STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 02/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 000	INITIAL COMMENTS The survey team entered the facility on 1/2/19 to conduct a complaint survey and exited on 1/4/19. Per CMS and management review of the 2567, additional information was obtained on 1/30/19, 1/31/19, 2/1/19, and 2/4/19. The Statement of Deficiencies was amended on 2/13/19. Tag F 607 and F609 were ammended. Tag F 602 was added. The exit date was changed to 2/4/19. .	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		2/1/19

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

Electronically Signed | 01/28/2019

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F 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to effectively resolve Resident Council (RC) grievances for 3 (September, October and November 2018) of 3 months reviewed for RC grievances. The facility also failed to respond to RC grievances within 5 working days for 2 (September, and November 2018) of 3 months reviewed for RC grievances. The findings included Review of the facility's policy dated revised May 2017 titled Grievances/Complaints, Filing read in part that upon receipt of a grievance, the Grievance Officer will review and investigate the allegations and submit a written report of the findings to the Administrator within five (5) working days of receiving the grievances. The resident or person filing the grievance will be informed on the findings of the investigation within 5 working days of filing the grievance. Review of the September RC minutes dated 9/26/18 included a grievance dated 9/26/18 regarding call bells not being answered in a timely manner. The resolution was to increase the sound of the audible tone of the call bells. The grievance indicated written follow up was completed with the RC members on 9/28/18.	F 565	F 565 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Administrator presented a resolution to the Resident Council President on 1/25/19 for the grievance of answering call lights timely to include monitoring of call lights on each unit, each shift 3 times a week for 4 weeks, to assure call lights are answered timely. The resolution was accepted by the resident council committee on 1/25/19. The Social Service Director (SSD) provided a written letter of follow up to the Resident Council President on 1/25/19 to be shared during the next Resident Council meeting on 1/25/19. The Administrator presented a resolution to the Resident Council President on 1/25/19, for the grievance of cold food to include monitoring food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during meal pass in the	

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F 565	Continued From page 2 Review of the September RC minutes dated 9/26/18 included a grievance dated 9/26/18 regarding cold food in the dining room and on the hall. The resolution was staff education with written follow up was completed with the RC members on 10/23/18 (17 days). Review of the October RC minutes dated 10/24/18 included a grievance dated 10/24/18 regarding the nursing staff not passing the meal trays timely resulting in cold food. The resolution was an in-service completed on 10/25/18 to address the meals trays not being passed out timely. The grievance indicated follow up was completed with the RC members on 10/25/18. Review of the November RC minutes dated 11/28/18 included a grievance dated 11/28/18 regarding call bells not being answered in a timely manner. The resolution was a new camera system was installed. The grievance indicated follow up was completed with the RC members on 12/20/18 (16 days). In an interview and observation on 1/3/19 at 8:45 AM, Resident #21 confirmed she was the Resident Council President. She stated long call bell response time and unappetizing food had been a problem for a while and that the RC member completed a grievance on several occasions with little to no improvements. In an interview on 1/3/19 at 10:40 AM, the Social Worker stated she logged each grievance as to when it was received and forwarded the grievance to the department responsible for the investigation, resolution and written notice.	F 565	dining room and hallways, for breakfast, lunch and dinner 5 times a week, to assure food temperatures remain within acceptable temperature range of 125 degrees or resident preference. The resolution was accepted by the resident council committee. The SSD provided a written letter of follow up to the Resident Council President on 1/25/19, to be shared during the next resident council meeting on 1/251/9. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the same deficient practice of the facility failure to provide resolution and follow up to grievances voiced during resident council meetings. The Administrator and/or the SSD reviewed grievances received from the Resident Council group from September 2018 through December 2018, to validate that resolutions were initiated or obtained, and the resident council group was given a follow up letter regarding the resolution. There were no other grievances identified that were not investigated and followed up according to facility protocol. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator provided education on 1/23/19, for the Interdisciplinary Team (IDT), which consists of the Director of Nursing (DON), Assistant Director of	

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F 565	Continued From page 3 In an interview on 1/4/19 at 10:30 AM, the Administrator stated she reviewed each grievance after the completion of any grievance investigation and resolution to ensure the grievance was addressed and notice was provided within the specified 5 working day. She was unable to explain the root cause as to why the RC grievances were not effectively and timely addressed with resident notice of the resolution. The Administrator stated it was her expectation that the grievance policy and procedure be followed for any resident grievance. In an interview on 1/4/19 at 10:40 AM, the Dietary Manager (DM) was unable to provide any food temperature monitoring completed after 9/8/18 which indicated the food was served at the proper temperature. The provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she was unable to provide evidence of call bell monitoring for compliance after the RC grievance dated 9/26/18 until one audit completed on 10/13/18 on third shift, another audit completed 11/20/18 on first shift and on 12/10/18 also on first shift. The DON was also unable to provide any evidence of monitoring that the meals trays were being passed out timely after the 10/25/18 in-service.	F 565	Nursing (ADON), Social Service Director (SSD), Dietary Manager (DM), Activities Director (AD), Rehab Manager (RM) and Maintenance director (MD), regarding response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Activities Director will document grievances received during resident council meetings on the approved Grievance form and will forward the grievance form to the SSD to be logged onto the Resident Council Grievance log. The SSD will then forward the grievance form to the Administrator, who will give to the appropriate IDT member to investigate and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to review and approve, then the SSD will submit a follow up letter to the Resident Council president and/or group within 5 days of the receipt of the grievance. A copy of the follow up letter will be kept with the monthly resident council meeting minutes. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the Director of Nursing will review resident council grievance log 5 x a week for 4 weeks then weekly for 5 months, to validate that grievances received from the resident council group were investigated, a resolution was initiated/completed and a follow up letter was provided to the	

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F 565	Continued From page 4	F 565	resident council president and/or resident group within 5 days of receiving the grievance. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 1, 2019	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		2/5/19

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F 585	Continued From page 5 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 6 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to effectively resolve grievances regarding staff not providing showers for 2 (Resident #9 and	F 585	F 585 Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 585	Continued From page 7 Resident #13) of 4 residents reviewed for grievances. The facility failed to resolve a grievance regarding the facility not following the daily menus for 1 residents (Resident #6) of 4 residents reviewed for grievances. The facility also failed to respond within 5 working days of filing a grievance for 3 (Resident #9 and Resident #13 and Resident #6) of 4 residents reviewed for grievances. The findings included Review of the facility's policy dated revised May 2017 titled Grievances/Complaints, Filing read in part that upon receipt of a grievance, the Grievance Officer will review and investigate the allegations and submit a written report of the findings to the Administrator within five (5) working days of receiving the grievances. The resident or person filing the grievance will be informed on the findings of the investigation within 5 working days of filing the grievance. 1. Resident #9 was admitted on 7/6/08 with cumulative diagnoses of Cerebral Vascular Accident (CVA) with Hemiplegia. Resident #9's undated electronic Kardex read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Resident #9's care plan last revised 7/28/18 read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Review of the facility grievance log revealed a grievance dated 11/28/18 which read Resident #9 was not getting her showers. The grievance read notification was provided on 12/20/18 (16 days)	F 585	practice; The facility provided a shower for Resident #9 on 1/4/19, following survey exit, and has received showers every _Tuesdays and Friday, per residents shower schedule. The Director of Nursing (DON) discussed the shower schedule and resolution with Resident #9 on 1/4/19, as a resolution to the grievance documented 11/28/18, showers will be offered and given by the certified nursing assistant (CNA) on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the Medication administration record (MAR). The facility provided a shower for Resident #13 on 1/5/19, following survey exit, and has received showers every _Wednesday and Saturday, per residents shower schedule. The DON discussed the shower schedule and resolution with Resident #13 on 1/4/19, as a resolution to the grievance documented on 11/28/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. The Dietary Manager (DM) met with Resident #6 on 1/25/19, to discuss the residents food preferences and updated tray card on 1/25/19 to include Resident #6s likes/dislikes. DM informed Resident #6 that if she received a food item that she did not like or want, she could ask for an alternate. Resident #6 verbalized understanding and was	

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F 585	Continued From page 8 and resolution was that new shower sheets were created for documentation to include education was provided to nurses and aides. Resident #9's quarterly Minimum Data Set (MDS) dated 12/15/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for total staff assistance with bathing. Review of the documentation from 11/1/18 to 1/4/19 indicated Resident #9 only received one shower on 12/21/18. In an interview on 1/3/19 at 10:40 AM, the Social Worker stated she logged each grievance as to when it was received and forwarded the grievance to the department responsible for the investigation, resolution and written notice. In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time. She stated she completed a grievance but there had been no improvement in receiving her showers. Resident #9 appeared clean, absent of odors and dressed for season. In an interview on 1/4/19 at 10:30 AM, the Administrator stated she reviewed each grievance after the completion of any grievance investigation and resolution to ensure the grievance was addressed and notice was provided within the specified 5 working day. She was unable to explain the root cause as to why the Resident #9's grievance was not effectively addressed with timely follow up within 5 working days. The Administrator stated it was her expectation that the grievance policy and procedure be followed for any resident grievance.	F 585	pleased with the resolution to her grievance that was received on 10/4/18. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the same deficient practice of the facility failure to provide resolution and follow up to grievances. The Administrator and/or the SSD reviewed grievances received from October 1, 2018 through January 17, 2019, to validate that resolutions were initiated or obtained and the resident and/or resident representative was given a follow up letter regarding the resolution with in 5 days of receiving the grievance. There were (5) grievances documented in December that were investigated but a letter of follow up was sent later than the required 5 days. All other grievances were investigated and follow up letter sent within 5 days. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator provided education on 1/23/19, to the Interdisciplinary Team (IDT), which consists of the Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Service Director (SSD), Dietary Manager (DM), Activities Director (AD), Rehab Manager (RM) and Maintenance director (MD), regarding	

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F 585	Continued From page 9 In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she was unable to provide documentation of monitoring for compliance with Resident #9's shower schedule. She stated it was her expectation that grievances be effectively resolved with written follow up within 5 working days. 2. Resident #13 was admitted on 1/15/18 and readmitted 6/29/18 with cumulative diagnoses of CVA, Diabetes and Congestive Heart Failure (CHF). Resident #13's quarterly MDS dated 11/25/18 indicated moderate cognitive impairments with no behaviors. She was coded as requiring total staff assistance with bathing. Resident #13's undated electronic Kardex read she required staff assistance for showers every Wednesday and Saturday on second shift and as needed. Resident #13's care plan last revised on 11/27/18 read she required staff assistance with showers every Wednesday and Saturday on second shift and as needed. Review of the documentation from 11/1/18 to 1/4/19 indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/26/18. Review of the facility grievance log revealed a grievance dated 11/28/18 which read Resident #13 was not getting her showers. The grievance read notification was provided on 12/20/18 (16 days) and resolution was that new shower sheets	F 585	response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Administrator and/or the DON completed education on 1/25/19 for all nursing staff to include licensed nurses and certified nursing assistants, all shifts, all days including weekends and prn staff, regarding completion of grievance forms when a grievance is voiced and process for reporting the grievance to the supervisor. Nursing staff will be educated regarding the Grievance policy and process during new hire orientation. When staff members receive a grievance from a resident and/or resident representative, they will assist the resident and/or representative as needed to write the grievance on the grievance form and will forward the grievance form to the SSD to be logged onto Grievance log. The SSD will then forward the grievance form to the Administrator, who will give to the appropriate IDT member to investigate and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to review and approve, then the SSD will submit a follow up letter to the resident and/or resident representative within 5 days of the receipt of the grievance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the Director of Nursing will review the grievance log 5 x a week for 4 weeks then weekly for 2 months, to validate that grievances	

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F 585	Continued From page 10 were created for documentation to include education was provided to nurses and aides. In an interview on 1/3/19 at 10:40 AM, the Social Worker stated she logged each grievance as to when it was received and forwarded the grievance to the department responsible for the investigation, resolution and written notice. In an interview and observation on 1/3/19 at 4:50 PM, Resident #13 stated she had not been receiving her scheduled showers and she completed a grievance with little improvement in receiving her showers. Resident #13 appeared clean, absent of odors and dressed for season. In an interview on 1/4/19 at 10:30 AM, the Administrator stated she reviewed each grievance after the completion of any grievance investigation and resolution to ensure the grievance was addressed and notice was provided within the specified 5 working day. She was unable to explain the root cause as to why the Resident #13's grievance was not effectively addressed with timely follow up within 5 working days. The Administrator stated it was her expectation that the grievance policy and procedure be followed for any resident grievance. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she was unable to provide documentation of monitoring for compliance with Resident #13's shower schedule. She stated it was her expectation that grievances be effectively resolved with written follow up within 5 working days. 3. Resident #6 was admitted on 6/26/17 with cumulative diagnoses of Chronic Obstructive	F 585	received were investigated, a resolution was initiated/completed, and a follow up letter was provided to the resident and/or resident representative within 5 days of receiving the grievance. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 1, 2019	

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Pulmonary Disease and a Colostomy.

