STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to protect two of four residents ' privacy by not covering a urinary drainage bag with a privacy bag. (Residents #64 and 98). The findings included: 1. Resident #64 was admitted to the facility on 3/19/15 with diagnoses including hypertension, dementia and dysfunction of the bladder. The Minimum Data Set (MDS) dated 1/15/16, a quarterly, indicated Resident #64 had an indwelling urinary catheter and a neurogenic bladder. The MDS included Resident #64 had short and long term memory impairment. Observations on 03/02/16 at 8:23 AM in the main dining room, revealed Resident #64 was sitting in a geri-chair with a urinary drainage bag attached to the arm rest on the geri-chair. The urinary drainage bag was not covered with a privacy bag. There were visitors, other residents and staff in the main dining room during the observation. Cloudy light yellow urine was observed in the drainage tubing up to drainage bag. Observations on 03/02/16 at 9:26 AM revealed Resident #64 was removed from the dining room and taken to her room. The urinary drainage bag remained on the arm of the geri-chair with no	F 241	1) On 3/2/16, the nurse assigned to Resident #64 located the privacy bag on the side of the resident□s geri-chair and placed the urinary drainage bag in the privacy bag. On 3/2/16, the Director of Nursing conducted targeted education sessions with staff regarding the necessity of covering urinary drainage bags to protect resident privacy. The Director of Nursing also conducted pre-scheduled, monthly nursing department meetings which were held on 3/8/16 and 3/14/16. The topics of mandatory privacy bags, proper placement of catheters on wheelchairs, geri-chairs, and beds were added to agenda as was proper securing of catheter tubing via leg straps. The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below	3/31/16

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

Electronically Signed | 03/24/2016

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F 241	Continued From page 1 privacy covering on the drainage bag. Observations on 03/02/16 at 9:47 AM with NA #6 revealed Resident #64 did not have a privacy cover on the urinary drainage bag positioned on the armrest of the geri-chair. NA#6 explained the drainage bag was positioned on the arm rest due to not being able to place it anywhere else on the geri chair. Interview on 03/02/16 at 9:50 AM with NA #7, (assigned to resident #64) revealed she was not sure if the resident had a privacy bag. Further interview revealed NA #7 had provided care to Resident #64 about three weeks ago and she did not remember a privacy bag in use at that time. Interview with Nurse #2 on 100 hall on 03/02/16 at 10:05 AM revealed the urinary drainage bag should have a privacy cover on the drainage bag. After the interview with Nurse #2, she went to Resident #64 ' s room. Inspection of the urinary drainage bag by nurse #2, NA # 6 and #7 revealed a privacy bag was attached on the right side of the geri-chair footrest. Nurse #2 removed the privacy bag and placed the urinary drainage bag in the cover. Interview with the Director of Nursing (DON) on 03/02/16 at 10:25 AM revealed she would expect the aides to have a privacy cover on the urinary drainage bag. 2. Resident #98 was admitted to the facility on1/7/16 with diagnoses of neurogenic bladder and diabetes. The Minimum Data Set (MDS), an admission, dated 1/13/16 indicated Resident #98 had impaired short and long term memory, moderate	F 241	the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. Upon investigation, it was revealed that there were no privacy bags in the supply closet. The facility supply clerk indicated the items had been ordered but were not available from the vendor on 3/2/16. The privacy bags were received from the vendor on Thursday 3/3/16 and the need for privacy bags was determined to be for only one resident, #98 at which time, the privacy bag was put into place and the urinary drainage bag was placed in it. 2) On 3/22/16, the facility supply clerk researched the possibility of other urinary catheter privacy options. Urinary drainage bags with attached privacy flaps were identified and ordered. The use of this equipment will take the place of separate privacy bags when available. 3) Daily care guides will be implemented immediately following staff training. A daily care guide will be generated from American Health Tech based on the information entered into each individual care plan by the MDS staff. A printed copy of each resident□s daily care guide will be placed in a clear, protective covering on the inside door of each resident□s closet. Daily care guides will be updated based on changes in information, status, physician orders, and care plan updates. These changes will be documented by the nurse receiving the information and will be	

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F 241	Continued From page 2 impairment with daily decision making abilities and had an indwelling urinary catheter. Observations on 03/01/16 at 8:57 AM revealed Resident #98 was in her room. The urinary drainage bag was positioned on the bottom of the bedframe, facing the open door to the hall. A privacy bag was not in place over the drainage bag. Observations of Resident #98 on 03/02/16 at 8:00 AM revealed a privacy bag was not used to cover the urinary drainage bag. The drainage bag with urine was visible from the hallway. Observation of Resident #98 on 03/02/16 at 10:50 AM revealed she was in her room and a privacy bag was not used to cover the urinary drainage bag. The drainage bag was visible from the hallway. Interview with Nurse Aide (NA) #8 on 03/02/16 at 10:55 AM revealed she provided care for Resident #98 on 03/01/16 and today on 03/02/16. Further interview with NA #8 revealed Resident #98 did not have a privacy bag for the urinary drainage bag. NA# explained a privacy bag was also not present yesterday. During the interview with NA #, she aide explained she had asked the treatment nurse for one (privacy bag) this morning (3/2/16). Interview with the Director of Nursing (DON) on 03/02/16 at 10:25 AM revealed she would expect the aides to have a privacy cover on the urinary drainage bag.	F 241	dated and signed appropriately. All currently employed nursing staff will be educated on location and content of daily care guides. Newly hired staff will be educated on the daily care guide use during the orientation process. New admissions will have a written daily care guide based on their initial assessment and physician orders and will be utilized until the care plan assessment has been completed. 4) The Director of Nursing and the nurse management team met on 3/21/16 to discuss necessary changes to ensure privacy bags and leg straps were mandatory. The decision was made to add these items to the Treatment Administration Record (TAR). This procedure change will prevent the absence of these necessities from occurring again. Signing off on these items by the treatment staff will be performed daily. 5) The facility urinary drainage catheter policy was updated on 3/21/16 to include the mandatory use of leg straps to secure tubing and privacy bags or flaps for all indwelling catheters as well as urinary drainage bag placement to be lower than the bladder to prevent infection. 6) Daily care guides, and dignity concerns will be added to the monthly nursing department staff meeting agenda. 7) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be	

