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	345282	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		4/12/18

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

Electronically Signed | 04/04/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to maintain the dignity of a resident by providing incontinence care for a resident (Resident #7) reviewed for dignity and respect. The findings included: Resident #7 was admitted to the facility on 08/08/13 with diagnoses which included Parkinson's disease, degenerative joint disease, panic disorder, anxiety and others. Review of Resident #7's comprehensive MDS dated 09/13/17 revealed the resident had adequate vision with glasses, understood, understands, and an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #7 required extensive assistance of one with dressing, toileting and personal hygiene and was frequently incontinent of bowel and bladder. Review of Resident #7's CAA summary for ADL dated 09/27/17 revealed she required extensive assistance of 2 with bed mobility, extensive assistance of one with dressing, toileting and personal hygiene. Review of Resident #7's care plan dated 03/15/18 revealed she was care planned for ADL. The goal was for the resident to maintain current ability to assist in daily care through the next review. Interventions included extensive assistance of one for dressing, toileting and	F 550	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F550 SS=D The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: During the complaint survey ending 3/15/18, a surveyor interviewed Resident #7 and determined that nurse aides failed to perform a basic nurse aide skill of providing timely incontinence care. Resident #7 was interviewed by the Director of Nursing to ensure concerns were addressed. All nursing staff were provided education regarding delegation of assigned duties. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Facility Educator provided inservices to nursing staff and nursing assistants on the	

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F 550	Continued From page 2 personal hygiene and others. An interview was conducted with Resident #7 on 03/15/18 at 10:26 AM. Resident #7 stated she did not feel like there was enough staff at the facility to take care of her. She stated she had accidents waiting for the staff to put her on the bedpan or help her to the bathroom and it happened frequently. She stated when she had an accident she felt "humiliated" because she could not get the bedpan in time to prevent an accident. She stated when she rang for assistance they would often come in and turn the light off and then say they would be back but it would sometimes be an hour before they came back and by then it was too late she had already had an accident. She stated she knew she waited an hour because she timed it by her watch. Resident #7 stated she had seen her NA one time today and that was when she came in to get her up in her chair. Resident #7 stated the nurses and NAs were much more respectful when she came to the facility about 5 years ago but now not so much and stated maybe it was because they were so busy now. An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. NA #12 stated that Resident #7 had wet her brief and had bowel movement before when waiting for assistance to the bathroom or waiting for the bedpan. NA #12 stated they had been told if a	F 550	expectation to provide timely incontinence care. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. 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: To evaluate compliance with residents receiving timely incontinence care, Director of Nursing or designee will conduct resident interviews weekly, with 10% of the interviewable residents, for 4 weeks. At the conclusion of 4 weeks, will conduct resident interviews bi-weekly for six weeks, with 10% of the interviewable residents. Any identified issues will be addressed through the progressive discipline process. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be responsible for oversight for this plan of correction. Date certain 4/12/18.	

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F 550	Continued From page 3 resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7 when she called for assistance at the change of shift. An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. Nurse #5 stated Resident #7 was able and did call for assistance with toileting and had accidents and would not be surprised if it was because the NAs were not able to get to her in time with the bedpan or going to the bathroom. She stated the staff did the best they could in caring for the residents. An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive incontinence care frequently and as needed and for residents to be treated with dignity and respect.	F 550		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive	F 676		4/12/18

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F 676	Continued From page 4 assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide	F 676	F676 SS=E	

