. She also reported last month a nursing assistant (NA) got her up at 5:30 AM, providing her with a quick partial bed bath to her upper extremities and slipping a T-shirt over her head to wear. She reported the NA told her she would have to stay in bed all day because there was not enough staff to get her up. The resident commented she had relayed to staff she would like to be gotten out of bed about 8:00 AM each morning, but she guessed honoring choices was not possible when the facility was so short-staffed. Resident #155 stated she loved to play Bingo, and she had missed the activity several times because staff did not have her up out of bed. She also reported it was a challenge to get to therapy, and once recently the therapist had to change her so she could get to the gym to participate. According to Resident #155, she enjoyed getting a shower, but had not gotten one since the residents were treated for bugs (scabies) multiple months ago (a 02/21/17 physician order initiated the resident's precautionary treatment for scabies). She stated she thought it was facility policy that residents were offered showers twice a week, but when she asked to receive a shower, she was told that there was not enough staff working on the halls to provide one. The resident commented she just felt much cleaner when she received a shower versus a bed bath. At 3:38 PM on 08/17/17 Therapy Assistant #4, who brought residents to the therapy department from their rooms, stated there were multiple days when he had to visit resident rooms several times before staff had the residents up out of bed, bathed, and dressed so he could take them to the therapy gym.	F 242	preferences are being honored. Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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At 10:33 AM on 08/18/17 Nurse #12 stated Resident #155 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift a lot stated sometimes there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents. They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented there were many times when showers could not be given due to a shortage of staff, and about all that were able to provide were quick bed baths. According to these NAs, when there were only four NAs between the two heavy-care halls they could not even get residents out of bed who required lift transfers much less honor any resident choices regarding the time they were gotten of bed, bathed, and dressed.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) and Administrator stated they expected resident preferences and choices about their care to be honored. They reported it was not acceptable for residents who wanted to be out of bed before lunch each day to have to wait until second shift for staff to assist or transfer them out of bed, bath them, and dress them. The DON commented currently the facility had no accurate documentation as to whether residents received showers or bed baths daily. However, she stated the facility had a shower schedule which should be followed, and it specified the two days of the week that different residents were supposed to be offered showers. According to the DON, the staff was supposed to follow the schedule, and if

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they could not, they were to be notifying her of the problem.

2. Resident #28 was admitted to the facility on 03/22/15. The resident's documented diagnoses included chronic kidney disease stage III, diabetes, osteoarthritis, bladder dysfunction, cardiac arrhythmias, and chronic obstructive pulmonary disease.

The resident's 08/04/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, and except for eating she required extensive assistance to being totally dependent on two staff members for her activities of daily living (ADLs).

At 2:50 PM on 08/14/17 Resident #28 was observed in bed in her gown. She stated she missed her therapy appointment today because there was not enough staff to get her out of bed, bathed, and dressed.

At 8:33 PM on 08/15/17 Resident #28 stated she had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17. She commented she had shared with staff that she liked to be out of bed, bathed, and dressed by 11:00 AM daily, but that did not always happen because for the last couple of months the facility was very short staffed. She reported it did not do any good to ring the call bell when the facility was under-staffed because the nursing assistants (NAs) and nurses would just say that they could not get you up at all or that they would get to you when they could. She explained she did not like this practice, but there was not much that she could do about it. Resident #28 stated there were

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multiple days when therapy would come to get her, and she was not out of bed, bathed, and dressed. She commented that it was frustrating for herself and the therapists to keep making repeated attempts to get her into the therapy gym. She also reported she missed Bible study multiple times because staff had not gotten her out of bed, and finally her pastor went to the Director of Nursing (DON) about the problem which resulted in staff getting written up.

At 3:04 PM on 08/17/17 Resident #28's certified occupational therapy assistant (COTA) #1 stated she provided electrical stimulation (e-stim) to the resident in her room on 08/14/17 because the resident was unable to complete range of motion and strengthening exercises in the gym. She reported she heard there were not enough staff to get the resident out of bed and bathed.

At 3:38 PM on 08/17/17 Therapy Assistant #4, who brought residents to the therapy department from their rooms, stated there were multiple days when he had to visit Resident #28's room several times before staff had the resident up out of bed, bathed, and dressed so he could take her to the therapy gym.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #28 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents. They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the

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halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they could not even get residents out of bed who required lift transfers much less honor any resident choices regarding the time they were gotten of bed, bathed, and dressed.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) and Administrator stated they expected resident preferences and choices about their care to be honored. They reported it was not acceptable for residents who wanted to be out of bed before lunch each day to have to wait until second shift for staff to assist or transfer them out of bed, bath them, and dress them.

3. Resident #90 was admitted to the facility on 05/08/15. Her documented diagnoses included restless leg syndrome, right foot drop, and osteoarthritis.

The resident's 06/16/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, and except for eating she required extensive assistance to being totally dependent on one or two staff members for her activities of daily living (ADLs).

Review of Resident #90's care plan, last updated on 08/09/17, documented the resident had a "personal preference to be out of bed early."

At 3:25 PM on 08/14/17 Resident #90 was observed in bed. She reported she had been in the bed, without being turned and repositioned, since about 10:00 PM the previous night. According to the resident, she had asked to get up out of bed twice so far today, but was told that

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there was not enough staff to do so.

At 10:02 AM on 08/18/17 Resident #90 stated she had shared multiple times with the staff that she would like to be gotten out of bed each day at around 7:00 AM because she got stiff if she stayed in bed much longer. She reported within the past couple months her request was not honored because she was told there was not enough direct care staff.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #90 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents. They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they could not even get residents out of bed who required lift transfers much less honor any resident choices regarding the time they were gotten of bed, bathed, and dressed.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) and Administrator stated they expected resident preferences and choices about their care to be honored. They reported it was not acceptable for residents who wanted to be out of bed before lunch each day to have to wait until second shift for staff to assist or transfer them out of bed, bath them, and dress them.

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4. a Resident #181 was admitted to the facility on 11/11/16. The residents documented diagnoses included paraplegia, pressure ulcer stage 4 of the sacral region, and neuromuscular dysfunction of bladder.

Resident #181's quarterly Minimum Data Set (MDS) dated 07/20/17 revealed the resident's cognition was intact, and he required extensive to total assistance by staff for bed mobility, transfers, and toileting. The resident was always incontinent of bowel and had an indwelling catheter. Resident #181's assistive device was a wheelchair for mobility.

Resident #181 was observed on 08/14/2017 (Monday) at 4:30 PM. The resident was lying supine in the bed watching television and using a cell phone. The resident stated that he had not been out of bed for two days. The resident stated that he was placed in bed on Saturday evening at bedtime and hadn't been out of bed at all since Saturday. The resident stated that he requested multiple times over the last couple of days to get up and be placed in his wheelchair. The resident stated that his request was never honored and that nurse aide (NA) #1 responded to his request stating that they would get to him as soon as they could but there were other residents who needed more attention. The resident also stated that the nurse aide #1 reported that the facility was short staffed and couldn't get him up at that time.