Resident #6's annual MDS dated 10/21/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for supervision with eating.

Review of the facility grievance log revealed a grievance dated 10/4/18 which read Resident #6 meal tray did not match what on the daily menu. The grievance read notification was provided on 10/23/18 (13 days) and resolution was that chef was to review the menus with the dietary staff.

Review of the facility grievance log revealed a grievance dated 10/12/18 which read Resident #6 meal tray did not match what on the daily menu. The grievance read notification was provided on 10/23/18 (8 days) and resolution was staff education.

In an interview on 1/2/19 at 11:20 AM, the Dietary Manager (DM) stated she was out on leave in September 2018 through 10/29/18 and while she was out, the Chef oversaw ordering the food. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave.

In an interview on 1/2/19 at 3:00 PM, Resident #6 stated the facility gave her a copy of the daily menu, but they did not follow it. She stated it was an ongoing problem that she had written grievances about with no improvement. Resident #6 stated completing a grievance did not result in any resolutions, so she stopped bothering to complete grievances. Resident #6 stated food

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F 585	Continued From page 12 was all she had to look forward to and with her Colostomy, there were certain food she could not eat. In an interview and observation on 1/3/19 at 8:30 AM, Resident #6 was in bed. She stated she did not feel well and was not bothering to eat her breakfast. Her breakfast tray included eggs, toast and grits. The tray ticket matched what was on her tray. In an interview on 1/3/19 at 10:40 AM, the Social Worker stated she logged each grievance as to when it was received and forwarded the grievance to the department responsible for the investigation, resolution and written notice. In an interview on 1/4/19 at 10:30 AM, the Administrator stated she reviewed each grievance after the completion of any grievance investigation and resolution to ensure the grievance was addressed and notice was provided within the specified 5 working day. She was unable to explain the root cause as to why the Resident #6's grievance was not effectively addressed with timely follow up within 5 working days. The Administrator stated the facility started a food committee back late summer if an effort to discuss the residents' concerns with the food. She stated they met monthly and was aware of voiced concerns related to the kitchen not following the menus. The Administrator stated there was a period last fall where the food was not being ordered correctly because the DM was out on leave. The Administrator stated it was her expectation that the grievance policy and procedure be followed for any resident grievance.	F 585		
F 602	Free from Misappropriation/Exploitation	F 602		2/5/19

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F 602 SS=D	Continued From page 13 CFR(s): 483.12 §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 medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and family interview for one (Resident # 4) of three sampled residents, the facility failed to address the relationship with Resident # 4 and a housekeeping aide concerning financial areas, car ownership and use of resident items with his permission. The findings included: Record review revealed Resident # 4, who was 86 years of age, was admitted to the facility on 4/20/18. One of the resident's diagnoses included a progressive neurodegenerative disorder which is known to affect brain activity. Record review revealed upon his 4/20/18 admission, the resident was responsible for himself. A family member was listed as an emergency contact. There was no power of attorney for Resident # 4 upon admission. Review of Resident # 4's admission minimum data set (MDS) assessment, dated 4/27/18, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 10. (A cognitively intact score is considered 13 to 15). The resident was also assessed to have signs of depression on the MDS.	F 602	F 602 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility completed a 24-hour report on 1/4/19, and 5-day investigation was completed on 1/9/19 for Resident #4, regarding resident exploitation and misappropriation of resident funds and personal belongings. This was a situation that occurred with Resident #4□s consent while he was competent with a BIMS score of 15. Employee #1 quit working at the facility on 7/25/18. The Police and APS were notified in September 2018, when the resident had failed to make payment to the facility. Resident #4 requested his son be notified and allegations against employee #1 were made. The police and APS worker informed the facility, following their investigations, that the resident was cognitively intact and made his own decisions during the time when the funds and the car were made available to	

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F 602	Continued From page 14 On 6/11/18 a MDS assessment was completed upon "change of therapy." The resident's BIMS score was assessed to be 15, which indicated he was cognitively intact. Record review revealed Resident # 4 was hospitalized from 8/22/18 to 8/28/18 secondary to renal failure. Hospital records included documentation the resident had delirium and memory disturbance upon his 8/22/18 hospital admission date. Record review revealed on a 10/21/18 quarterly MDS assessment, Resident # 4 was assessed to have a BIMS score of 15. The resident was also coded on this MDS assessment to have signs of depression. The facility business administration employee was interviewed on 1/4/19 at 9:33 AM. The facility business administration employee reported the following. Resident # 4 had Medicaid approval when he was first admitted to the facility on 4/20/18. The resident routinely paid any money he owed to the facility himself up until August, 2018. The resident had been hospitalized in August, 2018. Upon his August hospital return, his September balance was due and he had not had the money to pay for August, 2018. The business administration employee stated Resident # 4's son then became involved and provided them with power of attorney papers dated 8/31/18. According to the business employee the facility was named as social security payee following 8/31/18, and they had thereafter been paid for Resident # 4's care. It was validated on 1/31/19 with the facility	F 602	employee #1. The facility became Rep payee in October of 2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Administrator and/or the Social Service Director (SSD) reviewed the grievance logs from July 2018- January 21, 2019, to identify concerns regarding resident exploitation and/or misappropriation, to validate that an investigation was completed and was reported to the state agency. There were no other concerns identified that had not been investigated and/or reported to the state agency. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Service director (SSD) completed interviews with current staff on 1/25/19, regarding knowledge of resident abuse, exploitation and misappropriation, that has not been previously reported. There were no other allegations identified that were not investigated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator and/or the DON completed education on 1/25/19, for all facility staff, all shifts, all days including weekends and prn staff, regarding reporting and investigating allegations of abuse. The education will be included in new hire orientation. The staff will report immediately to the abuse officer any allegation of abuse to	

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F 602	Continued From page 15 Administrator that the facility's copy of the son's POA was notarized but had no seal on it. It was validated on 2/4/19 with the County Register of Deeds office that there was no registered POA on file for Resident # 4. The son's 8/31/18 copy was not registered in the county where the resident resided. Resident # 4's son was interviewed on 1/3/19 at 3:30 PM. The son stated he had taken action to be appointed power of attorney for Resident # 4 in the past several months. The son reported the following details. Prior to his April 2018 facility admission, Resident # 4 had resided at another facility. During Resident # 4's residency at the former facility, an employee, who was a housekeeping aide, had "taken a liking to him," and the other facility had terminated the employee. When Resident # 4 moved to the current facility, the employee followed Resident # 4 and obtained a job. The son stated the employee took thousands of dollars of money from Resident # 4's bank accounts, arranged to become Resident # 4's social security payee, had him sign his car over to her at the DMV (Division of Motor Vehicles), and would give him drugs and alcohol. During the time that the employee became payee of his social security check, she did not pay his bills for which he was responsible. The son stated he reported his concerns to the facility. The son could not give definitive dates when all of this occurred or when he had reported it, but stated the events had transpired in approximately the last six months. The son named Employee # 1 as the housekeeping aide who allegedly did these things. The son stated his concerns had also been reported to the police and APS (Adult Protective Services) and "they couldn't do anything about it." According to the	F 602	include resident exploitation and misappropriation. The abuse officer will submit the 24-hour report to the state agency and an investigation will begin at that time and within 5 days of the allegation the abuse officer will submit the 5-day investigative report to the state agency. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator, DON and/or the SSD will interview 5 staff members weekly for 4 weeks then 10 staff members monthly for 2 months, to validate that allegations of abuse were reported to the abuse officer and an investigation was initiated and reported to the state agency. The Administrator and/or the Director of Nursing will review the grievance log 5 x a week for 4 weeks then weekly for 2 months, to validate that grievances of missing items and/or care concerns were investigated and reported to the State agency as required, if the items were misappropriated or abuse situations were identified. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will	

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son, the police had determined there had been no criminal activity determined, and the son provided no evidence of his allegations against Employee # 1.

Resident # 4 was interviewed on 1/4/19 at 11:25 AM. Resident # 4 was interviewed regarding whether an employee had ever stolen from him or taken advantage of him. Resident # 4 shook his head and stated, "I just don't know. I just don't know." He would not expound further. Resident # 4's affect was observed to be flat and depressed. As he shook his head, he looked away and avoided further conversation.

Review of Employee # 1's personnel file revealed she was 29 years of age. There was no hire date on the personnel file. A new employee orientation competency form had been completed on 6/8/18. The employee's termination date was 7/25/18. According to an interview with the administrator on 1/4/19 at 11:10 AM, this indicated Employee # 1 had worked for the facility for at least 48 days. The phone number listed for Employee # 1 in the personnel file was no longer a working number.

On 1/4/19 at 1:45 PM it was confirmed with the administrator that the only documentation regarding the incident was in the resident's record on 9/11/18. On this date, the SW noted adult protective services was notified on behalf of the resident's family member. The reason was not noted in the resident's record or on any other facility documentation. According to the administrator she was not aware she was responsible for investigating since the allegation had been made following Employee # 1's resignation. According to the Administrator, none of her staff had ever witnessed Employee # 1

be completed;
February 5, 2019

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give Resident # 4 drugs or alcohol and she was not aware of any evidence to validate misappropriation or exploitation.

On 1/31/19 at 8:15 AM Employee # 1 was contacted by using an alternative family's number for the Employee, and an interview was obtained. The Employee reported the following details. Employee # 1 stated she had been trying to help Resident # 4 when she became involved with him. Resident # 4 did not have a good relationship with his family, and he still had a home. While she was still employed at the facility, the resident asked her to help him go home while saying that he would rather pay her to help him be at home than pay the nursing home. The resident persisted with his requests by saying, "Let's get this show on the road." Over a course of several days, she talked to the resident to make sure he was alert and oriented, and not confused regarding what he wanted to do. In talking with him, she felt he was alert to make sound decisions, and she felt it would be good for him to be in his home than the nursing home since this was his desire. While she was employed at the facility, she met with the resident during her lunch break, and drew up a written contract to work for him. The contract was witnessed. The goal was that the resident eventually be able to go back home full time with her providing 24 hour care. She talked to the resident's family and made them aware of the plan, and they were in agreement. She quit her job, and started taking the resident home and allowing him to stay there for interims.

On several occasions she assisted him to go to the bank at his request where he "moved money around from one account to another." One day

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he asked her to take him to the Social Security Administration Office, and he insisted when they got there that she be made his social security payee. They were together at the time, and the social security administration employee recognized that she (Employee # 1) was trying to help the resident. Employee # 1 could not recall the exact date on which they had gone to the Social Security Administration Office.