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F 676	Continued From page 5 showers for one resident (Resident #5), personal hygiene for one resident (Resident #7), turning and positioning for one resident (Resident #6), timely incontinence care for four residents (Residents #4, #6, #7, and #8) and assistance with bathing for one resident (Resident #9) reviewed for activities of daily living (ADL). The findings included: 1. Resident #5 was admitted to the facility on 10/16/2017 with diagnoses which included diabetes mellitus, type2, depression, fibromyalgia, anxiety disorder and others. Review of Resident #5's comprehensive admission Minimum Data Set (MDS) dated 10/23/17 revealed an assessment by the facility of moderately impaired cognition for daily decision making. The MDS also revealed Resident #5 required limited to extensive assistance with most ADL and required extensive assistance of one with bathing. Review of Resident #5's Care Area Assessment (CAA) summary for ADL dated 10/27/17 revealed she was admitted to the facility following a hospitalization for weakness and sudden dizziness. She was alert and able to verbalize needs but remained weak. Resident #5 currently required extensive assistance from staff with bed mobility, toileting and bathing but limited assistance with transfers and dressing. Resident #5 benefited from staff assistance with ADL care due to her chronic medical problems and weakness. Review of Resident #5's care plan dated 02/09/18 revealed she was care planned for ADL. The	F 676	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: During the complaint survey ending 3/15/18, surveyors interviewed Resident #5, #7, #6, #4, #8, and #9 and determined that nurse aides failed to perform resident□s Activities of Daily Living (ADLs). Those ADLs included the following: assisting with showers; assisting with personal hygiene; assisting with turning and positioning; provide timely incontinence care; assistance with bathing. Resident #7, #5, #6, #4, # 8 and #9 were interviewed by the Director of Nursing to ensure concerns were addressed. All nursing staff were provided education regarding delegation of assigned duties. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Facility Educator provided inservices to nursing staff and nursing assistants on the expectation to assist with showers, bathing, personal hygiene, turning and positioning, and provide timely incontinence care. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift.	

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F 676	Continued From page 6 goal was for the resident to maintain her current ability to assist in daily care through the next review date. The interventions included extensive assistance for bathing and others. An interview was conducted with Resident #5 on 03/15/18 at 10:13 AM. Resident #5 stated she had started washing herself off in the mornings because the staff had not had time to assist her with getting a shower. The resident stated it felt really good to get a shower but the staff don't have time to help her get one. She stated she had never refused a shower. Review of a bath report for 03/01/18 through 03/15/18 revealed Resident #5 had missed her shower on 03/08/18 and she had not refused her shower. An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time. An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always	F 676	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; To evaluate compliance with residents receiving assistance with showers, bathing, personal hygiene, turning and positioning and timely incontinence care, Director of Nursing or designee will conduct resident interviews weekly, with 10% of the interviewable residents, for 4 weeks. At the conclusion of 4 weeks, will conduct resident interviews bi-weekly for six weeks, with 10% of the interviewable residents. Any identified issues will be addressed through the progressive discipline process. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be responsible for oversight for this plan of correction. Date certain 4/12/18.	

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F 676	Continued From page 7	F 676		

call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/815/18 at 3:32 PM revealed they expected residents to receive their showers as scheduled.

2. Resident #7 was admitted to the facility on 08/08/2013 with diagnoses which included Parkinson's disease, degenerative joint disease, anxiety and others.

Review of Resident #7's most recent comprehensive MDS dated 09/13/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #7 required extensive assistance of one for personal hygiene.

Review of Resident #7's CAA summary for ADL dated 09/27/17 revealed she required extensive assistance with dressing, toileting and personal hygiene.

Review of Resident #7's care plan dated 12/20/17 revealed she was care planned for ADL. The goal was for the resident to maintain her current ability to assist in daily care through the next review date. The interventions included extensive assistance with personal hygiene and others.

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An interview was conducted with Resident #7 on 03/15/18 at 10:35 AM. Resident #7 stated she was just now getting up for the day. She stated the NA had been in to help her get dressed and hurried through dressing her and got her up in the chair and left. Resident #7 stated the NA did not comb her hair when she got her up, and stated they never comb her hair and it is difficult for her to do due to her Parkinson's and degenerative joint disease.

An interview with NA #9 on 03/15/18 at 2:34 PM revealed she was taking care of Resident #7 and she had gotten her up for the day in her wheelchair. NA #9 stated she had not combed Resident #7's hair and stated she just had forgotten to do it while she was in the room.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected

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F 676	Continued From page 9	F 676		

residents to receive assistance with their personal hygiene.

3. Resident #6 was admitted to the facility on 04/07/17 with diagnoses which included cervical disc disease with neurologic compromise to lower extremity, urinary retention, muscle weakness, chronic pain and others.

Review of Resident #6's comprehensive MDS dated 04/14/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #6 required extensive assistance of two with bed mobility.

Review of Resident #6's CAA summary for ADL dated 04/20/17 revealed she required extensive assistance of 2 with bed mobility, dressing, toileting and personal hygiene.

Review of Resident #6's care plan dated 12/25/17 revealed she was care planned for ADL. The goal was for the resident to be out of bed at least 3 times weekly and for ADL needs to be met daily through the next review. Interventions included extensive assistance of 2 for bed mobility, toileting needs, personal hygiene and dressing and others.