Resident #181 was observed on 8/15/2017 at 11:00 AM in his wheelchair in the hallway self-propelling. The resident stated that he was happy to be up in his wheelchair and out of the

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bed. The resident stated that he had a shower and felt great.
In an interview with Nurse #1 on 08/16/2017 at 3:38 PM, she reported that Resident #181 stated to her when she came on 2nd shift on Monday that he had not been out of bed since being put to bed on Saturday evening. Nurse#1 stated that resident #181 was very reliable and she felt that he was being truthful about not being assisted out of bed since Saturday evening.

Resident #181 was interviewed on 8/17/2017 at 9:46 AM. The resident reiterated that he was placed in bed around 9:00 PM on 8/12/17, and was in the bed continually until Tuesday morning on 8/15/2017 when he was gotten up to shower. The resident stated that he requested multiple times to various staff over various shifts to get up out of bed. The resident stated that NA #1 told him that she did her rounds in the order that she wanted to and would get to him when she could. Resident stated that nurse aide #1 communicated that they were short staffed and that other residents had more urgent needs than him. Resident #181 stated that it was hard on him if he laid for long periods of time without getting up because of being a paraplegic, his legs got stiff and it took him a long time to get acclimated with warming up his extremities when he was up out of bed.

During an interview with NA #1 on 8/18/2017 at 10:45 AM she stated the facility was always short staffed. She reported the NA's were always running behind with providing patient daily care. NA #1 stated that patient care suffered greatly because of the shortage of staff. NA #1 stated that the facility had many full assist residents that required heavy attention to needs and in turn this

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reduced the time to care for other patients when there was not enough staff already. The NA #1 stated that most of her residents were incontinent and were in need of extensive to total care. NA #1 stated that when the breakfast, lunch, and snack trays arrived to the hall, all patient care stopped and the NAs passed out food trays and assisted residents who needed feeding assistance. NA #1 stated that she determined her patient care schedule based on the needs of the residents and their acuity. NA#1 stated that she always provided incontinent care in a timely manner for all residents, but she was not able to always get the residents out of bed when they wanted to get up. NA#1 stated that she didn't get resident #181 out of bed on her shift this past weekend when the resident requested to get up because she didn't have enough time or help to accommodate him. NA#1 stated that Resident #181 required two or more persons to assist when he was getting out of bed, and she was unable to get any help to get him up.

4. b Resident #181 was admitted to the facility on 11/11/16. The resident's documented diagnoses included paraplegia, pressure ulcer stage 4 of the sacral region, and neuromuscular dysfunction of bladder.

Resident #181's quarterly Minimum Data Set (MDS) dated 07/20/17 revealed the resident's cognition was intact, and he required extensive to total assistance by staff for bed mobility, transfers, and toileting. The resident was always incontinent of bowel and had an indwelling Foley catheter. Resident #181's assistive device was a wheelchair for mobility.

Resident #181 was observed on 08/14/2017 at

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4:30 PM. Resident was lying supine in the bed watching television and using a cell phone. The resident stated that he had not had a shower in over a week. The resident stated that he was scheduled to have showers on Tuesdays and Fridays every week. The resident stated that he received bed baths daily but really enjoyed getting a shower, and a week with no shower was too long. The resident stated that he asked to get his shower, but was told by NA#1 that there wasn't enough staff since he required the assistance of two persons to shower.

Resident #181 was observed on 8/15/2017 at 11:00 AM in a wheelchair in the hallway self-propelling. The resident stated that he was happy to be up in his wheelchair and out of the bed. The resident stated that they had a shower and felt great.
Resident #181 was interviewed on 8/17/2017 at 9:46 AM and stated that he went a week with no shower even though he was scheduled for a shower twice a week on Tuesday and Friday. The resident stated that he requested a shower last week, but was not given one. The resident stated that he received his shower this week on Tuesday, 8/15/17, but he felt that was only because the surveyors were in the facility. The resident stated that he required a sit and stand with two-person assistance to shower because he became weak during showers.

Review of bathing schedule documentation for the month of August 2017 revealed that Resident #181 did not receive a shower during the dates of 8/1/17 through 8/9/17 which was a span of 9 days with 3 scheduled shower opportunities missed for resident #181.

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During an interview with nursing assistant (NA) #1 on 8/18/2017 at 10:45 AM she stated the facility was always short staffed. She reported the NA's were always running behind with providing patient daily care. NA #1 stated that patient care suffered greatly because of the shortage of staff. NA #1 stated that the facility had many full assist residents that required heavy attention to needs and in turn this reduced the time to care for other patients when there was not enough staff already. The NA #1 stated that most of her residents were incontinent and were very demanding of care. The NA #1 stated that when the breakfast, lunch, and snack trays arrived to the hall, all patient care stopped and the NA's passed out food trays and assisted residents who needed feeding assistance. NA #1 stated that she determined her patient care schedule based on the needs of the residents and their acuity. Every resident receives a bed bath daily and each resident was on a shower schedule that can be showered. NA#1 stated that there were days that residents did not get their scheduled shower if they were a two person assist because of not having enough staff to provide safe showers. Activities of daily living (ADL) were documented in the computer. If a NA was with an agency, they document in a notebook kept at each hall's nurse station. The documentation of the number "8" in the computer reflected that the activity did not occur. This is how NA's documented if a shower was not provided for a resident in the bathing schedule documentation in the computer. Daily bed baths were not usually documented, but showers were documented there. When asked about resident #181 not receiving a shower for over a week, NA #1 stated that it was very possible because of not having enough staff at the time because resident #181 was a two person assist with ADLs.

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F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure 1 of 1 cognitively impaired resident (Resident #88) sent out of the facility to the hospital for a x-ray unaccompanied by someone who could give consent for treatment. Resident #88 was cognitively impaired and could not give consent for treatment. The facility also failed to schedule and arrange transportation to a medical appointment for 1 of 2 residents (Resident #217) reviewed for medically-related social services. Findings Included: 1. Resident #88 was admitted on 08/19/13. The residents documented diagnosis included dementia with Lewy bodies, dysphagia, and generalized muscle weakness. Resident #88's Minimum Data Set (MDS) quarterly dated 05/20/17, revealed the resident's cognition was severely impaired and she had physical impairment on both sides of upper and lower extremities. The resident required extensive assistance by staff for bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. In a phone interview with resident's guardian, he stated that Resident #88 was a hospice resident at the facility. The Guardian stated that the facility failed to notify the him that the resident was going to be transported for an outpatient	F 250	F250 1. Resident #88 was discharged from the facility on 7/26/17. Resident #217 attended her appointment scheduled on 6/30/17. 2. Current residents requiring transportation to appointments have the risk of being affected by the same alleged deficient practice. Residents going out on an appointment will be evaluated by the Director of Nursing or designee to determine if it is necessary for an escort to attend. An escort will accompany the resident as deemed appropriate. 3. Systemic Measures Implemented to ensure the same alleged deficient practice does not recur are as follows: The Social Worker and Scheduler/Transporter will be educated regarding our transportation policy and providing escorts to those residents in need. Current residents will be reviewed by the Director of Nursing/designee to evaluate if they will need an escort if going out on an appointment. The Director of Nursing/designee will provide the scheduler/transporter a list of residents needing an escort based on the evaluation. Newly admitted resident□s discharge records will be reviewed by the Director of	9/15/17