Resident # 4 also asked her to take him to the NC Division of Motor Vehicles (DMV) one day to deal with the registration of his car. Once at the DMV, the resident insisted that her name be placed on the car title. According to Employee # 1 she had not stolen from the resident nor had she taken advantage of him. According to the employee, it was the resident's idea to drink alcohol at times when she took him home. Employee # 1 also reported that prior to Resident # 4 not being able to pay his nursing home bill, she had accompanied him to the bank. Employee # 1 stated the resident had wanted to remove money to pay his nursing home bill, and he also wanted extra money. Employee # 1 stated the money was placed in an envelope within his wallet, and then she made sure the wallet was in his shirt pocket where he typically kept it. Employee # 1 maintained that she had not taken the money, and that the resident had money when she had last seen him prior to him alleging money was gone and he could not pay his bill.

The Administrator (Administrator # 2) of the former facility, where Resident # 4 used to reside and to which the family referred to as the place where Employee # 1 first met Resident # 4, was interviewed on 1/31/19 at 9:38 AM. Administrator # 2 reported the following. The resident had

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resided "off and on" with them from 12/7/16 to 3/21/18. While Resident # 4 resided at their facility, he was alert, oriented, and responsible for himself and paying his own facility bill. The resident had a history of not paying his bill and the facility gave him a 30 day discharge notice on three occasions because of his refusal to pay. The resident also had a history of offering money to facility staff to buy him things and "carrying wads of cash." The resident also reported money was being taken from his bank account in 2017, and this was at a time period during which only his son had access to the resident's financial account and Employee # 1 was not an employee at the facility. According to the former facility's records, Employee # 1 had been at Administrator # 2's facility from 1/11/18 to 5/14/18. According to Administrator # 2, Employee # 1 had no relationship with Resident # 4 of which he was aware, and he did not recall personnel problems with Employee # 1 while she worked at the former nursing facility. It was validated that Employee # 1 had not been terminated as the family member of Resident # 4 alleged because of her involvement with Resident # 4; rather she quit work on her own accord. Also according to Administrator # 2, Resident # 4 applied for Medicaid during the resident's residency at the former facility. According to Administrator # 2, there had been problems with Resident # 4's family cooperating with the Medicaid application to assure Resident # 4 did not have too many valued items to qualify for Medicaid. The resident had not had his Medicaid approved before his final discharge on 3/21/18.

Interview with the police on 1/31/19 at 2:10 PM confirmed there had been no criminal activity substantiated in their investigation into the son's

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concerns that Resident # 4's money was misappropriated or that Resident # 4 was exploited. The police did provide records showing that Employee # 1 had been notified on 8/16/18 that she was being made Resident # 4's Social Security Representative Payee. The police also provided evidence that Employee # 1 was placed on Resident # 4's car title as a joint owner of his vehicle. According to the police there were records showing the car value was $4500.00. According to the police interview, Resident # 4 had been deemed alert and oriented during the police investigation. The police also stated that Employee # 1 had a signed and legal contract to work for Resident # 4.

Interview with an Adult Protective Services (APS) employee on 1/31/19 at 10:07 AM revealed they had no evidence of bank records validating Employee # 1 had stolen from Resident # 4. According to the APS worker, she received the referral on 9/10/18, and went to see Resident # 4 on 9/11/18. She administered a Short Portable Mental Status Exam (SPMSE) on this date, and he had the highest possible score. He appeared very alert and oriented. When she first questioned him, Resident # 4 told her it was not any business of a social worker's who he "gave" his money to. He then changed his statement to say, someone had taken his money, but it had been taken care of and he did not need the APS worker's help. She saw him again on 9/28/18, and again administered the SPMSE test. He again had the highest score. At that time, the resident told the APS worker Employee # 1 had taken his money and car. He told her that he had given her permission to drive the car, but not to take the money and car. He later stated he had made her his social security payee under the influence of

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drugs and alcohol. According to the APS worker, she validated from talking to the police that Employee # 1 was Resident # 4's social security representative payee in August, 2018. Therefore in determining the case, APS validated that Employee # 1 had failed to assure Resident # 4's safety and well-being when Employee # 1 failed to make sure Resident # 4's nursing home bill was paid. According to the APS worker, she was not aware Resident # 4 had a history of not paying his own bill on multiple occasions while residing at another facility when this decision was made regarding Employee # 1. The APS worker stated it was also determined that the resident did not need APS services because the facility became the resident's Social Security Representative after their investigation. Also according to the APS worker there was no county registered Power of Attorney for Resident # 4 as of 1/31/19. The APS worker stated Resident # 4's son had informed them that he would provide Power of Attorney documents, and never carried through.

Resident # 4 was interviewed again on 2/1/19 at 10:00 AM with the facility Administrator present. According to Resident # 4 he had not signed any contract with Employee # 1. The resident stated, "I didn't pay her to do nothing." Resident # 4 did report that Employee # 1 would take him to his home at times to "hang out" and maintained she did it for free. The resident also reported he would give Employee # 1 money to buy him alcohol while he was out with her at times. The resident reported that Employee # 1 never went to the bank with him. The resident stated Employee # 1 took money from him by having his Social Security check turned over to her against his will. The resident also stated she had taken his car.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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According to the resident, he was not aware that the car was still jointly owned by him and Employee # 1.

According to the interview with the resident it was validated that the resident made different statements contrary to evidence the police had and/or contrary to other interviews. According to the resident, he had not signed any contract or agreed to pay Employee # 1, but according to the police there was a signed and legal contract for Employee # 1 to work for Resident # 4. According to the resident, Employee # 1 had taken his car from him. According to the DMV title, which was obtained by the police, the resident's name still was on the title as joint owner of the car. According to the police the value of the car was $ 4500.00; which would have been in excess of the amount allowed for a Medicaid nursing home resident. According to the resident, Employee # 1 never went to the bank with him, but this is contrary to what Employee # 1 stated. According to Employee # 1, she went to assist the resident at the bank so he could check his balances and "move money around."

Also according to the interviews, the resident was inconsistent in the details of what he conveyed to individuals. During the interviews with the resident's current facility administrator and social worker, they stated the resident denied Employee # 1 was driving his car or doing anything wrong when they first approached him about problems with the resident driving his car. According to interviews, the resident then changed this to claim that the Employee had taken his car and money. Also, according to the APS worker's interview, the resident initially told her it was not a social worker's business who he had given his

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money to, and then changed what he said to indicate his money had been stolen.

According to the interview with the son it was validated that the son had made statements contrary to information presented by facility administration. During the interview with the son, the son alleged that Employee # 1 had been terminated because of her relationship with the resident at a previous facility. The interview with Administrator # 2 on 1/31/19 at 9:38 AM, revealed no personnel problems with Employee # 1 or relationship between her and Resident # 4. According to the interview with Administrator # 2, the resident had missing money when only the son had access to his bank accounts in 2017. It was validated with the APS worker on 1/31/19 at 10:07 AM that during this time in 2017, in which reportedly the son had access to the account, APS had validated money had being used to pay a Direct TV bill and gasoline from the resident's account, although the resident was in the nursing home, not in need of these items, and claiming he had money missing. Also as of 2/4/19 there was no record with the Register of Deeds office that there was any registered POA on file for Resident # 4. According to interviews with the police and the APS worker, the resident was considered alert and oriented. According to the interview with the APS worker on 1/31/19 at 10:07 AM, the resident had never been deemed incompetent. According to the APS worker the resident was deemed not to need APS services because the facility became his social security representative payee, and his bill would thereafter be assured to be paid. Therefore, the resident was considered to be in a safe environment by APS.

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F 607	Continued From page 24	F 607		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and family interview for one (Resident # 4) of three sampled residents, the facility failed to implement their policy regarding investigating misappropriation and exploitation when a resident failed to have money to pay his facility bill and a concern was voiced by a family member regarding an employee's involvement with the resident. The findings included: This tag is cross referred to: 1. F 602 : Based on record review, resident interview, staff interviews, and family interview for one (Resident # 4) of three sampled residents, the facility failed to address the relationship with Resident # 4 and a housekeeping aide concerning financial areas, car ownership and use of resident items with his permission. The findings included: Review of the facility's Abuse and Neglect policy,	F 607	F 607 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility completed a 24-hour report on 1/4/19, and 5-day investigation was completed on 1/9/19 for Resident #4, regarding resident exploitation and misappropriation of resident funds and personal belongings. This was a situation that occurred with Resident #4□s consent while he was competent with a BIMS score of 15. Employee #1 quit working at the facility on 7/25/18. The Police and APS were notified in September 2018, when the resident had failed to make payment to the facility. Resident #4 requested his son be notified and allegations against employee #1 were	2/5/19

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F 607	Continued From page 25 last revised on 9/24/18, revealed the following information was noted in the policy. The facility does not condone resident abuse by anyone; including staff members and other individuals who are not employees. According to the policy, misappropriation and exploitation were forms of resident abuse. Exploitation was defined within the facility's policy as "taking advantage of a resident for personal gain through use of manipulation, intimidation, threats, or coercion." According to the policy it is the Administrator's responsibility to appoint a staff member to investigate incidents of alleged misappropriation and the investigation is to include interviews with the person making the report, witnesses, family members, staff, and the resident. Also according to the policy, allegations of misappropriation and exploitation would be reported to the state agency. On 1/4/19 at 1:45 PM the administrator was interviewed. It was confirmed with the administrator that adult protective services was notified on 9/10/18 on behalf of Resident # 4's family member regarding an allegation of exploitation and misappropriation, but the facility did not implement their abuse policy and conduct an investigation nor submit a 24 hour report or 5 day report to the state agency. According to the administrator she was not aware she was responsible for investigating and reporting the allegation to the state agency since the allegation dealt with alleged events the administrator felt transpired following the alleged perpetrator's resignation of employment from the facility.	F 607	made. The police and APS worker informed the facility, following their investigations, that the resident was cognitively intact and made his own decisions during the time when the funds and the car were made available to employee #1. The facility became Rep payee in October of 2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Administrator and/or the Social Service Director (SSD) reviewed the grievance logs from July 2018- January 21, 2019, to identify concerns regarding resident exploitation and/or misappropriation, to validate that an investigation was completed and was reported to the state agency. There were no other concerns identified that had not been investigated and/or reported to the state agency. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Service director (SSD) completed interviews with current staff on 1/25/19, regarding knowledge of resident abuse, exploitation and misappropriation, that has not been previously reported. There were no other allegations identified that were not investigated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator and/or the DON completed education on 1/25/19, for all facility staff, all shifts, all days including	

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weekends and prn staff, regarding reporting and investigating allegations of abuse. The education will be included in new hire orientation.
The staff will report immediately to the abuse officer any allegation of abuse to include resident exploitation and misappropriation. The abuse officer will submit the 24-hour report to the state agency and an investigation will begin at that time and within 5 days of the allegation the abuse officer will submit the 5-day investigative report to the state agency.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
The Administrator, DON and/or the SSD will interview 5 staff members weekly for 4 weeks then 10 staff members monthly for 2 months, to validate that allegations of abuse were reported to the abuse officer and an investigation was initiated and reported to the state agency.
The Administrator and/or the Director of Nursing will review the grievance log 5 x a week for 4 weeks then weekly for 2 months, to validate that grievances of missing items and/or care concerns were investigated and reported to the State agency as required, if the items were misappropriated or abuse situations were identified.