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F 241	Continued From page 3	F 241	addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		3/31/16

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F 278	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to include the use of a restraint on the most recent Minimum Data Set assessment for one of one resident with a restraint. (Resident #90). The findings included: Resident #90 was admitted to the facility on 11/6/12 with diagnosis including Alzheimer's disease and stroke with left side weakness. A telephone order dated 12/28/15 indicated a soft mitt was to be used on the right hand to " protect skin from OCD (obsessive compulsive disorder) behaviors. " Instructions included to " check daily skin. " The Minimum Data Set (MDS) dated 12/31/15 indicated Resident #90 had long and short memory impairment with severe impairment of daily decision making abilities. This MDS assessed the resident as requiring total assistance with activities of daily living (ADLs). Resident #90 had bilateral impairment of both upper and lower extremities with functional movement. This MDS did not indicate a physical restraint was in use for Resident #90. The care plan with an update of 1/6/16 included problems of impaired thought processes and limited communication and behaviors of excessive rubbing her head with her fist. Interventions included the use of a soft mitt to the right hand and to check the skin under the mitt daily.	F 278	1) On 3/2/16, the nursing staff was immediately educated on proper use of the soft mitt based on the order indicating its use on the right hand. 2) Upon re-evaluation by the medical director and in the absence of documented OCD behaviors, the use of the soft mitt to the right hand was discontinued. No areas of skin breakdown or rash were present. The soft mitt was utilized as ordered until the discontinuation date on 3/11/16. 3) The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. Education was also provided to staff on the difference between a soft mitt and a restraint as well as other types of restraints. This information is based on the state□s definition of a restraint indicating any equipment that can hinder an individual□s	

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F 278	Continued From page 5 Observation on 03/01/16 at 3:29 PM of Resident #90 revealed she was in bed with soft mitt on right hand. Observations on 3/2/16 at 8:30 AM, 10:30 AM and 2:30 PM revealed Resident #90 had the soft mitt applied to the left hand. Interview with MDS nurse #1 on 03/02/16 at 8:27 AM revealed the soft mitt was not considered a restraint. The MDS nurse #1 explained the resident did not have " purposeful movement " of her right hand. " Interview with the Director of Nursing (DON) on 03/02/16 at 8:56 AM revealed she did not see it (soft mitt) as a restraint. She explained Resident #90 was to wear the mitt when she displayed behaviors of constant rubbing of her head. The current physician orders and TAR documentation were reviewed with DON and she explained, it did pose a question. The DON added, she thought it (soft mitt) was to be used as needed for behaviors of constant rubbing of her head.	F 278	normal body movement. Staff educated on the expectation to reevaluate or question treatments not found, not available, or not effective and where to find extra equipment (Clean linen supply closet located on the 400 hall). These topics will also be added to April□s monthly nursing department staff meeting. 4) For orders on devices or equipment that can be defined as restraints, clarification will be obtained as well as alternate interventions. All orders will be followed and added to the care plan. If an order contains information to check skin daily, this will be placed on the TAR and signed off on daily. If the intervention is deemed necessary and is defined as a restraint, appropriate documentation will be utilized per state regulations. Any such order will be added to the MDS assessment and subsequently to the daily care guide. The use of daily care guides will eliminate unanswered questions about the use of any equipment or proper placement of such equipment. 5) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		3/31/16

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F 280 SS=D	Continued From page 6 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update a care plan to include restorative nursing for one of two residents with restorative nursing (Resident #92). The findings included: Resident #92 was admitted to facility on 9/19/11 and readmitted on 9/27/15. The most recent diagnoses included chronic pain, muscle weakness, unspecified lack of coordination and osteoarthritis.	F 280	1) On 3/3/16, it was identified that Resident #92 had restorative needs that were not conveyed from the therapy department to the nursing department. Once revealed, the Restorative Nurse wrote the recommendations up on the restorative flowsheet, educated the hall staff about the current restorative needs, and provided education about the types of exercises. The Restorative plan was then implemented per therapy□s recommendations. 2) The Director of Nursing met with the	

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F 280	Continued From page 7 Review of the Minimum Data Set (MDS) dated 12/31/15, a quarterly, indicated Resident #92 had a Brief Interview for Mental Status (BIMS) of 13 which indicated long and short term memory was intact. This MDS indicated Resident #92 required extensive assistance of one staff for all activities of daily living (ADLs). Review of the MDS indicated Resident #92 did not ambulate, had limited functional movement on one side of her upper body and poor balance for sitting and transfer. The " Restorative Referral " signed by the therapist on 11/3/15 indicated Restorative care would begin on 11/9/15. This form was the method of communication between therapy and restorative nursing. The goals included " Patient will perform towel glides on table surface forward and back, also, side to side. 20 reps (repetitions) x (times) 2 sets Right Shoulder. " The program included bilateral upper extremity range of motion to be provided 5 times a week. PT referral for Restorative care would begin on 12/8/15. The goals included " Maintain pt (patient) current functional status. Maintain AROM on BLE (bilateral lower extremities) " The program included patient will perform BLE AROM exercises in all planes 2 times for 20 repetitions. Patient will perform transfers to and from the wheelchair with a rolling walker with contact guard assist. Review of the care plan updated on 1/13/16 included a problem of impaired mobility related to weakness and debility. The interventions included therapy to refer resident to restorative nursing once she has reached her max potential for a maintenance program. The therapy	F 280	nursing management staff on 3/21/16 to discuss necessary changes to the restorative program to guarantee proper follow through on therapy recommendations. 3) The Director of Nursing conducted pre-scheduled, monthly nursing department meetings which were held on 3/8/16 and 3/14/16. The topic of proper care and completion expectations related to the restorative program was discussed. The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. The importance of identifying and reporting changes in resident status was also discussed in order to prevent worsening conditions. Proper restorative program functions were discussed as well. Each of these types of care will be listed on the daily care guide. Clarifications were offered as to the types of exercises that were currently recommended for residents and what ADL	