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F 250	Continued From page 24 appointment to have an x-ray. The facility transported Resident #88 to the appointment unaccompanied by a facility staff member. The resident was placed on the transport vehicle and the transport driver dropped Resident #88 off at the outpatient appointment at the hospital for an x-ray. The resident was left there alone. The Guardian also stated that the resident had severe cognitive impairment and could not consent to treatment. The outpatient facility contacted the guardian to make him aware that the resident was there and they needed consent to treat. The Guardian stated that he drove to the outpatient facility to be with Resident #88 as soon as he received the phone call notification and consented to treatment on behalf of the resident. During an interview with the Health Information Coordinator (HIC) on 08/18/17 at 9:10 AM, she stated that it was her expectation when a resident was transported to an appointment that a staff member or family member go with the resident. She also stated that a resident's cognitive status should be taken into consideration with planning for transport to appointments. The HIC reported that it was her expectation that family or responsible party should always be called and made aware of a resident appointment or if a resident was going to be off facility property. The HIC also stated that Resident #88 was sent out for an outpatient x-ray at the hospital, and she planned with an outside transport company to take Resident #88 for treatment. The HIC reported that Resident #88 was a hospice patient and that the hospice nurse was with the resident the day she was being transported. The HIC stated that she assumed that the hospice nurse accompanied Resident #88 to the appointment because the hospice nurse left at the same time	F 250	Nursing and/or designee to determine if there are any follow-up appointments scheduled. An in-house communication will be provided to the transportation scheduler for any new residents and/or new appointments in which transportation is required. The Director of Nursing and/or designee will review the scheduled appointments weekly times 4 weeks and monthly times 2 months to ensure escorts are provided as needed. Newly admitted resident□s discharge orders will also be reviewed weekly times 4 weeks and then monthly times 2 months to ensure appointments/transportation has been scheduled accordingly. Any negative finding will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance	

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as the resident with the transport service. The HIC reported that she would not send a resident that was cognitively impaired out to an appointment without a staff member going with the resident but in this incident, she failed to provide a chaperone with Resident #88 to an appointment.

The facility administrator and the district manager of clinical services were interviewed on 08/18/17 at 12:30 PM. They both had the expectation that facility should follow the transportation policy by having a facility employee or family member accompany a resident to a medical appointment. Concerning Resident #88, the administrator stated that the facility failed to follow the transportation policy and didn't secure an employee or family member to accompany Resident #88 to her appointment to consent for treatment. The district manager of clinical services reported that the facility would never transport a resident, who was cognitively impaired, to an appointment and leave them there without a staff or family member. But in this incident with Resident #88, she stated the facility failed provision of a staff or family member to accompany the resident to an off-site appointment.

2. Resident #217 was admitted to the facility on 06/12/17 with cumulative diagnoses including pneumonia and lung cancer.

A hospital discharge summary dated 06/27/2017 revealed she had a chemotherapy infusion appointment scheduled for 06/30/17 at 8:30 AM with the cancer specialist.

Resident #217's Minimum Data Set (MDS) dated

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F 250	Continued From page 26 07/18/17 revealed the resident had no cognitive impairments. A review of the care plan dated 08/1/17 revealed Resident #217 required chemotherapy at the cancer specialist related to lung cancer. A review of the resident's August 2017 Medication Administration Record (MAR) revealed the facility was to contact Resident #217's (family member) to schedule all appointments, the (family member) was to go with the resident to all appointments, and the resident was to receive all chemotherapy at the cancer specialist's office. A review of the facility's transportation log for 06/30/17 revealed no scheduled transportation for Resident #217. A note from the facility's Social Worker (SW) revealed that to her knowledge transportation was not scheduled for Resident #217's appointment on 06/30/17, but she did not attend her appointment. An interview conducted on 08/17/17 at 10:20 AM and 3:00 PM with the Director of Nursing (DON) and Administrator revealed it was their expectation the facility should have scheduled and transported Resident #217 to her 06/30/17 chemotherapy infusion appointment and did not.	F 250		
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	F 279		9/15/17

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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 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)-

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F 279	Continued From page 28 (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 observation, staff interview and record review the facility failed to care plan contracture management for 1 or 1 residents (#118). Findings included: Resident #118 was admitted to the facility on 06/19/17 with diagnoses that included Cerebral Infarction and Monoplegia of Upper Limb Following Cerebral Infarction Affecting Left Dominant Side. Review of the admission Minimum Data Set (MDS) dated 06/26/17 revealed that the resident had intact cognition, required extensive assistance with activities of daily living with the exception of locomotion (wheelchair) and eating which required supervision only. The resident had no skin impairments. Review of the care plan dated 07/10/17 showed it did not include interventions for a left hand contracture, range of motion, splinting or	F 279	F279 1. Resident #28 care plan was updated to include interventions for contracture management. 2. Current residents requiring contracture management have the potential to be affected by the same alleged deficient practice. The care plans of those residents requiring contracture management were reviewed and updated as needed. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: The Interdisciplinary Team was re-educated on developing comprehensive care plans. The Director of Nursing, Resident Care Management Director and/or designee will review new orders daily Monday thru Friday during the Interdisciplinary Team meeting. Orders requiring care plan updates for contracture management will	

