DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345165	A. BUILDING ______ B. WING ______	C 11/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARION	**1264 AIRPORT ROAD MARION, NC 28752**

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F 000	INITIAL COMMENTS 1. 483.12 (F223) at J Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective. 2. 483.12 and 483.95 (F226) at J Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby and missed hitting Resident #23. The nurse aide was permitted to continue working with residents during the meal. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective. 3. 483.21 (F281) at J Immediate Jeopardy began on 10/21/17 when staff failed to monitor the blood clotting time for Resident #139, who was receiving Warfarin 10	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/15/2017

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

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F 000	Continued From page 1 milligrams (mg) once a day per, per the resident's physician's standing orders. Due to staff not transcribing Resident #139's physician's standing orders staff did not monitor the resident's blood clotting time on 10/21/17, 10/23/17, 10/25/17 and 10/27/17. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. 4. 483.45 (F329) at J Immediate Jeopardy began on 10/21/17 when staff failed to monitor the blood clotting time of Resident #139, who was on Warfarin 10 milligrams (mg), per the resident's standing orders. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. 5. 483.35 (F353) at J Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway, due to staffing frustrations and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby. The nurse aide was permitted to continue working with residents during the meal. Immediate Jeopardy for tags F223 and F226 was removed on 11/19/17 when	F 000		

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F 000	Continued From page 2 the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. This tag was left out of compliance at a lower scope and severity of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy). 6. 483.70 (F490) at J Immediate jeopardy began on 10/23/17 when Resident #71 was struck by a flying object from a meal tray thrown by a nurse aide. Nurse #1 permitted the nurse aide to continue to pass trays on that unit due to short staffing. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective and sufficient to meet the care needs of the residents. An extended survey was conducted as part of the facility's survey from 11/13/17 to 11/19/17. Event ID# 9KIX11	F 000		
F 223 SS=J	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse,	F 223		12/22/17

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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(a) The facility must-
(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview, and staff interviews, the facility failed to provide an environment that maintained 1 of 3 residents' right to be free from abuse (Resident #71). Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective.

The findings included:

Resident #71 was admitted to the facility on 06/30/14. Her diagnoses included aphasia following a cerebral infarction, muscle weakness and hemiplegia and hemiparesis.

Resident #71's annual Minimum Data Set (MDS)

Disclaimer
Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admissiion for purposes of general liability, professional malpractice, or any other court proceeding.

F223
During annual survey ending 11/19/2017, the Self-Reported Incident initiated on 10/23/17 was reviewed and it was determined that the abuse investigation was incomplete by not following the facility policy and procedures. Due to this, and Immediate Jeopardy was cited for the event that occurred on 10/23/2017 to 11/19/2017.

Reeducation was completed for current staff on 11/17/2017 concerning facility abuse policy and procedures and the new Manager on Duty process. Reeducation was performed by the Administrator, the

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dated 07/12/17 coded her with moderately impaired cognition and requiring extensive assistance with most activities of daily living skills.

The Care Area Assessment (CAA) related to cognition dated 07/23/17 stated Resident #71 scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS). The CAA noted she had confusion, forgetfulness and she showed signs of age related cognitive loss although she had no diagnoses of dementia. It was noted her BIMS scored varied. She was at risk for cognitive changes.

On 11/13/17 at 10:07 AM during an interview, Resident #71 denied she had been abused and denied she had been hit by a meal tray or anything. A follow up interview was conducted on 11/17/17 at 9:46 AM, Resident #71, when asked again about a tray incident, stated she recalled a tray being thrown but denied being hit by anything. She stated it happened so fast she did not know what to think and thinks it scared her a little. She further stated that the nurse aide involved was a good worker.

Review of a 24 hour initial report sent to the Health Care Personnel Investigations on 10/23/17 at 7:44 PM, revealed that a staff member reported that Nurse Aide (NA) #2 tossed a meal tray on 10/23/17 at 5:30 PM and that Resident #71 was wet with water.
Review of the investigation revealed written statements were obtained by the nurse on duty (Nurse #1), the Nurse Aide (NA) #1 who witnessed the incident, and NA #2 who was alleged to throw the tray.

The written statement from NA #1 dated 10/23/17

F 223

Regional Vice President of Operations, the Director of Nursing, and the Regional Director of Clinical Services.Any newly hired staff from November 17th 2017 forward will receive education on Abuse Policy and Procedure.

The Administrative Department Managers will complete abuse policy and procedure questionnaires on 3 staff member, 3x a week x4 weeks, then monthly x2 months. Any negative findings will be addressed immediately by Administrator or Director of Nursing.
Administrator/designee will complete resident questionnaires with 3 residents 3x weekly x4 weeks, then monthly x2 months related care and services. Any negative findings will be addressed immediately by Administrator or Director of Nursing.
The facility will have a Manager on Duty every Saturday and Sunday from 11am to 3pm. The 300 hall charge nurse is the designated nurse in charge in the absence of the Administrator, Director of Nursing, or the Manager on Duty. The Manager on Duty or the designated nurse in charge will report negative findings to the Administrator immediately. General information gathered will be shared with the Administrator in the next morning meeting.

Results of the questionnaires will be forwarded to the facility Quality Assurance Performance Improvement committee for 3 months for further review and

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F 223	Continued From page 5 stated that approximately at 5:30 PM, NA #2 threw a computer mouse out of the nurse's station and across the hall barely missing a resident. NA #2 then went to the kitchen to obtain the tray cart and NA #1 told her to "chill." NA #2 then "grabbed a tray off the cart and flung it across the hall. Items went flying everywhere including a glass full of water that hit (Resident#71) in the face. When asked what her problem was, NA #2 grabbed her stuff and walked out of the door. After (NA #1) checked on (Resident #71) (NA #1) reported it to the nurse who heard the incident." An interview was conducted with NA #1 on 11/15/17 at 8:23 AM. She recalled that on 10/23/17 she and NA #2 worked a 12 hour shift. Around supper time, an announcement over the speaker was made that the trays for this hall were ready. Then a nurse called the nursing station to make sure staff heard the announcement. Then NA #2 threw a mouse into the hall and left to get the tray cart. Upon return NA #1 told NA #2 to calm down and NA #2 then threw a tray off the cart with a cup hitting Resident #71. NA #2 left the unit and NA #2 told Nurse #1. A phone follow up interview with NA #1 on 11/16/17 at 4:17 PM revealed Resident #71 was about an arms length away from NA #2 when she threw the tray and NA #1 saw a cup of water hit Resident #71's left lower jaw. Resident #71 never reacted and was not injured. NA #1 stated she was intending on telling Nurse #1 about the mouse being thrown in the hall by NA #2, however, before she could leave the floor, NA #2 had thrown the tray. The written statement from NA #2 dated 10/23/17 stated NA #2 "had gotten very frustrated at work, to the 'breaking point.' I was about to pass out	F 223	recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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trays when someone told me I 'needed to chill', which set me over the edge. So, without thinking or being aware of who or what was around me, I took a tray from the cart and flung it across the hall. I did not know it affected (Resident #71), because she kept rolling by." The written statement also included that she did not think she caused them any more trouble than what all the staff has, by not being able to care for their needs to the fullest. It was not possible for two people to take care of 50 people like they should be taken care of. It's barely possible for 3 people to prove the care that is necessary for the residents at this facility. She stated she was frustrated because she felt as if there was too much that she could not handle and she didn't think anyone should have to work under the conditions that the staff are expected to work under at this facility.

A phone interview was conducted with NA #2 on 11/16/17 at 9:54 AM. She stated there were only 2 aides on the 100 hall. NA #2 got frustrated when a nurse called after the overhead announcement that the trays were ready. She stated she threw the mouse into the hall and went to get the trays. Her coworker (NA #1) told her several times she should chill out in a reprimanding way. After being told several times, NA #2 stated she took a tray off the cart and threw it into the hall. She then left the hall. She stated she was frustrated due to short staffing for months and not being able to give the residents the care that was needed. A follow up interview with NA #2 on 11/16/17 at 4:29 PM revealed she probably knew Resident #71 was rolling by but did not realize how close she was. She found out later an item hit Resident #71.

A written statement from Nurse #1 dated

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10/23/17 stated at 5:30 PM she heard a loud noise from the main dining room. The sound came from the day room on the 100 hall. NA #2 started walking down the hall with her coat and purse and Nurse #1 asked NA #2 what happened. NA #2 stated 'you can have this I'm done.' Nurse #1 wrote she went down the hall and Resident #71's shirt and pants were wet. Resident #71 stated 'that girl's mad and throwing stuff.' Resident #71 stated a plate hit her knee and she was wet. Resident #71's skin was checked and found no bruising or redness. The statement continued "at 5:37 I called (name of) DON and informed her of the situation."

Nurse #1 was interviewed via phone on 11/16/17 at 10:04 AM. Nurse #2 stated that she heard a noise and started to head up the hall when NA #2 passed her with her coat and purse saying she had enough and was leaving. Nurse #1 saw the tray and food all over the floor and Resident #71's shirt was 'soaked'. Resident #71 stated her knee hurt a little but she was alright and that girl was really mad. Nurse #1 helped NA #1 pick up the mess and tried to obtain information about what happened. NA #2 then came back in after about 30 minutes and Nurse #1 tried to gather information before calling administration. NA #2 stated she had not intended to hit anyone. NA #2 showed remorse and was calm when she returned from the break room. Nurse #1 stated she did not think NA #2 would endanger anyone. NA #2 apologized and Nurse #1 informed NA #2 she would call her boss. Nurse #1 stated NA #2 asked to continue working and Nurse #1 agreed as long as she did not throw anymore trays. Nurse #1 called the Administrator and DON and was instructed to take statements, not write up an incident report but to complete the 24 hour form

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and fax it to the Health Care Personnel Investigations unit and send NA #2 home. Nurse #1 stated that in hindsight she would have sent her home immediately and would have done so if there had been more aides to pass 30 trays and assist on the floor. No one was available to help.

During a follow up phone interview on 11/16/17 at 3:57 PM, Nurse #1 stated she learned about NA #2 throwing the mouse when she took NA #1's statement. She stated if she knew NA #2 had thrown a mouse earlier, she would have sent her home immediately after she threw the tray despite short staffing. She stated she thought the tray incident was an isolated incident. Nurse #1 stated NA #2 worked on the floor after the tray incident for approximately 10 minutes before the DON spoke to her on the phone and instructed her to leave.

Interview with the Administrator on 11/16/17 at 11:59 AM revealed she unsubstantiated the abuse following the investigation after a discussion with corporate and they felt it had to do with burnout. Education was provided to NA #2. The Administrator stated NA #2 should not have been permitted to work on the floor after throwing the tray.

Interview with the DON on 11/16/17 at 12:11 PM revealed she received a call on 10/23/17 from Nurse #1 around 5:30 to 6:00 PM. She learned that NA #2 was frustrated, threw a tray and left the building. Nurse #1 called the DON back after NA #2 returned, within 7 to 8 minutes, asking what she should do next. DON instructed Nurse #1 to put NA #2 in an office and obtain a written statement and then escort her out of the building.

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Per the undated Summary of the investigation of the 10/23/17 incident written by the DON, NA #2 was removed from the hall immediately, was educated on employee burnout and how to handle work related stress prior to allowing her to return to work. The allegation of abuse was unsubstantiated "due to no intent of harm."

The Administrator and Regional Clinical Nurse were informed of Immediate Jeopardy on 11/16/17 at 6:18 PM.

The facility provided an acceptable credible allegation of immediate jeopardy removal on 11/19/17 at 11:57 AM as follows:

The Plan of Correcting the specific deficiency.

The original allegation on 10/23/17 for Resident #71 was investigated and a Facility Reportable Incident was submitted by the administrator. The area of concern identified on 10/23/17 Nurse Aide (NA) #2 was not removed from her duties by Nurse #1 when she became upset and threw objects including a computer mouse and a resident's meal tray. This resulted in Resident #71 being hit with an object and NA#2 was allowed to continue to work before calling the Director of Nursing. An investigation was initiated by the Administrator and Director of Nursing on 10/23/17.

An investigation was conducted by the Administrator and Director of Nursing and Facility Reportable Incident submitted on 10/23/17 and 5 Day on 10/27/17.

The Marion Police were notified of the incident on 10/23/17 and no charges filed

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F 223	Continued From page 10 On 10/23/17 the resident was assessed for injury by licensed nurse and had no negative outcome On 11/16/17 the facility started another investigation related to incident of 10/23/17 for resident #71 occurrence due to additional findings during state survey interviews. This was conducted by the Administrator of Autumn Care of Drexel. It was identified that NA#2 was not immediately suspended and returned to care while Director of Nursing was being notified by the Nurse#1 on duty. On 11/16/17 the Nurse#1 and NA#2 from 10/23/17 occurrence were suspended pending investigation. NA#2 and Nurse#1 was terminated and removed from payroll system on 11/17/17 11/16/17 statements obtained for those staff in original investigation The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited. All residents have the potential to be affected. On 11/13/17 management staff was educated by the Administrator on the new Manager-On-Duty (MOD) process and implemented on weekends beginning on 11/19/17. This process is new to facility and provides for management /administrative coverage on weekends both scheduled and at random based on the needs of the center, to include management rounds and addressing concerns or allegation of abuse which will be handled immediately by the Manager on	F 223		

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Duty who will notify Administrator and Director of Nursing. The Nurse assigned to 300 Hall is the designated nurse in charge in the absence of the Administrator or Director of Nursing and will notify the Director of Nursing and Administrator immediately of any allegations of abuse or concerns.

To prevent this from recurring the Administrator and Regional Clinical Consultant started immediate in-house education on 11/16/17 related to F223 Abuse and F226 development and implementation of policy and procedures (screening/training/prevention/ identification/ investigation/protection/ reporting response and burnout. This education was performed to ensure staff was properly trained on abuse and aware that abuse would not be tolerated at the facility.

11/16/17 the Administrator re-educated department heads on abuse and policy and procedures

Department heads completed education for staff on duty and the education will continue through 11/17/17

Education will continue via telephone and staff will not be permitted to work until education is received.

New hires will be educated to abuse policy and procedure upon hire.

The Regional Vice President of Operation re-educated the Licensed Nursing Home Administrator on abuse, policy and procedures and conducting a proper/thorough investigation on 11/17/17

11/17/17 random staff interviews were conducted

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by Nursing Home Administrator related to abuse/reporting/ witnessing abuse and knowledge of abuse procedure.

On 11/17/17 the Business office manager completed an employee file audit to ensure appropriate pre-employment screening was completed for NA#2 and all other staff, including new hires.

Resident council minutes and resident concern forms for the last 3 months were reviewed by the Administrator of NA #2. No negative findings.

On 11/17/17 Facility resident interviews were conducted by Department Managers for those residents that are interviewable related to abuse. There were new negative findings.

On 11/17/17 body checks were completed for those residents that are not interviewable completed by Licensed Nurses. There were new negative findings.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

To monitor and maintain ongoing compliance:

The facility Administrative/Department Managers will start abuse questionnaires with all staff on 11/17/17 related to abuse and policy and procedures (7 elements). The audits will be completed on 3 staff, 3x weekly. Any negative findings will be addressed immediately Administrator or Director of Nursing.

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F 223	Continued From page 13 On 11/17/17 resident questionnaires will be conducted with 3 residents 3x weekly related to abuse. Any negative findings will be addressed immediately by Administrator of Director of Nursing. The facility will conduct an Ad HOC Quality Assurance Performance Improvement meeting on 11/17/17 with the facility Interdisciplinary team, the Regional Team and the Medical Director to review. The title of the person responsible for implanting the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 11/19/17	F 223		
F 224 SS=D	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN CFR(s): 483.12(b)(1)-(3) §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	F 224		12/22/17

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(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews, the facility neglected to provide incontinence care when needed to 3 of 12 sampled residents (Residents #27, #28, and 79).

The findings included:

1. Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure, adult failure to thrive and dementia.

The significant change Minimum Data Set dated 10/22/17 coded him with severely impaired cognition, having no behaviors, requiring extensive assistance with bed mobility, transfers, toileting and hygiene, and being frequently incontinent of bowel and bladder. The MDS noted no toileting program.

The Care Area Assessment for incontinence dated 11/03/17 stated he was at risk for increased episodes of incontinence as well as complications. The current care plan initiated 05/05/16 included a goal for Resident #27 to be assisted with elimination needs as needed through 01/02/18. Interventions included to monitor and assist with any incontinent episodes; provide assistance with toileting, pericare and clothing management as indicated and per resident request.

The Kardex Report, a care guide for nurse aides

Provider's Plan of Correction:

F224
Due to lack of clear and consice assignments for NA's Residents #27, #79 and #28 were found to have not been provided incontinence care. Their care plans have been updated by MDS nurse to reflect incontinence care during Nurse Aide rounds and AM/PM care, and as indicated.Assignment sheets have been implemented to include room #'s for each staff member along with dining and shower assignments.

Incontinent residents have been identified by the Nursing Management staff on 12/1/17. MDS has updated residents' care plans related to incontinence care as during Nurse Aide rounds, AM/PM care, and as indicated.

The Director of Nursing (DON)/ Administrator/ designee provided education on 12/8/17 to the Nurse Aides regarding incontinence care during nurse aide rounds and dignity related to incontinence care prior to meals.New daily assignment sheets have been implemented to include room numbers, dining and shower assignments for Certified nurse assistants. Any new staff or agency staff will be educated on above prior to taking assignment.

To monitor and maintain ongoing

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F 224	Continued From page 15 (NA) of individual resident care needs, revealed that incontinent care was to be provided as needed and staff should offer toileting with care rounds. Resident #27 was observed on 11/13/17 at 11:24 AM with a slight urine odor. On 11/14/17 at 8:10 AM, he was observed wheeling himself down the hall towards the dining room. He was wearing light blue thin pants which were observed to have a wet area around his crotch and darker dried rings at the edges of the wet area. A urine odor was observed as he passed the surveyor in the hall. At 8:12 AM NA #6 pushed him to the dining room door. He remained in the dining room through breakfast. Then at 9:35 AM, Resident #27 was observed in his room in his wheelchair with yellow dark stained light blue pants and the dried stain could be seen on his outer right thigh extending from his knee toward his bottom. Resident #27 was observed again on 1/14/17 at 9:42 AM and his crotch was very wet from his crotch to his knee on the inner thigh. A urine odor was evident. Staff entered the room across the hall at 9:46 AM. The odor of urine was strong in the hallway at this time and the surveyor could see his wet pants from the hall. At 9:48 AM the wound physician and Nurse #8 entered the room to provide wound care to Resident #27's roommate. Both the physician and Nurse #8 left Resident #27's room at 9:56 AM and continued on rounds. Resident #27 was still visibly wet from the hall. Resident #27 remained with the same wet blue pants, wetness observed under the right thigh when observed at 10:04 AM. The urine odor was observed from the hallway at 10:07 AM. Incontinence care was observed on 11/14/17 at 10:39 AM after NAs #9 and #11 had provided	F 224	compliance, the DON/Administrator/Designee will audit incontinence care for interviewable and non-interviewable residents.Audit to include 4 residents randomly prior to meal service (to include rounds and monitoring patients in the dining room) 2x weekly for 4 weeks and then once a week x 2 months. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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care to his roommate. NA #9 and NA #11 stated they had not planned on caring for Resident #27 at this time. They pushed Resident #27 into the bathroom and removed his clothes. His blue pants and socks were soaked through with urine and his pants had dried urine stains on the legs. NA #9 stated "this is bad" when she removed his wet clothing.

On 11/14/17 at 10:46 AM, interviews were conducted with NA #7, NA #8, NA #10, and an orientee NA #12, who were on the hall where Resident #27 resided. They all stated that they had no specific assignment regarding room/resident assignments they just pitched in and helped everyone. NA #7 produced the assignment sheet which listed the staff and the showers to be given and who was to pass ice but room numbers were not assigned. NA #7 stated the assignments depend on the number of nurse aides present. Sometimes they start providing care for residents at one end of the hall and others start at the other end of the hall and if enough, some start care in the middle. She further stated there were 2 other nurse aides at the far end of the hall where Resident #27 resided. NA #7, NA #8, NA #10 and NA #12 all stated they had not provided Resident #27 any care this morning.

NA #6 stated at 11/14/17 at 10:51 AM that she did not notice Resident #27 was wet when she pushed him down the hall toward the dining room.

On 11/14/17 at 10:53 AM, NA #9 stated she had not given him care this morning. Review of the assignment sheet on 11/14/17 at 10:57 AM revealed NA #9 was now assigned to Resident #27, as room assignments had been added next

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to staff names. Further interview with NA #9 stated she was not assigned to work this date and just came in to help. She had no assigned rooms as of 5 minutes prior to this conversation. She stated they usually do not have assigned rooms. She stated there should have been enough coverage for those who actually started the shift on time.

Interview with NA #11 on 11/14/17 at 11:09 AM revealed she was from an agency and this was her 3rd day in this facility. She stated there was no specific assignment of rooms, they just went from room to room to provide resident care. NA #11 stated she had received report from 3rd shift NA that Resident #27 took care of himself. She further stated that she had not given him care this morning and it would make it easier if there was an actual resident assignment provided to the staff.

NA #4 was interviewed via phone on 11/15/17 at 5:45 AM. NA #4 stated he had worked the night before (11/13/17 into 11/14/17). NA #4 stated he had dressed Resident #27 in khaki pants and put him back to bed the morning of 11/14/17. NA #4 stated Resident #27 had been declining over the past 2 to 3 months and needed more assistance although he could transfer himself out of the bed and take himself to the bathroom at times, however, he was less reliable regarding his ability to do care himself. NA #4 could not recall what he told the oncoming shift about Resident #27's needs.

During an interview on 11/17/17 at 4:14 PM, the Assistant Director of Nursing/Acting Director of Nursing stated regardless of staffing levels, resident care was always the first priority for

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nursing staff. Other than answering call lights in a timely manner, it was his expectation for NAs to provide incontinent care immediately even when they were doing rounds. Follow up interview on 11/19/17 at 5:12 PM revealed he expected nurse aides to have and know their assignments to provide the necessary care and services including checking and changing incontinent residents as needed.

2. Resident #28 was admitted on 06/09/17 with diagnoses including dementia.

Review of a care plan dated 06/13/17 revealed Resident #28 was admitted with a history incontinence of bowel and bladder and was a risk for complications related to incontinent episodes. Interventions included to check and change per routine and as needed; and check for wetness on rounds during the night and as needed.

Review of the Care Area Assessment (CAA) for Urinary Incontinence dated 06/22/17 revealed Resident #28 had episodes of incontinence of both bowel and bladder and required assistance with activities of daily living. It was noted despite her risk factors she had no complications related to incontinence.

Review of a quarterly Minimum Data Set (MDS) dated 09/15/17 revealed Resident #28 had severely impaired cognition and required extensive assistance with transfer, dressing, personal hygiene, and toilet use. The quarterly MDS indicated Resident #28 was always incontinent of bowel and bladder and noted no urinary toileting program had been attempted. Rejection of care was not observed.

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Observations of Resident #28 on 11/14/17 revealed at 4:20 PM she was observed self-propelling in the hall wearing a pair of pink pants. The crotch area of the pants were visibly wet and a faint urine odor was noted as well. At 5:05 PM Resident #28 was observed in her room and the crotch area of her pants remained visibly wet. Nurse #11 entered Resident #28's room at 5:24 PM and Resident #28 stated she had a headache. Resident #28's pants were visibly wet and a faint urine odor was noted as well. At 5:25 PM Nurse #11 wheeled Resident #28 to the dining room and asked her to rate her pain. Nurse #11 returned to the dining room at 5:31 PM and administered medication to Resident #28. Her pants remained visibly wet and the urine odor was noticeable when standing next to her wheelchair. Nurse Aide (NA) #16 served and set up Resident #28's supper tray at 5:33 PM and exited the dining room.

An interview with NA #17 on 11/14/17 at 5:33 PM revealed she was one of three NAs assigned to the 200 hall that evening and she did not get there until 4:00 PM. NA #17 stated the NAs worked together and did not have a specific resident or room assignment. NA #17 stated the other NAs had already started rounds before she arrived but they typically checked and changed everyone on the hall. NA #17 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

An interview with NA #18 on 11/14/17 at 5:39 PM revealed she did not assist with incontinence rounds that afternoon because she was giving showers. NA #18 was not observed checking on

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Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

During an interview on 11/14/17 at 5:44 PM NA #16 was asked which residents were checked and changed before supper. NA #16 stated they had checked and changed the residents that were in bed and the residents that turned on their call lights. NA #16 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

An interview with Nurse #11 on 11/14/17 at 5:50 PM revealed she did not notice Resident #28's pants were wet with urine or check her for incontinence before taking her to the dining room.

An interview was conducted with the Administrator on 11/14/17 at 5:54 PM. The Administrator stated it was not acceptable for a resident to be taken to the dining room or served a meal wearing pants wet with urine. The Administrator further stated she expected the NAs to check every resident on rounds at the beginning of the shift. The interview further revealed the Administrator thought the nurse had given the NAs a room assignment.

3. Resident #79 was admitted to the facility on 06/18/13 with diagnoses including hypertension, anxiety, depression, and amputation of right leg above knee.

Review of care plan dated 05/18/17 revealed Resident #79 was dependent on staff for toileting

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assistance. Interventions included providing toileting assistance or incontinence care routinely as needed and encouraging Resident #79 to call for assistance at the first urge.

Review of the Minimum Data Set (MDS) dated 09/13/17 revealed Resident #79 was cognitively intact and able to make decisions about daily care. She required extensive assistance of two or more staff for transfer, toileting, bed mobility, dressing, personal hygiene and bathing. Resident #79 was coded with impairment on right upper & lower extremities. The MDS further indicated Resident #79 was frequently incontinent with bladder and occasionally incontinent with bowel.

Review of care area assessments revealed Resident #79 required assistance with most of her activities of daily living (ADL) due to right above knee amputation (AKA). She was at risk for decline in her functional ADL abilities.

Review of daily staffing sheet dated 11/13/17 revealed Nurse Aide (NA) #3 was initially assigned to work on third shift on the 200 Hall and NA #4 was assigned to work on the 100 Hall. However, because the NA on the 100 Hall called in sick, NA #3 was re-assigned to work on the 100 Hall with NA #4.