The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review

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F 607	Continued From page 27	F 607	the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 5, 2019	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		2/5/19

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F 609	Continued From page 28 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and family interview for one (Resident # 4) of three sampled residents, the facility failed to submit a 24 hour and five day report to the state agency regarding an allegation of resident exploitation and misappropriation of resident's funds and personal belongings. The findings included: This tag is cross referred to: 1. F 602 : Based on record review, resident interview, staff interviews, and family interview for one (Resident # 4) of three sampled residents, the facility failed to address the relationship with Resident # 4 and a housekeeping aide concerning financial areas, car ownership and use of resident items with his permission. The findings included: On 1/4/19 at 1:45 PM the administrator was interviewed. It was confirmed with the administrator that adult protective services was notified on 9/10/18 on behalf of Resident # 4's family member regarding an allegation of exploitation and misappropriation, but the facility did not submit a 24 hour report or 5 day report to the state agency. According to the administrator she was not aware she was responsible for investigating and reporting the allegation to the state agency since the allegation dealt with alleged events the administrator felt transpired following the alleged perpetrator's resignation of employment from the facility.	F 609	F 609 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility completed a 24-hour report on 1/4/19, and 5-day investigation was completed on 1/9/19 for Resident #4, regarding resident exploitation and misappropriation of resident funds and personal belongings. This was a situation that occurred with Resident #4□s consent while he was competent with a BIMS score of 15. Employee #1 quit working at the facility on 7/25/18. The Police and APS were notified in September 2018, when the resident had failed to make payment to the facility. Resident #4 requested his son be notified and allegations against employee #1 were made. The police and APS worker informed the facility, following their investigations, that the resident was cognitively intact and made his own decisions during the time when the funds and the car were made available to employee #1. The facility became Rep payee in October of 2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Administrator and/or the Social Service Director (SSD) reviewed the grievance logs from July 2018- January	

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F 609	Continued From page 29	F 609	21, 2019, to identify concerns regarding resident exploitation and/or misappropriation, to validate that an investigation was completed and was reported to the state agency. There were no other concerns identified that had not been investigated and/or reported to the state agency. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Service director (SSD) completed interviews with current staff on 1/25/19, regarding knowledge of resident abuse, exploitation and misappropriation, that has not been previously reported. There were no other allegations identified that were not investigated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator and/or the DON completed education on 1/25/19, for all facility staff, all shifts, all days including weekends and prn staff, regarding reporting and investigating allegations of abuse. The education will be included in new hire orientation. The staff will report immediately to the abuse officer any allegation of abuse to include resident exploitation and misappropriation. The abuse officer will submit the 24-hour report to the state agency and an investigation will begin at that time and within 5 days of the allegation the abuse officer will submit the 5-day investigative report to the state agency.	

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F 609	Continued From page 30	F 609	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator, DON and/or the SSD will interview 5 staff members weekly for 4 weeks then 10 staff members monthly for 2 months, to validate that allegations of abuse were reported to the abuse officer and an investigation was initiated and reported to the state agency. The Administrator and/or the Director of Nursing will review the grievance log 5 x a week for 4 weeks then weekly for 2 months, to validate that grievances of missing items and/or care concerns were investigated and reported to the State agency as required, if the items were misappropriated or abuse situations were identified. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 5, 2019	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		2/5/19

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F 677	Continued From page 31 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to provide showers as scheduled for activities of daily living (ADL) dependent residents for 3 (Resident #9, Resident #13 and Resident #21) of 6 residents reviewed for ADLs. The findings included 1. Resident #9 was admitted on 7/6/08 with cumulative diagnoses od Cerebral Vascular Accident (CVA) with Hemiplegia. Resident #9's undated electronic Kardex read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Resident #9's care plan last revised 7/28/18 read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Review of the facility grievance log revealed a grievance dated 11/28/18 which read Resident #9 was not getting her showers. Resident #9's quarterly Minimum Data Set (MDS) dated 12/15/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for total staff assistance with bathing. Review of the documentation from 11/1/18 to present indicated Resident #9 received one shower on 12/21/18.	F 677	F 677 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility provided a shower for Resident #9 on1/4/19, following survey exit, and has received showers every _Tuesday and Friday per residents shower schedule. The Director of Nursing (DON) discussed the shower schedule and resolution with Resident #9 on 1/4/19, as a resolution to the grievance documented 11/28/18, showers will be offered and given by the certified nursing assistant (CNA) on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the Medication administration record (MAR). The facility provided a shower for Resident #13 on 1/5/19, following survey exit, and has received showers every Wednesday and Saturday per residents shower schedule. The DON discussed the shower schedule and resolution with Resident #13 on 1/4/19, as a resolution to the grievance documented on 11/28/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. The facility provided a shower for	

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F 677	Continued From page 32 Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #9 was still not getting her showers. In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time. She stated she completed multiple grievances but there had been no improvement in receiving her showers. Resident #9 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing.	F 677	Resident #21 on 1/5/19, following survey exit, and has received showers every Saturdays on first shift and Wednesday on second shit per residents shower schedule. The DON discussed the shower schedule and resolution with Resident #21 on 1/4/19, as a resolution to the grievance documented on 12/27/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the same deficient practice of not receiving showers as scheduled. The DON and ADONs completed an audit on 1/21/19, of shower documentation for current facility residents, to identify residents that had not received a shower as scheduled. There were 3 residents identified. Those residents were offered a shower on 1/21/19 and will be offered showers going forward according to shower schedule. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and/or ADONs provided education beginning on 1/22/19, for the licensed nurses and CNAs , all shifts, all	

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F 677	Continued From page 33 In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed. 2. Resident #13 was admitted on 1/15/18 and readmitted 6/29/18 with cumulative diagnoses of CVA, Diabetes and Congestive Heart Failure (CHF). Resident #13's quarterly MDS dated 11/25/18 indicated moderate cognitive impairments with no behaviors. She was coded as requiring total staff assistance with bathing. Resident #13's undated electronic Kardex read she required staff assistance for showers every Wednesday and Saturday on second shift and as needed. Resident #13's care plan last revised on 11/27/18 read she required staff assistance with showers every Wednesday and Saturday on second shift and as needed. Review of the documentation from 11/1/18 to present indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/26/18. Review of the facility grievance log revealed a	F 677	days, including weekends and prn staff, regarding providing showers to residents according to the shower schedule, with documentation by the CNA on the shower sheet, and the licensed nurse will validate shower was given and document on the residents MAR. When a resident refuses a shower, the CNA will report to the licensed nurse and the licensed nurse will follow up with the resident and document refusal or acceptance of the shower on the MAR. The education will be provided to newly hired staff during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON□s will audit shower sheets and MARS 5 times a week for 4 weeks then 3 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or the ADON□s will interview and/or observe 10 residents weekly for 4 weeks then 20 residents monthly for 5 months, to validate that showers are given as scheduled, as evidenced by alert and oriented resident voicing confirmation,and/ or observing cognitively impaired residents during shower. The Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The DON will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will	

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	345177	A. BUILDING _____ B. WING _____	C 02/04/2019

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F 677	Continued From page 34 grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview and observation on 1/3/19 at 4:50 PM, Resident #13 stated she had not been receiving her scheduled showers for some time. She stated she completed a grievance but there had been no improvement in receiving her showers. Resident #13 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing.	F 677	be completed; February 1, 2019	

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F 677	Continued From page 35	F 677		

In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed.

3. Resident #21 was admitted on 1/6/12 with cumulative diagnoses of Coronary Artery Disease and Diabetes.

Resident #21's quarterly MDS dated 10/16/18 indicated she was cognitively intact and exhibited no behaviors. She was coded as requiring total staff assistance with bathing.

Resident #21's undated electronic Kardex read she required staff assistance for showers every Wednesday and Saturday on second shift and as needed.

Resident #21's care plan last revised on 12/24/18 read she required staff assistance with showers every Wednesday and Saturday on second shift and as needed.

Review of the facility grievance log revealed a grievance dated 12/27/18 which read Resident #21 was not getting her showers.

Review of the documentation from 11/1/18 to present indicated Resident #21 only received a shower on 12/15/18, 12/19/18, 12/22/18 and 12/30/18.

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F 677	Continued From page 36	F 677		

In an interview and observation on 1/3/19 at 8:45 AM, Resident #21 confirmed she was the Resident Council President. She stated she had not been receiving her scheduled showers for some time. She stated she completed a grievance and brought the lack of showers in Resident Council meetings but there had been no improvement in receiving her showers. Resident #21 appeared clean, absent of odors and dressed for season.

In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing.

In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues.

In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers.

In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short

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F 677	Continued From page 37 staffing. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed.	F 677		
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.	F 725		2/5/19

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F 725	Continued From page 38 §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, resident and staff interviews and record review, the facility failed to provide sufficient staffing to provide showers for 3 (Resident #, Resident 13 and Resident #21) of 6 residents who required staff assistance with showers and failed to answer call bells timely for 1 resident (Resident #4) of 1 resident who required assistance with toileting. The findings included: 1. Resident #9 was admitted on 7/6/08 with cumulative diagnoses of Cerebral Vascular Accident (CVA) with Hemiplegia. Resident #9's undated electronic Kardex read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Resident #9's care plan last revised 7/28/18 read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Review of the facility grievance log revealed a grievance dated 11/28/18 which read Resident #9 was not getting her showers. Resident #9's quarterly Minimum Data Set (MDS) dated 12/15/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for total staff assistance with bathing.	F 725	F 725 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility provided a shower for Resident #9 on 1/4/19, following survey exit, and has received showers every Tuesday and Friday per residents shower schedule. The Director of Nursing (DON) discussed the shower schedule and resolution with Resident #9 on 1/4/19, as a resolution to the grievance documented 11/28/18, showers will be offered and given by the certified nursing assistant (CNA) on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the Medication administration record (MAR). The facility provided a shower for Resident #13 on 1/5/19, following survey exit, and has received showers every Wednesday and Saturday per residents shower schedule. The DON discussed the shower schedule and resolution with Resident #13 on 1/4/19, as a resolution to the grievance documented on 11/28/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The	

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F 725	Continued From page 39 Review of the documentation from 11/1/18 to present indicated Resident #9 only received one shower on 12/21/18. Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #9 was still not getting her showers. In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time. She stated she completed multiple grievances but there had been no improvement in receiving her showers. Resident #9 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers.	F 725	Licensed nurse will validate shower was given and document on the MAR. The facility provided a shower for Resident #21 on 1/5/19, following survey exit, and has received showers every Wednesday and Saturday per residents shower schedule. The DON discussed the shower schedule and resolution with Resident #21 on 1/4/19, as a resolution to the grievance documented on 12/27/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. Resident #4 requires assistance with toileting. The Director of Nursing provided in service education on 1/22/19, for the nursing staff regarding answering call lights timely to include not to turn call light off until resident needs are met. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that require assistance with ADLS (showers/toileting) have the potential to be affected by the deficient practice. The DON and ADON s completed an audit on 1/21/19, of shower documentation for current facility residents, to identify residents that had not received a shower as scheduled. There were 3 residents identified. Those residents were offered a shower on 1/21/19 and will be offered showers going forward according to shower schedule.	