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F 279	Continued From page 29 Restorative Therapy. Record review showed that the resident was discharged from Occupation Therapy on 07/26/17 with discharge recommendations to wear a splint on the left hand daily at all times except when bathing or exercising. No physician order was required. In an interview with Resident #118 on 08/14/17 at 10:30 AM she stated that no one had been putting the splint on her left hand. She stated that she wanted to wear the splint but that none of the nurse aides knew how to put it on. The resident's left hand was observed to be contracted. An observation on 8/15/17 at 11:15 AM and on 8/16/17 at 2:30 PM revealed that the resident was not wearing a splint on her left hand. In an interview conducted on 8/17/17 at 10:25 AM with the Rehab Manager, she stated the resident's contracture had been screened by the Occupational Therapist that morning . She stated the contraction had not worsened. She also revealed that the resident's splint could not be found and that a new one would be ordered. In an interview on 08/17/17 at 1:15 PM with Nurse #3, he stated that it was not on the resident's plan of care to wear a splint on her left hand. He said that it had not been communicated to him that the resident was to wear a splint on her left hand and therefore he did not put it on the plan of care. In an interview with the Director of Nursing on 08/18/17 at 11:46 AM she stated that it was her expectation that the facility follow therapy recommendations and continue therapy after a	F 279	be entered on to the plan of care and implemented accordingly. The Director of Nursing and/or designee will conduct weekly audits times 4 weeks and monthly times 2 months to ensure orders for contracture management have been documented on the plan of care. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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F 279	Continued From page 30 resident is discharged from skilled therapy services as a part of a resident's plan of care.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to follow professional standard of nursing practice resident dressings during dressing changes for 3 of 3 residents (Resident #6, Resident #181, and Resident #227). The findings included: 1. Resident #6 was admitted to the facility on 07/12/16 with cumulative diagnoses including stage 4 sacral pressure ulcer, rheumatoid arthritis, and cervical disc degeneration. Resident #6's Minimum Data Set (MDS) dated 07/19/017 revealed resident had no cognitive impairments. Resident needed extensive assistance with bed mobility, transfers, eating, toilet use, dressing, personal hygiene, and bathing. A pressure ulcer dressing change observation for Resident #6 was conducted on 08/16/17 at 3:29 PM with Nurse #6. The resident's existing stage 4 sacral pressure ulcer dressing was removed and observed not to be dated or initialed. After	F 281	F281 1. Resident #6, #181 and #227 had their dressing dated and initialed by the treatment nurse on 8/16/17. The Director of Nursing provided education to the treatment nurse regarding the standard of practice to date and initial dressings when changed. 2. Other residents requiring wound care dressings have the potential to be affected by the same alleged deficient practice. Those residents were reviewed by the treatment nurse and the dressings were dated and initialed as needed. 3. Systemic measures implemented to prevent the same alleged deficient practice does not recur include: Licensed staff will be educated on the dating and initialing of a dressing when it is changed as the standard of practice. The Director of Nursing and/or designee will conduct weekly audits times 4 weeks and then monthly times 2 months to ensure dressings are dated and initialed.	9/15/17

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F 281	Continued From page 31 Nurse #6 changed Resident #6's stage 4 sacral pressure ulcer dressing with a new dressing, she did not date and initial the new dressing. An interview was conducted on 08/16/17 at 4:00 PM with Nurse #6 who stated that before she worked for the facility she always dated and initialed all her dressing changes, which was good nursing practice. She said when she started as the facility's treatment nurse, she was told that it was not the facility's policy to date and initial dressings, and was told to discontinue dating and initialing on dressings, which she did do. An interview was conducted on 08/16/17 at 4:30 PM with the Director of Nursing (DON). The DON stated that dressings were not dated and initialed per facility policy. However, after reviewing the facility's policy and procedure on dressing changes dated December 2009, she reported moving forward it was her expectation (per professional clinical practice) that all dressings were required to be dated and initialed when placed and when changed. 2. Resident #181 was admitted to the facility on 11/11/16. The resident's documented diagnoses included paraplegia, pressure ulcer stage 4 of the sacral region, and neuromuscular dysfunction of bladder. Resident #181's quarterly Minimum Data Set (MDS) dated 07/20/17, revealed the resident's cognition was intact, and he required extensive to total assistance by staff for bed mobility, transfers, and toileting. The resident was always incontinent of bowel and had an indwelling catheter.	F 281	Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance	

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A pressure ulcer dressing change observation for Resident #181 was conducted on 08/16/17 at 10:03 AM with Nurse #6. The dressing on the resident's sacral ulcer was removed and observed not to be dated or initialed. Nurse #6 provided wound care and applied a new dressing to the pressure ulcer, but she did not date and initial the new dressing.

During an interview on 08/16/17 at 10:15 AM with Nurse #6 concerning wound care, she stated that she always dated and initialed all dressings prior to starting her employment at this facility. She stated that she was told by the director of nursing to not date dressing changes per the facility policy. She reported that today was the first time she has been notified that she needed to date dressing changes but she felt that it was best nursing practice to date all dressing changes. Nurse #6 reported that she was the designated wound care nurse for the facility. Nurse #6 admitted that she forgot to date and initial Resident #181's new pressure ulcer dressing because she wasn't in the habit of dating and initialing dressing changes in this facility.

An interview was conducted on 08/16/17 at 4:30 PM with the Director of Nursing (DON). The DON reported that dressings were not dated and initialed per the facility's policy. However, she reviewed the facility's policy and procedure dated December 2009 on dressing changes which revealed dressings should be dated and initialed. The DON stated that moving forward, it was her expectation that nurses should follow the professional standard of practice by dating and initialing all dressing changes.

3. Resident #227 was admitted to the facility on

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05/17/17. The residents documented diagnosis included cerebral infarction, hemiplegia, hemiparesis, dysphagia, aphasia post cerebral infarction, generalized muscle weakness, and unstageable sacral pressure ulcer.
During an interview on 08/16/17 at 10:15 AM with Nurse #6 concerning wound care, she stated that she always dated and initialed all dressings prior to starting her employment at this facility. She stated that she was told by the director of nursing to not date dressing changes per the facility policy. She reported that today was the first time she has been notified that she needed to date dressing changes but she felt strongly that it was best nursing practice to date all dressing changes. Nurse #6 reported that she was the designated wound care nurse for the facility. Nurse #6 admitted that she forgot to date and initial Resident #181's new pressure ulcer dressing, because she wasn't in the habit of dating and initialing dressing changes in this facility.

A pressure ulcer dressing change observation for Resident #227 was conducted on 08/16/17 at 10:30 AM with Nurse #6. The resident's existing sacral pressure ulcer dressing was removed and observed not to be dated or initialed. After Nurse #6 provided wound care and applied a new dressing to the sacral pressure ulcer, she dated and signed the new dressing.

An interview was conducted on 08/16/17 at 4:30 PM with the Director of Nursing (DON). The DON reported that dressings were not dated and initialed per the facility's policy. However, she reviewed the facility's policy and procedure dated December 2009 on dressing changes, which revealed dressings should be dated and initialed.

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F 281	Continued From page 34 The DON stated that moving forward, it was her expectation that nurses should follow the professional standard of practice by dating and initialing all dressing changes.	F 281		
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 observation, resident interview, staff interview, and record review the facility failed to provide activity of daily living (ADL) care over multiple shifts for 4 of 6 sampled residents (Resident #11, #28, #90 and #155) who complained about care during the initial tour of the facility. The facility failed to get three residents out of bed who required extensive assistance from staff with bed mobility and required extensive assist from staff to being dependent on staff for transfers (Resident #28, #90, and #155). The facility failed to bathe one resident who was dependent on staff for bathing (Resident #28). The facility failed to dress one resident who required extensive assistance from staff for dressing (Resident #28). The facility failed to provide incontinent care to two residents who required extensive assistance from staff with toileting (Resident #28 and #155). The facility failed to turn and reposition one resident who required extensive assistance from staff with bed mobility and was dependent on staff for transfers (Resident #90). The facility failed to cut fingernails for one resident who required extensive assistance from staff for hygiene	F 312	F312 1. Resident #28 was bathed dressed and out of bed. #155 received incontinent care and was assisted out of bed. #90 received personal care and assisted out of bed following their interview with the surveyor. Resident #11 received nail care immediately following the surveyor notifying the DON. 2. Current residents requiring assistance with activities of daily living (ADLs) are at risk for the same alleged deficient practice. Nursing Administration provided the care needed for those residents requiring assistance on 8/14/17. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: Additional short and long term agency Licensed Nurses and Certified Nurse Aides have been contracted to provide additional staffing coverage. . The Director of Nursing/designee will review the staffing daily to ensure coverage is adequate based on the needs of the residents.	9/15/17