An interview was conducted with Resident #6 on 03/15/18 at 10:26 AM. Resident #6 stated no one came in to turn her unless they came in to change her brief and she stated she got very stiff during the day from not moving. Resident #6 stated she usually gets up out of the bed for about 2 hours a day except the weekends. She stated there was not enough help at the facility on the weekends to get her up out of bed and by

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F 676	Continued From page 10	F 676		

Monday she was very stiff from not getting up out of bed.

An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to be turned and positioned timely and

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to be gotten up out of bed daily.

4. Resident #4 was admitted to the facility on 11/15/17 with diagnoses which included congestive heart failure, arthritis, history of falls and others.

Review of Resident #4's comprehensive admission MDS dated 11/22/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #4 required extensive assistance of 2 with toileting and was always incontinent of bowel and bladder.

Review of Resident #4's CAA summary for ADL dated 11/27/17 revealed she required extensive assistance of 2 with toileting and most ADL except eating.

Review of Resident #4's care plan dated 11/30/17 revealed she was care planned for ADL and for urinary incontinence. The goal was for the resident to maintain current ability to assist in daily care through the next review. Interventions included extensive assistance for toileting and others.

An interview was conducted with Resident #4 on 03/14/17 at 4:02 PM. Resident #4 stated there was not enough staff at the facility to take care of her. She stated she has to wait on them to get changed and it is sometimes uncomfortable when she has had a bowel movement. She stated she has had to eat her meal before with a dirty brief on because there was not enough staff to change her and work in the dining room and feed residents on the hall.

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An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive incontinence care timely and as needed.

5. Resident #6 was admitted to the facility on

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04/07/17 with diagnoses which included cervical disc disease with neurologic compromise to lower extremity, urinary retention, muscle weakness, chronic pain and others.

Review of Resident #6's comprehensive MDS dated 04/14/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #6 required extensive assistance of one with toileting and was always incontinent of bowel and bladder.

Review of Resident #6's CAA summary for ADL dated 04/20/17 revealed she required extensive assistance of 2 with dressing, toileting and personal hygiene.

Review of Resident #6's care plan dated 12/25/17 revealed she was care planned for ADL. The goal was for the resident to be out of bed at least 3 times weekly and for ADL needs to be met daily through the next review. Interventions included extensive assistance of 2 for bed mobility, toileting needs, personal hygiene and dressing and others.

An interview was conducted with Resident #6 on 03/15/18 at 10:26 AM. Resident #6 stated she did not feel like there was enough staff at the facility to take care of her. She stated she had to wait over 30 minutes and longer sometimes to get changed when she had a bowel movement in her brief. Resident #6 stated it was uncomfortable to sit in a brief with stool in it and stated she had sometimes had to eat her meals while having stool in her brief because they could not provide care until all the trays were passed out. She stated she knew how long she waited because she timed it with her watch.

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An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive incontinence care timely and as needed.

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6. Resident #7 was admitted to the facility on 08/08/13 with diagnoses which included Parkinson's disease, degenerative joint disease, panic disorder, anxiety and others.

Review of Resident #7's comprehensive MDS dated 09/13/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #7 required extensive assistance of one with dressing, toileting and personal hygiene and was frequently incontinent of bowel and bladder.

Review of Resident #7's CAA summary for ADL dated 09/27/17 revealed she required extensive assistance of 2 with bed mobility, extensive assistance of one with dressing, toileting and personal hygiene.

Review of Resident #7's care plan dated 03/15/18 revealed she was care planned for ADL. The goal was for the resident to maintain current ability to assist in daily care through the next review. Interventions included extensive assistance of one for dressing, toileting and personal hygiene and others.

An interview was conducted with Resident #7 on 03/15/18 at 10:26 AM. Resident #7 stated she did not feel like there was enough staff at the facility to take care of her. She stated she had accidents waiting for the staff to put her on the bedpan or help her to the bathroom and it happened frequently. She stated when she had an accident she felt "humiliated" because she could not get the bedpan in time to prevent an accident. She stated when she rang for assistance they would often come in and turn the light off and then say they would be back but it

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would sometimes be an hour before they came back and by then it was too late she had already had an accident. She stated she knew she waited an hour because she timed it by her watch. Resident #7 stated she had seen her NA one time today and that was when she came in to get her up in her chair. She stated she quickly got her dressed and put her in her chair and did not comb her hair. Resident #7 stated the nurses and NAs were much more respectful when she came to the facility about 5 years ago but now not so much and stated maybe it was because they were so busy now.