During an interview on 11/15/17 at 10:51 AM, Resident #79 stated she activated the call light on 11/14/17 at around 5:00 AM because she was soaking wet in bed. It took NA #3 about 5 minutes to answer her call light. When she told NA #3 that she was soaking wet and needed to be changed, NA #3 replied he had to finish the rounds and promised her to come back in a few minutes. NA #3 turned off the call light before leaving the

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room. Resident #79 said she waited for almost one hour without having any nursing staff addressing her incontinent needs. When she activated the call light again at around 6:00 AM, NA #3 came back and asked her what she needed. NA #3 then provided incontinent care and apologized indicating they were short of staff. Resident #79 stated she was upset, felt embarrassed, disregarded and forgotten as she had to wait in a soaking wet condition for almost an hour.

During an interview on 11/15/17 at 12:05 PM, Nurse #4 stated all NAs were required to complete their assigned rounds in a timely manner. However, as a nurse, she expected NAs to provide incontinent care as needed during the rounds as resident care had a higher priority.

During a phone interview on 11/15/17 at 12:43 PM, NA #3 confirmed he worked third shift on 100 Hall that ended on the morning of 11/14/17. He was not familiar with the residents as it was his second week working in the facility and his first time working on the 100 Hall. NA #3 said he started the last morning rounds at around 5:00 AM and he was overwhelmed with call lights as there were only 2 NAs working on the 100 Hall to provide care for around 50 residents. He could not recall answering any call light for incontinent care at around 5:00 AM or promising any resident to come back when he was doing his rounds. NA #3 stated if he knew Resident #79 was soaking wet that morning, he would have addressed her incontinent needs immediately.

During an interview on 11/16/17 at 8:28 AM, NA #4 confirmed he was working with NA #3 on third shift on the 100 Hall that ended on the morning of

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F 224	Continued From page 23 11/14/17. He could not remember seeing NA #3 respond to Resident #79's call light at around 5:00 to 6:00 AM as he was busy with resident care. He stated if a resident asked for incontinent care during his rounds, he would take care the resident first, then continue with the rounds. It was NA #3's first night working on the 100 hall. With only 2 NAs working on the 100 Hall for third shift, the work load was overwhelming for NA #3. He agreed resident care should be prioritized over the rounds at all times. During an interview on 11/17/17 at 4:14 PM, the Assistant Director of Nursing (DON)/Acting DON stated regardless of staffing level, resident care was always the first priority for nursing staff. Other than answering call lights in a timely manner, it was his expectation for NAs to provide resident care immediately even when they were doing rounds. He also expected NAs to leave the resident call lights on until they could actually provide the assistance requested.	F 224		
F 226 SS=J	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph	F 226		12/22/17

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F 226	Continued From page 24 §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to implement their abuse policy and procedures related to the prevention, protection and investigation for 1 of 3 residents who were reviewed for abuse investigations. Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby and missed hitting Resident #23. The nurse aide was permitted to continue working with residents during the meal. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is	F 226	F226 During annual survey ending 11/19/2017, the Self-Reported Incident initiated on 10/23/17 was reviewed and it was determined that the abuse investigation was incomplete by not following the facility policy and procedures. Due to this, and Immediate Jeopardy was cited for the event that occurred on 10/23/2017 to 11/19/2017. Reeducation was completed for current staff on 11/17/2017 concerning facility abuse policy and procedures and the new Manager on Duty process. Reeducation was performed by the Administrator, the Regional Vice President of Operations,	

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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 226	Continued From page 25 not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective. The findings included: The facility's Resident Abuse Policy, last revised 03/03/17, revealed Abuse was defined as including such actions such as the willful infliction of injury. The policy continued stating "Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury." Under the section of prevention was the deployment of staff on each shift in sufficient numbers to meet the needs of the residents. Under the section of how to investigate allegations included interview of all witnesses. The policy also indicated that if a staff member is accused or suspected of abuse, the Facility will immediately remove staff member from the resident care area and the accused staff member will remain under direct supervision until statement is complete. The policy also noted that there should be documentation in the nurses' notes including the results of the resident's range of motion, body assessment, vital signs, and notification of the physician and responsible party. Resident #71 was admitted to the facility on 06/30/14. Her diagnoses included aphasia following a cerebral infarction, muscle weakness and hemiplegia and hemiparesis. Resident #71's annual Minimum Data Set (MDS) dated 07/12/17 coded her with moderately impaired cognition and requiring extensive assistance with most activities of daily living skills.	F 226	the Director of Nursing, and the Regional Director of Clinical Services.Any newly hired staff from 11-17-2017 forward will receive education on Abuse policy and procedure. The Administrative Department Managers will complete abuse policy and procedure questionnaires on 3 staff member, 3x a week x4 weeks, then monthly x2 months. Any negative findings will be addressed immediately by Administrator or Director of Nursing. Administrator/designee will complete resident questionnaires with 3 residents 3x weekly x4 weeks, then monthly x2 months related care and services. Any negative findings will be addressed immediately by Administrator or Director of Nursing. The facility will have a Manager on Duty every Saturday and Sunday from 11am to 3pm. The 300 hall charge nurse is the designated nurse in charge in the absence of the Administrator, Director of Nursing, or the Manager on Duty. The Manager on Duty or the designated nurse in charge will report negative findings to the Administrator immediately. General information gathered will be shared with the Administrator in the next morning meeting. Results of the questionnaires will be forwarded to the facility Quality Assurance Performance Improvement committee for 3 months for further review and recommendations.	

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Review of a 24 hour initial report sent to the Health Care Personnel Investigations on 10/23/17 at 7:44 PM, revealed that a staff member reported that Nurse Aide (NA) #2 tossed a meal tray on 10/23/17 at 5:30 PM and that Resident #71 was wet with water.
Review of the investigation revealed written statements were obtained by the nurse on duty (Nurse #1), the Nurse Aide (NA) #1 who witnessed the incident, and NA #2 who was alleged to throw the tray.

The written statement from NA #1 dated 10/23/17 stated that approximately at 5:30 PM, NA #2 threw a computer mouse out of the nurse's station and across the hall barely missing a resident. NA #2 then went to the kitchen to obtain the tray cart and NA #1 told her to "chill." NA #2 then "grabbed a tray off the cart and flung it across the hall. Items went flying everywhere including a glass full of water that hit (Resident#71) in the face. When asked what her problem was, NA #2 grabbed her stuff and walked out of the door. After (NA #1) checked on (Resident #71) (NA #1) reported it to the nurse who heard the incident."

An interview was conducted with NA #1 on 11/15/17 at 8:23 AM. She recalled that on 10/23/17 she and NA #2 worked a 12 hour shift. Around supper time, an announcement over the speaker was made that the trays for this hall were ready. Then a nurse called the nursing station to make sure staff heard the announcement. Then NA #2 threw a mouse into the hall and left to get the tray cart. Upon return NA #1 told NA #2 to calm down and NA #2 then threw a tray off the cart with a cup hitting Resident #71. NA #2 left the unit and NA #2 told Nurse #1. After 10 to 15

Provider's plan of correction (F 226): The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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minutes, NA #2 came back and finished passing trays. A phone follow up interview with NA #1 on 11/16/17 at 4:17 PM revealed Resident #71 was about an arms length away from NA #2 when she threw the tray and NA #1 saw a cup of water hit Resident #71's left lower jaw. Resident #71 never reacted and was not injured. She again stated NA #2 continued to pass trays for about 20 minutes until NA #2 was instructed to write a statement. NA #1 stated she was intending on telling Nurse #1 about the mouse being thrown in the hall by NA #2, however, before she could leave the floor, NA #2 had thrown the tray.

The written statement from NA #2 dated 10/23/17 stated NA #2 "had gotten very frustrated at work, to the 'breaking point." I was about to pass out trays when someone told me I 'needed to chill', which set me over the edge. So, without thinking or being aware of who or what was around me, I took a tray from the cart and flung it across the hall. I did not know it affected (Resident #71 and Resident #23), because they kept rolling by ...After the tray, I got my things, told (Nurse #1) I was done, and went in the break room with intentions of clocking out. When I got to the break room, I came to my senses and decided to go back and finish the shift."

A phone interview was conducted with NA #2 on 11/16/17 at 9:54 AM. She stated there were only 2 aides on the 100 hall. NA #2 got frustrated when a nurse called after the overhead announcement that the trays were ready. She stated she threw the mouse into the hall and went to get the trays. Her coworker (NA #1) told her several times she should chill out in a reprimanding way. After being told several times, NA #2 stated she took a tray off the cart and

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threw it into the hall. She then left the hall and went to the break room but decided she had bills to pay and did not want to abandon her duties so she finished her shift via passing out trays and feeling a resident until her shift ended. She stated she was then placed on burn out leave for two days and allowed to return to work. She recalled the Director of Nursing meeting with her. She stated she was frustrated due to short staffing for months and not being able to give the residents the care that was needed. A follow up interview with NA #2 on 11/16/17 at 4:29 PM revealed she probably knew Resident #71 and her roommate (Resident #23) were rolling by but did not realize how close they were. She found out later an item hit Resident #71. NA #2 stated Nurse #2 let her pass trays which she did so and continued to work on the hall for approximately 45 minutes. She was interviewed by the Director of Nursing (DON) via phone that day and in person later.

A written statement from Nurse #1 dated 10/23/17 stated at 5:30 PM she heard a loud noise from the main dining room. The sound came from the day room on the 100 hall. NA #2 started walking down the hall with her coat and purse and the nurse asked NA #2 what happened. NA #2 stated 'you can have this I'm done.' Nurse #1 wrote she went down the hall and Resident #71's shirt and pants were wet. Resident #71 stated 'that girl's mad and throwing stuff.' Resident #71 stated a plate hit her knee and she was wet. Resident #71's skin was checked and found no bruising or redness. The statement continued "at 5:37 PM (NA #2) came back in the facility and asked if she could finish her shift stating 'I don't want to be got for abandonment.' I called (name of) DON and informed her of the situation."

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F 226	Continued From page 29 Nurse #1 was interviewed via phone on 11/16/17 at 10:04 AM. Nurse #2 stated that she heard a noise and started to head up the hall when NA #2 passed her with her coat and purse saying she had enough and was leaving. Nurse #1 saw the tray and food all over the floor and Resident #71's shirt was "soaked". Resident #71 stated her knee hurt a little but she was alright and that girl was really mad. Nurse #1 helped NA #1 pick up the mess and tried to obtain information about what happened. NA #2 then came back in after about 30 minutes and Nurse #1 tried to gather information before calling administration. NA #2 stated she did not intended to hit anyone. NA #2 showed remorse and was calm when she returned from the break room. Nurse #1 stated she did not think NA #2 would endanger anyone. NA #2 apologized and Nurse #1 informed NA #2 she would call her boss. Nurse #1 stated NA #2 asked to continue working and Nurse #1 agreed as long as she did not throw anymore trays. Nurse #1 called the Administrator and DON and was instructed to take statements, not write up an incident report but to complete the 24 hour form and fax it to the Health Care Personnel Investigations unit and send NA #2 home. Nurse #1 did not think NA #2 finished her shift. Nurse #1 stated that in hindsight she would have sent her home immediately and would have done so if there had been more aides to pass 30 trays and assist on the floor. No one was available to help. During a follow up phone interview on 11/16/17 at 3:57 PM, Nurse #1 stated she learned about NA #2 throwing the mouse when she took NA #1's statement. She stated if she knew NA #2 had thrown a mouse earlier, she would have sent her home immediately after she threw the tray despite short staffing. She stated she thought the	F 226		

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tray incident was an isolated incident. Nurse #1 stated NA #2 worked on the floor after the tray incident for approximately 10 minutes before the DON spoke to her on the phone and instructed her to leave.

Interview with the Administrator on 11/16/17 at 11:59 AM revealed she only interviewed NA #2 not the other witnesses. She further stated that the facility unsubstantiated the abuse following the investigation after corporate and they discussed it and felt it had to do with burnout. Education was provided to NA #2. The Administrator stated NA #2 should not have been permitted to work on the floor after throwing the tray.

Interview with the DON on 11/16/17 at 12:11 PM revealed she received a call on 10/23/17 from Nurse #1 around 5:30 to 6:00 PM. She learned that NA #2 was frustrated, threw a tray and left the building. Nurse #1 called the DON back after NA #2 returned, within 7 to 8 minutes, asking what she should do next. DON instructed Nurse #1 to put NA #2 in an office and obtain a written statement and then escort her out of the building. The DON stated she did not talk to NA #1 about what happened and thought the Administrator interviewed NA #1.

Review of the time clock documentation revealed NA #1 clocked out on 10/23/17 at 6:48 PM.

Review of the nursing notes revealed no notes regarding Resident #71 being hit with an object from a tray thrown by a nurse aide, no physical assessment of the resident and no documentation of notification to the physician or responsible party per the facility's abuse policy.

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On 11/16/17 at 2:41 PM, the Administrator stated there should have been a nursing note or documentation of the nurse's assessment of Resident #71 after the incident. Nurse #1 stated during telephone interview on 11/16/17 at 3:57 PM that when she called administration on 10/23/17 to obtain guidance, she asked if she should write an incident note or document the incident somewhere and was told by both the Administrator and the Director of Nursing (DON) she did not need to document anything unless administration later instructed her to. Administration just wanted the 24 hour report faxed to the Health care Personnel Investigations.

Record review revealed a skin assessment was completed on 10/24/17 at 12:56 AM by the DON which stated no current skin issues but did not specify anything about the incident or specifics relating to her knee or face (which were noted as being struck). The DON resigned prior to obtaining an interview relating to the skin assessment. The Administrator stated during interview on 11/16/17 at 2:41 PM that the nurse should have documented her skin assessment following the incident. A telephone interview with Nurse #1 on 11/16/17 at 3:57 PM revealed she was told not to make any nursing notes or additional documentation in the record and not to fill out an incident report by both the administrator and the DON.

Per the Summary of the investigation written by the DON, NA #2 was removed from the hall immediately, was educated on employee burnout and how to handle work related stress prior to allowing her to return to work. The allegation of abuse was unsubstantiated "due to no intent of harm."

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The Administrator and Regional Clinical Nurse were informed of Immediate Jeopardy on 11/16/17 at 6:18 PM.

The facility provided an acceptable credible allegation of immediate jeopardy removal on 11/19/17 at 11:57 AM as follows:

F226 Development/implementation of policy and procedures

The Plan of Correcting the specific deficiency.

The original allegation on 10/23/17 for Resident #71 was investigated and a Facility Reportable Incident was submitted by the Nurse #1 per the instruction of the Director of Nursing. The area of concern identified on 10/23/17 Nurse Aide (NA) #2 was not removed from her duties by Nurse #1 when she became upset and threw objects including a computer mouse and a resident's meal tray. This resulted in Resident #71 being hit with an object and NA#2 was allowed to continue to work before calling the Director of Nursing. This investigation did not include documented interviews of all witnesses and lacked documentation in the medical record. An investigation was initiated by the Administrator and Director of Nursing on 10/23/17.

An investigation was conducted by the Administrator and Director of Nursing and Facility Reportable Incident submitted on 10/23/17 and 5 Day on 10/27/17.

The Marion Police were notified of the incident on 10/23/17 and no charges filed

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F 226	Continued From page 33 On 10/23/17 the resident was assessed for injury by licensed nurse and had no negative outcome On 11/16/17 the facility started another investigation related to incident of 10/23/17 for Resident #71 occurrence due to additional findings, during state survey interviews. This was conducted by the Administrator of Autumn Care of Drexel. It was identified that NA#2 was not immediately suspended and returned to care while Director of Nursing was being notified by the Nurse#1 on duty. On 11/16/17 statements obtained for those staff in original investigation On 11/16/17 the Nurse #1 and NA #2 from 10/23/17 occurrence were suspended pending investigation. NA #2 and Nurse #1 was terminated and removed from payroll system on 11/17/17 The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited. All residents have the potential to be affected. On 11/13/17 management staff was educated by the administrator on the new Manager-On-Duty (MOD) process and implemented on weekends beginning on 11/19/17. This process is new to facility and provides for management /administrative coverage on weekends both scheduled and at random based on the needs of the center, to include management rounds and addressing concerns or allegation of abuse which will be handled immediately by the Manager on Duty who will notify Administrator and Director of	F 226		

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Nursing. The Nurse assigned to 300 Hall is the designated nurse in charge in the absence of the Administrator or Director of Nursing and will notify the Director of Nursing and Administrator immediately of any allegations of abuse. Also the Nurse will remove the alleged abuser.

To prevent this from recurring the Administrator and the Regional Clinical Services Director started immediate in-house education on 11/16/17 related to Abuse and development and implementation of policy and procedures (screening/training/prevention/ identification/ investigation/protection/ reporting response and burnout. This education was performed to ensure staff was properly trained on abuse and aware that abuse would not be tolerated at the facility.
- 11/16/17 the Administrator re-educated department heads on abuse and policy and procedures
- Department heads completed education for staff on duty and the education will continue through 11/17/17
- New Hires will continue to be educated on abuse policy and procedure upon hire.
- Education will continue via telephone and staff will not be permitted to work until education is received.
- The Regional Vice President of Operation re-educated the Licensed Nursing Home Administrator on abuse, policy and procedures and conducting a proper/thorough investigation on 11/17/17

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

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To monitor and maintain ongoing compliance:

The facility Administrative/Department Managers will start abuse questionnaires with all staff on 11/17/17 related to abuse and policy and procedures (7 elements). The audits will be completed on 3 staff members 3x weekly. Any negative findings will be addressed immediately by the Administrator or Director of Nursing.

The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement committee for further review and recommendations.

The facility will conduct an Ad HOC Quality Assurance Performance Improvement meeting on 11/17/17 with the facility Interdisciplinary team, the Regional Team and the Medical Director to review.

The title of the person responsible for implanting the acceptable plan of correction is the Administrator.

Date of Alleged Compliance is: 11/19/17

Immediate Jeopardy was removed on 11/19/17 when interviews with direct and supervisory staff confirmed they had been inserviced and knew the facility's abuse policy and procedures including that suspected staff had to be removed from resident care immediately, witnesses had to be interviewed, and documentation had to be included in the nursing notes including event information, assessment information and notification information. The staff knew signs of burnout and what to do if they were feeling

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F 226	Continued From page 36 burned out or observed other coworkers with signs of burnout.	F 226		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide incontinence care to 3 of 12 sampled residents resulting in 2 residents (Resident #27 and #28) eating while wet with urine and 1 resident's (Resident #79) request for incontinence care forgotten by staff. The findings included: Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure, and dementia. The significant change Minimum Data Set dated 10/22/17 coded him with severely impaired cognition, having no behaviors, requiring extensive assistance with bed mobility, transfers, toileting and hygiene, and being frequently incontinent of bowel and bladder. The Care Area Assessment for incontinence dated 11/03/17 stated he was at risk for increased episodes of incontinence as well as complication.	F 241	F241 During the survey process the NA's caring for residents #27, 79 and 28 did not provide incontinent care per the Kardex due to confusion related to lack of specific assignments. Resident's care plans have been updated by MDS nurse to reflect incontinence care during Nurse Aide rounds and AM/PM care, and as indicated and new assignment sheets have been implemented. Incontinent residents have been identified by the Nursing Management staff on 12/1/17. MDS has updated residents' care plans related to incontinence care as during Nurse Aide rounds, AM/PM care, and as indicated. The Director of Nursing (DON)/ Administrator/ designee provided education on 12/8/17 to the Nurse Aides regarding incontinence care during nurse aide rounds and dignity related to	12/22/17

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F 241	Continued From page 37 The current care plan initiated 05/05/16 included a goal for Resident #27 to be assisted with elimination needs as needed through 01/02/18. Interventions included to monitor and assist with any incontinent episodes, provide assistance with toileting, pericare and clothing management as indicated and per resident request. The Kardex Report, a care guide for nurse aides (NA) of individual resident care needs, revealed that incontinent care was to be provided as needed and staff should offer toileting with care rounds. Resident #27 was observed on 11/13/17 at 11:24 AM with a slight urine odor. On 11/14/17 at 8:10 AM, he was observed wheeling himself down the hall towards the dining room. He was wearing light blue thin pants which were observed to have a wet area around his crotch and darker dried rings at the edges of the wet area. A urine odor was observed as he passed the surveyor in the hall. At 8:12 AM NA #6 pushed him to the dining room door. He remained in the dining room through breakfast. Then at 9:35 AM, Resident #27 was observed in his room in his wheelchair with yellow dark stained light blue pants and the dried stain could be seen on his outer right thigh extending from his knee toward his bottom. Resident #27 was observed again on 1/14/17 at 9:42 AM and his pants were very wet from his crotch to his knee on the inner thigh. A urine odor was evident. Staff entered the room across the hall at 9:46 AM. The odor of urine was strong in the hallway at this time and the surveyor could see his wet pants from the hall. At 9:48 AM the wound physician and Nurse #8 entered the room to provide wound care to Resident #27's roommate. Both the physician and Nurse #8 left	F 241	incontinence care prior to meals.New daily assignment sheets have been implemented to include room numbers, dining and shower assignments. Any new staff or agency staff will be educated on above prior to taking assignment. To monitor and maintain ongoing compliance, the DON/Administrator/Designee will audit incontinence care 4 residents randomly prior to meal service (to include rounds and monitoring patients in the dining room). 2x weekly for 4 weeks and then once a week x 2 months The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 241	Continued From page 38 Resident #27's room at 9:56 AM and continued on rounds. Resident #27 was still visibly wet from the hall. Resident #27 remained with the same wet blue pants, wetness observed under the right thigh when observed at 10:04 AM. The urine odor was observed from the hallway at 10:07 AM. Incontinence care was observed on 11/14/17 at 10:39 AM after NAs #9 and #11 had provided care to his roommate. NA #9 and NA #11 stated they had not planned on caring for Resident #27 at this time. They pushed Resident #27 into the bathroom and removed his clothes. His blue pants and socks were soaked through with urine and his pants had dried urine stains on the legs. When Resident #27's wet clothing was removed, NA #9 stated "This is bad." On 11/14/17 at 10:46 AM, a group interview was conducted with NA #7, NA #8, NA #10, and an orientee NA #12, who were on the far end of the hall where Resident #27 resided. They all stated that they had no specific assignment regarding room/resident assignments they just pitched in and helped everyone. NA #7 produced the assignment sheet which listed the staff and the showers to be given and who was to pass ice but room numbers were not assigned. She further stated there were 2 other nurse aides at the far end of the hall where Resident #27 resided. NA #7, NA #8, NA #10 and NA #12 all stated they had not provided Resident #27 any care this morning. NA #6 stated at 11/14/17 at 10:51 Am that she did not notice Resident #27 was wet when she pushed him down the hall toward the dining room. On 11/14/17 at 10:53 AM, NA #9 stated she had not given him care this morning until 10:39 AM.	F 241		

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NA #9 stated she was not assigned to work this date and just came in to help later in the shift (after 8 AM). Review of the assignment sheet on 11/14/17 at 10:57 AM revealed NA #9 was now assigned to Resident #27, as room assignments had been added next to staff names.

Interview with NA #11 on 11/14/17 at 11:09 AM revealed she was from an agency and this was her 3rd day in this facility. She stated there was no specific assignment of rooms, they just went from room to room to provide resident care. NA #11 stated she had received report from 3rd shift NA that Resident #27 took care of himself. She further stated that she had not given him care this morning.

Administrator stated during interview on 11/14/17 at 5:54 PM it was not acceptable for a resident to eat with wet pants and would expect staff to check everyone on rounds at the beginning of the shift. She also thought the nurse had given room assignments.

Interview on 11/19/17 at 5:12 PM with the Assistant Director of Nursing (DON)/Acting DON revealed he expected nurse aides to have and know their assignments to provide the necessary care and services including checking and changing incontinent residents as needed.

2. Resident #28 was admitted on 06/09/17 with diagnoses including dementia.

Review of a care plan dated 06/13/17 revealed Resident #28 was admitted with a history incontinence of bowel and bladder and was a risk for complications related to incontinent episodes. Interventions included to check and change per

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F 241	Continued From page 40 routine and as needed; and check for wetness on rounds during the night and as needed. Review of the Care Area Assessment (CAA) for Urinary Incontinence dated 06/22/17 revealed Resident #28 had episodes of incontinence of both bowel and bladder and required assistance with activities of daily living. It was noted despite her risk factors she had no complications related to incontinence. Review of a quarterly Minimum Data Set (MDS) dated 09/15/17 revealed Resident #28 had severely impaired cognition and required extensive assistance with transfer, dressing, personal hygiene, and toilet use. The quarterly MDS indicated Resident #28 was always incontinent of bowel and bladder and noted no urinary toileting program had been attempted. Rejection of care was not observed. Observations of Resident #28 on 11/14/17 revealed at 4:20 PM she was observed self-propelling in the hall wearing a pair of pink pants. The crotch area of the pants were visibly wet and a faint urine odor was noted as well. At 5:05 PM Resident #28 was observed in her room and the crotch area of her pants remained visibly wet. Nurse #11 entered Resident #28's room at 5:24 PM and Resident #28 stated she had a headache. Resident #28's pants were visibly wet and a faint urine odor was noted as well. At 5:25 PM Nurse #11 wheeled Resident #28 to the dining room and asked her to rate her pain. Nurse #11 returned to the dining room at 5:31 PM and administered medication to Resident #28. Her pants remained visibly wet and the urine odor was noticeable when standing next to her wheelchair. Nurse Aide (NA) #16 served and set	F 241		

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F 241	Continued From page 41 up Resident #28's supper tray at 5:33 PM and exited the dining room. An interview with NA #17 on 11/14/17 at 5:33 PM revealed she was one of three NAs assigned to the 200 hall that evening and she did not get there until 4:00 PM. NA #17 stated the NAs worked together and did not have a specific resident or room assignment. NA #17 stated the other NAs had already started rounds before she arrived but they typically checked and changed everyone on the hall. NA #17 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11. An interview with NA #18 on 11/14/17 at 5:39 PM revealed she did not assist with incontinence rounds that afternoon because she was giving showers. NA #18 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11. During an interview on 11/14/17 at 5:44 PM NA #16 was asked which residents were checked and changed before supper. NA #16 stated they had checked and changed the residents that were in bed and the residents that turned on their call lights. NA #16 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11. An interview with Nurse #11 on 11/14/17 at 5:50 PM revealed she did not notice Resident #28's	F 241		

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pants were wet with urine or check her for incontinence before taking her to the dining room.

