

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE-CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA RD ASHEVILLE, NC 28801	
(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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility failed to provide ongoing assessment for use of restraints and failed to assess for the least restrictive restraint or make attempts at reduction of restraints for 2 of 2 sampled residents, (Resident's #1 and #15). 1. Resident # 15 was admitted to the facility on 12/13/04 with diagnoses which included cerebral palsy, seizure disorder and intellect disability. The Annual Minimum Data Set (MDS) dated 08/20/12 indicated that the resident had short and long term memory problems, had unclear speech, sometimes makes self understood and sometimes understood. In addition, the resident required assistance from staff for bed mobility, transfer and all activities of daily living (ADL) and uses a wheelchair. The resident was assessed as having a limited range of motion of upper and lower extremity on both sides of his body. The section for Physical Restraints documented that the resident had no physical restraints. The Care Area Trigger (CAT) for this MDS documented under the problem area of falls: "Potential risk for falls due to Cerebral Palsy, Intellect disability, seizure disorder, use of psychotropic medications, and gait instability. Resident continues with bed in low position, floor mat, and	F 221	1. Corrective actions for those affected: #1 On 7-24-13_ the physician will assess Residents #1 and 15 for positioning needs when out the bed to the chair. The IDT will follow MD order for positioning. # 2 Any Resident requiring a restraint will have MD order, consent form, and a Pre restraining Evaluation prior to the use of restraint. The IDT will complete a quarterly re-assessment of any resident with a restraint to determine appropriate reduction of the restraint. #3 On 7-22-13 the IDT will be in serviced by the regional clinical Nurse regarding the process of restraint initiation and on going assessment requirements.	08/02/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kamuna Basimu

07/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disposable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disposable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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sensor alarms. Table top continues while in w/c related to Cerebral Palsy, Poor posture and trunk control - Released for ADLs, activities, repositioning and as needed."

A review of the facility document titled "Restraints; Physical, General Guidelines for the Use of", undated and provided by the Administrator identified that: "The resident must be physically and cognitively able to self-release devices such as velcro lap trays or tables; seat belts with velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint." Number 13 in the document read: "Requirements: a) Consent Form b) Pre-restraining assessment c) Quarterly restraint assessment or upon change of condition."

The Residents current care plan included the problem area: "Potential for fall and fall-related injury related to history of fall, limited ROM hemiparesis, incontinence, seizure disorder, gait instability, dementia, use of psychotropic medication and restraint. "with the approach listed: "Tabletop to wheelchair as ordered, release for ADLs, repositioning and prn."

Review of the medical record revealed no physician order for a secured lap buddy, no documentation of a consent form for physical restraint, pre-restraining assessment, quarterly restraint assessment or a care plan in place to meet the specific needs for the resident due to the use of the secured lap buddy. Further review revealed no observation had been made of Resident #15 being able to remove the secured lap buddy since 12/17/2012.

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#4 The DON will complete audits of restraints for timely completion of the initial and/or ongoing re-assessments monthly x3 . Result of the audits will be presented to the QAPI committee by the DON monthly x 3 months. 08/02/2013

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Resident #15 was first observed on 06/24/2013 at 12:19 PM in his bedroom sitting upright in his wheelchair with his lap buddy in place.

Observations throughout the 4 days of the survey revealed Resident #15 independently mobile in his wheelchair the majority of the day sitting upright in his wheelchair to include mealtimes in the assisted dining room (ADR). Resident #15 was observed to have his secured lap buddy on at all times when he was up in his wheelchair to include mealtimes in the ADR. These observations include the following:

06/24/2013 at 1:04 PM Resident #15 was observed sitting in the ADR in his wheelchair with secured lap buddy in place, being served lunch by a nurse aide.

06/24/2013 at 3:50 PM Resident #15 was observed in the hall near the facility front door, independently ambulating around the halls sitting upright in his wheelchair with his secured lap buddy in place.

06/25/2013 at 9:15 AM Resident #15 was observed in the hall outside his room sitting in his wheelchair with his secured lap buddy in place.

On 06/25/2013 at 11:30 AM Resident #15 was observed in the ADR, independently ambulating around the room sitting upright in his wheelchair with his secured lap buddy in place.