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F 725	Continued From page 40 In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed and the facility have adequate staffing on all three shifts. 2. Resident #13 was admitted on 1/15/18 and readmitted 6/29/18 with cumulative diagnoses of CVA, Diabetes and Congestive Heart Failure (CHF). Resident #13's quarterly MDS dated 11/25/18 indicated moderate cognitive impairments with no behaviors. She was coded as requiring total staff assistance with bathing. Resident #13's undated electronic Kardex read she required staff assistance for showers every Wednesday and Saturday on second shift and as needed. Resident #13's care plan last revised on 11/27/18 read she required staff assistance with showers every Wednesday and Saturday on second shift and as needed.	F 725	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and/or ADON□s provided education beginning on 1/22/19, for the licensed nurses and CNA□s, all shifts, all days including weekends and prn staff, regarding providing showers to residents according to the shower schedule, with documentation by the CNA on the shower sheet, and the licensed nurse will validate shower was given and document on the residents MAR. When a resident refuses a shower, the CNA will report to the licensed nurse and the licensed nurse will follow up with the resident and document refusal or acceptance of the shower on the MAR. This education will be provided to newly hired nursing staff during new hire orientation. The Director of Nursing provided in service education on 1/22/19, for the nursing staff all shifts, all days including weekends and prn staff, regarding answering call lights timely to include not to turn call light off until resident needs are met. This education will be provided to newly hired nursing staff during new hire orientation. The Administrator and/or the DON will hire nursing staff to fill open positions as they occur in order to provide sufficient staff to meet resident care needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 725	Continued From page 41 Review of the documentation from 11/1/18 to present indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/26/18. Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview and observation on 1/3/19 at 4:50 PM, Resident #13 stated she had not been receiving her scheduled showers for some time. Resident #13 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1	F 725	The DON and/or the ADON□s will audit shower sheets and MARS 5 times a week for 4 weeks then 3 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or the ADON□s will interview and/or observe 10 residents weekly for 4 weeks then 20 residents monthly for 5 months, to validate that showers are given as scheduled, as evidenced by alert and oriented resident voicing confirmation, and/ or observing cognitively impaired residents during shower. The DON and/or ADON□s will monitor answering of call lights for all shifts 5 x a week for 4 weeks then 3 times a week for 2 months, to validate call lights are being answered timely to meet resident care needs. The DON and/or ADON□s will interview 10 residents weekly for 4 weeks then 20 residents monthly for 5 months, to validate that call lights are being answered timely to meet resident care needs. The Administrator and/or the DON will monitor staffing needs daily to validate and assure that sufficient staff is available to meet resident care needs. The Director of Nursing will review the audits/monitors/interviews to identify patterns/trends and will adjust the plan as necessary. The DON will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee.	

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F 725	Continued From page 42 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed and the facility have adequate staffing on all three shifts. 3. Resident #21 was admitted on 1/6/12 with cumulative diagnoses of Coronary Artery Disease and Diabetes. Resident #21's quarterly MDS dated 10/16/18 indicated she was cognitively intact and exhibited no behaviors. She was coded as requiring total staff assistance with bathing. Resident #21's undated electronic Kardex read she required staff assistance for showers every Wednesday and Saturday on second shift and as needed. Resident #21's care plan last revised on 12/24/18 read she required staff assistance with showers every Wednesday and Saturday on second shift and as needed. Review of the facility grievance log revealed a grievance dated 12/27/18 which read Resident #21 was not getting her showers.	F 725	Indicate dates when corrective action will be completed; February 1, 2019	

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F 725	Continued From page 43	F 725		

Review of the documentation from 11/1/18 to present indicated Resident #21 only received a shower on 12/15/18, 12/19/18, 12/22/18 and 12/30/18.

In an interview and observation on 1/3/19 at 8:45 AM, Resident #21 confirmed she was the Resident Council President. She stated she had not been receiving her scheduled showers for some time. She stated she completed a grievance and brought the lack of showers in Resident Council meetings but there had been no improvement in receiving her showers. Resident #21 appeared clean, absent of odors and dressed for season.

In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing.

In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues.

In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers.

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F 725	Continued From page 44	F 725		

In an interview on 1/4/19 at 6:35 AM, NA #3 stated the facility has been short staff for about 1 year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing.

In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed and the facility have adequate staffing on all three shifts.

4. Resident #4 was admitted 12/10/14 with cumulative diagnoses of Congestive Heart Failure and Parkinson's Disease.

Resident #4's quarterly MDS dated 10/21/18 indicated he was cognitively intact and exhibited no behaviors. He was coded for extensive staff assistance with toileting.

Resident #4 was care planned for staff assistance with his ADLs.

In an observation on 1/3/19 at 4:40 PM, Resident #4's call bell was observed lite to signify he required staff assistance.

In an observation at 1/3/19 4:50 PM, Resident #4 was observed self-propelling his wheelchair into the hall outside the doorway of his room. He stated required assistance going to the bathroom

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F 725	Continued From page 45 and his call bell had been ringing for over 10 minutes. Resident #4 stated he had difficulty getting timely assistance with his ADLs. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an observation a 1/3/19 at 5:05 PM, NA #5 retrieved the mechanical lift and proceeded to assist Resident #4. She stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed and the facility have adequate staffing on all three shifts.	F 725		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804		2/1/19

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F 804	Continued From page 46 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews and record review, the facility failed to ensure the food served was palatable and served at an appetizing temperature for 5 (Resident #9, Resident #10, Resident #21, Resident #22 and Resident #24) of 5 interviewable residents reviewed for palatable food. The findings included: Review of the September 2018 Resident Council (RC) minutes dated 9/26/18 included a grievance dated 9/26/18 regarding cold food in the dining room and on the halls. The resolution was staff education. Review of the October 2018 RC minutes dated 10/24/18 included a grievance dated 10/24/18 regarding the nursing staff not passing the meal trays timely resulting in cold food. The resolution was an in-service completed on 10/25/18 to address the meals trays not being passed out timely. 1. Resident #9 was admitted on 7/6/08 with cumulative diagnoses od Cerebral Vascular Accident (CVA) with Hemiplegia. Resident #9's quarterly Minimum Data Set (MDS) dated 12/15/18 indicated she was cognitively intact and exhibited no behaviors. In an interview on 1/2/19 at 11:20 AM, the Dietary	F 804	F 804 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Administrator presented a resolution to the Resident Council President on 1/25/19, for the grievance of cold food to include monitoring food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during meal pass in the dining room and hallways, for breakfast, lunch and dinner 5 times a week, to assure food temperatures remain within acceptable temperature range at the point of service of 125 degrees or resident preference. The resolution was accepted by the resident council on 1/25/19. The Administrator and/or the Director of Nursing (DON)and Dietary Manager (DM) met with Residents # 9, 10, 21,22, and 24 individually on 1/25/19, to present to them the new process for monitoring food temperatures in the dining room and on the hallways. These residents accepted the new process. The Administrator, DON and/or DM will interview Residents 9, 10, 21, 22 and 24, weekly for 4 weeks, to validate that food items were received at an acceptable	

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F 804	Continued From page 47 Manager (DM) stated the facility was under new management since July 2018 and there had been some changes to the menu. She stated the new management did not offer an "alternate" to what was on the main menu but rather have a "Always Available Menu" (AAM). The DM stated the items on the AAM included: grilled cheese sandwiches, soup, chef salad, garden salad, hot dog, chips and deli sandwiches. She stated a lot of the residents ordered from the AAM but did not think it was because the food on the menu was not palatable. The DM stated she was out on leave from September 2018 to 10/29/18 and in her absence, the Chef was in charge. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave. She stated she was aware of the complains of cold food. The DM stated a new menu cycle was scheduled to start on 1/7/19 and hoped the residents would be happy with the new menu cycle. In an interview and observation on 1/2/19 at 12:10 PM, Resident #9 was observed eating lunch in the dining room. She was served beef stroganoff with noodles. Resident #9 stated the food was often served cold. In an interview on 1/3/19 at 9:30 AM, the Administrator stated there was some "tweaking" of the menus a few months back and that management did not realize it would put the dietary department over budget. She stated the Chef was left in charge while the DM was on leave but there was oversight provided by the Director of Dining Services (DDS). The Administrator stated the DDS was at the facility	F 804	temperature. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that receive meal trays have the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing provided in service education on 1/22/19, for the nursing staff, all days all shifts including weekends and prn staff, regarding passing of meal trays timely to keep food at the point of resident service within the acceptable temperature range of 125 degrees or resident preference. This education will be provided to newly hired nursing staff during new hire orientation. The Dietary Manager completed education on 1/25/19, for the dietary staff, all days, all shifts, including weekends and prn staff , regarding maintaining acceptable food temperatures of 140 degrees or greater on the tray line. The Dietary Manager orders food weekly for the upcoming weekly menu and the always available menu. The DM and/or the cook will validate daily that food items are available for the following days menu and the Always Available menu. The DM is responsible for ordering food items and/or adjusting the menu with alternatives of equal nutritive value as necessary to accommodate resident preferences and to meet the nutritional	

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F 804	Continued From page 48 maybe every 2 weeks. She stated the facility was running out of food and that the Chef was not properly trained on how to order food based on the food count or menu. The Administrator she was currently aware of concerns in the dietary department and the unhappiness of residents. In an interview on 1/3/19 at 9:50 AM, Nursing Assistant (NA) #6 stated she was aware that the residents were unhappy with the food served at the facility. She stated the residents complained that they were not getting what was on the menu and that the kitchen would run out of food. NA #6 stated she had not noticed any improvements or worsening since the DM returned from leave. In a telephone interview on 1/3/19 at 9:55 AM, the Chef stated he was no longer employed at the facility. He stated he was aware the dietary staff were not following the menus and that residents had complained about cold food. He stated he was not properly trained on the facility's ordering system and the kitchen frequently ran out of food. The Chef stated the DDS came to the facility every few weeks to assist him. In an observation of the lunch meal in the main dining room on 1/3/19 at 12:10 PM, the menu was being followed and no reports of cold food from the sampled residents. In an interview on 1/3/18 at 11:35 AM, NA #4 stated her assigned residents often complained about the dietary department regarding cold food, not following the menus and the taste of the food. She stated she frequently had to reheat food. In an interview on 1/3/19 at 1:40 PM, Resident #9 stated she the food at the facility was "horrible".	F 804	guidelines as determined by the Dietician. The facility provides an Always Available Menu or Alternate menu, if the resident chooses not to want the food on the daily menu. The DON and/or ADON's will assign nursing staff to the dining area and hallways during meal times to assure meal trays are passed timely when they are sent from the kitchen. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DM, the cook and/or the Administrator will monitor food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks, then 3 times a week for 5 months to include weekends. Standard of practice is at each meal, ensuring foods are held at a temperature of above 140 degrees F. The DM, the cook and/or the Administrator will monitor food temperature during meal pass in the dining room and hallways, for breakfast, lunch and dinner 5 times a week for 4 weeks then 3 times a week for 5 months to include evenings and weekends, to assure food temperatures at point of service remain within acceptable temperature range of 125 degrees or resident preference. The DON and/or the ADON's will monitor the dining area and hallways during meal times 5 times a week for 4 weeks, then 3	

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F 804	Continued From page 49 She stated it was not always served at the proper temperature. In an interview on 1/3/19 at 2:45 PM, NA #2 stated food was a problem at the facility. She stated her assigned residents were vocal about the taste and temperature of the food. In a telephone interview on 1/3/19 at 3:10 PM, the DDS stated while the DM was out of leave, the Chef and the Administrator were charge of the daily operations of the kitchen. The DDS stated the Chef was adequately training on how to order food using the facility's system, but it was "proving to be unsuccessful." He stated he asked the DM to order the food while she was on leave because the Chef was not completing the inventory and the facility was not getting certain items. He stated he was not aware of the complains about cold food. In an interview on 1/3/19 at 5:05 PM, NA #5 stated her assigned residents frequently complained about the taste and temperature of the food. She stated a lot of the residents ordered from the AAM because they stated the food on the menu was "so bad". In an interview on 1/4/19 at 10:30 AM, The Administrator stated it was her expectation that the food served from the dietary department be palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed. In an interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the	F 804	times a week for 5 months including evenings and weekends, to validate that staff are present in the dining area and hallways and passing trays timely. The Administrator, DON and/or the dietary manager will interview 5 residents weekly for 4 weeks then 10 residents monthly for 5 months, to validate that food was delivered at an acceptable temperature according to resident preference. The Administrator, Dietary Manager and/or the Director of Nursing will review audits/monitors and interviews to identify patterns and trends and will adjust the plan as necessary. The Administrator/Dietary manager/DON will review the plan during monthly QAPIU meeting and will continue the plan at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 1, 2019	

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proper temperature. She provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals.