An interview was conducted with the Administrator on 11/14/17 at 5:54 PM. The Administrator stated it was not acceptable for a resident to be taken to the dining room or served a meal wearing pants wet with urine. The Administrator further stated she expected the NAs to check every resident on rounds at the beginning of the shift. The interview further revealed the Administrator thought the nurse had given the NAs a room assignment.

3. Resident #79 was admitted to the facility on 06/18/13 with diagnoses including hypertension, anxiety, depression, and acquired absence of right leg above knee. Review of the Minimum Data Set (MDS) dated 09/13/17 revealed Resident #79 was cognitively intact and able to make decisions about daily care. She required extensive assistance of two or more staff for transfer, toileting, bed mobility, dressing, personal hygiene and bathing. Resident #79 was coded with impairment on right upper & lower extremities. The MDS further indicated Resident #79 was frequently incontinent with bladder and occasionally incontinent with bowel.

Review of care area assessments revealed Resident #79 required assistance with most of her activities of daily living (ADL) due to right above knee amputation (AKA). She was at risk for decline in her functional ADL abilities.

Review of care plan dated 05/18/17 revealed Resident #79 was dependent on staff for toileting assistance. Interventions included providing toileting assistance or incontinence care routinely

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as needed and encouraging Resident #79 to call for assistance at the first urge.

Review of daily staffing sheet dated 11/13/17 revealed Nurse Aide (NA) #3 was initially assigned to work on third shift on the 200 Hall and NA #4 was assigned to work on the 100 Hall. However, because the NA on the 100 Hall called in sick, NA #3 was re-assigned to work on the 100 Hall with NA #4.

During an interview on 11/15/17 at 10:51 AM, Resident #79 stated she activated the call light on 11/14/17 at around 5:00 AM because she was soaking wet in bed. It took NA #3 about 5 minutes to answer her call light. When she told NA #3 that she was soaking wet and needed to be changed, NA #3 replied he had to finish the round and promised her to come back in a few minutes. NA #3 turned off the call light before leaving the room. Resident #79 said she waited for almost one hour without having any nursing staff addressing her incontinent needs. When she activated the call light again at around 6:00 AM, NA #3 came back and asked her what she needed? NA #3 then provided incontinent care and apologized indicating they were short of staff. Resident #79 stated she was upset, felt embarrassed, disregarded and forgotten as she had to wait in a soaking wet condition for almost an hour.

During an interview on 11/15/17 at 12:05 PM, Nurse #4 stated all NAs were required to complete their assigned round in a timely manner. However, as a nurse, she expected NAs to provide incontinent care as needed during the round as resident care had a higher priority.

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F 241	Continued From page 44 During a phone interview on 11/15/17 at 12:43 PM, NA #3 confirmed he worked third shift on 100 Hall that ended on the morning of 11/14/17. He was not familiar with the residents as it was his second week working in the facility and his first time working on the 100 Hall. He said he started the last morning round at around 5:00 AM and he was overwhelmed with call lights as there were only 2 NAs working on the 100 Hall to provide care for around 50 residents. He could not recall answering any call light for incontinent care at around 5:00 AM or promising any resident to come back when he was doing his round. NA #3 stated if he knew Resident #79 was in soaking wet that morning, he would address her incontinent needs immediately. During an interview on 11/16/17 at 8:28 AM, NA #4 confirmed he was working with NA #3 during third shift on 100 Hall that ended on the morning of 11/14/17. He could not remember seeing NA #3 respond to Resident #79's call light at around 5:00 to 6:00 AM as he was busy with resident care. He stated if a resident asked for incontinent care during his round, he would take care the resident first, then continue with the round. It was NA #3's first night working on the 100 hall. With only 2 NAs working on the 100 Hall for third shift, the work load was overwhelming for NA #3. He agreed resident care should be prioritized over the round at all times. During an interview on 11/17/17 at 4:14 PM, the Assistant Director of Nursing (DON)/Acting DON stated regardless of staffing level, resident care was always the first priority for nursing staff. Other than answering call lights in a timely manner, it was his expectation for NAs to provide resident care immediately even when they were	F 241		

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F 241	Continued From page 45 doing round. He also expected NAs to leave the resident call lights on until they could actually provide the assistance requested.	F 241		
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to provide residents with their preferred number of showers a week for 3 of 5 resident reviewed for choices (Resident #46, #66, and #174). The findings included: 1. Resident #66 was admitted on 09/23/16 with diagnoses including heart failure and left pubis ramus fracture. Review of a significant change Minimum Data Set (MDS) dated 01/27/17 revealed Resident #66's	F 242	F242 During Survey it was identified that Residents #46, #66, and #174 were not receiving their perfered number of showers per week.The shower assignments did not reflect resident choice and were not performed accordingly due to insufficient staffing. Director of Nursing completed an audit of all Admission Questionnaires related to resident preference for showers and showers were scheduled based upon resident choice on 12/13/17.	12/22/17

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F 242	Continued From page 46 cognition was intact and she required one person physical assistance with bathing. The significant change MDS indicated it was somewhat important to Resident #66 to choose between a shower, bed bath, or sponge bath. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living dated 02/09/17 revealed Resident #66 varied from independent to limited assistance with most care and tended to require more assistance at bedtime. The CAA Summary noted Resident #66 was still weak and had some limited movement on her left lower extremity from her fracture but was walking with a rolling walker. Review of a care plan dated 02/09/17 revealed Resident #66 had a self-care deficit related to advanced age, decreased mobility and other diagnoses. Interventions included to provide daily assistance as needed to complete all care and ensure her needs were met; and showers per schedule and as needed with assistance as needed. Review of a quarterly Minimum Data Set (MDS) dated 10/18/17 revealed Resident #66's cognition was intact and she was able to make her needs known. The quarterly MDS noted Resident #66 required one person physical assist with bathing and no rejection of care was noted. Review of the 100 hall shower schedule revealed Resident #66 was scheduled to receive showers on Tuesday and Friday during the second shift. During an interview on 11/13/17 at 10:18 AM Resident #66 stated she was supposed to get two showers a week but did not get them consistently	F 242	The DON/ADON in-serviced nursing staff (CNA and Licensed Nursing) on 12/8/2017 regarding documentation of giving showers and identifying schedule of shower on Nurse Aide assignment sheet.Any newly hired staff from 12-08-2017 forward will receive education on the above. To monitor and maintain ongoing compliance, the Director of Nursing/Designee will audit Point of Care documentation and Nurse Aide assignment sheets 6 random residents 2 x week x one month and then 1 x week x two months to validate completion of showers. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator	

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and this was a problem for her. Resident #66 further explained she had two showers last week but only one the week before.

An interview with Nurse Aide (NA) #12 on 11/15/17 at 9:00 AM revealed he was assigned to the "long" section of the 100 hall that day and the other NA on the 100 hall was agency and it was her second day working at the facility. NA #12 stated showers were not getting done because they don't have time due to the staffing.

A follow up interview was conducted with Resident #66 on 11/15/17 at 10:39 AM. Resident #66 stated she had not been getting two showers a week consistently due to staffing problems. Resident #66 indicated a lot of staff quit last month and there were not enough NAs for the hall.

An interview was conducted with the Assistant Director of Nursing (ADON)/Acting DON on 11/17/17 at 5:03 PM. The ADON stated his expectation was for the residents' to receive their preferred number of showers a week. The ADON indicated Resident #66 was alert and oriented and if she said she was not getting showers twice a week then she was not. The ADON further stated he felt showers were not being given consistently due to staffing issues.

2. Resident #174 was admitted on 11/01/17 with diagnoses including ventricular tachycardia, congestive heart failure, respiratory failure, diabetes mellitus, and muscle weakness.

Review of an "Admissions Bathing Services Questionnaire" dated 11/02/17 revealed Resident #174 requested 2 showers a week and did not

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have a preference what time of day.

Review of the admission Minimum Data Set (MDS) dated 11/08/17 revealed Resident #174's cognition was intact and he was able to make his needs known. The admission MDS noted he required extensive assistance with transfers and bathing. No rejection of care was noted. The admission MDS indicated it was somewhat important to Resident #174 to choose between a shower, bed bath, or sponge bath.

Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 11/14/17 revealed Resident #174 was admitted following a hospitalization with diagnoses including ventricular tachycardia, congestive heart failure, respiratory failure, diabetes mellitus, and muscle weakness. The CAA Summary noted he required assistance with all of his ADL except for eating and was at risk for a decline in his functional ADL or the inability to improve his functional ADL abilities.

Review of the 300 hall shower schedule revealed Resident #174 was scheduled to receive showers on Tuesday and Friday during the second shift.

An interview with Resident #174 on 11/14/17 (Tuesday) at 9:54 AM revealed he was told he would get two showers a week when he was admitted and expected to get them. Resident #174 stated he had only one shower last week and had not had a shower so far this week.

Review of a care plan for ADL function and rehabilitation potential dated 11/16/17 revealed Resident #174 required assistance with his ADL due to his diagnoses and medication use.

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F 242	Continued From page 49 Interventions included bathing and hygiene with the assistance of one person. During an interview on 11/15/17 at 12:01 PM Nurse Aide (NA) #19 confirmed she worked on the 300 hall from 6:45 AM until 11:00 PM on 11/14/17 because there were no agency NAs to cover the hall. NA #19 stated there was a shower list for the hall and she did not notice Resident #174 was scheduled for a shower on 11/14/17 until 9:30 PM and he was asleep. NA #19 indicated she typically notified the nurse and the NAs on the next shift when she was not able to do all her showers. NA #19 thought NA#18 told the night shift staff or left a note about the residents that did not get showers on 11/14/17. NA #19 stated staffing was not getting better and she was not always able to get all her showers completed due to staffing. An interview with NA #18 on 11/15/17 at 4:00 PM revealed she worked 17 hours on 11/14/17 because there were no agency NAs to cover the hall. NA #18 stated it got really busy on the 300 hall after they put everyone to bed and two male residents, including Resident #174, did not get showered. NA #18 further stated she usually stayed late and finished her showers if needed but she did not leave until 11:30 PM on 11/14/17 and was too tired. The interview further revealed the facility had been short staffed for the last 3 months and NA #18 was assigned the 300 hall by herself a few days this month. An interview with the Assistant Director of Nursing (ADON) on 11/15/17 at 4:01 PM revealed he was told by the Director of Nursing (DON) that two residents on the 300 hall did not gets showers the previous evening (11/14/17). The ADON noted	F 242		

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they did not have agency staff to cover the hall so NA #18 and NA #19 worked a double shift yesterday (7:00 AM to 11:00 PM). The ADON explained he texted NA #18 and she told him they were very busy and did not have time to give Resident #174 his shower on 11/14/17.

An interview with the DON on 11/15/17 at 4:06 PM revealed she was at the desk when Resident #174's family member reported he did not get a shower the previous evening (Tuesday). The DON stated she expected the NAs to tell the nurses if they could not complete all the showers. The DON explained the facility did not have assignments or a shower schedule when she came two months ago and she had worked on that.

A follow up interview with the ADON/Acting DON on 11/17/17 at 5:00 PM revealed he was aware the NAs were not able to give Resident #174 his shower on 11/14/17 due to staffing and would expect residents to get their preferred number of showers per week.

3. Resident #46 was admitted to the facility on 03/11/17 with current diagnoses of coronary artery disease, respiratory failure and non-Alzheimer's dementia.

Review of the care plan dated 08/16/17 revealed Resident #46 had an activity of daily living (ADL) deficit related to limited mobility and cognitive deficits secondary to dementia, history of traumatic brain injury, bladder cancer, chronic obstructive pulmonary disease, osteoarthritis, muscle weakness and debility. The goal was for Resident #46 to participate in care as able through the next review. The interventions

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included: required extensive to total assistance with showers per schedule and as needed.

Review of the annual Minimum Data Set (MDS) dated 10/03/17 revealed Resident #46 was severely cognitively impaired but could understand and make his needs understood. The MDS further revealed Resident #46 required extensive assistance with bathing and it was very important for him to choose between a bath or shower.

Review of the facility shower sheets from 09/2017 through 11/2017 revealed Resident #46 only received 1 shower per week for the weeks of 09/04/17 to 09/10/17, 10/02/17 to 10/08/17, 10/23/17 to 10/29/17, 10/30/17 to 11/05/17, and 11/06/17 to 11/12/17.

An interview conducted on 11/15/17 at 9:00 AM with Nurse Aide (NA) #12 revealed he has worked at the facility for two months and has never worked anywhere that staffing was this low. He stated 7 or 8 NAs quit at the same time along with the shower team. He stated he did his best to get his showers done and sometimes he stayed after his shift was over to do them but if he was too busy with rounds or assisting with meals he didn't get to them. NA #12 stated he had not given Resident #46 a shower today and it was him and one other NA on the hall and didn't see how they could get showers done today. He further stated he reported to the nurse when he didn't get the showers done but the next shift was just as under staffed and usually didn't get them done either.

An interview conducted on 11/15/17 at 9:05 AM with NA #13 revealed she was an Agency NA and

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F 242	Continued From page 52 this was her 3rd day working at the facility. She stated she had not done any showers during her 3 days at the facility and when she asked other staff about showers they told her they were too short staffed to give them. An interview conducted on 11/17/18 at 5:03 PM with the Assistant Director of Nursing (DON)/Acting DON revealed if a resident's bathing preference sheet said they wanted 2 showers per week then their choice for 2 showers per week should be honored and the showers should be given. He stated the NA should report to the nurse if the shower wasn't given and the next shift should give it. He further stated if the showers weren't given it was probably related to low staffing.	F 242		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to unclog resident sink with poor drainage on 1 of 3 halls. 1 of 26 rooms was affected on 100 hall (Room #112). The facility failed to repair broken resident doors with sharp splintered wood on 2 of 3 halls. 1 of 26 rooms was affected on 100 hall (Room #112) and 1 of 13 rooms was affected on 200 hall (Room #202). The facility failed to repair and repaint walls with holes on 2 of 3 halls. 2 of 13 bathrooms were affected on 100 hall (Bathroom #113/114, # 115/116) and 1 of 5 bathrooms was affected on 200 hall (Bathroom # 202/203). The facility failed	F 253	F253 During Survey the areas below were identified to be in need of repair: The sink in Room 112 has been unclogged by Maintenance. The splintered wood on the doors of Rooms 112 and 202 have been repaired. The holes in the wall in Rooms 113/114, 115/116, 202/203 were repaired. The caulking was replaced around toilets in bathrooms of Rooms 113/114, 115/116, 121/122, 202/203, 204/205, 304/305 and 314/315.	12/22/17

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F 253	Continued From page 53 to repair or replace bathroom with broken or stained caulking on 3 of 3 halls. 3 of 13 bathrooms were affected on 100 hall (Bathroom # 113/114, #115/116, #121/122), 2 of the 5 bathrooms were affected on 200 hall (Bathroom #202/203, #204/205), and 2 of the 9 bathrooms were affected on 300 hall (Bathroom #304/305, # 314/315). The facility failed to label and cover bed pan, wash basin and fracture pan found on the floor near commode on 2 of 3 halls. 2 of 13 bathrooms were affected on 100 hall (Bathroom #113/114, # 123/124) and 1 of 9 bathrooms was affected on 300 hall (Bathroom # 304/305). The facility failed to repair bathroom floor with broken tiles on 1 of 3 halls. 2 of 5 bathrooms were affected on 200 hall (Bathroom #201, #204/205). The facility failed to clean bathroom floor with dirty stains on 1 of 3 halls. 2 of 5 bathrooms were affected on 200 hall (Bathroom #201, # 202/203). The facility failed to repair heater/air conditional (AC) unit and bathroom sink that were pulling away from the wall in 1 of 3 halls. 1 of 13 rooms was affected on 200 hall (Room #203) and 1 of 5 bathrooms was affected on 200 hall (Bathroom #202/203). The facility failed to cover plungers found on the floor near the commode on 2 of 3 halls. 1 of the 5 bathrooms was affected on 200 hall (Bathroom #204/205) and 2 of the 9 bathrooms were affected on 300 hall (Bathroom #304/305, #316/317). In addition, the facility failed to control odors in the facility and maintain an elevated toilet seat in clean and sanitary condition. The findings included: 1. The following observations were related to facility's failure to unclog resident sink with poor drainage:	F 253	Covers with residents' name were placed on bedpan, fracture pan and wash basin in Rooms 113/114 and 123/124. Broken tiles in bathroom of Room 201 and 204/205 were replaced. The air conditioning unit and sink in Room 202/203 were repaired. Plungers in Rooms 304/305 and 316/317 were covered. The elevated toilet seat in bathroom 304/305 was cleaned by housekeeping staff. Resident #27's room was deep cleaned and mattress was replaced. The Maintenance Director, Housekeeping Manager and Administrator have completed rounds of facility rooms and bathrooms to identify any other resident rooms with the above identified concerns. Any identified concerns will be addressed by Maintenance and Housekeeping. The Administrator in-serviced the Maintenance Director and Housekeeping Supervisor on the cleaning of resident rooms and bathrooms and the maintenance of toilets/sinks and A/C units on 12/11/2017. The Administrator and Housekeeping Manager have initiated a deep cleaning schedule of resident rooms and bathrooms. Department Heads/Designee will monitor cleanliness of rooms, bathrooms and appropriate storage of bed pans and wash basins, condition of doors,caulking at base of toilet and sinks and AC units secured to the wall by management room	

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a. Observation of Room #112 on 11/14/17 at 3:28 PM revealed the sink was clogged up with poor drainage. Subsequent observations made on 11/15/17 at 10:32 AM and at 3:36 PM revealed the sink remained clogged.

2. The following observations were related to facility's failure to repair broken resident room and bathroom doors with sharp splintered wood at the lower edges:

a. Observation of Room #112 on 11/14/17 at 3:28 PM revealed the lower edges of the room door and the bathroom door were broken with sharp splintered wood. Subsequent observations made on 11/15/17 at 10:32 AM and at 3:36 PM revealed the doors remained in disrepair.

b. Observation of Room #202 on 11/14/17 at 3:49 PM revealed the lower edges of the bathroom door was broken with sharp splintered wood. Subsequent observations made on 11/15/17 at 10:47 AM and at 4:03 PM revealed the door remained in disrepair.

3. The following observations were related to facility's failure to repair and repaint the walls with holes:

a. Observation of Bathroom #113/114 on 11/14/17 at 3:31 PM revealed a hole approximately 1 inch in diameter in the wall behind the commode. Subsequent observations made on 11/15/17 at 10:35 AM and at 3:39 PM revealed the hole remained in disrepair.

b. Observation of Bathroom #115/116 on 11/14/17 at 3:35 PM revealed a hole approximately 1 inch

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rounds 2 x weekly x 1 month and then 1 x weekly x 2 months. Any identified concerns will be forwarded to Administrator for follow up.

The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.

The title of the person responsible for implementing the acceptable plan of correction is the Administrator

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in diameter in the wall behind the commode. Subsequent observations made on 11/15/17 at 10:37 AM and at 3:42 PM revealed the hole remained in disrepair.

c. Observation of Bathroom #202/203 on 11/14/17 at 3:49 PM revealed the wall below the sink approximately 5 inches in diameter was unevenly patched and the wall at both sides of the sink approximately 6 x 6 inches were touched up with different color. Subsequent observations made on 11/15/17 at 10:47 and at 4:03 PM revealed the wall remained in disrepair.

4. The following observations were related to facility's failure to repair or replace bathrooms with broken, cracked, discolored or stained caulking around the base of the commode or along the bathtub:

a. Observation of Bathroom #113/114 on 11/14/17 at 3:31 PM revealed the caulking around the base of the commode was stained. Subsequent observations made on 11/15/17 at 10:35 AM and at 3:39 PM revealed the caulking around the base of the commode remained stained.

b. Observation of Bathroom #115/116 on 11/14/17 at 3:35 PM revealed the caulking around the base of the commode was stained. Subsequent observations made on 11/15/17 at 10:37 AM and at 3:42 PM revealed the caulking around the base of the commode remained stained.

c. Observation of Bathroom #121/122 on 11/14/17 at 3:37 PM revealed the caulking around the base of the commode was stained. Subsequent observations made on 11/15/17 at 10:40 AM and at 3:50 PM revealed the caulking

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around the base of the commode remained stained.

d. Observation of Bathroom #202/203 on 11/14/17 at 3:49 PM revealed the caulking around the base of the commode was stained and the caulking along the bathtub was broken. Subsequent observations made on 11/15/17 at 10:47 AM and at 4:03 PM revealed the caulking around the base of the commode and along the bathtub remained unchanged.

e. Observation of Bathroom #204/205 on 11/14/17 at 4:04 PM revealed the caulking around the base of the commode was discolored. Subsequent observations made on 11/15/17 at 10:55 AM and at 4:10 PM revealed the caulking around the base of the commode remained discolored.

f. Observation of Bathroom #304/305 on 11/14/17 at 4:09 PM revealed the caulking around the base of the commode was cracked and discolored. Subsequent observations made on 11/15/17 at 11:00 AM and at 4:14 PM revealed the caulking around the base of the commode remained unchanged.

g. Observation of Bathroom #314/315 on 11/14/17 at 4:12 PM revealed the caulking around the base of the commode was stained. Subsequent observations made on 11/15/17 at 10:40 AM and at 3:50 PM revealed the caulking around the base of the commode remained stained.

5. The following observations were related to facility's failure to label and cover bed pan, wash basin and fracture pan found on the floor near

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commode:

a. Observation of Bathroom #113/114 on 11/14/17 at 3:31 PM revealed an unlabeled and uncovered bucket with lid on the floor near the commode. Subsequent observations made on 11/15/17 at 10:35 AM and at 3:11 PM revealed the bucket remained unchanged.

b. Observation of Bathroom #123/124 on 11/14/17 at 3:39 PM revealed an unlabeled and uncovered bed pan on the floor near the commode. Subsequent observations made on 11/15/17 at 10:42 AM and at 3:15 PM revealed the bed pan remained unchanged.

c. Observation of Bathroom #304/305 on 11/14/17 at 4:09 PM revealed an unlabeled and uncovered wash basin under the sink. In addition, an unlabeled and uncovered fracture pan observed on the floor at the back of the commode. Subsequent observations made on 11/15/17 at 11:00 AM and at 3:26 PM revealed the wash basin and fracture pan remained unchanged.

6. The following observations were related to facility's failure to repair bathroom floor with broken tiles:

a. Observation of Bathroom #201 on 11/14/17 at 3:44 PM revealed the tiles on the bottom row of the bathroom wall approximately 6 x 30 inches were broken. Subsequent observations made on 11/15/17 at 10:45 AM and at 3:58 PM revealed the tiles remained unchanged.

b. Observation of Bathroom #204/205 on 11/14/17 at 4:04 PM revealed the tiles near the

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base of the commode were cracked. Subsequent observations made on 11/15/17 at 10:55 AM and at 4:10 PM revealed the tiles remained unchanged.

7. The following observations were related to facility's failure to clean bathroom floor with dirty stains:

a. Observation of Bathroom #201 on 11/14/17 at 3:44 PM revealed the floor at the corners was dirty with visible stains. Subsequent observations made on 11/15/17 at 10:45 AM and at 3:17 PM revealed the floor remained dirty.

b. Observation of Bathroom #202/203 on 11/14/17 at 3:49 PM revealed the floor was dirty with visible stains around the bathtub and at the corners. Subsequent observations made on 11/15/17 at 10:47 AM and at 3:20 PM revealed the floor remained dirty.

8. The following observations were related to facility's failure to repair the heater/AC unit and bathroom sink that were pulling away from the wall:

a. Observation of Room #203 on 11/14/17 at 3:58 PM revealed the heater/AC unit was approximately 1 inch pulling away from the wall. Subsequent observations made on 11/15/17 at 10:52 AM and at 4:07 PM revealed the condition of the heater/AC unit remained unchanged.

b. Observation of Bathroom #202/203 on 11/14/17 at 3:58 PM revealed the sink was approximately 1 inch pulling away from the wall. Subsequent observations made on 11/15/17 at 10:52 AM and at 4:07 PM revealed the condition

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of the sink remained unchanged.

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9. The following observations were related to facility's failure to cover the plungers found on the floor near the commode:

a. Observation of Bathroom #204/205 on 11/14/17 at 4:04 PM revealed the plunger was uncovered on the floor near the commode. Subsequent observations made on 11/15/17 at 10:55 AM and at 3:21 PM revealed the plunger remained uncovered.

b. Observation of Bathroom #304/305 on 11/14/17 at 4:09 PM revealed the plunger was uncovered on the floor near the commode. Subsequent observations made on 11/15/17 at 11:00 AM and at 3:26 PM revealed the plunger remained uncovered.

c. Observation of Bathroom #316/317 on 11/14/17 at 4:15 PM revealed the plunger was uncovered on the floor near the commode. Subsequent observations made on 11/15/17 at 11:07 AM and at 3:30 PM revealed the plunger remained uncovered.

During an interview on 11/15/17 at 2:21 PM, Housekeeper #1 stated daily cleaning of resident rooms included trash removal, window cleaning, dusting, floor sweeping and mopping, and bathroom cleaning. She received 3 days of housekeeping training from her supervisor during job orientation. On average, she cleaned about 16 resident rooms daily and required to perform deep cleaning for 2 rooms per week on Friday. She would report to the maintenance department when she observed any maintenance related issues. She added the plungers should be

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covered with plastic bag and put it in the corner of the bathroom. She denied her workload was overwhelming.

During an environment tour and interview on 11/15/17 at 2:41 PM, the Housekeeping Manager (HM) stated she had 14 staff under her leadership, in which 4 among the 14 staff were part-time employees. For the first shift, she assigned 4 housekeepers for cleaning resident rooms, 1 housekeeper cleaning common areas, and 3 staff to do laundry. She scheduled 1 housekeeper and 1 laundry staff on second shift. She audited each housekeeper's works at least 2 times monthly and follow up with feedbacks for performance enhancement. The HM stated she had not been able to be fully staffed in the past 6 months. As she had to perform housekeeper's task frequently, she did not have sufficient time to supervise her staff to ensure optimum cleanliness of the facility. After the tour to the areas of concern, the HM agreed those issues needed to be addressed as soon as possible.