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F 312	Continued From page 35 (Resident #11). Findings included: 1. Resident #28 was admitted to the facility on 03/22/15. The resident's documented diagnoses included chronic kidney disease stage III, diabetes, osteoarthritis, bladder dysfunction, cardiac arrhythmias, and chronic obstructive pulmonary disease. The resident's 08/04/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required extensive assistance from staff for bed mobility/dressing/toileting, she was dependent on staff for bathing and transfers, she was always incontinent of bowel and bladder, and she had no pressure ulcers. The resident's care plan, last updated on 08/04/17, identified bowel and bladder incontinence and ADL self-care deficit as problems. A goal for the incontinence was to keep the resident clean and dry with provision of timely incontinent care by the staff, and a goal for ADL deficit was staff assistance to turn and reposition in bed. The care plan also documented Resident #28 had to be transferred via lift and two-person staff assist. At 2:50 PM on 08/14/17 Resident #28 was in bed in her gown. She also reported she was wet, and needed to be changed. At 8:33 PM on 08/15/17 Resident #28 stated she had to remain in bed from 10:00 PM on Sunday, 08/13/17, until 7:00 PM on Monday, 08/14/17. She commented she stayed wet from the early morning hours of 08/14/17 until she was changed, and received a quick bed bath later that	F 312	Staffing assignments will also be evaluated by the Director of Nursing/designee and adjusted accordingly based on resident need. Current employees who are reporting off of work on their scheduled time will notify the Director of Nursing/designee personally. The Director of Nursing/designee will then attempt to ensure there is adequate coverage to provide care for those residents who require assistance. In the event coverage is unable to be obtained the Administrative Nursing Team will report to facility to assist with care needs. The Director of Nursing/designee will conduct care audits daily for 1 week and then weekly times 3 weeks and monthly times 2 to ensure care is being provided as needed. Resident interviews weekly times 4 and then monthly times 2 to ensure care needs are being met. Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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same evening at 7:00 PM. The resident reported she was "sopping wet" by the time she was changed. According to the resident, her nursing assistants (NAs) told her they would get to her when they could, but they were extremely short staffed. The resident stated she used the clock on the wall across from her bed to gauge the time. She commented she rang the call bell once when she was first wet, but had to wait so long she eventually fell asleep, and when she awoke someone had cut the call light out. She explained she did not ring the call bell again because either it would be ignored or turned off by staff with promises to return later because they were too under-staffed to get to her right then. The resident commented that this was the type of culture that had developed in the facility over the last couple of months. Resident #28 stated she did not like to be wet, but there was not much she could do about it.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #28 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents. They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get some residents out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents. They explained that those residents who suffered the most were those like

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Resident #28 who had to be transferred via lift because it was almost impossible to come up with a second NA to help operate the lift safely. According to the NAs, even though they realized most all residents preferred to be up and out of bed on first shift and preferred to be clean and dry, many times they had to leave residents in bed and wet and/or soiled and hope that second shift would be more heavily staffed.

At 3:35 PM on 08/18/17 the DON stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be repositioned frequently to help with pain control and reduction of pressure ulcer formation.

2. Resident #155 was admitted to the facility on 07/13/15. The resident's documented diagnoses included Parkinson's disease, rheumatoid arthritis, chronic pain, anxiety, and depression.

The resident's 05/17/17 annual minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required extensive assistance from staff for toileting/bed mobility/transfers, she was occasionally incontinent of urine but always continent of bowel, and she had a stage III pressure ulcer (sacral ulcer since healed).

The resident's care plan, last updated on 08/13/17, identified risk for and existence of a pressure ulcer as a problem with interventions that included "offer to turn and reposition frequently" and "provide incontinent care as

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indicated." The care plan also documented Resident #155 required assistance from staff with transfers. The resident's care plan also addressed the provision of appropriate activities, with Bingo identified as a preferred activity. Interventions included "invite the resident to scheduled activities of interest."

At 2:56 PM on 08/14/17 Resident #155 stated she would like to be changed since she had been wet since 12 noon. She reported she asked about an hour earlier to be changed, but the nursing assistant (NA) told her she could not get to her yet because the hall was short of staff. She commented that the inability to get timely care was a reoccurring problem over the last couple of months.

At 8:42 PM on 08/15/17 Resident #155 stated last month a NA got her up at 5:30 AM, providing her with a quick partial bed bath to her upper extremities and slipping a T-shirt over her head to wear. She reported the NA told her she would have to stay in bed all day because there was not enough staff to get her up. She commented she also remained wet and soiled before lunch until 8:00 PM that same evening when she was finally changed. According to the resident, she rang the call bell to be changed once on first shift and once on second shift, but both times staff informed her she would have to wait to be changed. She stated the facility had worked diligently to heal her sacral pressure ulcer, and she sure did not want that wound to re-open. She remarked she did not like to be wet and soiled, but it was getting to be a common occurrence in the facility so she did not have much choice but to deal with it.

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At 10:33 AM on 08/18/17 Nurse #12 stated Resident #155 was interviewable and reliable.

At 2:40 PM on 08/18/17 three NAs, #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents (Resident #155 resided on one of these halls). They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get some residents out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents. According to the NAs, even though they realized most all residents preferred to be up and out of bed on first shift and preferred to be clean and dry, many times they had to leave residents in bed and wet and/or soiled and hope that second shift would be more heavily staffed.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be repositioned frequently to help with pain control and reduction of pressure ulcer formation.

3. Resident #90 was admitted to the facility on 05/08/15. Her documented diagnoses included restless leg syndrome, right foot drop, and osteoarthritis.

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The resident's 06/16/17 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required extensive assist from staff with bed mobility and transfers, and she had no pressure ulcers.

The resident's care plan, last updated on 08/09/17, documented the resident had arthritis in her bilateral shoulders and lower extremities. The goal for the management of this arthritis pain was to remain free of complications related to arthritis, contractures, joint stiffness, swelling, and decline in mobility. Interventions for the problem included "turn and reposition frequently" and "report to MD (physician) signs and symptoms of complications related to arthritis." The care plan also documented Resident #90 had a "personal preference to be out of bed early."

At 3:25 PM on 08/14/17 Resident #90 stated she was in discomfort due to stiffness, cramping, and muscle spasms in her legs and feet. She reported she had been in the bed, without being turned and repositioned, since about 10:00 PM the previous night. According to the resident, she had asked to get up out of bed twice so far today, but was told that there was not enough staff to do so. However, she commented she had not told staff about the discomfort that she was experiencing. After surveyor intervention, a NA got Resident #90 out of bed.

At 10:33 AM on 08/18/17 Nurse #12 stated Resident #90 was interviewable and reliable.