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F 280	Continued From page 8 referrals from 11/4/15 and 12/1/15 were not included on the care plan. Interview with the MDS Nurse #1 on 3/3/16 at 10:48 AM revealed she had not updated the care plan to include the range of motion exercises. She explained it must have been missed.	F 280	functions were equivalent to those types of movement. It was specifically addressed that CNAs assigned to each hall were responsible for performing the restorative functions as ordered. Proper documentation on the restorative flowsheet will serve a proof of compliance. Weekly monitoring by the Restorative Nurse will take place. 4) 0n 3/22/16, the Therapy Director, the Director of Nursing, and the Staff Development Coordinator discussed the need for in-services for the nursing staff related to the functional restorative exercises, rationale behind the exercises, and the need for consistent movement via the restorative recommendations. It was determined that mandatory in-services would be conducted by the therapy staff for all nursing department staff. 5) As of 3/23/16 the Restorative Program will be conducted as such: when a restorative need has been identified or determined by the therapy department, the recommendation(s) will be communicated on a Restorative Referral form and the staff will be educated on the particular type of exercises to be performed. Copies of the referral form will be given to the MDS/Care Plan nurses and to the Restorative Nurse. The care plan will be updated. The referral will be written up on a restorative flowsheet by the Assistant Director of Nursing (functioning as the Restorative Nurse) and placed in the appropriate Restorative book designated by each resident hall. Any additions or changes to daily care will be added to the resident□s individual daily	

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F 280	Continued From page 9	F 280	care guide. The hall staff will have access to the restorative recommendations as each book will be kept on its designated hall. 6) Once the Restorative plan has been written up by the Restorative Nurse, the referral form is placed in the resident□s medical chart behind the Restorative tab. 7) The therapy department will follow up and ensure compliance by keeping an up to date, running list of residents in need of a restorative plan. This list will be categorized by resident name, start date, restorative recommendations and frequency of exercises. A reassessment date will also be scheduled for each resident to evaluate appropriateness and possible continuation of the program. 8) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		3/31/16

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F 282	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to follow care plan interventions for of one residents with a restraint (Resident #90), one of two residents with an indwelling urinary catheter (Resident #64), one of three residents with Pressure ulcers (Resident # 2) and one of three residents with decreased range of motion (Residents # 2). The findings included: 1.Resident #90 was admitted to the facility on 11/6/12 with diagnosis including Alzheimer's disease and stroke with left side weakness. A telephone order dated 12/28/15 indicated a soft mitt was to be used on the right hand to " protect skin from OCD (obsessive compulsive disorder) behaviors. " Instruction included to " check daily skin. " The Minimum Data Set (MDS) dated 12/31/15 indicated Resident #90 had long and short memory impairment with severe impairment of daily decision making abilities. This MDS assessed the resident as requiring total assistance with activities of daily living (ADLs). Resident #90 had bilateral impairment of both upper and lower extremities with functional movement. This MDS did not indicate a physical restraint was in use for Resident #90. The care plan with an update of 1/6/16 included problems of impaired thought processes and limited communication and behaviors of excessive rubbing her head with her fist. Interventions included the use of a soft mitt to the right hand and to check the skin under the mitt	F 282	1) The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. 2) Daily care guides will be implemented immediately following staff training. A daily care guide will be generated from American Health Tech based on the information entered into each individual care plan by the MDS staff. A printed copy of each resident□s daily care guide will be placed in a clear, protective covering on the inside door of each resident□s closet. Daily care guides will be updated based on changes in information, status, physician orders, and care plan updates. These changes will be documented by the nurse receiving the information and will be dated and signed appropriately. All currently employed nursing staff will be educated on location and content of daily	

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F 282	Continued From page 11 daily. The February 2016 monthly orders included the use of a hand mitt on the right hand due to obsessive compulsive behavior of rubbing her head with her fisted hand. The skin was to be inspected daily under the mitt. Review of the Treatment Administration Record (TAR) for February 2016 revealed the ordered soft mitt to the right hand was not applied for 8 days due to "mitten not in room" and "mitten being washed." Observations on 2/29/2016 at 9:45 AM revealed Resident had nothing on her right hand. The resident was observed using her right hand to grab her blanket and pull it up to her chest. Observation on 3/1/2016 at 9:00 AM revealed Resident #90 had nothing on her right hand. The resident was observed rubbing her head with her hand in a closed fist. Observation on 03/01/2016 at 3:29 PM of Resident #90 revealed she was in bed with soft mitt on right hand. Observations on 3/2/2016 at 8:30 AM, 10:30 AM and 2:30 PM revealed Resident #90 had the soft mitt applied to the left hand. Interview with Nurse #1 on 03/02/2016 at 9:06 AM revealed the right hand mitt was to be applied when Resident #90 was awake for the most part. She explained the mitt didn't "stay on well, she is active with that hand " Nurse #1 explained the resident would scratch herself and had repetitive motions and the mitt would come off. The	F 282	care guides. Newly hired staff will be educated on the daily care guide use during the orientation process. New admissions will have a written daily care guide based on their initial assessment and physician orders and will be utilized until the care plan assessment has been completed. 3) For orders on devices or equipment that can be defined as restraints, clarification will be obtained as well as alternate interventions. All orders will be followed and added to the care plan. If an order contains information to check skin daily, this will be placed on the TAR and signed off on daily. If the intervention is deemed necessary and is defined as a restraint, appropriate documentation will be utilized per state regulations. Any such order will be added to the MDS assessment and subsequently to the daily care guide. The use of daily care guides will eliminate unanswered questions about the use of any equipment or proper placement of such equipment. 4) Staff educated on 3/22/16, 3/26/16, and 3/24/16 about the expectation to reevaluate or question treatments not found, not available, or not effective and where to find extra equipment (Clean linen supply closet located on the 400 hall). These topics will also be added to April□s monthly nursing department staff meeting. 5) The facility urinary drainage catheter policy was updated on 3/21/16 to include the mandatory use of leg straps to secure tubing and privacy bags or flaps for all indwelling catheters as well as urinary	