An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to

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do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive incontinence care timely and as needed.

7. Resident #8 was admitted to the facility on 06/19/17 with diagnoses which included diabetes mellitus, type 2, scoliosis, obstructive sleep apnea, paraplegia and others.

Review of Resident #8's comprehensive MDS dated 08/31/17 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed Resident #8 required extensive assistance of one with dressing, toileting and personal hygiene and was always incontinent of bowel and bladder.

Review of Resident #8's CAA summary for ADL dated 09/14/17 revealed she required extensive assistance of one with dressing, toileting and personal hygiene.

Review of Resident #8's care plan dated 03/04/18 revealed she was care planned for ADL. The goal was for Resident #8 to maintain current ability to assist in daily care through the next review. Interventions included frequently offer assistance with toileting needs, extensive assistance with dressing and personal hygiene and total assistance with toileting and bathing and

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others.

An interview was conducted with Resident #8 on 03/15/18 at 11:27 AM. Resident #8 stated the facility needed more NAs. She stated she limited her calls because she knew they were busy and it still took 30 minutes or longer for her to get her brief changed. Resident #8 stated she only called for water and to be changed and it still took a while to get assistance. She stated she timed it by the clock on the wall. Resident #8 stated "once in a blue moon the nurse would change her" but not as a rule.

An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to

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do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive incontinence care timely and as needed.

8. Resident #9 was admitted to the facility on 02/23/18 with diagnoses which included hypertension, right tibia fracture and left pubic ramus fracture and others.

Review of Resident #9's comprehensive MDS dated 03/02/18 revealed an assessment by the facility of intact cognition for daily decision making. The MDS also revealed she required extensive assistance of one with toileting, supervision of one with bed mobility and personal hygiene and limited assistance of one with transfers and was always continent of bowel and bladder.
Review of Resident #9's CAA summary for ADL dated 03/14/18 revealed she required extensive assistance of one with toileting due to her functional limitations resulting from her fractures.

Review of Resident #9's interim care plan dated 02/23/18 revealed she was care planned for bladder and bowel continence with the goal of continence level will be optimal as evidenced by maintained to improved bowel/urinary function and will have bowel movements every 3 days. The interventions included monitor bowel

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elimination status and bowel management protocol as needed and monitor for decline in continence status and others.

An interview was conducted with Resident #9 on 03/15/18 at 1:31 PM. Resident #9 stated she was at the facility for rehab following a car accident and surgery on her right leg. She stated during the day the facility seemed to be staffed ok but night shift was "terrible." She stated she and her roommate waited sometimes for an hour or longer for assistance to the bathroom. She stated that she had timed it by the clock on the wall. Resident #9 stated it was even worse on the weekends and this past weekend (03/10/18 and 03/11/18) and the previous weekend (03/03/18 and 03/04/18) she felt they were neglected. Resident #9 stated it was 9:30 AM before they received their breakfast trays on Saturday 03/10/18 and had not seen anyone in the room prior to them bringing in their tray. Resident #9 stated she did not receive help with getting washed up and on Saturday it was 11:15 AM or so before she and her roommate got water in their basins to wash up. She stated the occupational therapist got their water for them in their basins so they could wash up and get ready for therapy. On Sunday, 03/11/18 Resident #9 stated it was hours after they had eaten before trays were picked up and no one passed ice water on Sunday so they had no fresh ice water all day. She stated she could hear lights going off out in the hallway and saw nurses pass by and not answer the lights and stated she overheard two of the NAs say "they can wait" when lights were beeping in the hallway. Resident #9 stated she had to request her female urinal be emptied and rinsed before she could use it again and stated the NAs do not flush the toilet after her

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roommate uses it and she has to flush it almost every time she goes to use it. Resident #9 stated she would be nervous if something happened to her, especially on the weekend because there just was not enough staff at the facility to care for the residents.

An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically worked first shift. NA #12 stated when they worked short it was impossible to give all the showers, complete incontinence rounds every 2 hours, get everyone fed and turned and get residents that require two assists up for the day. She stated they were not allowed to have overtime and had to clock out on time. The NA stated they had been told if a resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time.