During an environmental tour and interview on 11/15/17 at 4:13 PM the Maintenance Manager (MM) confirmed there were 27 bathrooms and 56 bedrooms in the skilled side of the facility. He acknowledged that the above areas of concern were in disrepair and needed to be fixed as soon as possible. According to the MM, he was the only maintenance staff in the facility in the past 7 to 8 months. The facility hired one maintenance assistant about 1 month ago. The work load was heavy and overwhelming. He made routine rounds at least 4 to 5 times daily to look for maintenance tasks that needed to be addressed for bed rooms, bath rooms, hallways, and other common areas. He relied on staff to report

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maintenance concerns via verbal reports or work orders. However, the MM stated he was unaware of the above areas of concern as the staff did not communicate maintenance related issues with him. The work orders folders were located at each nurse station and he checked at least 2 to 3 times daily. The MM added maintenance work was prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third.

During an interview on 11/17/17 at 9:00 AM, NA #5 stated she would check resident's bathroom on her rounds to ensure the toilet was clean, odorless, and free of clutter. Devices such as bed pan, urinal and fracture pan were covered in the plastic bag and labeled with resident's name.

During an interview on 11/17/17 at 4:03 PM, the Assistant Director of Nursing (DON)/Acting DON stated it was his expectation for residents to live in a clean environment and in proper repair. Other than staffing issues, the Acting DON attributed the incident as a result of lack of communication among the staff, housekeeping department, and maintenance department.

During an interview on 11/17/17 at 4:48 PM, the Administrator stated it was her expectation for the staff to maintain the facility at the highest level of cleanliness as possible and in proper repair. All the identified housekeeping and maintenance issues should be addressed accordingly and in a timely manner.

10. Resident #27's room was observed to smell of urine on 11/14/17 at 2:17 PM. The urine odor was observed around this resident's room from the hallway on 11/14/17 at 4:11 PM. On 11/15/17

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F 253	Continued From page 62 at 9:15 AM the bedroom smelled of urine. An interview with the housekeeper #1 on 11/15/17 at 12:25 PM revealed she has noticed a urine odor in this room before. She stated she mopped around the toilet and used air freshener to clear up the odor. The bedroom of Resident #27 smelled of stale urine when observed on 11/15/17 at 4:51 PM and on 11/16/17 at 8:04 AM. Housekeeper #2 stated during interview on 11/16/17 at 8:13 AM that she had noticed an odor form this room. She stated that she sprays an air freshener when she noted it. She stated the facility started a deep cleaning schedule for rooms on 10/25/17. There was no record of which rooms had been deep cleaned prior to this date and she noted Resident #27's room had not been deep cleaned since the documentation began. She further stated that this room had to be sprayed regularly as he often stored soiled briefs in his closet. She stated she routinely checked his closet for soiled briefs. The urine odor was noticeable from the hall when observed on 11/17/17 at 8:24 AM. The Assistant Director of Nursing/Acting Director of Nursing stated on 11/19/17 at 5:12 PM that he expected staff to notify him of rooms that continuously smelled of urine. 11. Observations of shared bathroom for rooms 304/305 on 11/14/17 at 9:33 AM revealed the elevated toilet seat had areas of dried brown matter covering the entire circumference of the underside of the seat opening. A subsequent	F 253		

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observation on 11/15/17 at 8:14 AM revealed the elevated toilet seat remained unclean as observed the previous day.

An interview with Housekeeper #2 on 11/15/17 at 8:14 AM revealed she had worked at the facility for almost two years and confirmed she was assigned to the 300 hall that day. Housekeeper #2 stated residents' rooms and bathrooms were cleaned daily and the toilets were cleaned and disinfected including the seat and the underside of the seat.

On 11/15/17 at 2:49 PM Housekeeper #2 was observed leaving the 300 hall with her cart.

An observation of the elevated toilet seat in the shared bathroom for rooms 304/305 on 11/15/17 at 2:29 PM revealed the elevated toilet seat had areas of dried brown matter covering the entire circumference of the underside of the seat opening.

On 11/15/17 at 2:53 PM Housekeeper #2 confirmed she was done for the day. Housekeeper #2 was asked when and how she cleaned and disinfected the elevated toilet seats in the bathrooms. Housekeeper #2 stated she moved the elevated toilet seat away from over the toilet and sprayed it with a disinfectant and wiped down all of the surfaces including the underside of the seat. Housekeeper #2 could not recall if she cleaned and disinfected the elevated toilet seat in the shared bathroom for rooms 304/305 that day.

An interview was conducted with the Housekeeping Supervisor on 11/15/17 at 3:13 PM. The Housekeeping Supervisor stated the

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F 253	Continued From page 64 Housekeepers were expected to spray the sink and toilet with disinfectant and return to clean the bathroom after they have cleaned the residents' room. The Housekeeping Supervisor explained the entire toilet including the lid, seat, bowl and base were to be scrubbed. The interview further revealed the entire seat top and underside should be cleaned as well. On 11/15/17 at 3:14 PM the Housekeeping Supervisor was accompanied to the shared bathroom for rooms 304/305 and observed the condition of the elevate toilet seat. The Housekeeping Supervisor stated it was not acceptable and would be cleaned immediately.	F 253		
F 272 SS=E	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 272		12/22/17

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F 272	Continued From page 65 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for Cognitive Loss/Dementia, Communication, Activities of Daily Living, and Urinary Incontinence for 8 of 26 sampled residents (Resident #27, #28, #38, #46, #60, #64, #71, and #123). The findings included: Resident #28 was admitted on 06/09/17 with	F 272	F272 During the survey process it was identified Care Area Assessments were incomplete in addressing underlying causes and contributing factors related to Cognition, Communication, Activities of Daily Living and Urinary Incontinence for Resident # 28,#38 #46,#64 and #71 and resident #123. Resident #123 no longer resides in the facility. The Cognition Care Area	

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diagnoses including dementia.

Review of the admission Minimum Data Set (MDS) dated 06/16/17 revealed Resident #28 had severely impaired cognition, could make herself understood, and usually understands. The admission MDS noted Resident #28 required extensive assistance with all her activities of daily living and was frequently incontinent of bowel and bladder.

Review of the Care Area Assessment (CAA) Summary for Cognitive Loss/Dementia revealed Resident #28 had a diagnosis of dementia and was at risk for complications associated with the progression of her dementia including: continued nursing home placement, increased dependence on others to meet her basic daily needs, continued decrease in mental/physical capabilities, and mood and behavior issues. The CAA Summary and analysis of findings did not analyze how Resident #28's cognitive impairment affected her day to day function and care or include her strengths and weaknesses.

An interview was conducted with the Social Worker (SW) on 11/17/17 at 2:10 PM. The SW stated she had been doing MDS assessments and CAA Summaries for several years. The SW noted when completing the assessment she interviewed the resident if they were able, talked with staff, reviewed the notes for the look back period, and made some observations of the resident. She typically included why the resident had the cognition issue, what had been going on, and the risk of the cognition problem when writing the analysis of findings. The SW further stated that years ago she was told she was putting too much information in the CAA Summary and

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Assessment for Residents #28, #38,#46, #64, and #71 has been completed by Social Service Manager to indicate how the residents' cognition affected their ability to make decisions, interact with staff, and communicate needs and how it affects their ability to care for themselves. MDS nurses also updated the Care Area Assessment for Resident #27 regarding urinary incontinence and how it affects skin integrity. The Communication Care Area Assessment for Resident #27 has been updated by Social Service to include audiology recommendation for hearing aids and pending follow up appointment January 2018 for hearing aids. The ADL Care Area Assessment for Resident #60 has been completed by MDS nurse to include how her ADL decline affects her daily routine or ability to care for herself. MDS nurse and Social Service will proceed to care plan based upon triggered Care Area Assessment. All Care Area Assessment updates for specific areas for identified residents were completed by MDS nurse, Activities Director and Social Services Manager by 12/8/2017.

MDS staff will review MDS assessments completed in the past 30 days to validate completion of triggered Care Area Assessments and will complete care plans for triggered Care Area Assessments. MDS staff and Interdisciplinary Team will be in-serviced by Regional Reimbursement Specialist on completion of Care Area Assessments and proceeding to care plan based upon

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analysis of findings. The SW confirmed she had completed Section C (Cognitive Patterns) and the CAA Summary for Cognitive Loss/Dementia for Resident #28's admission MDS and indicated she could have added more resident specific information.

2. Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure, adult failure to thrive and dementia.

The significant change Minimum Data Set dated 10/22/17 coded him with severely impaired cognition, having moderately impaired hearing loss without hearing aids, having no behaviors, requiring extensive assistance with bed mobility, transfers, toileting and hygiene, and being frequently incontinent of bowel and bladder.

Review of the Care Area Assessments (CAA) completed 11/03/17 revealed there was no description of his strengths, weakness, or how the triggered area impacted his day to day routine or care needs as follows:

a. The cognition CAA stated Resident #27 was a long term placement and his baseline mental functioning varied. He had a diagnoses of dementia and considering his age, dementia and multiple comorbid diagnoses, he remained at risk for further cognitive declines and increasing dependence on others to meet his daily needs. The CAA summary did not indicate how the resident's cognition affected his ability to make decisions or how his memory affected his ability to do things for himself.
b. The urinary incontinence CAA stated Resident

triggered Care Area Assessments on 11/28/2017.

The Administrator will audit triggered Care Area Assessments for completion of two residents' assessments 2 x weekly x 1 month and then once a week x 2 months.

The results of the audits will be forwarded by MDS to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.

The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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F 272	Continued From page 68 #27 had a diagnoses of dementia and urinary obstruction with a recent hospitalization of cholelithiasis (gall stones). He has experienced episodes of incontinence and required assistance with transfers, toileting, dressing, hygiene and incontinent care. He verbalized understanding to alert nurse of any signs or symptoms of complications related to incontinence. The CAA summary did not indicate how the frequent incontinence episodes (coded on the MDS) affected him, his skin integrity, or his abilities to care for his needs. c. The CAA for communication stated that Resident #27 was hard of hearing and did not utilize hearing aids. He heard best out of his right ear and understood if you spoke directly into his right ear. The speaker may need to adjust voice or tone or repeat communication to be sure he heard what was said. A consult was not indicated or desired at this time. The Care Area Assessment summary did not indicate the resident had been seen by an audiologist, that hearing aids had been recommended, or if a decision had been make about having the resident fitted for hearing aids. Interview with the MDS Nurse #1 on 11/17/17 at 11:24 AM revealed she completed the communication and urinary incontinence CAA. She gathered her information for MDS and CAAs from observing the resident, talking to the resident, reviewing the medical record, and talking to staff. She stated she then tried to paint a picture of the resident in the CAA describing the problem and why the facility would care plan the problem. During a follow up interview with MDS Nurse #1 on 11/18/17 at 8:22 AM, she stated that she was unaware of Resident #27's visit to the audiologist and if she had been aware of the	F 272		

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appointments and recommendations for hearing aids, she would have added that information in the CAA.

Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary.

3. Resident #123 was admitted to the facility most recently on 08/05/17. Her diagnoses included atherosclerotic heart disease, major depressive disorder, Parkinson's Disease, and dementia.

The significant change Minimum Data Set dated 03/31/17 coded her with severely impaired cognition with no mood or behavior symptoms. She was coded as requiring extensive assistance with most activities of living skills (ADL).

The Care Area Assessment (CAA) summaries did not include a description of the problem or how the problem impacted her day to day function as follows:

a. The cognition CAA dated 04/07/17 stated Resident #123 had active dementia and since admission she had scored as having impaired cognitive skills using the brief interview for mental status assessment tool. The CAA continued stating 'given the progressive declining nature of her dementia disease process, she remains at risk for declines impacting all aspects of her life.

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She remained long term placement with increasing dependence on others to meet her basic needs.' The CAA summary did not indicate how the resident's cognition affected her ability to make decisions or how her memory affected her ability to do things for herself.
b. The ADL CAA dated 04/14/17 stated that due to Resident #123's history and diagnoses, she was at risk for a decline in her functional ADL abilities resulting in requiring more assistance and a care plan would be developed. The CAA summary did not describe the amount of assistance required, possible complications due to inactivity, any strengths or weakness that impacted her abilities to care for any of her ADL.

Interview with the MDS Nurse #1 on 11/17/17 at 11:24 AM revealed she completed the communication and urinary incontinence CAA. She gathered her information for MDS and CAAs from observing the resident, talking to the resident, reviewing the medical record, and talking to staff. She stated she then tried to paint a picture of the resident in the CAA describing the problem and why the facility would care plan the problem. She stated that Resident #123's significant change was due to her coming off hospice services.

Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary.

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4. Resident #71 was admitted to the facility on 06/30/14. Her diagnoses included aphasia following a cerebral infarction, muscle weakness and hemiplegia and hemiparesis.

Resident #71's annual Minimum Data Set (MDS) dated 07/12/17 coded her with moderately impaired cognition and requiring extensive assistance with most activities of daily living skills.

The Care Area Assessment (CAA) related to cognition dated 07/23/17 stated Resident #71 scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS). The CAA noted she had confusion, forgetfulness and she showed signs of age related cognitive loss although she had no diagnoses of dementia. It was noted her BIMS scored varied. She was at risk for cognitive changes. There was no description as to how her cognition affected her abilities to make decisions day to day, why she experienced the cognitive changes, or how her memory affected her abilities to do things for herself.

Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary.

5. Resident #38 was admitted to the facility on 12/08/08. Her diagnoses included heart failure, cerebrovascular disease, anxiety disorder and

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major depressive disorder.

The significant change Minimum Data Set dated 07/26/17 coded her with severely impaired cognitive skills, and having no moods or behaviors and requiring extensive assistance with most activities of daily living skills.

The Care Area Assessment summary related to cognition dated 08/08/17 stated that given the progressive, declining course of the resident's dementia disease and diagnosis, she remained at risk for further cognitive decline and development of behaviors issues, increasing dependence on other to meet basic daily needs and social isolation. There was no description as to how her cognition affected her abilities to make decisions day to day or how her memory affected her abilities to do things for herself.

Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary.

6. Resident #46 was admitted to the facility on 03/11/14 with current diagnoses of heart failure, end stage renal disease and non-Alzheimer's dementia.

Review of the annual Minimum Data Set dated 10/03/17 revealed Resident #46 was severely cognitively impaired with no mood or behavior

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F 272	Continued From page 73 symptoms. Review of the Care Area Assessment (CAA) for cognition dated 10/16/17 revealed Resident #46 was a long term resident of the facility and upon admission his family reported he had a history from a young age of memory/cognitive loss related to traumatic brain injury from a motor vehicle accident in his early 20's. Resident #46's history of traumatic brain injury and vascular dementia put him at risk for complications including continued long term care, increasing dependence on others to meet his daily needs, physical declines, and social isolation. The CAA summary did not indicate how the resident's cognition affected his ability to make decisions, interact with staff, communicate needs, or how his memory affected his ability to do things for himself. Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary. 7. Resident #64 was admitted to the facility on 09/07/17 with diagnoses of Alzheimer's disease and non-Alzheimer's dementia. Review of the admission Minimum Data Set dated 09/19/17 revealed Resident #64 was severely cognitively impaired with no mood or behavior symptoms.	F 272		

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Review of the Care Area Assessment (CAA) for cognition dated 09/18/17 revealed Resident #64 would remain at risk for continued cognitive decline related to the progression of her dementia and Alzheimer's diagnoses. Complications may include continued long term placement, increasing dependence on others to meet daily needs, and social isolation. The CAA summary did not indicate how the resident's cognition affected her ability to make decisions, interact with staff, communicate needs, or how her memory affected her ability to do things for herself.

Interview on 11/17/17 at 2:10 PM with the Social Worker who completed the cognition CAA revealed that she typically would include in the CAA why the resident had a cognition issue such as due to age and disease, the risks and complications of the cognition problems and explain why she would care plan the issue. She stated she did not add the specific details describing the individual resident in the CAA summary.

8. Resident #60 was admitted to the facility on 05/30/16 with diagnoses of anemia, weakness and chronic obstructive pulmonary disease.

Review of the annual Minimum Data Set dated 06/07/17 revealed Resident #60 was cognitively intact and required only supervision to limited assistance with activities of daily living (ADL).

Review of the Care Area Assessment (CAA) dated 06/21/17 revealed Resident #60 was at risk for decline in her functional ADL abilities due to her diagnoses, history and medication use. The

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F 272	Continued From page 75 CAA summary did not indicate how her ADL function affected her daily routine or her ability to do things for herself. An interview conducted on 11/17/17 at 11:24 with MDS Nurse #1 revealed she completed the ADL CAA for Resident #60. She stated she gathered her information from observations, record review and Nurse Aide documentation and staff interviews. She stated she tried to paint a picture of the resident in the CAA summary by describing the problem and why it would be care planned. She stated she did not add specific details about the resident in the summary.	F 272		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		12/22/17

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(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to accurately code the history of falls on the Minimum Data Set (MDS) for 1 of 8 residents reviewed for falls (Resident #69).

The findings included:

Resident #69 was admitted to the facility on 10/03/17 with diagnoses including muscle weakness, atrial fibrillation and ischemic cardiomyopathy.

Resident #69's admission MDS (Minimum Data Set) dated 10/10/17 coded him with intact cognition, requiring extensive assistance with bed mobility, transfers, toileting and having had no falls since admission and no history of falls prior to admission.

The Care Area Assessment (CAA) dated 10/16/17 stated that per his pre-admission social history completed by the resident and his wife, Resident #69 had a fall 30 days prior to admission and a fall 2 to 6 months prior to

F 278
It was identified that MDS for Resident #69 inaccurately coded history of falls prior to admission. A correction to the Admission assessment for Resident #69 was completed, transmitted and accepted on 11/21/2017 by MDS. This resident no longer resides in the facility.

The MDS staff will review coding of history of falls prior to Admission for Admission assessments completed in the past 30 days to identify MDS for accuracy. A Correction to prior assessment(s) will be completed for any inaccurate coding identified related to history of falls on Admission assessment. The Regional Reimbursement Specialist has educated the MDS staff on accuracy of coding related to falls on 11/28/2017.

To monitor ongoing compliance, the MDS staff will audit MDS assessments for accurate coding of history of falls on

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F 278	Continued From page 77 admission. Interview with the MDS Nurse #1 on 11/18/17 at 8:14 AM revealed the preadmission history was obtained prior to admission in order to have any necessary equipment needed in house prior to admission. She recalled speaking to the resident and the wife but was not sure about the specifics. She looked in the computer system for the pre-admission social history but it was not in the computer system for review. She stated it appeared the coding for falls was incorrect.	F 278	Admission assessments x 3 months. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for the implementing of the acceptable plan of correction is the Administrator.	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		12/22/17

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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)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to develop a dental care plan for 1 of 4 residents reviewed for dental needs (Resident

F279
Residents #123, #38, #27 and #46 were identified as having incomplete care

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#46). The facility also failed to develop activity care plans with measurable goals and needed interventions for 3 of 3 residents sampled for activities (Residents #27, #38, and #123).

The findings included:

1. Resident #123 was readmitted to the facility on 08/05/17. Her diagnoses included Parkinson's disease, dementia, and major depressive disorder.

The significant change Minimum Data Set (MDS) dated 03/31/17 coded her with severely impaired cognitive skills, having interests of somewhat importance with newspapers, music, animals, news, group activities and going outside in nice weather. Attending favorite activities and religious activities were noted to be very important to her. This information for activity preferences for the assessment was provided by family.

Although there was no Care Area Assessment for activities triggered for Resident #123, the current care plan was developed on 04/26/16 and addressed the activity needs including that she preferred and enjoyed listening to music, watching television, being around people and visiting with family. It was also noted that she attended group activities with reminders and staff assistance and required one on one visits at times. The care plan goal was for Resident #123 to "attend the activity of interest daily/weekly thru next review." The target date was 04/28/17. There was only one intervention listed with a date initiated on 04/26/16 that she would receive a monthly calendar.

plans. Resident #123 no longer resides in the facility. The activity care plans were updated by the Activity Director for Residents #38 and #27 with interventions based upon likes provided by family. The Dental care plan for Resident #46 was updated by the MDS nurse. These were completed by 12/8/2017.

The MDS staff reviewed the care plans for dental and activity needs based on triggered Care Area Assessments in the MDS assessments completed within the past 30 days.

The Regional Reimbursement Specialist in-serviced the Interdisciplinary Team on completion of Comprehensive Care plans and measurable goals on 11/28/2017.

To monitor ongoing compliance, the Administrator/Designee will audit triggered Care Area Assessments and review care plan for completion of interventions based on triggered Care Area Assessments and measurable goals x 3 months.

The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.
The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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Activity notes dated 05/18/17, 08/01/17 and 10/25/17 included that she attended group events with the assistance and encouragement from staff, staff provided one on one visits, and monitored her needs.

Interview with the Activity Director on 11/17/17 at 2:40 PM revealed that when she developed a care plan for activities she included what the resident did at home and then tried to find their interests in the facility. She stated that when she developed a goal she wanted to get the resident to attend as much as she would go to. The Activity Director stated she had noticed a decline in Resident #123's attendance because the Activity Director worked at the facility full time. The Activity Director stated the goal itself was not measurable to other staff reading it. In addition, the Activity Director stated more interventions were provided to the resident including encouraging her to attend activities, taking her to activities and one on one activities which were not included in the care plan.

2. Resident #38 was admitted to the facility on 12/08/08. Her diagnoses included heart failure, major depressive disorder, and anxiety disorder.

The significant change Minimum Data Set (MDS) dated 07/26/17 coded her with having severely impaired cognition. Family was noted to answer the questions related to her interests and she was coded as having somewhat of an interest in newspapers, music, group activities, favorite activities, going outside and religious activities.

Although no Care Area Assessment for activities triggered for Resident #38 the current care plan was developed on 04/28/16 and addressed the

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activity needs including that she preferred and enjoyed singing, socials and church events with encouragement and assistance from staff. Other interests included nail club, bingo and family visits. The care plan goal was for Resident #38 to "attend the activity of interest daily/weekly thru next review." The target date was 01/10/18. There was only one intervention listed with a date initiated on 04/28/16 that she would receive a monthly calendar.

Interview with the Activity Director on 11/17/17 at 2:40 PM revealed that when she developed a care plan for activities she included what the resident did at home and then tried to find their interests in the facility. She stated that when she developed a goal she wanted to get the resident to attend as much as she would go to. The Activity Director stated she determined if a goal was met by her personal observations of the resident's attendance at activities. She stated that the goal was not measurable to other staff. In addition, the Activity Director stated more interventions were provided to Resident #38 which she should have included in the care plan.

3. Resident #27 was admitted to the facility on 10/13/15 and recently readmitted on 10/15/17. His diagnoses included adult failure to thrive, atrial fibrillation, and dementia.

The significant change Minimum Data Set dated 10/22/17 coded him with severely impaired cognition and moderately impaired hearing. The family provided answers to resident #27's activity preferences and noted that doing his favorite activities and religious activities were very important to him and other interests of somewhat importance included newspapers, music,

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animals, news and group activities.

Although there was no Care Area Assessment for activities triggered for Resident #37 the current care plan was developed on 05/02/16 and had a target date of 01/02/18. The activity needs were that he preferred and enjoyed watching television and socializing with his roommate. Other interests were people watching, singings church events and socials. It was noted that he was hard of hearing and needed to sit near the front during a group event. The goal was for him to "attend activities of interest daily/weekly thru next review." There were 2 interventions both initiated 05/02/16 as follows: engage resident in group activities and resident will receive a monthly calendar.

Interview with the Activity Director on 11/17/17 at 2:40 PM revealed that when she developed a care plan for activities she included what the resident did at home and then tried to find their interests in the facility. She stated that when she developed a goal she wanted to get the resident to attend as many activities as he would go to. The Activity Director stated she determined if a goal was met by her personal observations of the resident's attendance at activities. She stated that the goal was not measurable to other staff.
4. Resident #46 was admitted to the facility on 03/11/17 with current diagnoses of coronary artery disease, respiratory failure and non-Alzheimer's dementia.

Review of the annual Minimum Data Set (MDS) dated 10/03/17 revealed Resident #46 was severely cognitively impaired but could understand and make his needs understood. The MDS further revealed Resident #46 had no

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F 279	Continued From page 83 natural teeth or tooth fragments (edentulous). Review of the Care Area Assessment (CAA) dated 10/13/17 revealed Resident #46 was edentulous and did not utilize upper or lower dentures. He denied chewing problems and did not appear to have any difficulty with his current diet. His intake was good. He also denied oral pain or problems and none were noted. Gums remained healthy, pink and free of lesions. He could perform oral care with set up, supervision and cues but generally staff assistance was needed. Dental consult 09/19/17. Care plan yes. Review of the care plan dated 10/13/17 revealed no dental care plan for Resident #46. An interview conducted on 11/17/17 at 11:25 AM with MDS Nurse #1 revealed if the CAA summary stated a triggered area would be care planned a care plan should be completed. She stated a dental care plan should have been completed for Resident #46 and did not know how it was missed.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		12/22/17

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(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

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F 280	Continued From page 85 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update care plans for 2 of 8 sampled residents (Residents #38 and #63) reviewed for accidents and 1 of 11 sampled residents (Resident #123) for activities of daily living needs. The findings included: 1. Resident #38 was admitted to the facility on	F 280	F280 The following residents were identified as not having up to date care plans related to accidents and toileting. The Toileting and Fall care plan for resident #63 has been updated by the MDS nurse. The Activities Care Plan has been updated by Activities Director for resident #38. Resident #123 no longer resides in the facility. Updates were completed by 12/8/2017.	

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12/08/08. Her diagnoses included major depressive disorder, anxiety disorder and cerebrovascular disease.

A care plan most recently updated 11/14/17 with interventions included a call bell in reach (added 07/11/16); anti-roll back device on the wheelchair (added 12/19/16); frequent safety reminders (added 12/19/16); nonskid mat beside bed(added 12/19/16); and nonskid socks in bed (added 03/17/17).

Review of an incident report revealed Resident #38 experienced a fall on 05/29/17 at 8:30 AM. She was found sitting on her buttocks between the wheelchair and the bed. The resident stated she was trying to get back into bed. Per the follow up notes dated 06/05/17, a dycem (nonskid surface) was added to the wheelchair seat.