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F 282	Continued From page 12 resident did not remove the soft mitt at will. Further interview revealed Resident #90 could not open up the fingers of the right hand. Resident #90 did have "pincher" type movement of her fingertips and could pinch, or grasp without the mitt. During the interview Nurse #1 explained she was not aware of any device for the left hand. Interview with NA#1on 03/02/2016 at 9:12 AM revealed she was not assigned to Resident #90, but knew she had a mitt for the right hand. Continued interview revealed the mitt would be worn all day because Resident #90 would scratch and/or rub herself with that hand. Observation on 03/02/2016 at 10:35 AM with the hospice nurse and the therapy manager revealed the mitt was on the wrong hand. It was on the left hand and not the right. Interview with NA#2 on 03/02/2016 at 10:42 AM revealed she was assigned to Resident #90 but had not put the mitt on the resident. NA #2 explained night shift gets the resident up in the morning and put the mitt on her. Further interview with NA #2 revealed she did not know which hand should have the mitt. Observations on 03/02/2016 at 12:54 PM revealed the soft mitt remained on left hand and not right hand. Resident #90 was in a geri-chair and observed rubbing on her knee with her right hand. Observations on 03/02/2016 3:27 PM revealed Resident #90 was in bed with the mitt on the left hand and continuously scratching her leg and rubbing her knee.	F 282	drainage bag placement to be lower than the bladder to prevent infection. 6) Pressure relieving devices will be placed on the TAR per standing order for residents identified to have skin breakdown or potential for skin breakdown. This will be signed off on by the treatment staff every shift. This information will also be on the daily care guide. 7) As of 3/23/16 the Restorative Program will be conducted as such: when a restorative need has been identified or determined by the therapy department, the recommendation(s) will be communicated on a Restorative Referral form and the staff will be educated on the particular type of exercises to be performed. Copies of the referral form will be given to the MDS/Care Plan nurses and to the Restorative Nurse. The care plan will be updated. The referral will be written up on a restorative flowsheet by the Assistant Director of Nursing (functioning as the Restorative Nurse) and placed in the appropriate Restorative book designated by each resident hall. Any additions or changes to daily care will be added to the resident□s individual daily care guide. The hall staff will have access to the restorative recommendations as each book will be kept on its designated hall. 8) Once the Restorative plan has been written up by the Restorative Nurse, the referral form is placed in the resident□s medical chart behind the Restorative tab. 9) The therapy department will follow up and ensure compliance by keeping an up	

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F 282	Continued From page 13 Interview with NA #3 on 03/02/2016 at 3:39 PM revealed she was providing care for the resident today on 3-11 shift. NA#3 explained she was familiar with the Resident #90 and would know what to do for the resident by their care plans kept at the nurse's station. She did not have access to the care plans and would have to ask the nurse for the care plan. NA#3 further explained the nurse would inform her of anything new or that was needed for the resident. The mitt for Resident #90 was for her agitation and she would scratch herself. It was to be applied to her contracted hand (left hand). Observations on 03/03/2016 at 6:55 AM revealed Resident #90 did not have a mitt on either hand. Interview with NA #4 on 3/3/16 at 6:55 AM revealed she had provided care for the resident on 11-7 shift on 3/2/16. The resident wore a mitt at times. When asked what it was for she explained the resident would rub or scratch on herself. When asked which hand would require the mitt, she explained " it would depend, it could be either hand. " Further interview revealed the resident could open both hands. NA#4 explained while providing incontinence care this morning, the resident did not want to be bothered and she opened up both hands. 2. Resident #64 admitted to the facility on 3/19/15 with diagnosis including hypertension, dementia and dysfunction of the bladder. The Minimum Data Set (MDS) dated 1/15/2016, a quarterly, indicated Resident #64 had an indwelling urinary catheter, a neurogenic bladder and had not had a urinary infection in the last 30 days.	F 282	to date, running list of residents in need of a restorative plan. This list will be categorized by resident name, start date, restorative recommendations and frequency of exercises. A reassessment date will also be scheduled for each resident to evaluate appropriateness and possible continuation of the program. 10) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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The care plan with an update of 1/27/16 for a problem of an indwelling catheter, with the states goal to minimize risk of complications. The interventions included observe for symptoms of UTI, secure tubing to resident's thigh to prevent pulling, catheter care daily, encourage fluid intake, monitor tubing for kinks or twists in tubing, change catheter every month.

Observations on 03/02/2016 at 8:23 AM in main dining room, revealed Resident #64 was sitting in a geri-chair with a urinary drainage bag attached to the arm rest on the geri-chair. The urinary drainage bag was above the bladder and was not draining. Cloudy light yellow urine was observed in the drainage tubing up to drainage bag.

Observations on 03/02/2016 at 9:26 AM revealed Resident #64 was removed from the dining room and taken to her room. The urinary drainage bag remained on the arm of the geri-chair.

Observations on 03/02/2016 at 9:47 AM with NA #6 revealed Resident #64 did not have a securing strap in place on her leg and the urinary drainage bag was not positioned below the level of the bladder. NA#6 explained the drainage bag was positioned on the arm rest due to not being able to place it anywhere else on the geri chair.