An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift and sometimes medication pass could take up to 3 or 3 ½ hours. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always call-ins especially with the NAs and it happened 3-4 times weekly. The nurse stated it was hard for them to help the NAs because they had so much of their own work to do. The nurse stated she was aware all showers and personal hygiene were not done, residents were not turned every 2 hours and incontinence care was not provided every 2 hours. She stated the staff did the best they could in caring for the residents.

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F 676	Continued From page 22 An interview with the assistant Director of Nursing (ADON) and Director of Nursing (DON) on 03/15/18 at 3:32 PM revealed they expected residents to receive assistance with bathing as needed.	F 676		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(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. §483.35(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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 725	F725	4/12/18

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F 725	Continued From page 23 and staff interviews, the facility failed to provide sufficient nursing staff resulting in missed shower (Resident #5), personal hygiene not being done (Resident #7), turning and positioning not being done (Resident #6) and incontinence care not being provided (Residents #4, #6, #7 and #8) and assistance with bathing not being provided (Resident #9) for residents reviewed. The findings included: 1. Cross refer to tag F0676. Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers for one resident (Resident #5), personal hygiene for one resident (Resident #7), turning and positioning for one resident (Resident #6), incontinence care for four residents (Residents #4, 6, 7, and 8) and assistance with bathing for one resident (Residents #9) reviewed for activities of daily living (ADL). 2. Cross refer to tag F0550. Based on observations, record review, resident and staff interviews the facility failed to maintain the dignity of a resident by providing timely incontinence care for a resident (Resident #7) reviewed for dignity and respect. Interview with NA #1 on 03/14/18 at 6:30 AM revealed she had worked at the facility for some time and enjoyed taking care of the residents. She stated there was not enough time in the shift to get all the work done. NA #1 stated the every 2 hour rounds could not ever be done and they were lucky to get 2 rounds done. She stated they had not been able to get early risers up and especially the ones that took 2 to get them up because there was not enough staff. She stated	F 725	SS=E The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: During the complaint survey ending 3/15/18, surveyors interviewed Resident #5, #7, #6, #4, #8, and #9 and determined that nurse aides failed to perform resident□s Activities of Daily Living (ADLs). Those ADLs included the following: assisting with showers; assisting with personal hygiene; assisting with turning and positioning; provide timely incontinence care; assistance with bathing. Resident #7, #5, #6, #4, # 8 and #9 were interviewed by the Director of Nursing to ensure concerns were addressed. All nursing staff were provided education regarding delegation of assigned duties. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: At the facility, a Hiring/Job Fair is scheduled on 4/10/18 with assistance from Human Resources and Continuing Care Senior Leadership. In addition, there are recruitments efforts amongst local community colleges for nurses and nursing assistants. The facility will be offering staff incentives for individual filling in gaps, as new staff are onboarded. The facility also engaged with the Carolinas	

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F 725	Continued From page 24 the showers were not done and had to be passed on to 1st shift to do. NA #1 stated in addition to the patient care they had to put up stock, and change everyone's water pitchers. An interview with Nurse #1 on 03/14/18 at 6:47 AM revealed she had worked at the facility for a short time and had been asked to come in early and had been asked to work over when someone had called in. The nurse stated staffing was based on census and fluctuated based on resident numbers. She stated the nurses are usually able to get their work done but they really did not have time to help the NAs because of all they had to do for the residents. Nurse #1 stated the nurses sometimes have to clock out and stay over to get their work done when it is hectic and sometimes on weekends. Nurse #1 stated there were several open NA positions and some nurse positions and stated they did not have enough help currently to take care of the residents. Interview with NA #2 on 03/14/18 at 7:00 AM revealed she had worked at the facility for some time and stated they had worked short for some time. She stated they could not get baths and showers done and had to give residents a quick wash off. NA #2 stated they had to get the stock put up at night and were usually only able to do 2 rounds for incontinence care and that really was not often enough for some residents. Interview with NA #3 on 03/14/18 at 7:12 AM revealed she had worked at the facility for a short time and stated they commonly work short on night shift. She stated she is rarely able to get all her showers done and was only able to get 2 out of 3 done last night and doesn't ever have time to do all 3. She stated the weekend staffing for the	F 725	HealthCare System resource team to provide immediate support for open positions when available. Human Resources has reduced the turnaround process from hire date to start date. This was accomplished by increasing new employee orientations to weekly. In addition, a weekly recruitment call will be conducted with Human Resources and Continuing Care Senior Leadership. In an effort to promote teamwork and pride in the workplace, on 4/13/18 an Employee Appreciation Day has been scheduled. In addition, on 4/18/18 and 4/20/18, Employee Forum sessions are scheduled to provide opportunities for staff to be informed about staffing efforts and to gain their ideas about initiatives to promote teamwork and pride in the workplace. 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: To evaluate compliance with residents receiving assistance with showers, bathing, personal hygiene, turning and positioning and timely incontinence care, Director of Nursing or designee will conduct resident interviews weekly, with 10% of the interviewable residents, for 4 weeks. At the conclusion of 4 weeks, will conduct resident interviews bi-weekly for	