At 2:40 PM on 08/18/17 three nursing assistants (NAs), #1, #3, and #4, who were assigned to work first shift on 08/14/17 stated there were only

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two NAs scheduled to work on each of the two halls in the building which housed the heavier care residents (Resident #90 resided on one of these halls). They reported that in order for residents to receive timely and quality care on these halls there needed to be four NAs on the longer of the halls and three NAs on the other heavy care hall. They commented with only four NAs between the two halls they were unable to get residents who required lift transfers out of bed, could only provide incontinent care at the most once a shift, and could not turn and reposition residents.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated it was her personal and facility expectation that residents be up and out of bed, bathed, and dressed on first shift (unless the residents voiced otherwise), that residents be checked and changed if needed every two hours during incontinent rounds, and that residents be repositioned frequently to help with pain control and reduction of pressure ulcer formation.

4. Resident #11 was admitted to the facility on 01/21/15 with cumulative diagnoses including spinal stenosis, major depression, and systemic lupus.

Resident #11's Minimum Data Set (MDS) dated 06/14/17 revealed the resident had no cognitive impairments. Resident #11 required extensive assistance of one person for personal hygiene. Rejection of care was not indicated as having occurred during the assessment period.

A review of the care plan dated 06/20/17 revealed Resident #11 required extensive assistance with

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F 312	Continued From page 42 personal hygiene. On 08/15/17 at 9:05 AM, Resident #11 was observed to have long jagged fingernails on both hands. On 08/15/17 at 9:30 AM, an observation of Resident #11 was conducted with the Director of Nursing (DON). She stated she expected nursing staff to monitor, clean, and clip Resident #11's fingernails during morning care when giving baths. The DON observed Resident #11's fingernails, and said the long jagged fingernails should have been cut, and had not been. Resident #11 stated she had been asking the nurses to cut her fingernails for 3 months, and they never did.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to provide contracture management for 1 of 1 residents (#118). Findings included:	F 318	F318 1. On 8/17/17 resident # 118 was screened by therapy and it was determined there was no worsening of the	9/15/17

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F 318	Continued From page 43 Resident #118 was admitted to the facility on 06/19/17 with diagnoses that included Cerebral Infarction and Monoplegia of Upper Limb Following Cerebral Infarction Affecting Left Dominant Side. Review of the admission Minimum Data Set (MDS) dated 06/26/17 revealed that the resident had intact cognition, required extensive assistance with activities of daily living with the exception of locomotion (wheelchair) and eating which required supervision only. The resident had no skin impairments. Review of the care plan dated 07/10/17 showed it did not include interventions for a left hand contracture, range of motion, splinting or Restorative Therapy. Record review showed that the resident was discharged from Occupation Therapy on 07/26/17 with discharge recommendations to wear a splint on the left hand daily at all times except when bathing or exercising. No physician order was required. Review of the Restorative Aide schedule for March, April, May, June, July and August of 2017 revealed that the Restorative Aide had worked as a staff nurse aide every scheduled day except for one day a month when weights were obtained. In an interview with Resident #118 on 08/14/17 at 10:30 AM she stated that no one had been putting the splint on her left hand. She stated that she wanted to wear the splint but that none of the nurse aides knew how to put it on. The resident's left hand was observed to be contracted.	F 318	resident□s contracture. The order for the splint was written and the care plan was updated. 2. Other resident requiring splints are at risk for the same alleged deficient practice. Resident was screened by therapy to ensure there was no worsening of contractures. Physician orders for splinting were written/transcribed, plans of care updated and splints applied accordingly. 3. Systemic measures to ensure the same alleged deficient practice does not recur include: Therapy to re-educate Licensed Nurses and Certified Nursing Assistants on the current residents have splints and how to apply and remove the splint. Kardexes will be updated accordingly. Pictures of the splint and directions for the splint will be placed inside the resident□s closet for future reference. The Director of Nursing, Resident Care Management Director and/or designee will review new orders daily Monday thru Friday during the Interdisciplinary Team meeting. Orders requiring care plan updates for contracture management will be entered on to the plan of care and implemented accordingly. The staff will be educated by therapy when a new splint is initiated. The Director of Nursing and/or designee will conduct weekly audits times 4 weeks and monthly times 2 months to ensure orders for contracture management have been documented on the plan of care and the staff have been educated. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the	

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F 318	Continued From page 44 An observation on 8/15/17 at 11:15 AM and on 8/16/17 at 2:30 PM revealed that the resident was not wearing a splint on her left hand. In an interview conducted on 08/17/2017 at 9:25 AM with Occupational Therapy Aide #1 she revealed that she had trained a nurse aide how to put the splint on the resident's left hand contracture but stated she had not seen that nurse aide lately. She said there was no Restorative Therapy program at the facility. She stated that she often trained nurse aides how to apply splints and then the next week she would notice that the aide she trained was no longer employed at the facility due to a high turn over in staff. In an interview conducted on 8/17/17 at 10:25 AM with the Rehab Manager, she stated the resident's contracture had been screened by the Occupational Therapist that morning . She stated the contraction had not worsened. She also revealed that the resident's splint could not be found and that a new one would be ordered. In an interview with Nurse #2 on 8/17/17 at 1:10 PM he revealed that there was no documentation showing that a splint had been applied for the resident. He stated that normally splinting would be on the plan of care in Point Click Care as a task for the nurse aides to complete but it was not. He said the Restorative Therapy aide had been working on the floor as a nurse aide because the facility has been short staffed so there had been no Restorative Therapy aide for several months. In an interview on 08/17/17 at 1:15 PM with Nurse	F 318	effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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F 318	Continued From page 45 #3, he stated that it was not on the resident's plan of care to wear a splint on her left hand. He said that it had not been communicated to him that the resident was to wear a splint on her left hand and therefore he did not put it on the plan of care. He was able to locate the resident's missing splint on the floor behind a chair in the resident's room on 8/17/17 at 4:30 PM. In an interview with the Director of Nursing on 08/18/17 at 11:46 AM she stated that it was her expectation that the facility follow therapy recommendations and continue therapy after a resident is discharged from skilled therapy services as a part of a resident's plan of care.	F 318		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		9/15/17

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F 323	Continued From page 46 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide supervision for 1 of 1 cognitively impaired residents (Resident #88) by not having staff or family accompany the resident to a medical appointment. Findings included: Resident #88 was admitted on 08/19/13. The residents documented diagnosis included dementia with Lewy bodies, dysphagia, and generalized muscle weakness. Resident #88's Minimum Data Set (MDS) quarterly dated 05/20/17, revealed the resident's cognition was severely impaired and she had physical impairment on both sides of upper and lower extremities. The resident required extensive assistance by staff for bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. In a phone interview with resident's guardian, he stated that Resident #88 was a hospice resident at the facility. The Guardian stated that the facility failed to notify him that the resident was going to be transported for an outpatient appointment to have an x-ray. The facility transported Resident #88 to the appointment unaccompanied by a facility staff member. The resident was placed on the transport vehicle and the transport driver dropped Resident #88 off at the outpatient appointment at the hospital for an x-ray. The resident was left there alone. The	F 323	F323 1. Resident # 88 was discharged from the facility on 7/26/17. 2. Current residents requiring escorts during transportation and/or appointments are at risk for the same alleged deficient practice. Current residents going out on an appointment will be evaluated by the Director of Nursing or designee to determine if it is necessary for an escort to attend. An escort will accompany the resident as deemed appropriate. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: The Social Worker and Scheduler/Transporter will be educated regarding our transportation policy and providing escorts to those residents in need. The Director of Nursing and/or designee will review the scheduled appointments weekly times 4 weeks and monthly times 2 months to ensure escorts are provided as needed. Any negative finding will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to	