The significant change Minimum Data Set (MDS) dated 07/26/17 noted she had severely impaired cognition, required extensive assistance with most activities of daily living skills and had no falls since the previous assessment (06/30/17).

The Care Area Assessment dated 08/08/17 for falls noted she was at risk for falls secondary to her advancing age, cognitive deficits and multiple comorbid diagnoses. It was noted that she exhibited good safety awareness and utilized the call system for assistance.

Review of incident reports revealed that on 10/25/17 at 2:47 AM, Resident #38 was found in the bathroom on her bottom between the toilet and wall. The immediate action taken per the incident report was non-skid mat in the bathroom. Per the follow up notes dated 10/26/17 the

F 280

The Interdisciplinary Team has reviewed care plans of other residents in the facility to validate care plan is up to date with resident's current status including falls, activities, and Activities of Daily Living including eating ability, bathing and toileting. The Regional Reimbursement Specialist in-serviced the Interdisciplinary Team on completion of updates to care plan when resident's status changes on 11/28/2017. The licensed nurses were in-serviced on 12/8/2017 regarding updating the care plan when the resident has a status change including a fall.

The Interdisciplinary Team will review care plans prior to care plan meetings to validate that the care plan is up to date with current resident status. The Interdisciplinary Team will review Physician orders and changes in resident status as part of morning risk meeting and weekly resident review meeting and update care plan as resident status or orders change. The MDS staff and Director of Nursing will complete an audit 1 x a week of 4 random residents for three months with identified falls, new physician orders or changes of status to verify care plan is updated.

The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.
The title of the person responsible for implementing the acceptable plan of

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F 280	Continued From page 87 resident was to be offered toileting on care rounds and as needed and an antiskid mat was placed in the bathroom. Review of the current care plan revealed the care plan was updated with toileting on care rounds, after meals and as needed on 10/26/17. The care plan did not include the antiskid mat in the bathroom or the dycem in the wheelchair. In addition, the Kardex used by nurse aides for individual care did not include the antiskid mat in the bathroom or dycem in the wheelchair. Observations made on 11/13/17 at 2:56 PM, on 11/14/17 at 8:18 AM, on 11/16/17 at 8:05 AM, and 11/17/17 at 10:39 AM revealed there was no anti-skid mat in the bathroom adjacent to her room. Observations made on 11/13/17 at 11:05 AM, 11/14/17 at 10:40 AM, 11/15/17 at 12:13 PM, 11/16/17 at 8:05 AM and 11/18/17 at 11:33 AM no dycem was observed being in the wheelchair. Interview with MDS Nurse #1 on 11/17/17 at 11:44 AM indicated falls were discussed during morning meetings on weekdays and the care plans were reviewed and revised then. She could not say how the dycem or the antiskid mat in the bathroom were missed being placed on the care plan. Interview with the Assistant Director of Nursing/Acting Director of Nursing on 11/18/17 at 5:26 PM revealed the falls were discussed every morning and the care plan updated at that time. Updating the care plan ensured the interventions were also automatically added on the Kardex for nurse aide information. He stated the dycem	F 280	correction is the Administrator	

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and anti-skid mat in the bathroom should have been updated on the care plan.

2. Resident #123 was admitted to the facility most recently on 08/05/16. Her diagnoses included Parkinson's Disease, dementia and dysphagia.

The quarterly Minimum Data Set (MDS) dated 08/14/17 coded her with severely impaired cognition and requiring set up for eating.

The next quarterly MDS dated 10/25/17 coded her again with severely impaired cognition and requiring extensive assistance with eating.

Review of the current care plan for activities of daily living skills last completed on last updated 11/03/17 included the goal for the resident to participate with ADL as able at the current level of function through the review dated of 04/28/17. Interventions included "Resident is generally independent with eating following set up. Supervise/Assist RN (as needed)."

On 11/15/17 at 8:38 AM, Nurse Aide (NA) #12 was observed to set up and serve Resident #123 her breakfast tray. Although he encouraged her and gave her a bite of food to get her started eating, Resident #123 did not attempt to feed herself any food items and a nurse had to feed her the breakfast meal.

On 11/15/17 at 12:36 PM, Resident #123 was observed to feed herself some of her lunch tray. At 12:44 PM DNA #12 sat and encouraged her to drink independently. At 12:53 PM a nurse sat and began to feed Resident #123 her meal.

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MD'S Nurse #2 was interviewed on 11/17/17 at 11:24 AM. She stated she was new to the facility and doing MD'S and care plans. She could not recall reviewing this care plan for Resident #123 but stated it was reviewed on 11/03/17. She stated the care plan should have been updated to reflect her change in ability to feed herself and the need for more assistance.

3. Resident #63 was admitted to the facility on 11/18/15 with diagnoses of non-Alzheimer's dementia, restlessness/agitation and muscle weakness.

Review of the facility incident report dated 10/07/17 revealed Resident #63 had an unwitnessed fall attempting to go to the toilet unassisted. The interventions to be put into place were to educate Resident #63 to use her call light for assistance and to initiate the toileting program for her.

Review of the care plan dated 10/25/17 revealed Resident #63 was a fall risk due to actual falls and further falls related to advanced age, unsteady gait/balance, poor safety awareness, dementia, multiple co-morbid medical diagnoses, and use of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fall through next review and no fall related injuries requiring hospitalization through next review. The interventions included: anti-rollback to wheelchair, fall mat at bedside, maintain call light within easy reach and bed in adjusted position, non-skid mat at bedside, non-skid shoes during the day, non-skid socks at bedtime, and offer toileting with care rounds as needed. The care plan was not updated with the toileting program intervention from the fall on

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10/07/17.

Review of the quarterly Minimum Data Set (MDS) dated 10/27/17 revealed Resident #63 was cognitively intact and had 1 fall since the last review.

Review of the facility kardex, an information guide for the Nurse Aides for resident care, revealed Resident #63 was not on a toileting program. Resident #63 was never placed on the toileting program due to the intervention not being added to the kardex and the care plan.

An interview conducted on 11/18/17 at 5:26 PM with the Assistant Director of Nursing/Director of Nursing (ADON/DON) revealed after a resident has a fall it was reviewed in the fall huddle the next day with new interventions to be put into place to prevent future falls. He stated it was the DON's responsibility to add the new interventions to the care plan and kardex. He stated the toileting program was different than offering toileting with care rounds and should have been added to Resident #63's care plan after her fall on 10/07/17.

F 281 SS=J — SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (F 281) — Completion date: 12/22/17

CFR(s): 483.21(b)(3)(i)

(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

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F 281	Continued From page 91 by: Based on record review and Physician and staff interviews the facility failed to transcribe a physician standing orders for a laboratory test to monitor the clotting time of a resident's blood which led to the laboratory test being missed four times that resulted in an elevated bleeding time for 1 of 3 residents reviewed on Warfarin (blood thinner) therapy (Resident #139). Resident #139 admitted to the hospital and received treatment to reduce his elevated bleeding time. The facility also failed to confirm a therapeutic exchange for a physician ordered medication which resulted in a 2 day delay in administration of a medication ordered for bursitis for 1 of 1 resident reviewed for pharmaceutical services (Resident #66). Immediate Jeopardy began on 10/21/17 when staff failed to monitor the blood clotting time for Resident #139, who was receiving Warfarin 10 milligrams (mg) once a day per, per the resident's physician's standing orders. Due to staff not transcribing Resident #139's physician's standing orders staff did not monitor the resident's blood clotting time on 10/21/17, 10/23/17, 10/25/17 and 10/27/17. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The facility was cited at F281 for example #2 at a scope and severity level of D. The findings included:	F 281	F 281 It was identified during the survey process that resident #139 did not have standing orders transcribed related to lab monitoring of coumadin.Resident #139 is no longer in the facility.It was also identified that resident #66 did not receive celebrex as ordered due to nurse not confirming pharmacy therapeutic interchange. The orders of residents admitted 10/18/17 through 11/19/17, as well as residents with warfarin orders were audited for correct transcription of orders for INR labs related to warfarin. There were no negative findings based on this audit. A standing order for completion of INR labs for residents admitted with an order for warfarin was obtained from the Medical Director on 11/17/17 by the Director of Nursing. A cart to Medication Administration Record Audit was completed by the Director of Nursing of Autumn Care of Mocksville on 12/7/17 to identify any medications not available for administration. All medications were present based on this audit. Director of Nursing or designee staff will complete audits of residents receiving warfarin 3 x a week for 3 months to validate accurate transcription of INR orders into Point Click Care and onto the Coumadin flow sheet. They will also continue with review of new orders in the week day clinical meeting. Director of Nursing or designee will verify the presence of any newly ordered	

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F 281	Continued From page 92 1. Resident #139 was admitted to the facility on 10/18/17 with diagnoses of acute respiratory failure, Myasthenia Gravis, hypertension, duodenal ulcer, and pneumonia. Review of the admission Minimum Data Set dated 10/25/17 revealed Resident #139 was moderately cognitively impaired and received anticoagulants during the assessment period. Review of Resident #139's History and Physical from the hospital dated 10/10/17 revealed Resident #139 had a series of hospitalizations. He was discharged 09/10/2017 after being admitted with duodenal bleed while on Xarelto (a blood thinner). He was transfused a total of 4 units of blood during that stay. Resident #139 was subsequently readmitted on 10/02/17 with a possible pulmonary embolism with low clot burden as well as left lower lobe infiltrate. He was seen by hematology who recommended converting from Xarelto (blood thinner) to Lovenox (blood thinner). He was discharged on 10/07/17 and reported back to hospital on 10/10/17 for weakness. The hospital records didn't say what date the Lovenox was changed to Warfarin but he was discharged on Warfarin 10 mg as below. Review of the hospital discharge summary dated 10/18/17 revealed the impression/plan for Resident #139 was as follows: continue Warfarin, check International Normalized Ratio (INR) daily (laboratory test to check clotting time of blood), goal INR 2 to 3. Review of the hospital discharge summary dated 10/18/17 revealed Resident #139's	F 281	medication in the medication cart after review of orders in the week day clinical meeting. This will be audited 3x a week for 3 months Results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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anticoagulation therapy would be monitored by the Facility Physician. The next INR was due 10/21/17. The INR on 10/18/17 was 1.9 with a target INR of 2 to 3.

Review of the facility Standing Orders for Anticoagulants was:

INR will be performed monthly on all residents receiving Warfarin. If a resident is receiving upon admission or is started on medication, an INR will be performed every other day for 1 week, then every other week x 4, then monthly, unless otherwise ordered by MD.

Review of the care plan dated 10/18/17 revealed Resident #139 received anticoagulant use with a goal for no complications related to anticoagulant use. The interventions included: administer medications as ordered. Monitor for behavior changes. Monitor for signs and symptoms of internal/external bleeding. Monitor labs as ordered. Protect from injury.

Review of the facility physician orders for Resident #139 from 10/18/17 through 10/27/17 revealed the following:

-Warfarin 10 milligrams (mg) every afternoon for anticoagulation therapy.
-No orders for INR testing.

Review of the facility PT/INR/Warfarin Flowsheet revealed the INR was checked on 10/19/17 with a result of 2.1 with no change in orders for Warfarin 10 mg once a day.

Resident #139 missed INR checks on 10/21/17, 10/23/17, 10/25/17 and 10/27/17 per the standing

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orders.

Review of a nurse's note dated 10/27/17 at 4:38 PM revealed Resident #139 reported shortness of breath and a dark purple raised area was noted on his inner right calf. The physician was notified and an order was received for Resident #139 to sent to the emergency department (ED) for evaluation and treatment.

Review of a hospital discharge summary dated 10/28/17 revealed Resident #139 presented at the ED on 10/27/17 for bilateral lower extremity edema with extensive bruising and confusion. A family member reported they had noticed extensive bruising developing in both feet 2 days ago and given his medical history they had requested an evaluation. The Physician noted extensive bruising of the right lower extremity, a large hematoma on the top of of his right foot, and bruising on his left foot. Review of the hospital laboratory test results revealed an INR of 7.8 on 10/27/17. The plan was to hold the Warfarin, give Vitamin K (a medication used to reverse Warfarin), and consider Fresh Frozen Plasma (a blood product made from the liquid portion of whole blood) if there was further swelling of the hematoma. Resident #139 was transferred to a larger local hospital due to respiratory distress on 10/28/17.

Review of a hospital admission History and Physical dated 10/28/17 revealed Resident #139 was seen in the Emergency Room for swelling, shortness of breath and a concern of possible clots. The report stated his INR was elevated at 7.8 and a large central line was placed to correct his INR. He responded partially to Vitamin K and was given 2 units of Fresh Frozen Plasma.

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An interview conducted on 11/17/2017 at 4:20 PM with the facility physician revealed he reviewed Resident #139's INR one time (on 10/19/17) during his stay at the facility and it was in the therapeutic range. He stated the INR should have been checked after that per standing orders and any result above 3 or below 2 should have been called to him. He further stated it was his expectation for the nurses to enter the standing orders for the INR checks to be completed and the results called to him. He stated he was unaware Resident #139's INR's weren't being checked per the standing orders and should have been.

An interview conducted on 11/17/2017 at 6:44 PM with Nurse #2 revealed she worked the 11:00 PM to 7:00 AM shift on the night Resident #139 was admitted to the facility. She stated the 3:00 PM to 11:00 PM nurse entered all of Resident #139's admission orders into the computer. Nurse #2 stated when a new resident was admitted on Warfarin the standing orders should be entered into the computer for INR checks every other day for a week then 1 time a week for 4 weeks and then once a month. She stated the nurse that enters the admission orders should enter the standing order for INR checks if they are on Warfarin. She stated INR standing order should have been entered for Resident #139 for every other day INR checks because he was admitted on Warfarin.

An interview conducted on 11/17/17 at 7:00 PM with Nurse #3 revealed she admitted Resident #139 on 10/18/17 and put his orders in the computer. She stated she put his order for Warfarin 10 mg in the computer but she did not

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put the standing order for every other day INR checks in the computer. She stated she should have put the order for INR checks with the Warfarin order but overlooked it.

A follow up interview conducted on 11/18/17 at 9:17 AM with the facility Physician revealed an INR value of 7.8 was a critical lab value and had the INR checks been done it could have been avoided.

An interview conducted on 11/18/17 at 11:32 AM with the Assistant Director of Nursing (DON)/Acting DON revealed it was the nurse admitting the resident responsibility to enter the standing orders for INR checks to be done if the resident was on Warfarin. He stated the Risk Round Team that consisted of Administrative Nurses checked all new admission orders every morning and he did not know how the order was missed to check Resident #139's INR. He stated the INR should have been checked every other day for 1 week then once a week for 4 weeks then once a month.

An interview conducted with the Administrator on 11/19/17 at 7:30 AM revealed it was her expectation for the admitting nurse to put in the standing order for INR checks for residents admitted on Warfarin. She stated she did not know how the order was missed during Risk Round Checks.

The Administrator, DON, and the Regional Director of Clinical Services were informed of Immediate Jeopardy on 11/19/17 at 1:11 PM.

On 11/19/17 at 4:56 PM, the facility provided the following Credible Allegation of Compliance:

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F281 Meeting Professional Standards

The Plan of Correcting the specific deficiency

Resident # 139 was admitted to this facility on 10/18/17. Resident was on Warfarin upon admission. Licensed Nurse #3 failed to follow the policy for transcribing standing orders related to the monitoring of INRs, and the risk rounds failed to identify the missed transcription of the standing INR orders. As a result, facility failed to monitor Resident #139's INR on four occasions including; 10/21/17, 10/23/17, 10/25/17 and 10/27/17. Resident #139 was hospitalized on 10/27/17 and found to have an elevated INR level of 7.8.

The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.

All resident that receive Warfarin have the potential to be affected.

On 11/17/17 management staff began re-educating nurses on the policy and procedure as it relates to transcription of orders including ordering of lab for INR monitoring. Re-education is complete as of 11/19/17 or prior to their next scheduled shift to work.

New hires will be educated on the policy during orientation and prior to transcribing orders in to PCC.

Education with Nurse # 3 was completed on 11/17/17.

To prevent this from recurring the admitting nurse will enter the order into Point Click Care (PCC)

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and transcribe onto the PT/INR/Coumadin (Warfarin) flowsheet.

The transcription of the order and placement on the flowsheet will then be validated by a second nurse on the same shift.

To complete validation of accuracy, the administrative nurses will review the transcription of Warfarin orders in PCC and placement of INRs on a flowsheet and PCC treatment administration record as part of weekday morning risk meeting.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

Nursing management will complete an audit of residents with orders for Warfarin 3 x weekly to validate transcription of INR orders into PCC and to the flowsheet. Any identified discrepancies will be corrected immediately and the prescribing physician will be notified.

The title of the person responsible for implementing the acceptable plan of correction is the Director of Nursing.

Date of Alleged Compliance is: 11/19/17

Immediate Jeopardy was removed on 11/19/17 at 5:38 PM when interviews with Nurses confirmed they had received in-service training on how to transcribe standing orders for INR checks for residents on Warfarin.

2. Resident #66 was admitted to the facility on 07/31/14 with diagnoses included muscle

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weakness, age-related osteoporosis, osteoarthritis, and other fracture. Review of the Minimum Data Set (MDS) dated 10/18/17 revealed Resident #66 was cognitively intact with adequate vision and clear speech.

Review of care plan dated 02/09/17 revealed Resident #66 was at risk for pain related to left superior pubic fracture and osteoporosis. The goal was for Resident #66 to maintain comfort to the highest degree possible through next review. Interventions included administered pain medication as ordered, monitored effectiveness and reported unrelieved pain to the physician.

Review of Resident #66's physician order dated 10/13/17 revealed the physician had ordered Celebrex 200 milligram (mg) 1 capsule by mouth one time a day for bursitis for 5 days. The order was sent electronically to the pharmacy on the evening of 10/13/17.

Review of Resident #66's electronic Medication Administration Record (eMAR) revealed Celebrex 200 mg was not given and was discontinued on 10/14/17. An order for Meloxicam 7.5 mg 1 tab by mouth one time a day for bursitis for 5 days was started on 10/16/17. Meloxicam was discontinued after Resident #66 completed the 5-days therapy on 10/20/17.

During an interview on 11/14/17 at 10:15 AM, Resident #66 stated she thought she would receive Celebrex for her bursitis in October but she had no idea why she had did received the medication as soon as it was ordered. Resident #66 added she did receive Meloxicam on the morning of 10/16/17 and for a 5-days of therapy. She denied suffered any pain during the weekend

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when she was supposed to receive the Celebrex.

During an interview on 11/16/17 at 5:37 PM, Nurse #7 explained whenever there was a prescription order, the nurse who received the order had to input and submit the order electronically to the pharmacy. Nurse #7 stated she sent Resident # 66's Celebrex order to the pharmacy on 10/13/17 evening. She could not explain why the facility waited until 10/16/17 to start Resident #66's Meloxicam therapy.

During a phone interview on 11/17/17 at 8:57 AM, the Pharmacist stated the pharmacy received the Celebrex order electronically on 10/13/17 at 5:56 PM. Since the order came in after the 5:00 PM cut off time, it would be delivered on the next day. The Pharmacist explained the facility had a formulary agreement regarding therapeutic interchange. Any order for Celebrex 200 mg would be automatically switched to Meloxicam 7.5 mg and the pharmacy would send an "Order Pending Confirmation" electronically. The nurse who provided care for the specific resident was required to confirm the order with the physician before it could be started. According to the Pharmacist, the Meloxicam order was filled on 10/13/17, late evening, and the medications were delivered to the facility on 10/14/17 at 2:35 AM.

Per the Academy of Managed Care Pharmacy, therapeutic interchange was defined as "the practice of replacing, with the prescribing physician's approval, a prescription medication originally prescribed for a patient with a chemically different medication."

During an interview on 11/17/17 at 9:44 AM, the Assistant Director of Nursing (ADON)/Acting

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AUTUMN CARE OF MARION	**1264 AIRPORT ROAD MARION, NC 28752**

(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 281	Continued From page 101 DON explained whenever there was a therapeutic interchange, the nurse had to acknowledge the "Order Pending Confirmation" tab so that the order would appear on the eMAR and the resident would start to receive the medication. In this case, the nurses who provided care for Resident #66 on 10/14/17 morning through 10/15/17 evening had failed to confirm the order electronically in a timely manner. When the order was finally confirmed on 10/16/17 morning, Resident #66 started to receive her Meloxicam. During an interview on 11/17/17 at 10:01 AM, Nurse #4 acknowledged she was the nurse who failed to confirm Resident #66's Meloxicam order on the morning of 10/14/17. Nurse #4 stated she had been working for the facility since September 2017. She was unaware of the requirement to confirm the order as she had never been trained on handling "Order Pending Confirmation" electronically. During an interview on 11/17/17 at 4:10 PM, the Assistant Director of Nursing (DON)/Acting DON stated he expected the nurse to check for outstanding order pending confirmations at the beginning of the shift and before medication pass. The DON attributed the incident as lack of training. It was his expectation for all the medication orders to be filled and administered as ordered in a timely manner.	F 281		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 282		12/22/17

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must-

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and resident and staff interviews, the facility failed to implement care planned interventions for 2 of 11 residents reviewed for activities of daily living (Resident #28, #66) and 1 of 8 residents reviewed for accidents (Resident #63).

The findings included:

1. Resident #28 was admitted on 06/09/17 with diagnoses including dementia.

Review of a care plan dated 06/13/17 revealed Resident #28 was admitted with a history incontinence of bowel and bladder and was a risk for complications related to incontinent episodes. Interventions included to check and change per routine and as needed; and check for wetness on rounds during the night and as needed.

Review of the Care Area Assessment (CAA) for Urinary Incontinence dated 06/22/17 revealed Resident #28 had episodes of incontinence of both bowel and bladder and required assistance with activities of daily living. It was noted despite her risk factors she had no complications related to incontinence.

Review of a quarterly Minimum Data Set (MDS) dated 09/15/17 revealed Resident #28 had severely impaired cognition and required extensive assistance with transfer, dressing,

F 282

F282
During the survey process it was identified for residents #28,#66 and #63 that care plan interventions were not implemented for ADL's,accidents and resident choices due to lack of a specific assignments for NA's and the device list with fall interventions not being updated to reflect new or changes in assistive devices for each resident.New assignment sheets have been implemented with specific room assignments for each Nursing assistant and the fall interventions are being monitored and updated in morning risk meeting and monitored for the presence of during Management room rounds.

Resident requiring assistance with ADL care have been identified by the interdisciplinary team. Care plans and kardex were verified as accurately identifying needs with ADL care.
Nursing staff have been reeducated by 12/8/2017 by the Administrator and/or Director of Nursing/designee concerning the expectation that all residents are to receive ADL care according to their needs as documented on their care plans and kardex. The reeducation included the new process for the unit assignment sheets to

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F 282	Continued From page 103 personal hygiene, and toilet use. The quarterly MDS indicated Resident #28 was always incontinent of bowel and bladder and noted no urinary toileting program had been attempted. Rejection of care was not observed. Observations of Resident #28 on 11/14/17 revealed at 4:20 PM she was observed self-propelling in the hall wearing a pair of pink pants. The crotch area of the pants were visibly wet and a faint urine odor was noted as well. At 5:05 PM Resident #28 was observed in her room and the crotch area of her pants remained visibly wet. Nurse #11 entered Resident #28's room at 5:24 PM and Resident #28 stated she had a headache. Resident #28's pants were visibly wet and a faint urine odor was noted as well. At 5:25 PM Nurse #11 wheeled Resident #28 to the dining room and asked her to rate her pain. Nurse #11 returned to the dining room at 5:31 PM and administered medication to Resident #28. Her pants remained visibly wet and the urine odor was noticeable when standing next to her wheelchair. Nurse Aide (NA) #16 served and set up Resident #28's supper tray at 5:33 PM and exited the dining room. An interview with NA #17 on 11/14/17 at 5:33 PM revealed she was one of three NAs assigned to the 200 hall that evening and she did not get there until 4:00 PM. NA #17 stated the NAs worked together and did not have a specific resident or room assignment. NA #17 stated the other NAs had already started rounds before she arrived but they typically checked and changed everyone on the hall. NA #17 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room	F 282	identify dependent resident needs and bathing schedule To monitor and maintain ongoing compliance the Department heads and Director of Nursing or designee will monitor the care rounds and meal service 2x a week x4 weeks then monthly x2 months to validate tray set up, bathing and incontinent care are provided to dependent residents and that fall interventions are in place. Any negative findings will be immediately corrected. Results of the audits will be forwarded to the facility Quality Assurance Performance Improvement committee monthly x3 for further review and recommendations. The title of the person responsible for implanting the acceptable plan of correction is the Administrator. The Department Heads or designee will monitor for fall interventions being present during management room round 2x a week for 1 month and then weekly for 2 months to validate fall interventions are in place.	

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by Nurse #11.

An interview with NA #18 on 11/14/17 at 5:39 PM revealed she did not assist with incontinence rounds that afternoon because she was giving showers. NA #18 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

During an interview on 11/14/17 at 5:44 PM NA #16 was asked which residents were checked and changed before supper. NA #16 stated they had checked and changed the residents that were in bed and the residents that turned on their call lights. NA #16 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

An interview with Nurse #11 on 11/14/17 at 5:50 PM revealed she did not notice Resident #28's pants were wet with urine or check her for incontinence before taking her to the dining room.

An interview was conducted with the Administrator on 11/14/17 at 5:54 PM. The Administrator stated it was not acceptable for a resident to be taken to the dining room or served a meal wearing pants wet with urine. The Administrator further stated she expected the NAs to check every resident on rounds at the beginning of the shift.

2. Resident #66 was admitted on 09/23/16 with diagnoses including heart failure and left pubis ramus fracture.

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Review of a care plan dated 02/09/17 revealed Resident #66 had a self-care deficit related to advanced age, decreased mobility and other diagnoses. Interventions included to provide daily assistance as needed to complete all care and ensure her needs were met; and showers per schedule and as needed with assistance as needed.

Review of a quarterly Minimum Data Set (MDS) dated 10/18/17 revealed Resident #66's cognition was intact and she was able to make her needs known. The quarterly MDS noted Resident #66 required one person physical assist with bathing and no rejection of care was noted.