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	345282	A. BUILDING _____ B. WING _____	C 03/15/2018

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F 725	Continued From page 25 past 2 weekends had been bad. NA #3 stated they worked short almost every night and there did not seem to be a back-up plan for when NAs call in to work. Interview with Nurse #2 on 03/14/18 at 7:24 AM revealed she had worked at the facility for a short time and typically worked 3rd shift but worked some on 2nd shift and 12 hour shifts on the weekends. She stated she was able to get her work done when she worked night shift but during the day and evening shift it was hard to get everything done with physician orders and admissions and discharges. Nurse #2 stated they used to have supervisors that would help with admissions and orders but their positions had been eliminated. She stated they usually try to have a weekend supervisor but lately she has had to work a cart and that leaves no one extra to help out on the halls. On weekends it is hard to get all your work done and sometimes treatments are not done because we don't have time and we can't have overtime. It is hard when there is only one NA on each side because if the nurse is busy it is hard for them to help the NA and care does not get done. Interview with Nurse #3 on 03/14/18 at 7:38 AM revealed she had worked at the facility for a while and typically worked night shift. She stated she was able to get her work done but barely. She stated that staffing was not done by resident acuity and that night shift got one nurse per hall and one NA on each hall and that was it. Nurse #3 stated there were open NA and nurse positions and there was not enough staff at the facility to care for the residents. Interview with Nurse #4 on 03/14/18 at 8:00 AM	F 725	six weeks, with 10% of the interviewable residents. Any identified issues will be addressed through the progressive discipline process. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. The title of the person responsible for implementing the acceptable plan of correction. The Administrator will be responsible for oversight for this plan of correction. Date certain 4/12/18.	

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revealed she had worked at the facility for a while and stated she was usually able to get all her work done on her shift. She stated the current staffing pattern for night shift was 4 nurses and 4 NAs but should be 6 NAs. She stated they had worked short for some time and it makes it hard for them to get everything done when there is only 4 of them. She stated they are not able to get showers done and early risers are not always gotten up because most of them require 2 assists and there is just not enough help to get them up.

Interview with NA #4 on 03/14/18 at 11:53 AM revealed she had worked at the facility for some time and stated she typically worked 1st shift. NA #4 stated they had worked short for some time and when they did they were not able to get all the showers done, turn and position residents every 2 hours or provide incontinence care every 2 hours. She stated they were lucky to get 2 incontinence rounds done on everybody when they worked short. NA #4 stated there were several NA positions open but they had not hired anyone in a while. She stated she had been asked to stay over to help the next shift and come in early due to call-ins. NA #4 stated if the floor was short they would pull the Restorative Aid (RA) to work on the hall and then restorative services were not provided. She stated the RA had been pulled a lot lately to work the floor.

Interview with NA #5 on 03/14/18 at 12:13 PM revealed she had worked at the facility for a long time and typically works 1st shift. NA #5 stated she had been asked to come in early and work over due to call-ins. She stated she had been coming in early 4-5 days a week. NA #5 stated they were not able to get everybody up in the morning to go to the dining room so some of the

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residents had to eat their breakfast in their room. She stated if they are short they pull the RA and put her on the hall with an assignment and then restorative was not done that day for the residents.

Interview with NA #6 on 03/14/18 revealed she had worked at the facility for a short time and typically work 1st shift. She stated she was not always able to get all the work assigned done and do not get all the showers done and are not able to do every 2 hour incontinence rounds. NA #6 said it was hard to get everything done plus trays on the hall at meal time and helping in the dining room.