2. Resident #10 was admitted on 2/9/18 with cumulative diagnoses of Diabetes and Coronary Artery Disease.

Review of the facility grievance logs revealed a grievance dated 9/18/18 completed by Resident #10. The grievance read she was unhappy because she did not get what was listed on the menu. The resolution read the dietary department ran out of the item listed on the daily menu.

Resident #10's quarterly Minimum Data Set (MDS) dated 11/13/18 indicated she was cognitive intact and exhibited no behaviors.

In an interview on 1/2/19 at 11:20 AM, the DM stated the facility was under new management since July 2018 and there had been some changes to the menu. She stated the new management did not offer an "alternate" to what was on the main menu but rather have a "Always Available Menu" (AAM). The DM stated the items on the AAM included: grilled cheese sandwiches, soup, chef salad, garden salad, hot dog, chips and deli sandwiches. She stated a lot of the residents ordered from the AAM but did not think it was because the food on the menu was not palatable. The DM stated she was out on leave from September 2018 to 10/29/18 and in her absence, the Chef was in charge. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave. She stated she was

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F 804	Continued From page 51	F 804		

aware of the complains of cold food. The DM stated a new menu cycle was scheduled to start on 1/7/19 and hoped the residents would be happy with the new menu cycle.

In an interview on 1/3/19 at 9:30 AM, the Administrator stated there was some "tweaking" of the menus a few months ago and that management did not realize it would put the dietary department over budget. She stated the Chef was left in charge while the DM was on leave but there was oversight provided by the Director of Dining Services (DDS). The Administrator stated the DDS was at the facility maybe every 2 weeks. She stated the facility was running out of food and that the Chef was not properly trained on how to order food based on the food count or menu. The Administrator she was currently aware of concerns in the dietary department and the unhappiness of residents.

In an interview on 1/3/19 at 9:50 AM, NA #6 stated she was aware that the residents were unhappy with the food served at the facility. She stated the residents complained that they were not getting what was on the menu and that the kitchen would run out of food. NA #6 stated she had not noticed any improvements or worsening since the DM returned from leave.

In a telephone interview on 1/3/19 at 9:55 AM, the Chef stated he was no longer employed at the facility. He stated he was aware the dietary staff were not following the menus and that residents had complained about cold food. He stated he was not properly trained on the facility's ordering system and the kitchen frequently ran out of food. The Chef stated the DDS came to the facility every few weeks to assist him.

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In an interview on 1/3/18 at 11:35 AM, NA #4 stated her assigned residents often complained about the dietary department, cold food, not following the menus and the taste of the food. She stated she frequently had to reheat food.

In an interview on 1/3/19 at 12:00, Resident #10 stated the facility often did not follow what was listed on the posted menu and it was frustrating for her.

In an observation of the lunch meal in the main dining room on 1/3/19 at 12:10 PM, the menu was being followed and no reports of cold food from the sampled residents.

In an observation and another interview on 1/3/19 at 12:20 PM, Resident #10 received soup and a grilled cheese sandwich. She stated it was what she requested from the "Always Available Menu" (AAM) since she did not like what was being served as the main meal choice. She stated items on the AAM included soup and grilled cheese sandwiches, salads and hot dog. Resident #10 stated she frequently ordered from the AAM since the food was "so bad".

In an interview on 1/3/19 at 2:45 PM, NA #2 stated food was a problem at the facility. She stated her assigned residents were vocal about the taste and temperature of the food.

In a telephone interview on 1/3/19 at 3:10 PM, the DDS stated while the DM was out of leave, the Chef and the Administrator were charge of the daily operations of the kitchen. The DDS stated the Chef was adequately training on how to order using the facility's system, but it was "proving to

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F 804	Continued From page 53	F 804		

be unsuccessful." He stated he asked the DM to order the food while she was on leave because the Chef was not completing the inventory and the facility was not getting certain items. He stated he was not aware of the complains about cold food.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated her assigned residents frequently complained about the taste and temperature of the food. She stated a lot of the residents ordered from the AAM because they stated the food on the menu was "so bad".

In an interview on 1/4/19 at 10:30 AM, The Administrator stated it was her expectation that the food served from the dietary department be palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed.

In an interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the proper temperature. She provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals.

3. Resident #21 was admitted on 1/6/12 with cumulative diagnoses of Coronary Artery Disease and Diabetes.

Resident #21's quarterly MDS dated 10/16/18 indicated she was cognitively intact and exhibited no behaviors.

In an interview on 1/2/19 at 11:20 AM, the DM stated the facility was under new management

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since July 2018 and there had been some changes to the menu. She stated the new management did not offer an "alternate" to what was on the main menu but rather have a "Always Available Menu" (AAM). The DM stated the items on the AAM included: grilled cheese sandwiches, soup, chef salad, garden salad, hot dog, chips and deli sandwiches. She stated a lot of the residents ordered from the AAM but did not think it was because the food on the menu was not palatable. The DM stated she was out on leave from September 2018 to 10/29/18 and in her absence, the Chef was in charge. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave. She stated she was aware of the complains of cold food. The DM stated a new menu cycle was scheduled to start on 1/7/19 and hoped the residents would be happy with the new menu cycle.

In an interview on 1/3/19 at 9:30 AM, the Administrator stated there was some "tweaking" of the menus a few months ago and that management did not realize it would put the dietary department over budget. She stated the Chef was left in charge while the DM was on leave but there was oversight provided by the Director of Dining Services (DDS). The Administrator stated the DDS was at the facility maybe every 2 weeks. She stated the facility was running out of food and that the Chef was not properly trained on how to order food based on the food count or menu. The Administrator she was currently aware of concerns in the dietary department and the unhappiness of residents.

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In an interview and observation on 1/3/19 at 8:45 AM, Resident #21 confirmed she was the Resident Council President. She stated the RC members had completed several grievances about the food. She stated it was the hope of the RC members that with return on the Dietary Manger, the food would improve but to date, there was not much improvement.

In an interview on 1/3/19 at 9:50 AM, NA #6 stated she was aware that the residents were unhappy with the food served at the facility. She stated the residents complained that they were not getting what was on the menu and that the kitchen would run out of food. NA #6 stated she had not noticed any improvements or worsening since the DM returned from leave.

In a telephone interview on 1/3/19 at 9:55 AM, the Chef stated he was no longer employed at the facility. He stated he was aware the dietary staff were not following the menus and that residents had complained about cold food. He stated he was not properly trained on the facility's ordering system and the kitchen frequently ran out of food. The Chef stated the DDS came to the facility every few weeks to assist him.

In an interview on 1/3/18 at 11:35 AM, NA #4 stated her assigned residents often complained about the dietary department, cold food, not following the menus and the taste of the food. She stated she frequently had to reheat food.

In an observation of the lunch meal in the main dining room on 1/3/19 at 12:10 PM, the menu was being followed and no reports of cold food from the sampled residents.

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In an interview on 1/3/19 at 2:45 PM, NA #2 stated food was a problem at the facility. She stated her assigned residents were vocal about the taste and temperature of the food.

In a telephone interview on 1/3/19 at 3:10 PM, the DDS stated while the DM was out of leave, the Chef and the Administrator were charge of the daily operations of the kitchen. The DDS stated the Chef was adequately training on how to order using the facility's system, but it was "proving to be unsuccessful." He stated he asked the DM to order the food while she was on leave because the Chef was not completing the inventory and the facility was not getting certain items. He stated he was not aware of the complains about cold food.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated her assigned residents frequently complained about the taste and temperature of the food. She stated a lot of the residents ordered from the AAM because they stated the food on the menu was "so bad".

In an interview on 1/4/19 at 10:30 AM, The Administrator stated it was her expectation that the food served from the dietary department be palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed.

In an interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the proper temperature. She provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals.

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4. Resident #22 was admitted 12/27/17 with cumulative diagnoses of Cerebral Vascular Accident and Diabetes.

Resident #22's annual MDS dated 12/7/18 indicated she was cognitive intact and exhibited no behaviors.

In an interview on 1/2/19 at 11:20 AM, the DM stated the facility was under new management since July 2018 and there had been some changes to the menu. She stated the new management did not offer an "alternate" to what was on the main menu but rather have a "Always Available Menu" (AAM). The DM stated the items on the AAM included: grilled cheese sandwiches, soup, chef salad, garden salad, hot dog, chips and deli sandwiches. She stated a lot of the residents ordered from the AAM but did not think it was because the food on the menu was not palatable. The DM stated she was out on leave from September 2018 to 10/29/18 and in her absence, the Chef was in charge. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave. She stated she was aware of the complains of cold food. The DM stated a new menu cycle was scheduled to start on 1/7/19 and hoped the residents would be happy with the new menu cycle.

In an interview on 1/3/19 at 9:30 AM, the Administrator stated there was some "tweaking" of the menus a few months ago and that management did not realize it would put the dietary department over budget. She stated the

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Chef was left in charge while the DM was on leave but there was oversight provided by the Director of Dining Services (DDS). The Administrator stated the DDS was at the facility maybe every 2 weeks. She stated the facility was running out of food and that the Chef was not properly trained on how to order food based on the food count or menu. The Administrator she was currently aware of concerns in the dietary department and the unhappiness of residents.

In an interview on 1/3/19 at 9:50 AM, NA #6 stated she was aware that the residents were unhappy with the food served at the facility. She stated the residents complained that they were not getting what was on the menu and that the kitchen would run out of food. NA #6 stated she had not noticed any improvements or worsening since the DM returned from leave.

In a telephone interview on 1/3/19 at 9:55 AM, the Chef stated he was no longer employed at the facility. He stated he was aware the dietary staff were not following the menus and that residents had complained about cold food. He stated he was not properly trained on the facility's ordering system and the kitchen frequently ran out of food. The Chef stated the DDS came to the facility every few weeks to assist him.

In an interview on 1/3/18 at 11:35 AM, NA #4 stated her assigned residents often complained about the dietary department, cold food, not following the menus and the taste of the food. She stated she frequently had to reheat food.

In an observation of the lunch meal in the main dining room on 1/3/19 at 12:10 PM, the menu was being followed and no reports of cold food

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from the sampled residents.

In an interview on 1/3/19 at 1:50 PM, Resident #22 stated she regularly attended the RC meetings and the food committee meetings. She stated management was aware of that the resident's disliked the food and stated the food at the facility was "terrible." Resident #22 stated she frequently ordered from the AAM because the food on the menu was not palatable.

In an interview on 1/3/19 at 2:45 PM, NA #2 stated food was a problem at the facility. She stated her assigned residents were vocal about the taste and temperature of the food.

In a telephone interview on 1/3/19 at 3:10 PM, the DDS stated while the DM was out of leave, the Chef and the Administrator were charge of the daily operations of the kitchen. The DDS stated the Chef was adequately training on how to order using the facility's system, but it was "proving to be unsuccessful." He stated he asked the DM to order the food while she was on leave because the Chef was not completing the inventory and the facility was not getting certain items. He stated he was not aware of the complains about cold food.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated her assigned residents frequently complained about the taste and temperature of the food. She stated a lot of the residents ordered from the AAM because they state the food on the menu was "so bad".

In an interview on 1/4/19 at 10:30 AM, The Administrator stated it was her expectation that the food served from the dietary department be

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palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed.

In an interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the proper temperature. She provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals.

5. Resident #24 was admitted 11/28/17 with Chronic Renal Disease and Diabetes.

Resident #24's annual MDS dated 11/2/18 indicated she was cognitive intact and exhibited no behaviors.