Observation on 03/02/2016 at 9:50 AM with NA #7, (assigned to resident #64) revealed she was not sure if the resident was supposed to have a strap to secure the catheter. Further interview revealed the urinary drainage bag was positioned below the bladder. NA #7 explained there was nowhere different to place the drainage bag. If placed on the foot rest frame, it would be caught

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when the chair was positioned in an upright position for meals.

Interview with the nurse #2 on 100 hall on 03/02/2016 at 10:05 AM revealed the urinary drainage bag should not be positioned on the arm side of the geri-chair. After the interview with Nurse #2, she went to Resident #64 ' s room. Inspection of the urinary drainage bag by nurse #2, NA # 6 and #7 revealed the urinary drainage bag could be positioned below the level of the bladder for proper drainage of urine. Nurse #2 repositioned the urinary drainage bag underneath the footrest. Interview with Nurse #2 revealed a securing strap was to be in place on the resident's leg. Nurse #2 was not aware it was not on the leg.

Interview with the DON on 03/02/2016 at 10:25 AM revealed she would expect the aides to have a securing strap on the resident and the drainage bag to be below the bladder for proper drainage.

3. Resident #2 was re-admitted to the facility on 7/12/14 with diagnoses including dementia and contracture.

Review of the Minimum Data Set (MDS), a quarterly, dated 12/10/15 indicated the resident had long and short term memory problems and severe impairment with decision making abilities. Resident #2 was totally dependent on one staff for all activities of daily living. Resident #2 had limitation of the lower extremity due to history of an amputation of one leg.

Review of the care plan with an update of 12/16/15 included a problem of potential for skin breakdown due to Peripheral vascular disease,

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diabetes and left above the knee amputation. The interventions included use of a heel protector to the right heel at all times.

Observations on 2/29/16 at 11:24 AM revealed Resident #2 was seated in a geri-chair with the right foot without a heel protector in place.

Observations on 3/2/16 at 9:00 AM revealed Resident #2 did not have the heel protector on the right heel.

Interview with Nurse Aide (NA#9) on 3/3/16 at 6:55 AM revealed the resident was supposed to have a padded soft boot (heel protector) on her right foot. The aide explained the resident did not have a boot on her foot when she first came on duty. The aide looked in the resident's closet and did not find a boot to apply on the resident's foot.

Interview with the Director of Nursing on 03/03/16 at 9:47 AM revealed she would expect the aides to apply the heel protector according to the care plan.

4. Resident #2 was re-admitted to the facility on 7/12/14 with diagnoses including dementia and contracture.

Review of the Minimum Data Set (MDS), a quarterly, dated 12/10/15 indicated the resident had long and short term memory problems and severe impairment with decision making abilities. Resident #2 was totally dependent on one staff for all activities of daily living. Resident #2 had limitation of the lower extremity due to history of an amputation of one leg.

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Review of the care plan with an update of 12/16/15 included a problem of potential for skin breakdown. The interventions included application of a carrot spacer in the left hand to maintain left hand positioning daily.

Review of February splinting flowsheet sheet revealed documentation for the dates 2/1 to 2/8/16 and 2/19/16 indicating the carrot spacer was in place. Review of the March splinting flowsheet revealed no documentation for 3/1 to 3/3/16 for use of the carrot spacer.

Observations on 3/1/16 at 3:47 PM revealed the carrot spacer was not in Resident #2's hand.

Observations on 3/2/16 at 8:30 AM revealed the carrot spacer was not in Resident#2's hand.

Observations of Resident #2 on 3/3/16 at 9:15 AM revealed there was no device in her left hand. She kept the left hand closed in a tight fist.

Interview on 03/03/16 at 6:55 AM with Nurse Aide (NA) #5 revealed the resident did not have anything that was to be kept in her hand.

Interview with the Director of Nursing (DON) on 03/03/16 at 9:36 AM revealed contracture management of left hand would be done according to the care plan. Further interview revealed she would expect the aides on the floor to apply the carrot in the resident's hand daily. The aides would document the device was used on the "splinting restorative flowsheet."

Interview with MDS Nurse #1 on 03/03/16 at 10:48 AM revealed the carrot was to be used to prevent further contractures in the left hand.

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F 282	Continued From page 18 Further interview revealed the hand contracture had not become worse.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to secure an indwelling urinary catheter tubing and maintain the urinary drainage bag below the bladder for proper drainage for one of three residents with an indwelling urinary catheter. (Resident #64) The findings included: Resident #64 admitted to the facility on 3/19/15 with diagnosis including hypertension, dementia and dysfunction of the bladder. The Minimum Data Set (MDS) dated 1/15/2016, a quarterly, indicated Resident #64 had an indwelling urinary catheter, a neurogenic bladder and had not had a urinary infection in the last 30 days.	F 315	1) On 3/21/16, the Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. In addition, visual	3/31/16