Review of the 100 hall shower schedule revealed Resident #66 was scheduled to receive showers on Tuesday and Friday during the second shift.

During an interview on 11/13/17 at 10:18 AM Resident #66 stated she was supposed to get two showers a week but did not get them consistently and this was a problem for her. Resident #66 further explained she had two showers last week but only one the week before.

An interview with Nurse Aide (NA) #12 on 11/15/17 at 9:00 AM revealed he was assigned to the "long" section of the 100 hall that day and the other NA on the 100 hall was agency and it was her second day working at the facility. NA #12 stated showers were not getting done because they don't have time due to the staffing.

A follow up interview was conducted with Resident #66 on 11/15/17 at 10:39 AM. Resident #66 stated she had not been getting two showers

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a week consistently due to staffing problems. Resident #66 indicated a lot of staff quit last month and there were not enough NAs for the hall.

An interview was conducted with the Assistant Director of Nursing (ADON)/Acting DON on 11/17/17 at 5:03 PM. The ADON stated his expectation was for the residents' to receive their preferred number of showers a week. The ADON indicated Resident #66 was alert and oriented and if she said she was not getting showers twice a week then she was not. The ADON further stated he felt showers were not being given consistently due to staffing issues.

3. Resident #63 was admitted to the facility on 11/18/15 with diagnoses of non-Alzheimer's dementia, restlessness/agitation and muscle weakness.

Review of the care plan dated 10/25/17 revealed Resident #63 was a fall risk due to actual falls and further falls related to advanced age, unsteady gait/balance, poor safety awareness, dementia, multiple co-morbid medical diagnoses, and use of psychoactive medications. The goal was for Resident #63 to have no complications related to recent fall through next review and no fall related injuries requiring hospitalization through next review. The interventions included: anti-rollback to wheelchair, fall mat at bedside, maintain call light within easy reach and bed in adjusted position, non-skid mat at bedside, non-skid shoes during the day, non-skid socks at bedtime, and offer toileting with care rounds as needed.

Review of the quarterly Minimum Data Set (MDS)

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F 282	Continued From page 107 dated 10/27/17 revealed Resident #63 was cognitively intact and had 1 fall since the last review. Review of the facility kardex, an information guide for the Nurse Aides for resident care, revealed Resident #63 should have a fall mat and non-skid mat at her bedside. Observations made on 11/15/17 at 8:35 AM, 11/16/17 at 8:08 AM, 11/16/17 at 9:01 AM, and 11/18/17 at 12:39 PM, and 11/18/17 at 2:58 PM of Resident #63 lying in her low bed revealed no fall mat or anti-skid mat at her bedside. An interview conducted on 11/16/17 at 8:25 AM with Nurse #10 revealed Resident #63 did not use a fall mat or a non-skid mat at her bedside. An interview conducted on 11/18/17 at 3:00 PM with Nurse Aide #14 revealed she provided care for Resident #63 on the 3:00 PM to 11:00 PM shift frequently and she had never had a fall mat or non-skid mat at her bedside. An interview conducted on 11/18/17 at 5:26 PM with the Assistant Director of Nursing (DON)/Acting DON revealed it was his expectation for an intervention on the care plan and the kardex to be in place for the resident and the fall mat and non-skid mat should have been in place for Resident #63.	F 282		
F 312 SS=E	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		12/22/17

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services to maintain good nutrition, grooming, and personal and oral hygiene.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and interviews the facility failed to provide incontinent care (Resident #27, #28, and #79) and assistance with tray set up (Resident #123) for 4 of 11 sampled residents reviewed for activities of daily living.

The findings included:

1. Resident #28 was admitted on 06/09/17 with diagnoses including dementia.

Review of a care plan dated 06/13/17 revealed Resident #28 was admitted with a history incontinence of bowel and bladder and was a risk for complications related to incontinent episodes. Interventions included to check and change per routine and as needed; and check for wetness on rounds during the night and as needed.

Review of the Care Area Assessment (CAA) for Urinary Incontinence dated 06/22/17 revealed Resident #28 had episodes of incontinence of both bowel and bladder and required assistance with activities of daily living. It was noted despite her risk factors she had no complications related to incontinence.

Review of a quarterly Minimum Data Set (MDS) dated 09/15/17 revealed Resident #28 had severely impaired cognition and required extensive assistance with transfer, dressing, personal hygiene, and toilet use. The quarterly MDS indicated Resident #28 was always incontinent of bowel and bladder and noted no

F 312

F-312
During the survey process it was identified the facility staff did not provide necessary ADL assistance for Residents #27, #28, # 123, and #79 due to lack of specific assignments for NA's and insufficient staffing. New assignments sheets with specific assignments has been implemented and staffing initiative continues with improvements noted.
Resident requiring assistance with ADL care have been identified by the interdisciplinary team. Care plans and kardex were verified as accurately identifying needs with ADL care.
Nursing staff have been reeducated by 12/8/2017 by the Administrator and/or Director of Nursing/designee concerning the expectation that all residents are to receive ADL care according to their needs as documented on their care plans and kardex. The reeducation included the new process for the unit assignment sheets to identify dependent resident needs and bathing schedule
To monitor and maintain ongoing compliance the Department heads and Director of Nursing or designee will monitor the care rounds and meal service 2x a week x4 weeks then monthly x2 months to validate tray set up, bathing and incontinent care are provided to interviewable and non-interviewable residents. Any negative findings will be immediately corrected.

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urinary toileting program had been attempted. Rejection of care was not observed.

Observations of Resident #28 on 11/14/17 revealed at 4:20 PM she was observed self propelling in the hall wearing a pair of pink pants. The crotch area of the pants were visibly wet and a faint urine odor was noted as well. At 5:05 PM Resident #28 was observed in her room and the crotch area of her pants remained visibly wet. Nurse #11 entered Resident #28's room at 5:24 PM and Resident #28 stated she had a headache. Resident #28's pants were visibly wet and a faint urine odor was noted as well. At 5:25 PM Nurse #11 wheeled Resident #28 to the dining room and asked her to rate her pain. Nurse #11 returned to the dining room at 5:31 PM and administered medication to Resident #28. Her pants remained visibly wet and the urine odor was noticeable when standing next to her wheelchair. Nurse Aide (NA) #16 served and set up Resident #28's supper tray at 5:33 PM and exited the dining room.

An interview with NA #17 on 11/14/17 at 5:33 PM revealed she was one of three NAs assigned to the 200 hall that evening and she did not get there until 4:00 PM. NA #17 stated the NAs worked together and did not have a specific resident or room assignment. NA #17 stated the other NAs had already started rounds before she arrived but they typically checked and changed everyone on the hall. NA #17 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

An interview with NA #18 on 11/14/17 at 5:39 PM

F 312

Results of the audits will be forwarded to the facility Quality Assurance Performance Improvement committee monthly x3 for further review and recommendations. The title of the person responsible for implanting the acceptable plan of correction is the Administrator.

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revealed she did not assist with incontinence rounds that afternoon because she was giving showers. NA #18 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

During an interview on 11/14/17 at 5:44 PM NA #16 was asked which residents were checked and changed during rounds at the beginning of the shift. NA #16 stated they had checked and changed the residents that were in bed and the residents that turned on their call lights. NA #16 was not observed checking on Resident #28 at any time during a continuous observation from 4:20 PM until 5:25 PM when she was wheeled into the dining room by Nurse #11.

An interview with Nurse #11 on 11/14/17 at 5:50 PM revealed she did not notice Resident #28's pants were wet with urine or check her for incontinence before taking her to the dining room.

An interview was conducted with the Administrator on 11/14/17 at 5:54 PM. The Administrator stated it was not acceptable for a resident to be taken to the dining room or served a meal wearing pants wet with urine. The Administrator further stated she expected the NAs to check every resident on rounds at the beginning of the shift. The interview further revealed the Administrator thought the nurse had given the NAs a room assignment.

2. Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure,

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F 312	Continued From page 111 adult failure to thrive and dementia. The significant change Minimum Data Set (MDS) dated 10/22/17 coded him with severely impaired cognition, having no behaviors, requiring extensive assistance with bed mobility, transfers, toileting and hygiene, and being frequently incontinent of bowel and bladder. The MDS noted no toileting program. Under bathing, the MDS noted the activity did not occur. a. The Care Area Assessment for incontinence dated 11/03/17 stated he was at risk for increased episodes of incontinence as well as complication. The current care plan initiated 05/05/16 included a goal for Resident #27 to be assisted with elimination needs as needed through 01/02/18. Interventions included to monitor and assist with any incontinent episodes; provide assistance with toileting, pericare and clothing management as indicated and per resident request. The Kardex Report, a care guide for nurse aides (NA) of individual resident care needs, revealed that incontinent care was to be provided as needed and staff should offer toileting with care rounds. Resident #27 was observed on 11/13/17 at 11:24 AM with a slight urine odor. On 11/14/17 at 8:10 AM, he was observed wheeling himself down the hall towards the dining room. He was wearing light blue thin pants which were observed to have a wet area around his crotch and darker dried rings at the edges of the wet area. A urine odor was observed as he passed the surveyor in the hall. At 8:12 AM NA #6 pushed him to the dining room door. He remained in the dining room	F 312		

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through breakfast. Then at 9:35 AM, Resident #27 was observed in his room in his wheelchair with yellow dark stained light blue pants and the dried stain could be seen on his outer right thigh extending from his knee toward his bottom. Resident #27 was observed again on 1/14/17 at 9:42 AM and his crotch was very wet from his crotch to his knee on the inner thigh. A urine odor was evident. Staff entered the room across the hall at 9:46 AM. The odor of urine was strong in the hallway at this time and the surveyor could see his wet pants from the hall. At 9:48 AM the wound physician and Nurse #8 entered the room to provide wound care to Resident #27's roommate. Both the physician and Nurse #8 left Resident #27's room at 9:56 Am and continued on rounds. Resident #27 was still visibly wet from the hall. Resident #27 remained with the same wet blue pants, wetness observed under the right thigh when observed at 10:04 AM. The urine odor was noted from the hallway at 10:07 AM.

Incontinence care was observed on 11/14/17 at 10:39 AM after NA #9 and #11 had provided care to his roommate. NA #9 and NA #11 stated they had not planned on caring for Resident #27 at this time. They pushed Resident #27 into the bathroom and removed his clothes. His blue pants and socks were soaked through with urine and his pants had dried urine stains on the legs. NA #9 stated at this time "This is bad."

On 11/14/17 at 10:46 AM, interviews were conducted during a group interview with NA #7, NA #8, NA #10, and an orientee NA #12, who were on the hall where Resident #27 resided. They all stated that they had no specific assignment regarding room/resident assignments they just pitched in and helped everyone. NA #7

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produced the assignment sheet which listed the staff and the showers to be given and who was to pass ice but room numbers were not assigned. NA #7 stated the assignments depend on the number of nurse aides present. Sometimes they start providing care for residents at one end of the hall and others start at the other end of the hall and if enough, some start care in the middle. She further stated there were 2 other nurse aides at the far end of the hall where Resident #27 resided. NA #7, NA #8, NA #10 and NA #12 all stated they had not provided Resident #27 any care this morning.

NA #6 stated at 11/14/17 at 10:51 AM that she did not notice Resident #27 was wet when she pushed him down the hall toward the dining room.

On 11/14/17 at 10:53 AM, NA #9 stated she had not given him care this morning. Review of the assignment sheet on 11/14/17 at 10:57 AM revealed NA #9 was now assigned to Resident #27, as room assignments had been added next to staff names. Further interview with NA #9 stated she was not assigned to work this date and just came in to help. She had no assigned rooms as of 5 minutes prior to this conversation. She stated they usually do not have assigned rooms. She stated there should have been enough coverage for those who actually started the shift on time.

Interview with NA #11 on 11/14/17 at 11:09 AM revealed she was from an agency and this was her 3rd day in this facility. She stated there was no specific assignment of rooms, they just went from room to room to provide resident. Care. NA #11 stated she had received report from 3rd shift NA that Resident #27 took care of himself. She

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further stated that she had not given him care this morning and it would make it easier if there was an actual resident assignment provided to the staff.

During an interview on 11/17/17 at 4:14 PM, the Assistant Director of Nursing/ Acting Director of Nursing stated regardless of staffing levels, resident care was always the first priority for nursing staff. Other than answering call lights in a timely manner, it was his expectation for NAs to provide incontinent care immediately even when they were doing rounds. Follow up interview on 11/19/17 at 5:12 PM revealed he expected nurse aides to have and know their assignments to provide the necessary care and services including checking and changing incontinent residents as needed.

b. The Care Area Assessment for activities of daily living (ADL) dated 11/03/17 stated Resident #27 had a recent illness and he was at risk for the inability to improve his ADL abilities.

The current care plan, initiated 05/05/16 and with a target goal of 01/02/18 for the problem of Resident #27 exhibiting self care performance had a goal for him to participate with ADL as able. Under bathing it was noted he required assistance of 1 with bathing and showers.

The Kardex Report, a care guide for nurse aides (NA) of individual resident care needs, revealed that his showers were due on Tuesdays and Fridays.

Review of the bathing assignments per room/bed provided by the facility, revealed Resident 27's room/bed was not on the list to be captured for

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showers. Review of the ADL documentation in the medical record completed by nurse aides, revealed he had not been showered from 09/22/17 through 09/30/17; from 10/06/17 through 11/15/17.

Resident #27 was observed to have urine odors on 11/13/17 at 11:24 AM and 11/14/17 at 8:10 AM.

Interview with the Assistant Director of Nursing/Acting Director of Nursing (ADON) on 11/17/17 at 4:23 PM, the ADON stated that upon admission the activity staff asked about bathing preferences. The nurse then took this information and placed it on the shower schedule. The ADON stated the shower team who completed all showers on first shift was dissolved and the showers then spread over first and second shift by the DON (no longer employed). He stated generally showers for the beds by the doors were scheduled for first shift and the beds by the windows were scheduled for second shift. However, this change had not been updated in the computer system and therefore did not allow staff to document showers given per the new schedule. ADON then provided a new system developed by the previous DON to document showers based on the new schedule. Review of these forms starting on 10/23/17 revealed Resident #27's room/bed was not listed on any sheet from 10/23/17 through 11/19/17 revealing no documentation that he received any showers.

Nurse Aide #15 was interviewed on 11/17/17 at 5:14 PM. She stated she cared for Resident #27 and went by the written assignment sheet for providing him showers. She stated she had never given him a shower on second shift.

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3. Resident #123 was readmitted to the facility on 08/05/16. Her diagnoses included atherosclerotic heart disease, dysphagia, dementia and Parkinson's disease.

The Care Area Assessment (CAA) dated 04/03/17 for nutrition stated she received a regular ground meat diet with nectar thick liquids and ate in the day room where she had supervision.

The quarterly Minimum Data Set dated 10/25/17 coded her with severely impaired cognition, requiring extensive assistance with all activities of daily living skills including eating and she was receiving a therapeutic diet.

Resident #123 was seen by speech therapy from 10/13/17 through 11/01/17. Per the discharge summary dated 11/01/17, Resident #123 safely tolerated mechanical soft solids and nectar thick liquids with mild overt signs and symptoms of penetration/aspiration. This was an improvement from having had moderate overt signs and symptoms of penetration/aspiration during initial assessment on 10/13/17.

Nursing notes dated 11/01/17 at 12:56 PM revealed that Resident #123 was noted chocking multiple times on mechanical soft diet and order was changed to pureed.

On 11/15/17 at 8:38 AM Nurse Aide (NA) #12 was observed delivering and setting up her meal tray. She received her food pureed with a small container of bread crumbs off to the side. The bread crumbs were never opened or added to the food even when NA #15 sat and assisted feeding

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F 312	Continued From page 117 her at 9:18 AM. On 11/16/17 at 9:00 AM NA #13 set her meal tray up, uncovered the container of bread crumbs and Resident #123 began to feed herself. NA #13 did not mix the bread crumbs into the pureed food. NA #13 was interviewed on 11/16/17 at 9:14 AM. She stated that the bread crumbs were used to thicken food but had never seen a pureed diet receive bread crumbs. She stated she had asked NA #12 about them and he stated the crumbs were to make the food thicker and she could add it to the food if she wanted. Interview with the corporate dietician revealed that for pureed diets, the bread crumbs were the substitute for the bread per the menu for pureed diets. She stated the staff were to mix the breadcrumbs into a food item with tray set up. She further stated that the nurses were responsible for educating staff on the need to mix the bread crumbs into the food at tray set up. 4. Resident #79 was admitted to the facility on 06/18/13 with diagnoses included hypertension, anxiety, depression, and amputation of right leg above knee. Review of the Minimum Data Set (MDS) dated 09/13/17 revealed Resident #79 was cognitively intact and able to make decisions of daily care. She required extensive assistance with 2 + persons physical assist with transfer, toileting, bed mobility, dressing, personal hygiene and bathing. Resident #79 was coded with impairment on right upper & lower extremities. The MDS further indicated Resident #79 was frequently incontinent with bladder and was occasionally incontinent with bowel.	F 312		

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F 312	Continued From page 118 Review of care area assessments revealed Resident #79 required assistance with most of her activities of daily living (ADL) due to right above knee amputation (AKA). She was at risk for decline in her functional ADL abilities. Review of care plan dated 05/18/17 revealed Resident #79 was dependent on staff for toileting assistance. Interventions included providing toileting assistance or incontinence care routinely as needed and encouraging Resident #79 to call for assistance at the first urge. During an interview on 11/15/17 at 10:51 AM, Resident #79 stated she activated the call light on 11/14/17 at around 5:00 AM as she was soaking wet in bed. It took NA #3 about 5 minutes to answer her call light. When she told NA #3 that she was soaking wet and needed to be changed, NA #3 replied he had to finish rounding on his residents and promised her to come back in a few minutes. NA #3 turned off the call light before leaving the room. Resident #79 waited for almost one hour without having any nursing staff addressing her incontinent needs. When she activated the call light again at around 6:00 AM, NA #3 came back and asked her what she needed? NA #3 then provided incontinent care and apologized indicating they were short of staff. Resident #79 stated she was upset, felt embarrassed, disregarded and forgotten as she had to wait in soaking wet condition for almost an hour. During an observation on 11/15/17 at 10:59 AM, Resident #79 was alert and oriented, cognitively intact, able to voice her needs verbally and had AKA on her right leg.	F 312		

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During an interview on 11/15/17 at 12:05 PM, Nurse #4 stated all NAs were required to complete their assigned rounds in a timely manner. However, as a nurse, she expected NAs to provide incontinent care as needed during the rounds as resident care had a higher priority.

During a phone interview on 11/15/17 at 12:43 PM, NA #3 confirmed he worked third shift on the 100 Hall that ended on the morning of 11/14/17 and he was taking care of Resident #79. He was not familiar with the residents as it was his second week working in the facility and his first time working at 100 Hall. He started the last morning rounds at around 5:00 AM and he was overwhelmed with call lights as there were only 2 NAs working at on 100 Hall to provide care for around 50 residents. He could not recall answering any call light for incontinent care at around 5:00 AM or promising any resident to come back when he was doing his rounds. NA #3 stated if he knew Resident #79 was in soaking wet that morning, he would have addressed her incontinent needs immediately.

During an interview on 11/16/17 at 8:28 AM, NA #4 confirmed he worked with NA #3 on third shift on the 100 Hall that ended on the morning of 11/14/17. He could not remember seeing NA #3 responding to Resident #79's call light at around 5:00 to 6:00 AM as he was busy with resident care. He stated if a resident was asking for incontinent care during his rounds, he would take care of the resident first, then continue with the rounds. It was NA #3's first night working at 100 hall. With only 2 NAs working on 100 Hall for third shift, the work load was overwhelming for NA #3. He agreed resident care should be prioritized over the rounds at all times.

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F 312	Continued From page 120 During an interview on 11/17/17 at 4:14 PM, the Assistant Director of Nursing (DON)/Acting DON stated regardless of staffing level, resident care was always the first priority for nursing staff. Other than answering call lights in timely manner, it was his expectation for NAs to provide resident care immediately even when they were doing rounds. He also expected NAs to leave the resident call lights on until they could actually provide the assistance requested.	F 312		
F 313 SS=D	TREATMENT/DEVICES TO MAINTAIN HEARING/VISION CFR(s): 483.25(a)(1)(2) (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow through with an audiology recommendation for bilateral hearing aids for 1 of 1 sampled resident reviewed for hearing loss (Resident #27). The findings included:	F 313	F313 During the survey process it was identified that Resident #27 did not have an appointment to follow up on recommendation for hearing aids due to that facility not having a tracking process in place for follow-up appointments. Resident #27 has an appointment	12/22/17

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F 313	Continued From page 121 Resident #27 was originally admitted to the facility on 10/31/15 and recently readmitted on 10/15/17. His diagnoses included muscle weakness, atrial fibrillation, diastolic heart failure, and dementia. Review of the medical record revealed Resident #27 had been to the audiologist on 08/07/17 for a hearing test. Resident #27 also was seen by a physician on 09/11/17 in order to obtain medical clearance for hearing aids. At this appointment, he had wax removed from his ears and the physician recommended bilateral hearing aids. A nursing note dated 09/11/17 at 2:51 PM written by Nurse #7 noted Resident #27 had returned from the appointment with recommendations for bilateral hearing aids. The medical record did not contain any further information related to Resident #27 having any follow up audiology appointments or follow up on obtaining hearing aids. Resident #27 was observed not wearing hearing aids on 11/13/17 at 11:25 AM and 4:13 PM; on 11/14/17 at 8:08 AM and 2:17 PM; on 11/15/17 at 8:46 AM and 2:48 PM and on 11/16/17 at 8:08 AM. The significant change Minimum Data Set (MDS) dated 10/22/17 coded him moderately impaired hearing with no hearing aid. The Care Area Assessment dated 11/03/17 for communication stated that Resident #27 was hard of hearing and did not utilize hearing aids. He heard best out of his right ear and understood if you spoke directly into his right ear. The speaker may need to adjust voice or tone or repeat communication to	F 313	scheduled on 1/22/2018 with Asheville ENT at 1 PM for evaluation of need for hearing aids. Social Service will monitor that resident has an appointment and is transported to appointment to obtain hearing aids if ordered. Family has been notified of appointment. Social service and transportation staff will audit MD orders daily ongoing for any identified orders for outside services related to hearing to validate appointment scheduled and completed. Social Service and Transportation staff educated by Administrator on use of tracking log for validation of hearing appointments on 12/13/17.. Social Service and Transportation staff will maintain a log of requests for hearing service appointments and validate completion of appointment. The results of the audit will be forwarded to the facility monthly QAPI committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the administrator	

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be sure he heard what was said. A consult was not indicated or desired at this time.

Interview with Nurse Aide (NA) #2 on 11/14/17 at 4:16 PM revealed she was unaware of Resident #27 having hearing aids and stated he was very hard of hearing.

Interview with NA #4 on 11/15/17 at 5:45 AM revealed that Resident #27 was extremely hard of hearing and staff had to yell at him to get him to hear what they wanted him to do.

On 11/16/17 at 2:11 PM an interview was conducted with NA #6 who made appointments and transported many residents to their appointments regularly. She explained there were appointment sheets at each nursing station for nurses to complete if a resident was admitted with an order for a consult or their physician ordered a consult. She stated that she reviewed these appointment sheets daily and followed up with making requested appointments and arranging transportation. If NA #6 took the resident to an appointment, she returned with a consult report and if an additional appointment was noted as being needed she would subsequently schedule the new appointment. She further stated she did not take Resident #27 to the appointment on 09/11/17. She also checked and found no record of an appointment sheet being filled out by nursing for a follow up to obtain hearing aids. A second transporter, NA #7 was present during this interview and also stated she did not know anything about a follow up appointment being needed.

On 11/16/17 at 2:36 PM, NA #6 stated that because the hearing aid appointment had been

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F 313	Continued From page 123 overlooked, she had just scheduled an appointment in January 2018 for Resident #27. Interview with Nurse #7 on 11/16/17 at 6:02 PM stated that she noted the consult with recommendations for bilateral hearing aids in the nursing notes. She recalled trying unsuccessfully to reach via phone the responsible party who had been very hard to get a hold of via phone and then passed the information onto the next shift. She stated it was protocol to fill out an appointment sheet and thought she would have done so. Interview with the Director of Nursing on 11/16/17 at 3:54 PM verified the system was for an appointment sheet to be filled out so that follow up for appointments could be made by the transporters.	F 313		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (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.	F 323		12/22/17

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F 323	Continued From page 124 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with 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 observations, record review, and staff interviews, the facility failed to initiate planned interventions of a nonskid mat in the bathroom, toileting after meals and a nonskid mat in the wheelchair to prevent falls for 1 of 8 residents reviewed for falls (Resident #38). The findings included: Resident #38 was admitted to the facility on 12/08/08. Her diagnoses included heart failure, major depressive disorder, anxiety, and hypertension. Review of the fall care plan initiated on 05/02/16 revealed she had an actual fall and remained at risk for falls due to advanced age, independent ambulation and multiple co-morbid medical diagnoses and antidepressant use. The goal was for Resident #38 to have no fall related injuries requiring hospitalization through next review. This goal was initiated 05/02/16. Interventions included: *frequent safety reminders and verbal cues to allow staff to assist when feeling weak or to assist with dressing (initiated 12/19/16); *maintain call light in easy reach (initiated	F 323	F323 It was identified during the survey process that interventions for falls were not in place for Resident #38 due to lack of process in place for updating and monitoring. Planned fall interventions are now in place and the fall interventions will be updated with an immediate intervention by the nurses and will be follow-up in clinical rounds and fall intervention device list will be updated for Department managers to monitor during management room rounds. Care plans for residents at risk for falls were updated to reflect resident's risk for falls and interventions to reduce the risk of falls by the Interdisciplinary Team on 12/8/17. The licensed nurses and nurse aides were in-serviced by Director of Nursing (DON)/ Administrator/Designee on reviewing care plan and Kardex to identify and initiate care planned interventions to prevent falls on 12/8/2017. The Interdisciplinary Team will review new admissions at risk for falls and any resident who has a fall as part of weekday	

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F 323	Continued From page 125 05/02/16); *bed in lowest position (initiated 05/02/16); *monitor ambulation ability and need for assistance with activities of daily living skills as resident is generally independent (initiated 05/02/16); *nonskid mat at bedside (initiated 07/02/16); and *nonskid socks at bedtime (initiated 12/14/16). The quarterly Minimum Data Set (MDS) dated 04/03/17 coded her with moderately impaired cognition, and needing limited assistance with bed mobility and transfers and having had a fall with no injury since the last assessment. Review of the incident report for a fall dated 05/29/17 at 8:30 AM revealed the nurse heard Resident #38 calling for help and found her sitting in the floor on her buttocks between the wheelchair and the bed. Resident stated she was trying to get back in bed. The investigation revealed she had removed her shoes and tried to transfer back to bed. At this time the intervention was to place a dycem (nonskid surface) in the wheelchair seat. A quarterly MDS dated 06/30/17 coded Resident #38 with decreased cognition, now having severely impaired cognition and needing extensive assistance with bed mobility and transfers. She was noted with 1 fall and no injuries since previous assessment. A significant change MDS dated 07/26/17 coded her with severely impaired cognition, and needing extensive assistance with bed mobility and transfers and having had no falls since the previous assessment.	F 323	morning clinical meeting, as well as, weekly resident risk review meeting to ensure care plan and Kardex are updated to reflect current resident status including interventions this will be an ongoing process. The Department heads will monitor that interventions for fall reduction are in place as identified on the fall care plan as part of the management rounds. Any newly hired Department Heads after 12-08-2017 will be educated on the above process. Department Heads/Designee will monitor for fall interventions being present during management room rounds 2 x a week for 1 month and then once a week for 2 months to validate fall interventions are in place. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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The Care Area Assessment (CAA) relating to falls dated 08/08/17 stated that she had advancing age, cognitive deficits and multiple co-morbid diagnoses and used antidepressants. Despite these risks she had no recent falls and exhibited good safety awareness daily. A care plan would be developed.