In an interview on 1/2/19 at 11:20 AM, the DM stated the facility was under new management since July 2018 and there had been some changes to the menu. She stated the new management did not offer an "alternate" to what was on the main menu but rather have a "Always Available Menu" (AAM). The DM stated the items on the AAM included: grilled cheese sandwiches, soup, chef salad, garden salad, hot dog, chips and deli sandwiches. She stated a lot of the residents ordered from the AAM but did not think it was because the food on the menu was not palatable. The DM stated she was out on leave from September 2018 to 10/29/18 and in her absence, the Chef was in charge. She stated the Chef did not "catch on" to the ordering process that resulted in the facility running out of food. The DM stated she was aware that the menus were not being followed so she ordered the food remotely while on leave. She stated she was

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F 804	Continued From page 61	F 804		

aware of the complains of cold food. The DM stated a new menu cycle was scheduled to start on 1/7/19 and hoped the residents would be happy with the new menu cycle.

In an interview on 1/3/19 at 9:30 AM, the Administrator stated there was some "tweaking" of the menus a few months ago and that management did not realize it would put the dietary department over budget. She stated the Chef was left in charge while the DM was on leave but there was oversight provided by the Director of Dining Services (DDS). The Administrator stated the DDS was at the facility maybe every 2 weeks. She stated the facility was running out of food and that the Chef was not properly trained on how to order food based on the food count or menu. The Administrator she was currently aware of concerns in the dietary department and the unhappiness of residents.

In an interview on 1/3/19 at 9:50 AM, NA #6 stated she was aware that the residents were unhappy with the food served at the facility. She stated the residents complained that they were not getting what was on the menu and that the kitchen would run out of food. NA #6 stated she had not noticed any improvements or worsening since the DM returned from leave.

In a telephone interview on 1/3/19 at 9:55 AM, the Chef stated he was no longer employed at the facility. He stated he was aware the dietary staff were not following the menus and that residents had complained about cold food. He stated he was not properly trained on the facility's ordering system and the kitchen frequently ran out of food. The Chef stated the DDS came to the facility every few weeks to assist him.

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F 804	Continued From page 62	F 804		

In an interview on 1/3/18 at 11:35 AM, NA #4 stated her assigned residents often complained about the dietary department, cold food, not following the menus and the taste of the food. She stated she frequently had to reheat food.

In an observation of the lunch meal in the main dining room on 1/3/19 at 12:10 PM, the menu was being followed and no reports of cold food from the sampled residents.

In an interview on 1/3/19 at 1:45 PM, Resident #24 stated management was aware of that the resident's disliked of the food and stated the food at the facility was "terrible." Resident #24 stated she frequently ordered from the AAM because the food on the menu was not palatable.

In an interview on 1/3/19 at 2:45 PM, NA #2 stated food was a problem at the facility. She stated her assigned residents were vocal about the taste and temperature of the food.

In a telephone interview on 1/3/19 at 3:10 PM, the DDS stated while the DM was out of leave, the Chef and the Administrator were charge of the daily operations of the kitchen. The DDS stated the Chef was adequately training on how to order using the facility's system, but it was "proving to be unsuccessful." He stated he asked the DM to order the food while she was on leave because the Chef was not completing the inventory and the facility was not getting certain items. He stated he was not aware of the complains about cold food.

In an interview on 1/3/19 at 5:05 PM, NA #5 stated her assigned residents frequently

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F 804	Continued From page 63 complained about the taste and temperature of the food. She stated a lot of the residents ordered from the AAM because they state the food on the menu was "so bad". In an interview on 1/4/19 at 10:30 AM, the Administrator stated it was her expectation that the food served from the dietary department be palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed. In another interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the proper temperature. She provided tray delivery times monitoring beginning 12/10/18 of the breakfast and lunch meals.	F 804		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) to maintain implanted procedures and monitor interventions that the committee put into to place following a complaint survey dated 6/15/18. This was for three recited deficiencies in the areas of Resident Rights at F565-not effectively resolve	F 867	F 867 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; cross reference to the following: F 565	2/1/19

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F 867	Continued From page 64 grievances of the Resident Council with timely response, Quality of Life at F677-not providing showers as scheduled, and Food and Nutrition Services at F804- not serving food at a palatable temperature. The findings included: This citation is cross referenced to: F565- Based on staff and resident interviews and record review, the facility failed to effectively resolve Resident Council (RC) grievances for 3 (September, October and November 2018) of 3 months reviewed for RC grievances. F677- Based on observation, staff and resident interviews and record review, the facility failed to provide showers as scheduled for activities of daily living (ADL) dependent residents for 3 (Resident #9, Resident #13 and Resident #21) of 6 residents reviewed for ADLs. F804- Based on observations, resident interviews and staff interviews and record review, the facility failed to ensure the food served an appetizing temperature for 5 (Resident #9, Resident #10, Resident #21, Resident #22 and Resident #24) of 5 interviewable residents reviewed for palatable food. In an interview on 1/4/19 at 10:30 AM, the Administrator was unable to explain the repeated citations in the areas of grievances and showers. The Administrator stated there had been some issues in the dietary department while the Dietary	F 867	The Administrator presented a resolution to the Resident Council President on 1/25/19 for the grievance of answering call lights timely to include monitoring of call lights on each unit, each shift 3 times a week for 4 weeks, to assure call lights are answered timely. The resolution was accepted by the resident council committee. The Social Service Director (SSD) provided a written letter of follow up to the Resident Council President on 1/25/19 to be shared during the next Resident Council meeting on 1/25/19. The Administrator presented a resolution to the Resident Council President on 1/25/19, for the grievance of cold food to include monitoring food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during meal pass in the dining room and hallways, for breakfast, lunch and dinner 5 times a week, to assure food temperatures remain within acceptable temperature range of 125 degrees or resident preference. The resolution was accepted by the resident council committee. The SSD provided a written letter of follow up to the Resident Council President on 1/25/19, to be shared during the next resident council meeting on 1/251/9. F 677 The facility provided a shower for Resident #9 on1/4/19, following survey exit, and has received showers every _Tuesday and Friday per residents' shower schedule. The Director of Nursing (DON) discussed the shower schedule and resolution with Resident #9 on 1/4/19,	

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F 867	Continued From page 65 Manager was on leave, but she was working with the residents in the food committee meetings to improve the dining experience.	F 867	as a resolution to the grievance documented 11/28/18, showers will be offered and given by the certified nursing assistant (CNA) on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the Medication administration record (MAR). The facility provided a shower for Resident #13 on 1/5/19, following survey exit, and has received showers every Wednesday and Saturday per residents' shower schedule. The DON discussed the shower schedule and resolution with Resident #13 on 1/4/19, as a resolution to the grievance documented on 11/28/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. The facility provided a shower for Resident #21 on 1/5/19, following survey exit, and has received showers every Saturdays on first shift and Wednesday on second shit per residents' shower schedule. The DON discussed the shower schedule and resolution with Resident #21 on 1/4/19, as a resolution to the grievance documented on 12/27/18, showers will be offered and given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the MAR. F804 The Administrator presented a resolution to the Resident Council President on	

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F 867	Continued From page 66	F 867	1/25/19, for the grievance of cold food to include monitoring food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during meal pass in the dining room and hallways, for breakfast, lunch and dinner 5 times a week, to assure food temperatures remain within acceptable temperature range at the point of service of 125 degrees or resident preference. The resolution was accepted by the resident council. The Administrator and/or the Director of Nursing (DON)and Dietary Manager (DM) met with Residents # 9, 10, 21,22, and 24 individually on 1/25/19, to present to them the new process for monitoring food temperatures in the dining room and on the hallways. These residents accepted the new process. The Administrator, DON and/or DM will interview Residents 9, 10, 21, 22 and 24, weekly for 4 weeks, to validate that food items were received at an acceptable temperature. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; cross referenced to the following: F 565 Current facility residents have the potential to be affected by the same deficient practice of the facility failure to provide resolution and follow up to grievances voiced during resident council	

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F 867	Continued From page 67	F 867	meetings. The Administrator and/or the SSD reviewed grievances received from the Resident Council group from September 2018 through December 2018, to validate that resolutions were initiated or obtained, and the resident council group was given a follow up letter regarding the resolution. F 677 Current facility residents have the potential to be affected by the same deficient practice of not receiving showers as scheduled. The DON and ADON's completed an audit on 1/21/19, of shower documentation for current facility residents, to identify residents that had not received a shower as scheduled. There were 3 residents identified. Those residents were offered a shower on 1/21/19 and will be offered showers going forward according to shower schedule. F 804 Current facility residents that receive meal trays have the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; cross referenced to the following: F 565 The Administrator provided education on 1/23/19, for the Interdisciplinary Team (IDT), which consists of the Director of	

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F 867	Continued From page 68	F 867	Nursing (DON), Assistant Director of Nursing (ADON), Social Service Director (SSD), Dietary Manager (DM), Activities Director (AD), Rehab Manager (RM) and Maintenance director (MD), regarding response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Activities Director will document grievances received during resident council meetings on the approved Grievance form and will forward the grievance form to the SSD to be logged onto the Resident Council Grievance log. The SSD will then forward the grievance form to the Administrator, who will give to the appropriate IDT member to investigate and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to review and approve, then the SSD will submit a follow up letter to the Resident Council president and/or group within 5 days of the receipt of the grievance. A copy of the follow up letter will be kept with the monthly resident council meeting minutes. F 677 The DON and/or ADON's provided education beginning on 1/22/19, for the licensed nurses and CNA's regarding providing showers to residents according to the shower schedule, with documentation by the CNA on the shower sheet, and the licensed nurse will validate shower was given and document on the residents MAR. When a resident refuses a shower, the CNA will report to the licensed nurse and the licensed nurse will	

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F 867	Continued From page 69	F 867	follow up with the resident and document refusal or acceptance of the shower on the MAR. The education will be provided to newly hired staff during new hire orientation. F 804 The Director of Nursing provided in service education on 1/22/19, for the nursing staff, regarding passing of meal trays timely to keep food at the point of resident service within the acceptable temperature range of 125 degrees or resident preference. This education will be provided to newly hired nursing staff during new hire orientation. The Dietary Manager completed education for the dietary staff on 1/25/19, regarding maintaining acceptable food temperatures of 140 degrees or greater on the tray line. The Dietary Manager orders food weekly for the upcoming weekly menu and the always available menu. The DM and/or the cook will validate daily that food items are available for the following days menu and the Always Available menu. The DM is responsible for ordering food items and/or adjusting the menu with alternatives of equal nutritive value as necessary to accommodate resident preferences and to meet the nutritional guidelines as determined by the Dietician. The facility provides an Always Available Menu or Alternate menu, if the resident chooses not to want the food on the daily menu. The DON and/or ADON's will assign nursing staff to the dining area and hallways during meal times to assure	

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F 867	Continued From page 70	F 867	meal trays are passed timely when they are sent from the kitchen. The facility failed to follow the QAPI process for identifying, planning and implementing quality plans for improvement and did not continue ongoing monitoring to assure continued compliance in areas identified. The Regional Director of Clinical Services provided education on 1/23/19, to the Interdisciplinary team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activities Director, Dietary Manager, Maintenance Director and Housekeeping supervisor, regarding the QAPI process to include how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The Administrator is the QA coordinator at the facility and will hold monthly QAPI meetings to review and update plans that have been implemented to assure continued compliance. Members of the QAPI committee will consist of at least the Administrator, Director of Nursing, Medical Director, Social Service Director, Activities Director, Infection Control Nurse, Care plan coordinator, Dietary Manager, Maintenance Director and Housekeeping supervisor. A member of the direct care staff will also be invited to participate. Active Quality Plans will be reviewed weekly by the Administrator and the department managers to validate audits/monitors are being completed and adjust plans as necessary for continued compliance.	