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F 323	Continued From page 47 Guardian also stated that the resident had severe cognitive impairment. During an interview with the Health Information Coordinator (HIC) on 08/18/17 at 9:10 AM, she stated that it was her expectation when a resident was transported to an appointment that a staff member or family member go with the resident. She also stated that a resident's cognitive status should be taken into consideration with planning for transport to appointments. The HIC reported that it was her expectation that family or responsible party should always be called and made aware of a resident appointment or if a resident was going to be off facility property. The HIC also stated that Resident #88 was sent out for an outpatient x-ray at the hospital, and she planned with an outside transport company to take Resident #88 for treatment. The HIC reported that Resident #88 was a hospice patient and that the hospice nurse was with the resident the day she was being transported. The HIC stated that she assumed that the hospice nurse accompanied Resident #88 to the appointment because the hospice nurse left at the same time as the resident with the transport service. The HIC reported that she would not send a resident that was cognitively impaired out to an appointment without a staff member going with the resident but in this incident, she failed to provide a chaperone with Resident #88 to an appointment. The facility administrator and the district manager of clinical services were interviewed on 08/18/17 at 12:30 PM. They both had the expectation that facility should follow the transportation policy by having a facility employee or family member accompany a resident to a medical appointment.	F 323	maintain substantial compliance.	

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F 323	Continued From page 48 Concerning Resident #88, the administrator stated that the facility failed to follow the transportation policy and didn't secure an employee or family member to accompany Resident #88 to her appointment. The district manager of clinical services reported that the facility would never transport a resident, who was cognitively impaired, to an appointment and leave them there without a staff or family member. But in this incident with Resident #88, she stated the facility failed provision of a staff or family member to accompany the resident to an off-site appointment.	F 323		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services 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	F 353		9/15/17

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F 353	Continued From page 49 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 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 observation, resident interview, staff interview, and record review the facility failed to provide a sufficient number of nursing staff to meet the needs of residents as evidenced by failure to provide activity of daily living (ADL) care for 4 of 6 sampled residents (Resident #11, #28, #90, and #155) who expressed care concerns during the initial tour of the facility and failure to honor care preferences for 4 of 6 sampled residents (Resident #28, #90, #155, and #181) who expressed care concerns during the initial tour of the facility. The facility also neglected 3 of 6 sampled residents (Resident #28, #90, and #155) by not meeting their care needs over	F 353	F353 1. Resident #28 was bathed dressed and assisted out of bed. #155 received incontinent care and was assisted out of bed. #90 received personal care and assisted out of bed. Resident #11 had her nails cut on 8/15/17. 2. Current residents requiring assistance with activities of daily living (ADLs) are at risk. Nursing Administration provided the care needed for those residents requiring assistance on 8/14/17. 3. Systemic measures implemented to ensure the same alleged deficient practice	

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F 353	Continued From page 50 multiple shifts. Findings included: 1. Cross reference to tag F312: Based on observation, staff interview, and record review the facility failed to provide activity of daily living (ADL) care over multiple shifts for 4 of 6 sampled residents (Resident #11, #28, #90 and #155) who complained about care during the initial tour of the facility. The facility failed to get three residents out of bed who required extensive assistance from staff with bed mobility and required extensive assist from staff to being dependent on staff for transfers (Resident #28, #90, and #155). The facility failed to bathe one resident who was dependent on staff for bathing (Resident #28). The facility failed to dress one resident who required extensive assistance from staff for dressing (Resident #28). The facility failed to provide incontinent care to two residents who required extensive assistance from staff with toileting (Resident #28 and #155). The facility failed to turn and reposition one resident who required extensive assistance from staff with bed mobility and was dependent on staff for transfers (Resident #90). The facility failed to cut fingernails for one resident who required extensive assistance from staff for hygiene (Resident #11). 2. Cross reference to tag F242: Based on observation, staff interview, and record review the facility failed to honor preferences regarding bathing and getting out of bed in the mornings for 4 of 6 sampled residents (Resident #28, #90, #155, and #181) who expressed care concerns during initial tour of the facility. 3. Cross reference to tag F224: Based on observation, staff interview, and record review the	F 353	does not recur include: Additional short and long term agency Licensed Nurses and Certified Nurse Aides have been contracted to provide additional staffing coverage. . The Director of Nursing/designee will review the staffing daily to ensure coverage is adequate based on the needs of the residents. Staffing assignments will also be evaluated by the Director of Nursing/designee and adjusted accordingly based on resident need. Current employees who are reporting off of work on their scheduled time will notify the Director of Nursing/designee personally. The Director of Nursing/designee will then attempt to ensure there is adequate coverage to provide care for those residents who require assistance. In the event coverage is unable to be obtained the Administrative Nursing Team will report to facility to assist with care needs. Resident interviews weekly times 4 and then monthly times 2 to ensure care needs are being met. Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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F 353	Continued From page 51	F 353		

facility neglected 3 of 6 sampled residents (Resident #28, #90 and #155), who complained about care during the initial tour of the facility, by leaving residents in bed without bathing, changing, and/or repositioning them over multiple shifts.

Review of facility staffing assignments revealed that there were only two nursing assistants (NAs) scheduled on each of the two heavier care halls in the building on 07/03/17 first shift, 07/27/17 second shift, 08/12/17 first shift, 08/13/17 second shift, and 08/14/17 first shift.

At 2:42 PM on 08/16/17 Nurse #4 stated on the hall where Residents #11, #28, #90, and #155 resided 80% of the residents had to be transferred using a lift with two person assist, many of the residents on the hall liked to attend activities, many of the residents on the hall liked to eat in the dining room, and a lot of dialysis residents and residents who attended therapy resided on the hall. She reported with only two NAs on the hall care did not always get provided on first and second shifts. She commented that even with three NAs on that hall on first and second shift it might require residents to wait a long time to get the care they needed. According to Nurse #4, the facility was hiring a lot of agency staff which proved time consuming because they did not know residents' preferences and care needs so large amounts of time had to be spent reviewing resident cardexes to familiarize them with the residents they were going to be caring for.