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F 315	Continued From page 19 The care plan with an update of 1/27/16 for a problem of an indwelling catheter, with the states goal to minimize risk of complications. The interventions included observe for symptoms of UTI, secure tubing to resident's thigh to prevent pulling, catheter care daily, encourage fluid intake, monitor tubing for kinks or twists in tubing, change catheter every month. The monthly February 2016 orders indicated the catheter was to be changed monthly, care to be provided daily and the type/size of catheter was 16 French with 5cc (cubic centimeter) balloon to straight drainage. Record review revealed a history of urinary infections, with no current infections of the bladder. The nurse notes for the month of February 2016 indicated the urine was straw colored. Observations on 03/02/2016 at 8:23 AM in main dining room, revealed Resident #64 was sitting in a geri-chair with a urinary drainage bag attached to the arm rest on the geri-chair. The urinary drainage bag was above the bladder and was not draining. Cloudy light yellow urine was observed in the drainage tubing up to drainage bag. Observations on 03/02/2016 at 9:26 AM revealed Resident #64 was removed from the dining room and taken to her room. The urinary drainage bag remained on the arm of the geri-chair. Observations on 03/02/2016 at 9:47 AM with NA #6 revealed Resident #64 did not have a securing strap in place on her leg and the urinary drainage bag was not positioned below the level of the	F 315	education was provided by using a geri-chair and a wheelchair to show the options for urinary drainage bag placement. 2) The facility urinary drainage catheter policy was updated on 3/21/16 to include the mandatory use of leg straps to secure tubing and privacy bags or flaps for all indwelling catheters as well as urinary drainage bag placement to be lower than the bladder to prevent infection. 3) The Director of Nursing and the nurse management team met on 3/21/16 to discuss necessary changes to ensure privacy bags and leg straps were mandatory. The decision was made to add these items to the Treatment Administration Record (TAR). This procedure change will prevent the absence of these necessities from occurring again. Signing off on these items by the treatment staff will be performed daily. 4) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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bladder. NA#6 explained the drainage bag was positioned on the arm rest due to not being able to place it anywhere else on the geri chair.

Observation on 03/02/2016 at 9:50 AM with NA #7, (assigned to resident #64) revealed she was not sure if the resident was supposed to have a strap to secure the catheter. Further interview revealed the urinary drainage bag was positioned below the bladder. NA #7 explained there was nowhere different to place the drainage bag. If placed on the foot rest frame, it would be caught when the chair was positioned in an upright position for meals.

Interview with the nurse #2 on 100 hall on 03/02/2016 at 10:05 AM revealed the urinary drainage bag should not be positioned on the arm side of the geri-chair. After the interview with Nurse #2, she went to Resident #64 ' s room. Inspection of the urinary drainage bag by nurse #2, NA # 6 and #7 revealed the urinary drainage bag could be positioned below the level of the bladder for proper drainage of urine. Nurse #2 repositioned the urinary drainage bag underneath the footrest. Interview with Nurse #2 revealed a securing strap was to be in place on the resident ' s leg. Nurse #2 was not aware it was not on the leg.

Interview with DON on 03/02/2016 at 10:25 AM the aides know how to care for the residents with catheters because it is basic care. The nurse would report to the aides any changes or info needed. She explained she would expect the aides to have a securing strap on the resident and the drainage bag to be below the bladder for proper drainage.

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interview and staff interviews the facility failed to provide restorative nursing according to the restorative plan of care for Resident #92 and failed to provide a contracture management device for Resident #2 according to the restorative plan of care. This was for two of three residents with restorative nursing. The findings included: 1. Resident #92 was admitted to facility on 9/19/11 and readmitted on 9/27/15. The most recent diagnoses included chronic pain, muscle weakness, unspecified lack of coordination and osteoarthritis. Review of the Minimum Data Set (MDS) dated 12/31/15, a quarterly, indicated Resident #92 had a Brief Interview for Mental Status (BIMS) of 13 which indicated long and short term memory was intact. This MDS indicated Resident #92 required extensive assistance of one staff for all activities of daily living (ADLs). Review of the MDS indicated Resident #92 did not ambulate,	F 318	1) On 3/3/16, it was identified that Resident #92 had restorative needs that were not conveyed from the therapy department to the nursing department. Once revealed, the Restorative Nurse wrote the recommendations up on the restorative flowsheet, educated the hall staff about the current restorative needs, and provided education about the types of exercises. The Restorative plan was then implemented per therapy□s recommendations. 2) On 3/9/16, the Occupational Therapist evaluated Resident #2 based on a nursing staff report of mixed use with the left hand. OT determined that it was not necessary to continue the use of the carrot orthotic because the resident displayed abnormal reflex activity with minimal contracture. A physician order was obtained to discontinue the carrot on 3/9/16. 3) The Director of Nursing conducted pre-scheduled, monthly nursing department meetings which were held on	3/31/16

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F 318	Continued From page 22 had limited functional movement on one side of her upper body and poor balance for sitting and transfer. Resident #92 received occupational therapy (OT) from 9/28/15 to 11/4/15. Review of the OT discharge summary dated 11/4/15 indicated Resident #92 was being seen for active range of motion (AROM) of the right upper extremity, pain management, transfer, and self- feeding. Upon discharge the resident was able to self-feed, and transfer with minimal assist of 2 staff. Staff (Nurse Aides) were educated in AROM of right upper extremity to manage pain levels and maintain range of motion for functional use. The " Restorative Referral " signed by the therapist on 11/3/15 indicated Restorative care would begin on 11/9/15. This form was the method of communication between therapy and restorative nursing. The goals included " Patient will perform towel glides on table surface forward and back, also, side to side. 20 reps (repetitions) x (times) 2 sets Right Shoulder. " The program included bilateral upper extremity range of motion to be provided 5 times a week. Resident #92 received physical therapy (PT) from 11/18/15 to 12/1/15. Resident #92 received PT for standing balance assistance, strength general, transfer bed to wheelchair and back. Upon discharge the resident required minimal assistance from staff. PT referral for Restorative care would begin on 12/8/15. The goals included " Maintain pt (patient) current functional status. Maintain AROM on BLE (bilateral lower extremities) " The program included patient will perform BLE AROM	F 318	3/8/16 and 3/14/16. The topic of proper care related to the restorative program was discussed. The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effective reference tool for staff providing daily care to residents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags, leg straps to secure catheter tubing, placement of urinary drainage bags below the bladder to prevent infection, the classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief. The importance of identifying and reporting changes in resident status was also discussed in order to maintain function and prevent worsening conditions. Proper restorative program functions were also discussed. Each of these types of care will be listed on the daily care guide. Clarifications were offered as to the types of exercises that were currently recommended for residents and what ADL functions were equivalent to those types of movement. It was specifically addressed that CNAs assigned to each hall were responsible for performing the restorative functions as ordered. Proper documentation on the restorative flowsheet will serve a proof of compliance. Frequent monitoring by the Restorative Nurse will take place.	