On 06/25/2013 at 4:15 PM Resident #15 was observed in the hallway next to the 100 hall nursing station sitting in his wheelchair with his

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<p>F 221</p>	<p>Continued From page 3 secured lap buddy in place.</p> <p>On 06/26/2013 at 10:20 AM Resident #15 was observed in the hallway outside the conference room independently ambulating around the hallways sitting upright in his wheelchair with his secured lap buddy in place.</p> <p>On 06/26/2013 at 1:40 PM Resident #15 was observed in the ADR, sitting upright in his wheelchair at the table with his secured lap buddy in place.</p> <p>On 06/27/2013 at 9:15 AM Resident #15 was observed in the 200 hallway independently ambulating around the hallways sitting upright in his wheelchair with his secured lap buddy in place.</p> <p>On 06/27/2013 at 10:50 AM Resident #15 was observed ambulating independently outside the conference room sitting upright in his wheelchair with his secured lap buddy in place.</p> <p>An interview with the Director of Nurses (DON) on 06/26/2013 at 2:00 PM revealed no residents in the facility were restrained and Resident #15 was using the lap buddy as a positioning device to hold him up in the chair. The DON confirmed the staff member responsible for completing the MDS assessments would do any needed quarterly assessments during his regular MDS paperwork along with the Occupational Therapists who also did an assessment on Resident #15 every six months to look at his positioning. The DON also noted Resident #15 was known to be able to undo his lap buddy if he wanted to although she had not seen him take it off.</p>	<p>F 221</p>		
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An interview with Nurse #5, who reported she worked regularly with Resident #15, on 06/26/2013 at 11:30 AM revealed Resident #15 could not get the secured lap buddy off and that it is used to protect him from falling and to keep him positioned upright in the wheelchair. Nurse #5 stated the lap buddy also helped to keep him sitting upright in the wheelchair while he was being served meals.

An interview on 06/26/13 at 3:36 PM with Physical Therapist #1 (PT #1) revealed the secured lap buddy was used for Resident #15 for function, positioning, and to prevent falls. The PT #1 reported the most recent restraint screen completed by the therapy department for Resident #15 was from 2010 and involved a lap tray.

On 06/26/2013 at 4:10 PM interview with MDS Coordinator #1 revealed the facility documents available to her for assessment use did not include a restraint form on her computer or that could be printed out. The MDS Coordinator #1 confirmed the MDS documented no restraints were used on Resident #15 however she confirmed Resident #15 was restricted by the lap buddy and would come out of his wheelchair without it. The MDS Coordinator #1 noted she had not seen Resident #15 take his lap buddy off.

On 06/27/2013 at 9:55 AM interview with Nurse Aide #4 (NA#4) revealed she had never seen Resident #15 take his secured lap buddy off. NA #4 stated she only took the lap buddy from the resident when he came out of the wheelchair to toilet or to lay in bed. NA#4 also stated Resident

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 #15 would fall or slide out of the wheelchair if staff removed the secured lap buddy.

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On 06/27/2013 at 10:10 AM NA#4 was observed to ask Resident #15 several times to remove his lap buddy, however, Resident #15 was unable to follow directions and did not remove the belt.

On 06/27/2013 at 11:15 AM interview with the DON confirmed there were no restraint consent documents for Resident #15 since she did not have a restraint.

2. Resident # 1 was admitted to the facility on 06/26/97 with diagnoses which included cerebral palsy, seizure disorder and intellect disability. The Annual Minimum Data Set (MDS) dated 01/23/2013 indicated that the resident had short and long term memory problems, had unclear speech, sometimes makes self understood but rarely understands. In addition, the resident was totally dependent on staff for bed mobility, transfer and all activities of daily living (ADL) and non ambulatory. The resident was assessed as having a limited range of motion of upper and lower extremity on one side of her body. The section for Physical Restraints documented that the resident had no physical restraints. The Care Area Trigger (CAT) for this MDS documented under the problem area of falls: "Resident has a seizure disorder and is unable to walk. She has a Velcro belt on her wheelchair to help protect her from falling out the wheelchair if she has a seizure; however given her condition she has a risk of falling." The falls section of the MDS did not document that any falls had occurred.

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A review of the facility document titled "Restraints; Physical, General Guidelines for the Use of", undated and provided by the Administrator identified that: "The resident must be physically and cognitively able to self-release devices such as velcro lap trays or tables; seat belts with velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint." Number 13 in the document read: "Requirements: a) Consent Form b) Pre-restraining assessment c) Quarterly restraint assessment or upon change of condition."