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F 867	Continued From page 71	F 867	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; cross referenced to the following: F 565 The Administrator and/or the Director of Nursing will review resident council grievance log 5 x a week for 4 weeks then weekly for 5 months, to validate that grievances received from the resident council group were investigated, a resolution was initiated/completed and a follow up letter was provided to the resident council president and/or resident group within 5 days of receiving the grievance. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The Administrator will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. F 677 The DON and/or the ADON's will audit shower sheets and MARS 5 times a week for 4 weeks then 3 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or the ADON's will interview 10 residents weekly for 4 weeks then 20 residents monthly for 5 months, to validate that showers are given as scheduled. The Director of Nursing will review the audits to identify patterns/trends and will adjust the plan as necessary. The DON will review the plan during the monthly	

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F 867	Continued From page 72	F 867	QAPI meeting and audits will continue at the discretion of the QAPI committee. F 804 The DM, the cook and/or the Administrator will monitor food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks, then 3 times a week for 5 months. Standard of practice is at each meal, ensuring foods are held at a temperature of above 140 degrees F. The DM, the cook and/or the Administrator will monitor food temperature during meal pass in the dining room and hallways, for breakfast, lunch and dinner 5 times a week for 4 weeks then 3 times a week for 5 months, to assure food temperatures at point of service remain within acceptable temperature range of 125 degrees or resident preference. The DON and/or the ADON's will monitor the dining area and hallways during meal times 5 times a week for 4 weeks, then 3 times a week for 5 months, to validate that staff are present in the dining area and hallways and passing trays timely. The Administrator, DON and/or the dietary manager will interview 5 residents weekly for 4 weeks then 10 residents monthly for 5 months, to validate that food was delivered at an acceptable temperature according to resident preference. The Administrator, Dietary Manager and/or the Director of Nursing will review audits/monitors and interviews to identify patterns and trends and will adjust the	

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F 867	Continued From page 73	F 867	plan as necessary. The Administrator/Dietary manager/DON will review the plan during monthly QAPI meeting and will continue the plan at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; February 1, 2019	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to maintain an effective pest control program on one of two halls observed (100 Hall). The findings included: An interview was conducted on 1/2/19 at 10:50 AM with Resident #11. Information provided by the facility indicated Resident #11 was alert and oriented. During the interview, Resident #11 stated his room was kept clean. However, the resident also reported there was a "bad problem with roaches." The resident reported he saw one cockroach last night on the privacy curtain in his room. He also recalled that last week he felt something crawling on him when he was lying in bed. He stated it was a cockroach. When asked if he had told anyone about the problem with	F 925	F 925 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #11's room 113 was treated on 12/12/18, 12/27/18 and 1/15/19. Room 111 was treated on 12/12/18, 12/27 and 1/15/19. Room 124 was treated on 12/12/18, 12/27/18 and 1/15/19. Room 127 was treated on 12/27/18. Visitors bathroom near lobby was treated 12/12/18, 12/27/18 and 1/15/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	2/1/19

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F 925	Continued From page 74 roaches, he stated he did when he was first admitted to the facility. However, he reported he did not say anything to anyone about the cockroaches last week or last night because the staff was already aware of this problem from his previous reports. Additionally, Resident #11 stated the nursing staff has talked about cockroaches being a concern in other residents ' rooms as well. A review of Resident #11 ' s medical record revealed the resident was admitted to the facility on 9/4/18 from a hospital. A review of Resident #11 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 12/12/18 revealed the resident was assessed to have moderately impaired cognitive status for daily decision making. An interview was conducted on 1/2/19 at 3:35 PM with the facility ' s Assistant Director of Nursing (ADON) for the Long Term Care unit, which included Resident #11 ' s hall. Upon inquiry, the ADON reported Resident #11 was alert and oriented. She stated Resident #11 could answer questions appropriately and reliably. An interview was conducted on 1/2/19 at 11:30 AM Interview with Housekeeper #2. At the time of the interview, Housekeeper #2 was working on Resident #11 ' s hall. Housekeeper #2 reported she worked full time on 1st shift. Upon inquiry, the housekeeper stated she last saw a dead cockroach on another hall last week. She reported the roaches typically came out of a night, so the only ones she would find would likely be dead. Housekeeper #2 stated she thought the problem with cockroaches might be a little better than it had previously been.	F 925	The Maintenance director completed a 100% audit of the facility on 1/4/19, to identify areas of pest infestation. Focus areas identified are Kitchen, service hall, Long term care (LTC) med room, LTC nursing station, LTC locker room, LTC main hallway, rooms 113, 123 and 124. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Maintenance director, Administrator and/or the Director of Nursing (DON) completed education on 1/25/19 for all staff, all days, all shifts including weekend and prn staff, regarding process for reporting when pest is observed, to include a Pest Control log book located at each nurse's station. Staff will document on the log, where the pest were observed and type of pest. The Maintenance director, Housekeeping supervisor and/or manager on duty will monitor the logs daily and provide appropriate treatments or notify pest control company. The facility obtained a contract with a new pest control company on 12/12/18. The company will treat facility at least twice a month and/or as needed. The company has treated the facility and focus areas on the following dates: 12/12/18, 12/27/18 and 1/15/19. The facility has provided written notice to current residents and/or resident representatives to store food items in closed containers. The facility will provide containers as needed. Facility protocol for	

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F 925	Continued From page 75 An observation was made on 1/3/19 at 8:35 AM of a small (approximately 1/2 inch long), dead black bug in the corner of a restroom adjacent to the common hallway near the facility ' s lobby. Housekeeper #1 was observed to be working near the bathroom at the time of the observation. Upon request, Housekeeper #1 observed the dead insect and stated it was a dead cockroach. At that time, she reported there have been cockroaches in the facility. An interview was conducted on 1/3/19 at 11:35 AM with the facility ' s Director of Housekeeping. The Director reported he worked with Maintenance to control pests in the facility. Upon inquiry, the Director reported there has been a problem with cockroaches in the facility but noted, "For the last 2-3 months we have been really crunching down on it." He stated a lot of the problem stemmed from the residents ' families bringing in outside food without placing the food items in sealed containers. The Director reported the facility has been talking about buying some type of container to store food items in the residents ' rooms. The Director recalled an insect spray and deep clean was recently done due in Room #111 due to cockroaches having been reported in that room (a room on Resident #11 ' s hallway). An interview was conducted on 1/3/19 at 11:44 PM with the facility ' s Director of Maintenance. The Director reported he started at the facility in October, 2018. When he started his position, he was told bugs were being seen in the facility. The contracted pest control company was coming out monthly at that time. The Director stated he has asked staff to keep him informed of any pest	F 925	storage of food items in residents' rooms will be provided and reviewed with new admissions in the new admission packet. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Director of Maintenance will monitor focus areas at least 5 times a week for 8 weeks then 3 x week for 4 weeks. Director of Maintenance will monitor the other areas of the facility weekly for 4 weeks then q 2 weeks for 2 months. Director of Maintenance will review audits/logs monthly to identify patterns/trends and will adjust plan as necessary The plan will be reviewed during monthly QAPI and will continue at the discretion of the QAPI committee Indicate dates when corrective action will be completed; February 1, 2019	

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problems and to keep the rooms cleaned from crumbs. The Director reported when he continued to receive complaints about cockroaches from staff, he asked a new pest control service to come out to the facility. The new pest control company came out to do a general spray on 12/12/18. On 12/27/18, the new pest control company come back to target Room #111 and to re-treat the dining room, kitchen, main hall, and a service hall. To date, the Director of Maintenance stated the facility had not developed a Quality Assurance and Performance Improvement (QAPI) plan to present at the QAPI monthly meetings.

A review of the facility ' s pest control invoices from the past 3 months included:
--On 9/6/18, a monthly service for cockroaches was provided; no special instructions were noted on the invoice.
--On 10/4/18, a service (not specified) was provided; no special instructions were noted on the invoice.
--On 11/1/18, a monthly service for cockroaches was provided; no special instructions were noted on the invoice.
--On 12/12/18, an invoice from the new pest control company indicated general pest control was provided.
--On 12/27/18, an invoice from the new pest control company indicated a general pest control respray was done and included Room #111.

An interview was conducted on 1/3/19 at 2:55 PM with Nursing Assistant (NA) #7. NA #7 worked on 2nd shift and reported she was frequently assigned to care for Resident #11. During the interview, the NA reported the resident was alert, oriented and reliable. When asked if she had

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seen any cockroaches in his room, the NA stated, "They are all over the place, but it ' s gotten better the last 3 weeks." The NA reported about 2-3 months ago when she went into a drawer to retrieve something for Resident #11 ' s roommate, a cockroach ran up her arm. The NA stated she did report the incident.

An interview was conducted on 1/3/19 at 3:00 PM with NA #6. NA #6 reported she worked on 1st shift. Upon inquiry, the NA stated she saw three live cockroaches climbing on the privacy curtain in Room #124 this morning. Upon request, the NA accompanied surveyor to Room #124. The NA was observed as she hit the corner guard on the wall located between Bed #1 ' s privacy curtain and the bathroom. At that time, a live, brown bug briefly appeared before crawling back under the corner guard. The NA confirmed this was a live cockroach. When asked if she had told anyone about the roach, the NA stated she told the Assistant Housekeeper and the Director of Maintenance three days ago when she saw roaches in the room. The NA stated she did not report seeing the cockroaches today because they had already been told about the problem.

An interview was conducted on 1/3/19 at 3:10 PM with the Director of Maintenance. During the interview, the Director was asked if he had been told about any concerns of cockroaches in Room #124. He stated he had not. Upon request, the Director went to Room #124. At that time, a live cockroach was observed to be climbing on the wall just to the right of the bathroom door in the resident ' s room. The Director confirmed this was a cockroach. When asked, the Director of Maintenance reported there were generally three means of communicating pest control problems

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or maintenance issues to him. He stated any concerns could be shared verbally with him, brought up in the daily stand-up meeting, or submitted electronically as a work order.

An interview was conducted on 1/3/19 at 3:15 PM with NA #8. When asked if she had seen any cockroaches today, the NA stated she did see one live roach running across the baseboard in Room #127 earlier today. When asked if she had told anyone, she stated she was not sure whether or not she did. However, the NA reported that normally she would report something like this to either maintenance or housekeeping. The NA stated, "I ' ve seen them pretty much everywhere, just not as much as before."

A follow-up interview was conducted on 1/4/19 at 8:35 AM with the Director of Housekeeping. During the interview, the Director was asked if he was recently told staff and residents saw live cockroaches in the residents ' rooms. The Director of Housekeeping reported that other than Room #111 (which had been re-sprayed and deep cleaned), he had not been told cockroaches were seen residents ' rooms within the last two weeks.

A follow-up interview was conducted on 1/4/19 at 11:20 AM with the Director of Maintenance. At that time, the Director was asked if the pest control company had provided any instructions to him when they last came to the facility. He reported he was told not to do any cosmetic or structural repairs until the cockroaches were eradicated. When asked, the Director of Maintenance stated the facility did not have a contract with the new pest control company at this time.

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F 925	Continued From page 79 An interview was conducted on 1/4/19 at 12:30 PM with the Assistant Housekeeper. Upon inquiry, the housekeeper stated no staff members had reported a concern to him about cockroaches within the last two weeks. He reported if he had been told about a problem, he would have notified his supervisor. An interview was conducted on 1/3/19 at 3:17 PM with the facility ' s Administrator. During the interview, the concerns regarding cockroaches in the facility were discussed. The Administrator stated the facility was currently on a 2-week cycle with a new pest control company. When asked if a plan of correction had been formulated to address the problem (including QAPI involvement), the Administration stated, "We have not done a QAPI plan." Upon inquiry, the Administrator stated her expectation would be for staff to notify either the Director of Maintenance or herself if cockroaches were seen in a resident ' s room.	F 925		