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F 318	Continued From page 23 exercises in all planes 2 times for 20 repetitions. Patient will perform transfers to and from the wheelchair with a rolling walker with contact guard assist. Review of the care plan updated on 1/13/16 included a problem of impaired mobility related to weakness and debility. The interventions included therapy to refer resident to restorative nursing once she has reached her max potential for a maintenance program. The therapy referrals from 11/4/15 and 12/1/15 were not included on the care plan. Review of the restorative nursing plan of care revealed the plan included range of motion to the lower extremities and transfers. Resident #92 was discharged from restorative dining due to " little effort to feed self. " The restorative plan for AROM to the upper extremity was not in the restorative plan of care. Review of the documentation by the restorative aides revealed the exercises to the bilateral lower extremities were being done for 15 minutes for five days a week in February 2016. There were 16 days of documented restorative care provided to the lower extremities. Interview on 03/03/16 at 8:21 AM with Resident #92 revealed staff did not come in and do exercises to her arms or legs. Resident #92 indicated it had been a " long while " since she had any exercises. An interview with Nurse Aide (NA) #5 who had documented the exercises were provided in February 2016 was conducted on 3/3/16 at 8:30 AM. NA #5 explained the NA ' s on the halls	F 318	4) As of 3/23/16 the Restorative Program will be conducted as such: when a restorative need has been identified or determined by the therapy department, the recommendation(s) will be communicated on a Restorative Referral form and the staff will be educated on the particular type of exercises to be performed. Copies of the referral form will be given to the MDS/Care Plan nurses and to the Restorative Nurse. The care plan will be updated. The referral will be written up on a restorative flowsheet by the Assistant Director of Nursing (functioning as the Restorative Nurse) and placed in the appropriate Restorative book designated by each resident hall. Any additions or changes to daily care will be added to the resident□s individual daily care guide. The hall staff will have access to the restorative recommendations as each book will be kept on its designated hall. 5) Once the Restorative plan has been written up by the Restorative Nurse, the referral form is placed in the resident□s medical chart behind the Restorative tab. 6) The therapy department will follow up and ensure compliance by keeping an up to date, running list of residents in need of a restorative plan. This list will be categorized by resident name, start date, restorative recommendations and frequency of exercises. A reassessment date will also be scheduled for each resident to evaluate appropriateness and possible continuation of the program. 7) Procedures will be assessed and reviewed at the upcoming quarterly QAA	

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F 318	Continued From page 24 provide the restorative care for residents. Further interview revealed exercises were counted as getting her up and out of bed, dressing, and showers. When NA#5 was asked if those activities were the same as providing AAROM for 20 repetitions she stated " no. " She further explained she had been a restorative aide. The restorative program was changed and the NA ' s on the floor were to do the exercises. When asked if she had provided the exercises according to the restorative plan of care she replied not always. Interview with the Therapy Director on 03/03/16 at 8:58 AM revealed Resident #92 was discharged from therapy (PT) on 12/7/15 and OT on 11/4/15. Referrals had been communicated to restorative that would include transfers from wheelchair and back with rolling walker, AROM of lower extremities. He further explained " all planes " would be lateral leg lift away from the body and knee flexions. When asked if these would be the same as the movements during daily care he stated " no. " The Therapy Director further explained Resident f#92 could do the leg exercises by herself. During the interview, he provided the referral form for AROM for perform towel glides on table surface forward and back also side to side 20 reps x 2 sets right shoulder. The right shoulder was the affected extremity due to pain, but both upper extremities should receive the exercises. Interview with the Director of Nursing (DON) on 03/03/16 at 9:32 AM revealed there was a nurse over the restorative program. Therapy provided the recommendations to the restorative nurse. That nurse would write the program with goals from therapy. The therapy provided education on	F 318	meeting. Chart reviews will continue on a weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern will be addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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the goals for the NA ' s. Restorative care would usually be a daily treatment. If it was not done on 7-3, then 3-11 would pick it up. The hall nurses received communication from the restorative nurse regarding any changes. The hall nurse would inform the hall NA ' s of any treatment, changes or additions.

Interview on 03/03/16 at 9:49 AM with the DON revealed she would expect the aides to do restorative as indicated on the program. She further explained without designated restorative aides it was difficult to carry out the program. During the interview the DON explained the aides made an attempt to do the program, we would like for it to be done like it was on the flowsheet. Further interviews revealed education was provided to the nursing staff and they understood it was more on them to do.

Interview with the restorative nurse on 03/03/16 at 10:15 AM revealed the NA ' s on the floor provided the restorative care according to the flowsheets. For Resident #92 the NA ' s would provide transfers to/from wheelchair with the rolling walker and AROM of the lower extremities. Further interview revealed she would expect the NA ' s to do the 20 repetitions for two sets. The restorative nurse was asked how she ensured the restorative care was provided, she replied " by their documentation. " Further interview revealed she had not observed the NA ' s providing the care and was not aware it was not being provided. During the interview the restorative nurse explained she had not received the communication form from therapy for the exercises to the bilateral upper extremities.

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2. Resident #2 was re-admitted to the facility on 7/12/14 with diagnoses including dementia and contracture.

Review of the Minimum Data Set (MDS), a quarterly, dated 12/10/15 indicated the resident had long and short term memory problems and severe impairment with decision making abilities. Resident #2 was totally dependent on one staff for all activities of daily living. Resident #2 had limitation of the lower extremity due to history of an amputation of one leg.

Review of the care plan with an update of 12/16/15 for a problem of potential for skin breakdown. The interventions included application of a carrot spacer in the left hand to maintain left hand positioning daily.