Review of the care plan revealed the only added interventions since 2016 was to leave the bathroom light on for a nightlight to increase safety (initiated on 03/13/17). The dycem was not added to the care plan.

On 10/12/17 a quarterly MDS noted she was assessed with impaired short and long term memory and severely impaired decision making ability (the previous brief interview for mental status was not successfully used). She had experienced no falls and required extensive assistance with bed mobility and transfers.

Interview with the MDS nurse #1 on 11/17/17 at 11:44 AM revealed that the computer did not always carry over the interventions. She noted via looking at her care plan that toileting after meals and as needed was added to the interventions on 10/26/17.

Per the incident report, another fall occurred on 10/25/17 at 2:47 AM. Resident #38 was heard hollering and she was found sitting on her bottom in the bathroom between the toilet and the wall. The immediate action taken was for staff to offer toileting on care rounds and place a nonskid mat in the bathroom. This intervention was not added to the care plan.

a. Observations made on 11/13/17 at 2:56 PM, on

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11/14/17 at 8:18 AM, on 11/16/17 at 8:05 AM, and 11/17/17 at 10:39 AM revealed there was no anti-skid mat in the bathroom adjacent to her room.

Resident 38's roommate (Resident #122 with her quarterly MDS dated 10/27/17 coding her with intact cognition) stated on 11/16/17 at 8:05 AM that she has never seen a nonskid mat in the bathroom.

Interview with the housekeeper #2 on 11/16/17 at 8:12 AM revealed she was the normal housekeeper for Resident #38's room and she could not recall any non-skid mat in the bathroom.

b. Observations made on 11/13/17 at 11:05 AM, 11/14/17 at 10:40 AM , 11/15/17 at 12:13 PM, 11/16/17 at 8:05 AM and 11/18/17 at 11:33 AM no dycem was observed being in the wheelchair.

c. On 11/15/17 at 1:02 PM Nurse Aide (NA) #13 was observed taking Resident #38 down to her room. At 1:05 PM, Resident #38 was observed using the toilet alone in the bathroom. Interview with NA #13 on 11/15/17 at 1:06 PM revealed that she took Resident #38 down to her room but that she normally did not start toileting until after all the trays were picked up. When asked if the resident was able to toilet herself she stated that she was not familiar with the resident as this was her second day. At 1:10 PM, Resident #38 was observed to independently walk to her bed and sit down.

Review of the Kardex used by nurse aides for reference on individual resident care needs, toileting was to be offered on care rounds, after meals and as needed. The Kardex was silent to

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F 323	Continued From page 128 the dycem in the wheelchair or the mat in the bathroom. Interview with the MDS Nurse #1 on 11/17/17 at 11:44 PM revealed that fall reports are reviewed every weekday morning and risk rounds are completed to ensure planned interventions are in place. She was unable to say why the dycem mat, toileting after meals and the nonskid mat in the bathroom was not put into the care plan. She also stated that when she ensures the care plan is complete, she updated the Kardex so nurse aides were provided the necessary information. She stated she was unaware of these planned interventions. Interview with the Assistant Director of Nursing/Acting Director of Nursing (ADON) on 11/18/17 at 5:26 PM revealed that after a fall, the nurse put in immediate interventions. Then the facility holds a fall huddle in which staff investigate the specifics of the incident and come up with interventions pertinent to the circumstances of the fall. It has been the DON's responsibility to ensure needed interventions are put into place. ADON stated the nurse who initiated the intervention should place it on the care plan which will then automatically put it on the nurse aides' Kardex. He stated he expected the interventions to be in the care plan and in place for Resident #38.	F 323		
F 329 SS=J	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		12/22/17

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F 329	Continued From page 129 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and Physician and staff interviews the facility failed to monitor the clotting time of a resident's blood which led to the	F 329	F 329 It was identified during the survey process that the admitting nurse did not transcribe	

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laboratory test being missed four times that resulted in an elevated bleeding time for 1 of 3 residents reviewed on Warfarin (blood thinner) therapy (Resident #139). Resident #139 admitted to the hospital and received treatment to reduce his elevated bleeding time.

Immediate Jeopardy began on 10/21/17 when staff failed to monitor the blood clotting time of Resident #139, who was on Warfarin 10 milligrams (mg), per the resident's standing orders. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training.

The findings included:

Resident #139 was admitted to the facility on 10/18/17 with diagnoses of acute respiratory failure, Myasthenia Gravis, hypertension, duodenal ulcer, and pneumonia.

Review of Resident #139's History and Physical from the hospital dated 10/10/17 revealed Resident #139 had a series of hospitalizations. He was discharged 09/10/2017 after being admitted with duodenal bleed while on Xarelto (a blood thinner). He was transfused a total of 4 units of blood during that stay. Resident #139 was subsequently readmitted on 10/02/17 with a possible pulmonary embolism with low clot burden as well as left lower lobe infiltrate. He was seen by hematology who recommended

F 329

a standing order for lab to monitor clotting time for Resident #139. Resident no longer resides in the facility. The standing order for labs was obtained by medical director and the orders for correct transcription on new admission and new orders will be monitored in clinical morning meeting.
Residents with warfarin orders were audited for correct transcription of orders for INR related to warfarin. There were no negative findings based on this audit. A standing order for completion of INRs for residents admitted with order for warfarin was obtained from the Medical Director on 11/17/17 by the Director of Nursing.
Nurses were in serviced 11/17/17 through 12/8/17 on standing order for INR. Orders of new admission and orders from the previous 24 hours will be reviewed in weekday morning clinical meeting. Newly hired nurses after 12-08-2017 will be educated on the above process.
Nursing Management staff will complete audits of residents receiving warfarin 3 x weekly x 3 months to validate accurate transcription of INR orders into Point Click Care and Coumadin flow sheet. They will also continue with review of new orders in weekday morning clinical meeting.
Results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.
The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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F 329	Continued From page 131 converting from Xarelto (blood thinner) to Lovenox (blood thinner). He was discharged on 10/07/17 and reported back to hospital on 10/10/17 for weakness. The hospital records didn't say what date the Lovenox was changed to Warfarin but he was discharged on Warfarin 10 mg as below. Review of the hospital discharge summary dated 10/18/17 revealed the impression/plan for Resident #139 was as follows: continue Warfarin, check International Normalized Ratio (INR) daily (laboratory test to check clotting time of blood), goal INR 2-3. Review of the hospital discharge summary dated 10/18/17 revealed Resident #139's anticoagulation therapy would be monitored by the Facility Physician. The next INR was due 10/21/17. The INR on 10/18/17 was 1.9 with a target INR of 2-3. Review of the care plan dated 10/18/17 revealed Resident #139 received anticoagulant use with a goal for no complications related to anticoagulant use. The interventions included: administer medications as ordered. Monitor for behavior changes. Monitor for signs and symptoms of internal/external bleeding. Monitor labs as ordered. Protect from injury. Review of the admission Minimum Data Set dated 10/25/17 revealed Resident #139 was moderately cognitively impaired and received anticoagulants during the assessment period. Review of the facility Standing Orders for Anticoagulants was:	F 329	.	

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INR will be performed monthly on all residents receiving Warfarin. If a resident is receiving upon admission or is started on medication, an INR will be performed every other day for 1 week, then every other week x 4, then monthly, unless otherwise ordered by MD.

Review of the facility physician orders for Resident #139 from 10/18/17 through 10/27/17 revealed the following:

Warfarin 10 milligrams (mg) every afternoon for anticoagulation therapy.

No orders for INR testing.

Review of the facility PT/INR/Warfarin Flowsheet revealed the INR was checked on 10/19/17 with a result of 2.1 with no change in orders for Warfarin 10 mg once a day.

Resident #139 missed INR checks on 10/21/17, 10/23/17, 10/25/17 and 10/27/17 per the standing orders.

Review of a nurse's note dated 10/27/17 at 4:38 PM revealed Resident #139 reported shortness of breath and a dark purple raised area was noted on his inner right calf. The physician was notified and an order was received for Resident #139 to sent to the emergency room for evaluation and treatment.

Review of a hospital discharge summary dated 10/28/17 revealed Resident #139 presented at the ED on 10/27/17 for bilateral lower extremity edema with extensive bruising and confusion. A family member reported they had noticed extensive bruising developing in both feet 2 days

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ago and given his medical history they had requested an evaluation. The Physician noted extensive bruising of the right lower extremity, a large hematoma on the top of of his right foot, and bruising on his left foot. Review of the hospital laboratory test results revealed an INR of 7.8 on 10/27/17. The plan was to hold the Warfarin, give Vitamin K (a medication used to reverse Warfarin), and consider Fresh Frozen Plasma (a blood product made from the liquid portion of whole blood) if there was further swelling of the hematoma. Resident #139 was transferred to a larger local hospital due to respiratory distress on 10/28/17.

Review of a hospital admission History and Physical dated 10/28/17 revealed Resident #139 was seen in the Emergency Room for swelling, shortness of breath and a concern of possible clots. The report stated his INR was elevated at 7.8 and a large central line was placed to correct his INR. He responded partially to Vitamin K and was given 2 units of Fresh Frozen Plasma.

An interview conducted on 11/17/2017 at 4:20 PM with the facility physician revealed he reviewed Resident #139's INR one time (on 10/19/17) during his stay at the facility and it was in the therapeutic range. He stated the INR should have been checked after that per standing orders and any result above 3 or below 2 should have been called to him. He further stated it was his expectation for the nurses to enter the standing orders for the INR checks to be completed and the results called to him. He stated he was unaware Resident #139's INR's weren't being checked per the standing orders and should have been.

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An interview conducted on 11/17/2017 at 6:44 PM with Nurse #2 revealed she worked the 11:00 PM to 7:00 AM shift on the night Resident #139 was admitted to the facility. She stated the 3:00 PM to 11:00 PM nurse entered all of Resident #139's admission orders into the computer. Nurse #2 stated when a new resident was admitted on Warfarin the standing orders should be entered into the computer for INR checks every other day for a week then 1 time a week for 4 weeks and then once a month. She stated the nurse that enters the admission orders should enter the standing order for INR checks if they are on Warfarin. She stated INR standing order should have been entered for Resident #139 for every other day INR checks because he was admitted on Warfarin. She further stated she had administered Resident #139's Warfarin but had never checked his INR.

An interview conducted on 11/17/17 at 7:00 PM with Nurse #3 revealed she admitted Resident #139 on 10/18/17 and put his orders in the computer. She stated she put his order for Warfarin 10 mg in the computer but she did not put the standing order for every other day INR checks in the computer. She stated she should have put the order for INR checks with the Warfarin order but overlooked it. She further stated she had administered Resident #139's Warfarin but had never checked his INR.

A follow up interview conducted on 11/18/17 at 9:17 AM with the facility Physician revealed an INR value of 7.8 was a critical lab value and had the INR checks been done it could have been avoided.

An interview conducted on 11/18/17 at 11:32 AM

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with the Director of Nursing (DON) revealed it was the nurse admitting the resident responsibility to enter the standing orders for INR checks to be done if the resident was on Warfarin. He stated the Risk Round Team that consisted of Administrative Nurses checked all new admission orders every morning and he did not know how the order was missed to check Resident #139's INR. He stated the INR should have been checked every other day for 1 week then once a week for 4 weeks then once a month.

An interview conducted with the Administrator on 11/19/17 at 7:30 AM revealed it was her expectation for the admitting nurse to put in the standing order for INR checks for residents admitted on Warfarin. She stated she did not know how the order was missed during Risk Round Checks. She further stated the INR should have been checked every other day for a week then once a week for 4 weeks then once a month.

The Administrator, DON, and the Regional Director of Clinical Services were informed of Immediate Jeopardy on 11/19/17 at 1:11 PM.

On 11/19/17 at 4:56 PM, the facility provided the following Credible Allegation of Compliance:

F329 Unnecessary Medication Use

The Plan of Correcting the specific deficiency

Resident # 139 was admitted to this facility on 10/18/17. Resident was on Warfarin upon admission. Licensed Nurse #3 failed to follow the policy for transcribing standing orders related to the monitoring of INRs, and the risk rounds failed

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to identify the missed transcription of the standing INR orders. As a result, facility failed to monitor Resident #139's INR on four occasions including; 10/21/17, 10/23/17, 10/25/17 and 10/27/17. Resident #139 was hospitalized on 10/27/17 and found to have an elevated INR level of 7.8.

The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited. All resident that receive Warfarin have the potential to be affected.

"An audit was completed on 11/17/17 by Director of Nursing of current residents currently receiving Warfarin to validate INR orders entered in Point Click Care (PCC) and on the PT/INR/Coumadin (Warfarin) flowsheet. No negative findings related to monitoring.

"An audit was completed on 11/19/17 by licensed nurse of residents. Admitted from 10/18/17 - 11/19/17 to validate INR orders entered in Point Click Care (PCC) and on the PT/INR/Coumadin (Warfarin) flowsheet. No negative findings related to monitoring.

"On 11/17/17 management staff began re-educating nurses on the policy and procedure as it relates to transcription of orders including ordering of lab for INR monitoring. Re-education is complete as of 11/19/17.

"Education with Nurse # 3 was completed on 11/17/17.

"To prevent this from recurring the admitting nurse will enter the order into PCC and transcribe onto the PT/INR/Coumadin (Warfarin) flowsheet.

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"The transcription of the order and placement on the flowsheet will then be validated by a second nurse on the same shift.

"To complete validation of accuracy, the administrative nurses will review the transcription of Warfarin orders in PCC and placement of INRs on a flowsheet and on the PCC treatment administration record (TAR) as part of weekday morning risk meeting.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

"Nursing management will complete an audit of residents with orders for Warfarin 3 x weekly to validate transcription of INR standing orders into PCC TAR and to the flowsheet. Any identified discrepancies will be corrected immediately and the prescribing physician will be notified.

"In addition nursing management will audit 3x weekly results of INRs to validate notification of Physician of abnormal INRs results.

The title of the person responsible for implementing the acceptable plan of correction is the Director of Nursing and Administrator.

Date of Alleged Compliance is: 11/19/17

Immediate Jeopardy was removed on 11/19/17 at 5:38 PM when interviews with Nurses confirmed they had received in-service training on how to follow standing orders for INR checks for residents on Warfarin.

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F 353	Continued From page 138	F 353		
F 353 SS=J	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 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 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.	F 353		12/22/17

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F 353	Continued From page 139 (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 observations, record reviews, resident interviews, family interviews, and staff interviews, the facility failed to provide sufficient staffing to care for 8 of 14 sampled residents (Residents #27, #28, #46, #66, #71, #79, #123, and #174). The facility failed to assign nurse aides in the number to prevent abuse, provide residents with incontinence care, toileting, and showers, provide training to agency staff so they were aware of their responsibilities for personal care and tray set up, and make assignments so nurse aides were aware of the individual residents and care needed for residents relating to toileting and showers. Immediate Jeopardy began on 10/23/17 when a nurse aide threw a meal tray into the hallway, due to staffing frustrations and an object from that meal tray hit Resident #71 as she was propelling her wheelchair nearby. The nurse aide was permitted to continue working with residents during the meal. Immediate Jeopardy for tags F223 and F226 was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. This tag was left out of compliance at a lower	F 353	F353 During the annual survey process it was identified the facility did not provide sufficient nursing staff to prevent abuse,provide incontinence care, toileting,showers and did not provide training to agency staff so they were aware of their responsibilities for personel care and tray set-up. The facility has a new staffing initiative to recruit additional staffing. During the Department Managers morning meeting staffing will be reviewed to ensure sufficient nursing staff is scheduled. The designated 300 hall charge nurse and/or Manager on Duty will contact the RN on call if there is an issue with sufficient staffing on the weekends. Adjustment of resources will be made as needed and department heads/nursing management/ancillary staff will be assigned duties that they are able to perform if needed. The facility will call in staff and/or utilize agency staffing if needed in order to	

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F 353	Continued From page 140 scope and severity of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) due to example #3, and examples #4, #5, and #6 are at the scope and severity level D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy). The findings included: 1.Cross Refer to F223: Based on record review, resident interview, and staff interviews, the facility failed to provide an environment that maintained 1 of 3 residents' right to be free from abuse (Resident #71). 2.Cross Refer to F226: Based on record review, and staff interviews, the facility failed to implement their abuse policy and procedures related to the prevention, protection and investigation for 1 of 3 residents (Resident #71 who were reviewed for abuse investigations. The Administrator and Regional Clinical Nurse were informed of Immediate Jeopardy on 11/16/17 at 6:18 PM. The facility provided an acceptable credible allegation of immediate jeopardy removal on 11/19/17 at 11:57 AM as follows: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. The areas of concern identified on 10/23/17 Nurse aide (NA)#2 was not removed from her duties by Nurse #1 when she became upset and	F 353	maintain consistent sufficient staffing. To monitor and maintain ongoing compliance the department managers will complete interviews with 3 residents 3x week, 3 residents weekly x4 weeks, and then 3 residents monthly x1 month to ensure there are no issues related to care and staffing. Any negative findings will be addressed immediately to the administrator. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement meeting for 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 353	Continued From page 141	F 353		

threw objects including a computer mouse and a resident's meal tray. This resulted in Resident #71 being hit with object and NA#2 was allowed to continue working before calling the Director of Nursing. When identifying the root cause of the outburst by the NA, she stated it occurred due to being frustrated related to inadequate staffing.

Administrator implemented a staffing initiative on 10/24/17 related to sufficient nursing services and sufficient staff with the following elements:

Human Resource Manager Evaluate Current nursing and nurse aide Vacancies nurse aides and licensed nurses and Update log weekly 10/24/17
a. Since 10/24/17 we have received 16 NA applications and hired 15 of those applicants.
b. Since 10/24/17 we have received 7 nurse applications and hired 5 of those applicants.

Administrator and Director of Nursing evaluated staffing and identified overstaffing on day shift, adequate staffing on night shift and understaffing on evening shift. Staffing was adjusted by implementing a master schedule to even out the staffing on days and evenings 10/24/2017.

Administrator improved recruiting online on numerous web sites on 10/26/2017 which has increased the number of applicants and new hires. Evaluated weekly by Human Resources Manager.

Administrator secured 2 Agency contracts which will be utilized to cover current staffing vacancies 10/26/2017.

Administrator initiated Sign On Bonus/referral

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F 353	Continued From page 142 bonus $650.00/$500.00-10/26/2017. Administrator implemented shift bonus for nurses and nursing assistants for those picking up extra shifts on 08/28/17. Administrator initiated a new Aide College program-10/26/2017- This is a contract with the local community college to sponsor a nursing assistant student who is attending their program or who to desires to attend the program. Facility is paying for tuition, books, and certification test in return for 6 months employment. Administrator and regional support staff attend daily staffing call to discuss needs and ongoing recruitment effort Administrator implemented Wage/Salary review and increase 11/10/2017. Administrator placed signs throughout community advertising for NAs on 11/10/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On 11/13/17 the Administrator educated the department managers on the Manager On Duty (MOD) policy and Department head duties. The MOD will be implemented 11/19/2017. This process is new to the facility and provides for management/administrative coverage on weekends both scheduled and at random based on the needs of the center, to include management rounds and addressing concerns or allegations of abuse which will be handled immediately by the MOD who will notify the Administrator and the Director of Nursing. The Nurse assigned to 300 hall is the designated nurse in charge in the absence of the	F 353		

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F 353	Continued From page 143 Administrator immediately of any staffing concerns. All residents have the potential to be affected. Residents were interviewed on 11/17/17 by facility department managers regarding care related to staffing. No new negative findings were identified. To prevent this from recurring the Administrator and Director of Nursing were educated by the Regional Vice President of Operations regarding Sufficient Staffing and ongoing staffing plan. The facility will continue with the staffing initiative indicated above and will continue to have a daily staffing meeting to assure sufficient nursing staffing is available during morning meeting to meet the resident's needs. Adjustment of resources will be made as needed and department heads/nursing management/ancillary staff will be assigned duties that they are able to perform if needed. The facility will call in available staff if needed and utilize agency staffing if needed. Resident council minutes will be reviewed monthly by the Administrator to identify any issues related to care and staffing. Resident concern forms will be reviewed daily to ensure any issues related to care and staffing are investigated and resolved by the Administrator and the Director of Nursing. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in	F 353		

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F 353	Continued From page 144 compliance with the regulatory requirements. To monitor and maintain ongoing compliance the department managers will complete interviews on 3 residents 3 x week x 4 weeks, weekly x 4 then monthly x 1 to ensure there are no issues related to care and staffing. Any negative findings will be addressed immediately to the administrator. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement meeting for further review and recommendations. The Administrator will conduct an Ad HOC Quality Assurance Performance Improvement meeting on 11/17/17 with the facility Interdisciplinary team, the Regional Team and the Medical Director to review. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is 11/19/17 Immediate Jeopardy was removed on 11/19/17 when observations and interviews with staff confirmed the facility had made adjustments in the master schedule to assure that staffing on all shifts was evenly distributed and staff were given actual assignments for covering resident care. Confirmation was obtained that the facility engages contracts for agency coverage for nurse aide vacancies and that the bonus incentive was implemented. The facility supervisory staff also confirmed the hiring of several new employees and their schedule for orientation. Supervisory staff interviews confirmed they had been	F 353		

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inserviced on the new Manager On Duty assignment and the expectation of obtaining appropriate nursing staff coverage during their oversight.

3. Cross refer to F312:
Based on observations, record reviews, and interviews the facility failed to provide incontinent care (Resident #27, #28, and #79) and assistance with tray set up (Resident #123) for 4 of 11 sampled residents reviewed for activities of daily living.

4. Cross Refer to F224:
Based on observations, record reviews and staff interviews, the facility failed to provide incontinence care when needed to 3 of 12 sampled residents (Residents #27, #28, and 79).

5. Cross Refer to F241:
Based on observations, record reviews and staff interviews, the facility failed to provide incontinence care to 3 of 12 sampled residents resulting in 2 residents (Resident #27 and #28) eating while wet with urine and 1 resident's (Resident #79) request for incontinence care forgotten by staff.

6. Cross Refer to F242:
Based on record reviews and resident and staff interviews, the facility failed to provide residents' with their preferred number of showers a week for 3 of 5 resident reviewed for choices (Resident #46, #66, and #174).