Interview with NA #7 on 03/14/18 at 4:18 PM revealed she had worked at the facility for a short time and typically worked 2nd shift. NA #7 stated they could not get all the showers done especially if they were showers requiring 2 assists because there was not enough help. She stated they had to give residents bed baths instead of showers. NA #7 stated she had been called to work extra shifts, stay over and come in early. She stated the nurses do not help with the lights and they are constantly going off on 2nd shift. NA #7 stated the RA is often pulled to the floor to take an assignment because of call-ins and then the residents do not get restorative services and stated this happened frequently and especially on the weekend.

Interview with NA #8 on 03/14/18 at 4:49 PM revealed she had worked at the facility for some time and typically worked 2nd shift. She stated they were almost always short staffed on the weekends. She stated they were not always able to get all the resident showers done, residents

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turned and incontinence care done every 2 hours as was expected of them.

An interview with NA #10 on 03/15/18 at 2:44 PM revealed he had worked at the facility for a short time and had worked the weekend of 03/03/18 and 03/04/18. NA #10 stated it was a lot busier and more hectic that weekend and there were no showers given on 1st shift, weights were not done and trays on the floor were late getting to the residents.

An interview with NA #11 on 03/15/18 at 2:53 PM revealed she had worked at the facility for a short time and typically worked 1st shift. She stated she had worked the weekend of 03/03/18 and 03/04/18 and had not given any showers that day. She stated she only did 1 incontinence round because she had so many residents to take care of and stated a few may have been checked twice but most only once during the shift. NA #11 stated trays were late getting to residents on the fall because there were so many residents to feed. She stated there were a lot of family there that complained about the care that weekend.

An interview with NA #13 on 03/15/18 at 3:05 PM revealed she had worked at the facility for a short time and typically worked 2nd shift. She stated she had worked the weekend of 03/03/18 and 03/04/18 and had not been able to do any showers that day. NA #13 stated she had done 2 rounds for incontinence care on most of the residents but had not done any weights. She stated there were so many residents to feed that day they had to be rushed to feed everyone and when they were done it was late in the evening and time to get the residents ready for bed.

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An interview with NA #14 on 03/15/18 at 3:17 PM revealed she had worked at the facility for some time and had worked the weekend of 03/03/18 and 03/04/18. She stated she only had time to give one shower that day and was able to only get 2 incontinence rounds done on the residents. She stated there were several residents on the floor that had to be fed and there were no weights done that weekend. She stated that a resident had fallen on Saturday during 2nd shift while the NAs were taking residents to the dining room.

An interview with NA #15 on 03/15/18 at 3:24 PM revealed he had worked at the facility for a short time and typically worked 2nd shift. He stated he had worked the weekend of 03/03/18 and 03/04/18 and it was hectic that weekend and especially Saturday. He stated he had two showers on Saturday and was able to get them done and was able to get 2 rounds done for incontinence care. He stated he was able to get his residents fed and while taking some of the residents to the dining room another resident had fallen. He stated they had to watch this resident because she constantly tried to get up and was not able to ambulate on her own.

An interview on 03/15/18 at 3:58 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed they had a staffing assistant who was responsible for doing the schedule and printing it out. The ADON stated the staffing assistant was familiar with the staffing grid and takes into account the number of NAs on each shift based on the census. The ADON stated if there were call-ins she assisted the staffing assistant with calling staff that were not scheduled to get replacement for staff that have called in. The DON stated they staffed

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according to census and acuity and staffing fluctuates with census. The DON stated they have nurses that are on-call for call-ins but do not have NAs on call. The ADON and DON stated that no one had complained to them about their workload or the number of residents they have been assigned to take care of. The DON stated the weekend of 03/03/18 and 03/04/18 was the "perfect storm." She stated they had a staff member die, one went out on FMLA with gallstones, one was already on FMLA, one was just returning from FMLA and not familiar with the residents and there were 2 call-ins. The DON stated they had not had a high rate of turnover but she nor the ADON knew what their turnover rate was. The DON stated they completed exit interviews when they could but have not done any lately. She stated the day supervisor is constantly doing rounds and out on the hall and if they notice a NA always over her scheduled time they try to make adjustments to the assignments. The ADON and DON stated they had open positions for nurses and NAs but neither knew how many open positions they had. The ADON and DON stated they had not heard any complaints from staff regarding their workloads. The DON stated it was her expectation that residents receive their showers as scheduled, assistance with personal hygiene as needed, turned and positioned every 2 hours, incontinence care every 2 hours and as needed and assistance with bathing as needed.