Review of February splinting flowsheet sheet revealed documentation for the dates 2/1 to 2/8/16 and 2/19/16 indicating the carrot spacer was in place. Review of the March splinting flowsheet revealed no documentation for 3/1 to 3/3/16 for use of the carrot spacer.

Observations on 3/1/16 at 3:47 PM revealed the carrot spacer was not in Resident #2 ' s hand.

Observations on 3/2/16 at 8:30 AM revealed the carrot spacer was not in Resident#2 ' s hand.

Observations of Resident #2 on 3/3/16 at 9:15 AM revealed there was no device in her left hand. She kept the left hand closed in a tight fist.

Interview on 03/03/16 at 6:55 AM with Nurse Aide (NA) #5 revealed the resident did not have anything that was to be kept in her hand.

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F 318	Continued From page 27 Interview with the Director of Nursing (DON) on 03/03/16 at 9:36 AM revealed contracture management of left hand would be done according to the care plan. Further interview revealed she would expect the aides on the floor to apply the carrot in the resident ' s hand daily. The aides would document the device was used on the " splinting restorative flowsheet. " Interview with the restorative nurse on 03/03/16 at 10:15 AM revealed the NA ' s on the floor provided the restorative care according to the flowsheets. The restorative nurse was asked how she ensured the restorative care was provided, she replied " by their documentation. " Interview with the restorative nurse on 03/03/16 at 10:24 AM revealed Resident #2 was to have a carrot space in the left hand for at least 4 hours/day and up to all day. Observation with the restorative nurse on 03/03/16 at 10:30 AM revealed Resident #2 did not have the carrot spacer in her hand. Interview with MDS Nurse #1 on 03/03/16 at 10:48 AM revealed the carrot was to be used to prevent further contractures in the left hand. Further interview revealed the hand contracture had not become worse.	F 318		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		3/31/16

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F 356	Continued From page 28 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the required nurse staffing data for 4 of 4 days of the annual recertification survey conducted 2/29-3/3/16. The findings included: During the initial tour of the facility on 2/29/16 at 7:30 AM the nurse staffing information form was observed to be posted at the nurse ' s station to include the facility name, current date, total number of licensed and unlicensed nursing staff and the resident census. The nurse staffing	F 356	1) On 3/3/16, the staffing coordinator, the Director of Nursing, and the Administrator discussed the requirement related to Posted Nurse Staffing Information. While the facility name, census, current date, actual hours worked for RNs, LPNs, and CNAs, and total number of staff in each category was listed for all 3 shifts, the total number of hours worked was missing. The total number of hours worked was added to the	

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F 356	Continued From page 29 information form did not include the actual hours and it was posted for all 3 shifts. An observation for 4 consecutive days 2/29/16, 3/1/16, 3/2/16 and 3/3/16 at 10:00AM revealed a nurse staffing form was posted each morning to include the census, total number of nursing staff for all 3 shifts and did not include the actual hours worked for licensed and unlicensed nursing staff. During an interview with the staffing coordinator on 3/3/16 at 8:50 AM who is responsible for posting the nurse staffing form indicated that she prepares the nurse staffing form the day prior and the supervisors make changes each shift. The staffing coordinator provided the date, census, number of licensed and unlicensed nursing staff and provided the data for all 3 shifts. She further indicated that she was not aware that the data needed to include the total number of hours worked. An interview with the administrator on 3/3/16 at 9:00 AM confirmed that the nurse staffing data is posted each morning for all 3 shifts, he was not aware that the nurse staffing form did not include the total number of hours worked for licensed and unlicensed nursing staff. He further indicated that the form will be corrected today to indicate the required nurse staffing data.	F 356	current day□s posted information. 2) On 3/3/16, nursing supervisors were educated by the Director of Nursing on completing this form daily and updating it as staff hours change. 3) On 3/21/16, the staffing coordinator and the Director of Nursing revised the Posted Nurse Staffing Information document to include a section specifically for the total number of worked hours. 4) The Director of Nursing and the nurse management team met on 3/21/16 to discuss the Posted Staff Nurse Information requirement. All members present stated understanding. The changes to this procedure were added to the upcoming monthly nursing department staff meeting agenda. 5) On 3/21/16, the policy on Posting of Nurse Staffing Information was updated to include all the required information. 6) Procedures will be assessed and reviewed at the upcoming quarterly QAA meeting. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		3/31/16

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F 520	Continued From page 30 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance committee failed to implement, monitor and revise, as needed, the action plan developed for the deficiencies identified during the recertification survey dated 4/23/2015 in order to achieve and sustain compliance. The facility had a repeated deficiency at F 241. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: F 241 Based on observations, resident and staff interviews the facility failed to protect two of four residents' privacy by not covering their urinary drainage bag with a privacy bag (Resident #64	F 520	1) On 3/21/16, a Department Head/Management team meeting was held to discuss Quality Assessment and Assurance (QAA) committee requirements. 2) The facility (QAA) committee will meet quarterly. 3) The QAA committee meeting agenda will include current and past survey deficiencies. 4) An action plan will be developed for all concerns and deficiencies identified during the survey process. Efforts to prevent repeated deficiencies will be evaluated by the QAA committee based on the action plan interventions such as staff education and policy changes or updates that will prevent further	

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F 520	Continued From page 31 and Resident #98). During the recertification survey of 4/23/2015 the facility was cited at F 241 for failing to provide assistance with toileting during a meal, resulting in an undignified dining experience for a resident. The Administrator was interviewed on 3/3/2016 at 11:30 am. He explained that the committee meets quarterly to address concerns, but they have not identified issues with dignity. He indicated that they have addressed the care and use of indwelling catheters, related to the risk of urinary tract infections and proper treatment.	F 520	deficiencies in the same areas. 5) The updated QAA committee procedures will be assessed and reviewed at each quarterly QAA meeting and changes will be made immediately if necessary. The Administrator is responsible for overall compliance.	