The staffing interview was deferred to the Assistant Director of Nursing (ADON)/Acting DON by the Administrator and was conducted on 11/17/17 at 5:38 PM. The Acting DON stated

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F 353	Continued From page 146 staffing was becoming an issue at the end of the summer when staff were leaving due to salary and a proposal was made to corporate for a salary adjustment which did not happen until this month. The Acting DON explained when the previous DON came at the end of September 2017 she started a track schedule and a "blue dot" system for covering the assignment and absences which the nurse aides (NAs) did not like either. As a result more NAs resigned. The interview further revealed the goal was to have 10 NAs on the 7:00 AM to 3:00 PM (day) shift and the 3:00 PM to 11:00 PM shift (evening) and 6 to 7 NAs on the 11:00 PM to 7:00 PM (night) shift which had become difficult to cover beginning in September 2017 especially for the evening and night shifts. The Acting DON noted the facility covered the schedule by asking staff to come in early or stay over, trade shifts, offering bonuses for extra shifts, and having a nurse take an NA assignment. The Acting DON added he had stayed more times than he could count when there was not adequate coverage or call outs. Currently, the facility had 17 NA positions to be filled and had a contract with two agencies for NAs. He indicated the facility had 3 NAs starting orientation the following week.	F 353		
F 356 SS=B	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 356		12/22/17

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F 356	Continued From page 147 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		

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F 356	Continued From page 148 This REQUIREMENT is not met as evidenced by: Based on review of daily nurse staffing data and a staff interview the facility failed to maintain 18 months of daily nurse staffing data. The findings included: On 11/18/17 at 3:00 PM the Assistant Director of Nursing (ADON)/Acting DON provided the survey team with copies of the daily nurse staffing data and stated this was all he was able to locate. Review of the provided copies of the daily nurse staffing data revealed the documents were dated 01/09/17 through 11/17/17. On 11/19/17 at 8:21 AM the Acting DON stated they had looked in the previous DON's office and were not able to locate any of the daily nurse staffing data prior to 01/09/17.	F 356	F356 During the annual survey ending 11/19/17, it was discovered that the facility did not have 18 months of daily posted staffing data. The Director of Nursing has been reeducated by the Administrator to ensure the appropriate storage and retention of the daily posted staffing data. The data will now be stored in a binder and will be maintained for at least 18 months. The Director of Nursing will audit the binder 2x a week for 4 weeks and monthly for 2 months to ensure the plan is in place. The results of the audit will be forwarded to the facility Quality Assurance Performance Improvement committee for 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	
F 367 SS=D	THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN CFR(s): 483.60(e)(1)(2) (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician.	F 367		12/22/17

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F 367	Continued From page 149 (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide the physician ordered diets for 2 of 3 sampled residents on therapeutic diets. Resident #123's pureed diet was not followed and Resident #27's thickened liquid diet was not followed. The findings included: 1. Resident #123 was readmitted to the facility on 08/05/16. Her diagnoses included dysphagia, Parkinson's Disease and dementia. The quarterly Minimum Data Set (MDS) dated 10/25/17 coded her with severely impaired cognition, having no behaviors, requiring extensive assistance with all activities of daily living skills including eating and receiving a mechanically altered diet. Quarterly dietary notes dated 10/25/17 noted she was on a mechanical soft diet and nectar liquids. Nursing notes dated 11/01/17 at 12:56 PM stated that Resident #123 was noted choking multiple times on the mechanical soft diet and a physician's order changed the diet to pureed consistency. A physician's order dated 11/1/17 noted she was on a pureed texture diet.	F 367	F367 It was identified during the survey process that Residents #123 and #27 were served diets not consistent with physician orders.Dietary staff and Housekeeping supervisor did not follow the residents diet orders for pureed diet or thickened liquids. All diet orders have been verified for accuracy and tray cards match the M.D. order. There is also a updated list posted in the main dining room every morning for staff to verify diets. The dietary manager is also monitoring for correct diets being served. Resident #123 was assessed by Speech Therapist on 11/16/17 and diet was changed to mechanical soft, nectar thick. Resident #123 no longer resides in facility. Resident #27 diet was confirmed as thickened liquid. A list of all resident's diets and consistency is available in dining room for reference for staff prior to providing drink or food to residents. 100% review of diet orders was completed by the Regional Dietician on 11/16/17 to verify current diet orders in Point Click Care match dietary tray cards. Any identified discrepancies were corrected immediately. The Dietary Manager and dietary staff were in-serviced by Regional Dietician 11/16/17 regarding accuracy of tray card	

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Resident #123 was observed in the dining room on 11/15/17 at 8:38 AM served the breakfast meal of scramble eggs, oatmeal, and cheerios with thickened milk. The tray card that accompanied the meal included the need for pureed consistency and cheerios. At 9:06 AM as Nurse Aide (NA) #13 tried to feed her she was noted coughing on pureed foods. The cheerios were never offered.

Resident #123 again was served a pureed breakfast meal on 11/16/17 at 9:00 AM which contained a bowl of cheerios with thickened milk. Resident #123 began to feed herself the pureed foods.

The Speech Therapist was interviewed on 11/16/17 at 9:08 AM. She stated that she worked with Resident #123 before she transferred to being a hospice resident. At the time she worked with her Resident #123 was on a mechanical soft diet. She further stated that cheerios were not permitted for residents on a pureed diet.

On 11/16/17 at 9:12 AM the Dietary Manger was interviewed and stated that cold cereal should have thickened milk on it for pureed diets. She then stated that cheerios would be ok on a pureed diet if approved by the speech therapist.

Interview with NA #13 on 9:36 AM revealed she was agency staff and received no training when she arrived. She stated that she was unaware that cheerios should not be on a pureed diet and noted it was on the tray card.

The corporate Registered Dietician (RD) was interviewed on 11/16/17 at 12:44 PM. The RD

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to match dietary orders in Point Click Care. The facility staff who assist in delivery of meals were in-serviced by Dietary Manager and Director of Nursing or designee on 11/15/17 through 12/8/2017 regarding the use of tray card and diet list to verify diet and consistency prior to serving residents food or drink.Newly hired staff after 12-08-2017 will be educated on the above process.
Dietary Manager will complete audit 6 residents weekly x 3 months comparing diet orders,tray card accuracy, correct diet being served and availability of diet list in dining room for accuracy.
The results of audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations.
The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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	345165	A. BUILDING ______ B. WING ______	C 11/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARION	1264 AIRPORT ROAD MARION, NC 28752

(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 367	Continued From page 151	F 367		

stated that cheerios were not to be on a pureed diet tray as the physician ordered for Resident #123.

2. Resident #27 was admitted to the facility on 10/31/15 and most recently on 10/15/17. His diagnoses included dysphagia, adult failure to thrive and dementia.

The significant change Minimum Data Set dated 10/22/17 coded him with severely impaired cognition, eating with set up only, and receiving a mechanically altered diet.

Physician orders dated 10/31/17 noted he was to receive nectar consistency fluids.

The nutrition Care Area Assessment dated 11/03/17 stated he received a no added salt regular ground diet with nectar thick liquids.

On 11/15/17 at 8:00 AM, Resident #27 wheeled himself into the dining room for breakfast. The staff member present in the dining room was the Housekeeping supervisor. At 8:04 AM, the housekeeping supervisor provided Resident #27 a regular cup of coffee which he drank from. She stated that she sometimes helped in the dining room by opening it up if the residents were lined up in the hall waiting to enter and offer the residents drinks. She stated that a nurse aide was usually in the dining room with her. When asked how she knew the residents' diets she stated she would ask dietary or a nurse aide if she had questions about a resident's diet. She stated she did not know who was on thickened liquids and would have to ask dietary staff. She further stated that she was unaware Resident #27 needed thickened liquids.

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F 367	Continued From page 152 The Speech Therapist stated during interview on 11/16/17 at 9:09 AM that Resident #27 should be served nectar thick coffee.	F 367		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard 34 cartons of out of date whole milk and 32 cartons of out of date nutritional supplement shakes in the kitchen.	F 371	F371 It was identified that the facility had out of date cartons of milk and nutritional shakes which were disposed on 11/13/2017.	12/22/17

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F 371	Continued From page 153 The findings included: Observations made during the initial tour of the kitchen on 11/13/17 at 8:36 AM revealed the following: *25 cartons of single serve whole milk in the walk in cooler with an expiration date of 11/12/17. *9 cartons of single serve whole milk on the serving line, in ice, ready to be placed on resident breakfast trays, with an expiration date of 11/12/17. *23 nutritional supplement shakes with a handwritten date of 11/10/17 and 9 shakes with smeared illegible handwritten dates in the walk in cooler. An interview conducted on 11/13/17 at 8:40 AM with the Dietary Manager (DM) revealed the milk man had delivered milk earlier that morning and it was his job to take back all of the outdated milk. She stated the staff on the serving line should have caught the out of date milk and taken it off the serving line. The DM further stated the nutritional supplement shakes are dated for 14 days after being taken out of the freezer and placed into the walk in cooler to thaw. She stated the shakes should only be kept 14 days after being taken out of the freezer per manufacturer recommendation and the shakes dated 11/10/17 should have been discarded on 11/10/17 because that was the 14th day after being thawed. She further stated the 9 nutritional supplement shakes with smeared dates should have been discarded because there was no way of knowing what the date was that they were taken out of the freezer.	F 371	The Dietary Manger and the Regional Dietician reviewed all food items in the kitchen to identify any expired items on 11/14/17. No other items were identified. Dietary staff were in-serviced by the Dietary Manger and Regional Dietician on 11/16/17 and 11/17/17 regarding expiration dates of food items.Newly hired staff after 11-17-2017 will be educated on the above process. An audit of expiration dates for food items will be completed by the Dietary Manager 3 x per week for one month and then weekly for 2 months. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 371	Continued From page 154 An interview conducted on 11/19/17 at 8:00 AM with the Administrator revealed it was her expectation for the kitchen staff to make sure all food items were in date and served within that date.	F 371		
F 372 SS=E	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep 1 of 2 dumpsters from overflowing and covered. The findings included: An observation was made of the dumpster on 11/13/17 at 9:05 AM revealed bags of trash hanging over the side of the dumpster and the dumpster was uncovered. An interview conducted on 11/13/17 at 9:06 AM with the Dietary Manager revealed the Maintenance Director left the lid open on the dumpster from Friday to Monday due to overflow and to prevent staff from putting the bags on the ground. She stated the trash service picked up the garbage Monday through Friday but did not come on Saturday or Sunday. An interview conducted on 11/15/17 at 11:51 AM with the Maintenance Director revealed if he didn't leave the dumpster uncovered over the weekend staff would throw the trash bags on the ground and he would have a mess to clean up on Monday mornings. He stated the trash service	F 372	F372 It is the practice of this facility to dispose of garbage and refuse properly. The Maintenance Director and Dietary Manager have cleaned the area around the dumpster and the dumpster lid is closed as of 12/7/17. Dietary and Maintenance staff were educated by Regional Dietician on 11/16/17 and 11/17/17 on proper waste disposal including use of dumpster and keeping lid closed. An audit proper disposal of waste and dumpster closure will be completed by the Dietary Manager, Maintenance Director or Manager on weekend duty 2 x a week for one month and then weekly for 2 months. The results of the audits will be forwarded to the facility monthly Quality Assurance Performance Improvement committee x 3 months for further review and recommendations. The title of the person responsible for the implementing the acceptable plan of correction is the Administrator .	12/22/17

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F 372	Continued From page 155 they use does not run on Saturday and Sunday and there wasn't room for another dumpster. An interview conducted with the Administrator on 11/19/17 at 7:40 AM revealed it was unacceptable to leave the dumpster uncovered over the weekend and they would have to add another dumpster.	F 372		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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.	F 431		12/22/17

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F 431	Continued From page 156 (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 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 observations, record review, staff interviews, and manufacturer specifications, the facility failed to remove 20 capsules of expired Tamsulosin from 1 of 6 medication carts. Findings included: Manufacturer specifications for Tamsulosin per the package insert included, "Store at room temperature away from light and moisture. Do not store in the bathroom. Properly discard this product when it is expired or no longer needed."	F 431	F431 It was identified during the survey process that the facility did not remove a card containing 20 capsules of expired tamsulosin from a medication cart due to a process for checking medication carts was not in place.The expired medication was removed immediately and carts checked for any additional expired medications which none were found.There is a new system implemented for checking medication carts for expired medications.	

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F 431	Continued From page 157 During an observation on 11/15/17 at 3:35 PM, one medication card with 20 capsules of Tamsulosin 0.4 milligram (mg) with an expiration date of 05/29/17 was found in medication cart #1 at 200 Hall. During an interview on 11/15/17 at 3:40 PM, Nurse #7 stated if a medication was discontinued, it would be pulled and returned to the pharmacy by the nurse who received the order. The nurses were to check their respective medication carts for expired medication each shift and to check for expiration prior to medication administration. She attributed the incident to human error. During an interview on 11/15/17 at 3:55 PM, the Assistant Director of Nursing (ADON) who was also the Unit Manager stated the third shift nurses were expected to check their entire medication cart and medication storage rooms each night for expired medication. However, the facility did not document the nightly medication audit. He expected all the medication carts and storage rooms to be free of expired medication. During an interview on 11/17/17 at 4:07 PM, the Assistant Director of Nursing (ADON)/Acting DON stated the facility had a system in place to check for expired medications. Other than requiring the nurses to check for expiration before administration, the facility had scheduled the third shift nurses to check their respective medication carts and storage room every night. In addition, the consultant pharmacist had visited the facility for expired medication audit at least once quarterly or as needed. As the ADON, he had conducted random medication audit at least once weekly. At any time when a medication was discontinued, it was his expectation for the nurse	F 431	Medication carts and medication rooms were audited for expired medications by the Regional Nurse on 12-05-2017 and no other medications were found to be out of date. Licensed nurses were in-serviced regarding storage and labeling of medications by Administrator/Director of Nursing completed on 12-08-2017. Newly hired nurses 12-08-2017 forward will be educated on the above process. Medications carts will be audited for expired medications weekly x 2 weeks then monthly x 3 months by Director of Nursing/ designee. The audits will be reveiwed by the Quality Assurance Performance Improvement Committee monthly for 3 months for further review and recommendations. The person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 431	Continued From page 158 who received the order to pull the medication from the cart and return it to the pharmacy in a timely manner to ensure the facility was free of expired medication.	F 431		
F 490 SS=J	EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING CFR(s): 483.70 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 observations, record reviews and staff and resident interviews, the administration failed to operationalize a safe environment free from abuse for 1 of 3 sampled residents (Resident #71) and ensure resident needs were met for 8 of 14 sampled residents (Residents #27, #28, #46, #66, #71, #79, #123, and #174). Immediate jeopardy began on 10/23/17 when Resident #71 was struck by a flying object from a meal tray thrown by a nurse aide. Nurse #1 permitted the nurse aide to continue to pass trays on that unit due to short staffing. Immediate Jeopardy was removed on 11/19/17 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy Removal. The facility remains out of compliance at a scope and severity level of E (Pattern no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems put into place are effective and sufficient to meet the care	F 490	F490 During the annual survey process it was identified the facility did not provide sufficient nursing staff to prevent abuse,provide incontinence care, toileting,showers and did not provide training to agency staff so they were aware of their responsibilities for personel care and tray set-up.During annual survey ending 11/19/2017, it was identified that the facility did not follow the facility abuse policy and procedure resulting in an unsafe environment for resident #71. Reeducation was completed for current staff on 11/17/17 concerning facility abuse policy and procedures and the new Manager on Duty process. Reeducation was performed by the Administrator, the Regional Vice President of Operations, the Director of Nursing, and the regional	12/22/17

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Continued From page 159

needs of the residents.

The findings included:

1. Cross Refer to F223:
Based on record review, resident interview, and staff interviews, the facility failed to provide an environment that maintained 1 of 3 residents' right to be free from abuse (Resident #71).

2. Cross Refer to F226:
Based on record review, and staff interviews, the facility failed to implement their abuse policy and procedures related to the prevention, protection and investigation for 1 of 3 residents who were reviewed for abuse investigations (Resident #71).

3. Cross Refer to F353:
Based on observations, record reviews, resident interviews, family interviews, and staff interviews, the facility failed to provide sufficient staffing to care for 8 of 14 sampled residents (Residents #27, #28, #46, #66, #71, #79, #123, and #174).

The Administrator and Regional Clinical Nurse were informed of Immediate Jeopardy on 11/16/17 at 6:18 PM.

The facility provided an acceptable credible allegation of immediate jeopardy removal on 11/19/17 at 11:57 AM as follows:

The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency cited.

The areas of concern identified on 10/23/17 Nurse aide (NA) #2 was not removed from her duties by Nurse #1 when she became upset and

F 490

Director of Clinical Services.

The Administrative Department Managers will complete abuse policy and procedure questionnaires with 3 staff members 3x a week x 4 weeks, then monthly for 2 months. Any negative findings will be addressed immediately by the administrator or Director of Nursing.
The Administrator or designee will complete resident questionnaires with 3 residents 3x a weekx 4 wees, then monthly x2 months related to care and services. Any negative findings will be addressed immediately by the Administrator or Director of Nursing
The facility will have a Manager on Duty every Saturday and Sunday from 11am to 3pm. The 300 hall charge nurse is the designated nurse in charge in the absence of the Admnininistrator, Director of Nursing, Or the Manager on Duty. The Manager on Duty or the designated nurse in charge will report any negative findings to the Administrator immediately. General information gathered will be shared with the Administrator in the next manager morning meeting.

Results of the questionnaires will be forwarded to the facility Quality Assurance Performance Improvement committee for 3 months for further review and recommendations.

The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

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threw objects including a computer mouse and a resident's meal tray. This resulted in Resident #71 being hit with object and NA #2 was allowed to continue working before calling the Director of Nursing.

An investigation was conducted by the Administrator and Director of Nursing and Facility Reportable Incident submitted on 10/23/17 and 5 Day on 10/27/17.

The (Name of City Law Enforcement) were notified of the incident on 10/23/17 and no charges filed on 10/23/17, the resident was assessed for injury by licensed nurse and had no negative outcome

On 11/16/17 the facility started another investigation related to incident of 10/23/17 for resident #71 occurrence due to additional findings, during state survey interviews. This was conducted by the Administrator of (Name of Nursing Facility). It was identified that NA #2 was not immediately suspended and returned to care while Director of Nursing was being notified by the Nurse on duty.

On 11/16/17 the Nurse #1 and NA #2 from 10/23/17 occurrence were suspended pending investigation.

NA #2 and Nurse 1 was terminated and removed from payroll system on 11/17/17

11/16/17 statements obtained for those staff in original investigation

The procedure for implementing the acceptable plan of correction for the deficiency cited.

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All residents in the facility have the potential to be affected. Interviewable residents were interviewed on 11/17/17 by Department Managers regarding care issues and staffing. No new negative findings were noted. Residents who are non-interviewable had complete body checks completed by licensed nurses on 11/17/17. No new care concerns identified. When identifying the root cause of the outburst by the Nurse Aide #1 (NA). The NA#1 stated it occurred due to being frustrated related to staffing.

To prevent this from recurring the Administrator and Regional Clinical Services Director started immediate in-house education on 11/16/17 related to F223 Abuse and F226 development and implementation of policy and procedures (screening/training/prevention/ identification/ investigation/protection and reporting response.

11/16/17 the Administrator re-educated department heads on abuse and policy and procedures. Department heads completed education for staff on duty and the education will continue through 11/17/17. This education was performed to ensure staff was properly trained on abuse and aware that abuse would not be tolerated at the facility.

Education will continue via telephone and staff will not be permitted to work until education is received.

New hires will be educated on the abuse policy and procedure upon hire.

The Regional Vice President of Operation re-educated the Licensed Nursing Home

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Administrator on abuse, policy and procedures and conducting a proper/thorough investigation on 11/17/17.

Administrator implemented a staffing initiative on 10/24/17 to ensure sufficient nursing services and sufficient staff in order to use resources efficiently and effectively.

Administrator implemented a staffing initiative on 10/24/17 related to sufficient nursing services and sufficient staff with the following elements:
Human Resource Manager to evaluate current nursing and nurse aide vacancies and Update log weekly 10/24/17
Since 10/24/17 we have received 16 NA applications and hired 15 of those applicants.
Since 10/24/17 we have received 7 nurse applications and hired 5 of those applicants.

Administrator and Director of Nursing evaluated staffing and identified overstaffing on day shift, adequate staffing on night shift and understaffing on evening shift. Staffing was adjusted by implementing a master schedule to even out the staffing on days and evenings 10/24/2017.

Administrator improved recruiting online on various web site on 10/26/2017 which has increased the number of applicants and new hires. Evaluated weekly by Human Resources Manager.
- Administrator secured 2 Agency contracts to assist with staffing 10/26/2017
- Administrator implemented Wage/Salary review and increase 11/10/2017 for nurses and nurse aides
- Administrator initiated Sign On Bonus/referral bonus $650.00/$500.00 for nursing and nurse

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aide positions 10/26/2017
- Administrator implemented shift bonus for nurses and nursing assistants for those picking up extra shifts on 8/28/17.
- Administrator initiated a new Aide College program-10/26/2017- This is a contract with the local community college to sponsor a nursing assistant student who is attending their program or who to desires to attend the program. Facility is paying for tuition, books, and certification test in return for 6 months employment.
- Administrator and regional support staff on daily staffing call to discuss needs and ongoing recruitment efforts 10/24/17
- Administrator placed signs throughout community advertising for NAs on 11/10/2017.

On 11/13/17 the Administrator educated the department managers on the Manager On Duty (MOD) policy and Department head duties. This process is new to the facility and provides for management/administrative coverage on weekends both scheduled and at random based on the needs of the center, to include management rounds and addressing concerns or allegations of abuse which will be handled immediately the MOD who will notify the Administrator and the Director of Nursing. The Nurse assigned to 300 hall is the designated nurse in charge in the absence of the Administrator immediately of any allegations of abuse or concerns.

To prevent this from recurring the Administrator was educated by the Regional Vice President of operations regarding F490 Administration as it relates to the regulation and abuse policy and procedure including reporting and investigation on 11/17/17.

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	345165	A. BUILDING ______ B. WING ______	C 11/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARION	1264 AIRPORT ROAD MARION, NC 28752

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F 490	Continued From page 164	F 490		

The Administrator will continue with the staffing initiative indicated above and will have a daily staffing meeting to assure resources are used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Adjustment of resources will be made as needed and department heads/nursing management/ancillary staff will be assigned duties that they are able to perform if needed.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.

The facility will call in available staff if needed and utilize agency staffing if needed to monitor and maintain ongoing compliance:

The facility Administrative/Department Managers will start abuse questionnaires with all staff on 11/17/17 related to abuse and policy and procedures (7 elements). The audits will be completed on 3 staff, 3 x weekly. Any negative findings will be addressed immediately.

The facility will conduct an Ad HOC QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting on 11/17/17 with the facility IDT team, the Regional Team and the Medical Director to review.

To monitor and maintain ongoing compliance the Department Managers will complete interviews on 3 residents 3 x weekly to ensure there are no issues related to care and staffing. Any negative

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F 490	Continued From page 165 findings will be addressed immediately. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 11/19/17 Immediate jeopardy was removed on 11/19/17 when interviews with direct and supervisory staff confirmed they had been inserviced and knew the facility's abuse policy and procedures including that suspected staff had to be removed from resident care immediately, witnesses had to be interviewed, and documentation had to be included in the nursing notes including event information, assessment information and notification information. The staff knew signs of burnout and what to do if they were feeling burned out or observed other coworkers with signs of burnout. In addition, observations and interviews with staff confirmed the facility had made adjustments in the master schedule to assure that staffing on all shifts was evenly distributed and staff were given actual assignments for covering resident care. Confirmation was obtained that the facility engages contracts for agency coverage for nurse aide vacancies and that the bonus incentive was implemented. The facility supervisory staff also confirmed the hiring of several new employees and their schedule for orientation. Supervisory staff interviews confirmed they had been inserviced on the new Manager On Duty assignment and the expectation of obtaining appropriate nursing staff coverage during their oversight.	F 490		
F 514	RES	F 514		12/22/17

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F 514 SS=D	Continued From page 166 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 514	It was identified during the survey	

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F 514	Continued From page 167 facility failed to maintain a complete and accurate clinical record which included documentation of an abuse event, notifications of the physician and responsible party, and the resident's assessment for injury. This affected 1 of 3 residents reviewed for abuse (Resident #71). The findings included: Resident #71 was admitted to the facility on 06/30/14. Her diagnoses included aphasia following a cerebral infarction, muscle weakness and hemiplegia and hemiparesis. Resident #71's annual Minimum Data Set (MDS) dated 07/12/17 coded her with moderately impaired cognition and requiring extensive assistance with most activities of daily living skills. Review of a 24 hour initial report sent to the Health Care Personnel Investigations on 10/23/17 at 7:44 PM, revealed that a staff member reported that on 10/23/17 at 5:30 PM, Nurse Aide (NA) #2, tossed a meal tray across the hall and that the witness said Resident #71 was wet with water. Review of the investigation revealed written statements were obtained by the nurse on duty (Nurse #1), the Nurse Aide (NA) #1 who witnessed the incident, and NA #2 who was alleged to throw the tray. A written statement from Nurse #1 dated 10/23/17 stated at 5:30 PM she heard a loud noise from the main dining room. The sound came from the day room on the 100 hall. Nurse #1 wrote she went down the hall and Resident #71's shirt and pants were wet. Resident #71	F 514	process the facility did not document in resident#71 chart concerning an abuse event, notification of M.D. and responsibile party and the residents assessment for injury. A late entry has been added to the electronic chart on 12/15/2017 for patient #71 related to the abuse event on 10/23/17 to reflect resident assessments, MD and family notification and summary of event by current Director of Nursing. The Administrator and Director of Nursing have reviewed the abuse event over the past 30 days and the Facility Reportable Incident data to validate complete and accurate documentation is present in the medical record by 12/15/2017. Administrator and/or Director of Nursing or designee have in-service Department Heads and Nursing staff on complete and accurate documentation in the Medical Record of any abuse event including resident assessment, MD and family notification and details of events in-service was completed for current staff on 12-08-2017 and all newly hired staff 12-08-2017 forward will be educated on the above information. The Departments Heads will review abuse event in morning Department Head meeting to ensure complete and accurate documentation is completed. The Director of Nursing will maintain a log of abuse event to include completion of required documentation in the medical record (resident assessment, MD and family notification and details of events)ongoing.	

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F 514	Continued From page 168	F 514		

stated a plate hit her knee and she was wet. Resident #71's skin was checked and found no bruising or redness. The statement continued that the nurse informed the Director of Nursing at 5:37 PM.

Nurse #1 was interviewed via phone on 11/16/17 at 10:04 AM. Nurse #1 stated that she heard a noise and started to head up the hall. Nurse #1 saw the tray and food all over the floor and Resident #71's shirt was 'soaked'. Resident #71 stated her knee hurt a little but she was alright. Nurse #1 helped NA #1 pick up the mess and tried to obtain information about what happened. Nurse #1 called the administrator and DON and was instructed to take statements, not write up an incident report or make nursing notes but to complete the 24 hour form and fax it to the Health Care Personnel Investigations unit and send NA #2 home. During a follow up phone interview on 11/16/17 at 3:57 PM, Nurse #1 stated she asked about writing an incident report or note and was told by both the Director of Nursing and Administrator that they would let her know if she had to do any additional documentation following the Health Care Personnel Investigations report.

During interview on 11/16/17 at 2:41 PM, the Administrator stated there should have been a written nursing note that included a description of the incident, the assessment of the resident and notification of the physician and family.

Phone call to the responsible party on 11/17/17 at 8:51 AM confirmed he had been notified of the incident.

Phone call to the physician on 11/18/17 at 9:10 AM confirmed he was notified of the incident and

To monitor and maintain ongoing compliance the Administrator will audit the incident log weekly x4 weeks and then monthly x2 monthly to ensure complete and accurate documentation is in the medical record as it relates to an abuse event (resident assessment, MD and family notification and details of events). Results of the audits will be forwarded to the facility Quality Assurance Performance Improvement committee monthly x3 for further review and recommendations. The title of the person responsible for implanting the acceptable plan of correction is the Administrator.

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F 514	Continued From page 169 was in the facility at the time of the incident. Review of the resident's medical records revealed no documentation about the incident that happened on 10/23/17 or if the physician or the responsible party were notified or if there was an assessment for injury completed on the resident.	F 514		