At 10:00 AM on 08/18/17 nursing assistants (NAs) #1 and #8 stated when there were as few as two NAs assigned to each of the two heavier

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F 353	Continued From page 52 care halls the assignment was 20 - 22 residents apiece. They reported this assignment was not manageable, and not all residents could be gotten out of bed, showers could not be given, residents were lucky to receive incontinent care once a shift, and no residents were turned and repositioned. They commented even with two NAs on one of the heavier care halls and three NAs on the other heavier care hall residents went without care being provided. According to the NAs, it took 4 NAs on one heavy care hall and 3 NAs on the other heavier care hall to provide excellent care to residents. At 10:12 AM on 08/18/17 Nurse #12 stated aides on the heavier care halls often had as many as 20 residents on their assignments which resulted in residents not receiving the care that they needed. At 3:35 PM on 08/18/17 the Administrator and Director of Nursing (DON) stated in attempts to improve the staffing situation in the building the facility began hiring agency staff on 05/28/17. A staffing summary documented 2 agency registered nurses, 10 agency licensed practical nurses had been hired, and 12 agency NAs had been hired with 6 of those agency employees being terminated since hire. The summary also documented as many as 13 agency openings in various degrees of progress/fulfillment from awaiting training to awaiting hire. The DON stated the facility was not there yet, but its goal was to have 4 NAs on one heavy care hall and 3 NAs on the other heavy care hall.	F 353		
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		9/15/17

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F 368	Continued From page 53 (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to offer all residents an evening snack. Findings included: Review of resident council minutes from the 08/03/17 meeting documented residents had brought up a concern that not all residents were being offered an evening snack. At 8:20 PM on 08/15/17 Resident #239, residing on the 300 hall, stated he had never been offered an evening snack. At 8:22 PM on 08/15/17 Resident #999, residing on the 300 hall, stated that he doesn't usually get	F 368	F368 1. Resident # 239, #999, #143, #28 and #155 were provided snacks. 2. Current residents are at risk for the same alleged deficient practice. Evening snacks are being provided by dietary. 3. Systemic measures implemented to prevent the same alleged deficient practice does not recur include: The Dietary Department was educated on providing a variety of evening snacks for all residents not only those ordered a snack. The Nursing Department was re-educated on ensuring the snacks are offered to all residents and provided as requested. Resident interviews weekly	

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F 368	Continued From page 54 offered an evening snack, but would like to receive something like ice cream or chocolate milk. At 8:24 PM on 08/15/17 a tray of snacks was delivered to the 200 hall nurse's station. The tray contained 15 snacks labeled with resident names, and five extra snacks without resident names (two packs of crackers, an oatmeal cake, Graham crackers, and a bag of chips). At 8:30 PM on 08/15/17 Resident #143, residing on the 300 hall, stated she had never been offered an evening snack, but would possibly enjoy one. At 8:33 PM on 08/15/17 Resident #28 and #155, residing on the 200 hall, stated they had never been offered evening snacks. Resident #28 commented she had her own refrigerator, and depending on how well it was stocked, she would sometimes share a snack with Resident #155 in the evenings. However, both residents reported it would be much nicer if the facility offered snacks nightly so that they could consistently receive nourishment before bedtime. Resident #155 stated she and Resident #28 were both diabetics so a snack would help with better blood sugar control According to Resident #155, her pre-meal morning blood sugar was in the 60s a couple of times recently. (Record review revealed that Resident #155's blood sugar was 60 on 07/24/17 at 6:13 AM and on 08/17/17 at 6:14 AM with pre-breakfast blood sugars in the 70s on 07/31/17, 08/05/17, and 08/11/17). At 8:50 PM on 08/15/17 there was only one labeled snack sitting at the 100 hall nurse's station. Nurse #13 stated the 100 hall only	F 368	times 4 and then monthly times 2 to ensure snacks are being offered and provided. Negative findings will be addressed if noted. 4. The Quality Assessment Performance Improvement Committee will review the results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	

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F 368	Continued From page 55	F 368		

received labeled snacks at night, and currently only one resident on the hall had an order for an evening snack which justified labeling. She commented the 100 hall never received extra snacks in the evening to offer and pass out to residents who were still awake.

At 9:04 PM on 08/15/17 Nurse #1, caring for residents on the 300 hall, stated not all residents on the hall were offered evening snacks.

At 9:10 PM on 08/15/17 nursing assistant (NA) #6 stated the staff only had time to pass out labeled snacks at night because they were so busy providing incontinent care and getting residents back into bed.

At 9:14 AM on 08/15/17 NA #7 stated she passed mostly labeled snacks if she had time between providing PM care to her residents and putting them in bed for the night.

At 12:15 PM on 08/18/17 Resident #231, residing on the 100 hall, stated he was not offered snacks at night, but he would like something healthy like yogurt or ice cream

At 12:22 PM on 08/18/17 Resident #213, residing on the 100 hall, stated she was not offered an evening snack, but would love one since she had been getting very hungry between 10:00 PM and 11:00 PM and eating candy. She commented eating a healthy snack provided by the facility around 8:30 PM would be much better for her health.

At 3:35 PM on 08/18/17 the Director of Nursing (DON) stated all residents in the building should be offered an evening snack.

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F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		9/15/17

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in

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F 431	Continued From page 57 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to secure a plastic cup partially full of crushed medication, failed to secure an insulin pen in a locked cart, and failed to lock 2 of 5 medication carts during a medication pass. The findings included: During a medication pass on 08/16/17 at 9:00 AM a resident insulin pen was observed sitting on top of Nurse #10's medication cart left exposed and unattended. During a medication pass on 08/16/17 at 9:05 AM 2 of 5 medication carts were observed unlocked on the 300 hall left exposed and unattended. An interview was conducted on 08/16/17 at 9:10 AM with Nurse #10 who stated that she had just stepped away from her cart doing medication administration and that she usually secured the medications sitting on-top of her cart and locked the cart when she stepped into a resident room, but did not. She reported she should have locked up the insulin pen and locked the cart when she	F 431	F431 1. The medications were immediately removed from the top of the cart and secured in the medication cart. The cart was then locked. 2. Current residents have the potential to be affected by the same alleged deficient practice. All medication carts were audited on 8/16/17 and 8/17/17 to ensure medications were stored properly. 3. Systemic measures implemented to ensure the same deficient practice does not recur include: Licensed Nurses and Certified Medication Aides were re-educated on the storage of medications and locking the medication cart when left unattended. The Director of Nursing/designee will conduct daily audits for 1 week, weekly for 3 weeks and then monthly times 2 of the medication carts to check for medications not being stored properly or carts are left unlocked. 4. The Quality Assessment Performance Improvement Committee will review the	

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F 431	Continued From page 58 stepped away from the cart. During an early morning facility tour on 08/17/17 at 5:58 AM a 30 milliliter plastic cup partially full of crushed medication was observed sitting on-top of Nurse #5's medication cart left exposed and unattended. An interview was conducted on 08/17/17 at 6:00 AM with Nurse #5 who stated she just stepped away from her cart doing medication administration and that she usually locked the cart when stepped into a resident room, but did not. She reported she should have locked the medication cart when she stepped away from the cart. An interview was conducted on 08/17/17 at 9:30 AM with the Director of Nursing (DON). The DON stated the medications and carts should be secured and locked at all times when the nurse was not at the cart.	F 431	results of all audits to determine the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented by the Committee as deemed necessary to maintain substantial compliance.	