The Residents current care plan last updated 04/20/2013 included the problem area: "Risk for injury related to Seizure Disorder" with the approach listed: "Buckle belt when up in wheelchair for prevention of injury secondary, seizure activity, release for ADLs, toileting, repositioning & whenever necessary (PRN)." Also: "Risk for falls " with the approach listed: "Velcro belt on while in wheelchair." The problem onset date for both was documented as 10/31/2012.

The resident's current physician orders included the following with origination date as 11/13/2012: "Velcro belt as tolerated in WC (wheelchair) for prevention of injury secondary to seizure." Review of the medical record revealed no documentation of a consent form for physical restraint, pre-restraining assessment; quarterly restraint assessment or a care plan in place to meet the specific needs for the resident due to the use of the Velcro/buckle belt. Further review of the medical record revealed no documentation of Resident #1 removing the belt.

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F 221	Continued From page 7 Resident #1 was first observed on 06/24/2013 at 12:25 PM in the assistive dining room (ARD) serving herself lunch sitting upright in her wheelchair with her buckle belt in place. On 06/25/2013 at 8:30 AM Resident #1 was observed to be in bed without her buckle belt in place. Observations throughout the 4 days of the survey revealed Resident #1 independently mobile in her wheelchair the majority of the day sitting upright in her wheelchair to include mealtimes in the ARD. Resident #1 was observed to have her buckle belt on at all times when she was up in her wheelchair to include mealtimes in the ARD. These observations included the following: 06/25/2013 at 9:30 AM Resident #1 was observed rolling up the hall in her wheelchair with buckle belt in place. 06/26/2013 at 12:00 noon Resident #1 was observed in the ARD serving herself lunch sitting upright in her wheelchair with her buckle belt in place. 06/27/2013 at 10:00 AM Resident #1 was observed in the hall outside her room sitting in her wheelchair with her buckle belt in place. On 06/26/2013 at 2:00 PM interview with the Director of Nurses (DON) revealed no residents in the facility were restrained and Resident #1 was using the belt as a positioning device to hold her up in the chair. The DON confirmed the staff member responsible for completing the MDS assessments would do any needed quarterly	F 221		

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F 221	Continued From page 8 assessments during her regular MDS paperwork along with the Occupational Therapists who also did an assessment on Resident #1 every six months to look at her positioning. The DON also noted Resident #1 was known to be able to undo her belt if she wanted to although she had not seen her take it off. On 06/26/2013 at 4:10 PM interview with MDS Coordinator #1 revealed the facility documents available to her for assessment use did not include a restraint form on her computer or that could be printed out. The MDS Coordinator #1 confirmed the MDS documented no restraints were used on Resident #1 however she confirmed Resident #1 was restricted by the belt and would come out of her wheelchair without it. The MDS Coordinator #1 noted she had seen Resident #1 take her belt off but could find no written documentation in the chart. On 06/27/2013 at 10:55 AM interview with Nurse Aide #2 (NA#2) revealed she had never seen Resident #1 take her belt off. NA#2 confirmed the care instructions were to take off the belt when Resident #1 was in the bed or the shower. NA#2 noted she was told it was for positioning, balance and trunk stability. On 06/27/2013 at 11:00 AM NA#2 was observed to ask Resident #1 several times to remove her belt, however, Resident #1 was unable to follow directions and did not remove the belt. On 06/27/2013 at 11:15 AM interview with the DON confirmed there were no restraint consent documents for Resident #1 since she did not	F 221		

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have a restraint.

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F 250 483.15(g)(1) PROVISION OF MEDICALLY
SS=D RELATED SOCIAL SERVICE

F 250

F250

08/02/2013

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on staff and resident interviews, and record review, the facility failed to provide discharge planning services for 1 of 3 sampled residents (Resident #105).

The findings included:

Resident #105 was admitted to the facility on 02/26/13 with diagnoses which included recent respiratory failure with insertion of a tracheotomy. Resident #105's admission Minimum Data Set (MDS) dated 03/05/13 indicated intact cognition with the ability to understand others. The admission MDS indicated an active discharge plan was in place for Resident #105.

Review of Resident #105's care plan dated 03/13/13 revealed no documentation of a discharge plan.

Review of Resident #105's care plan conference summary dated 05/15/13 revealed documentation of a meeting with Resident #105 to discuss discharge plans. "Resident states she plans to return to local apartment. SW (Social Worker) to

#1 On 7-17-2013 Resident #105 was re-evaluated by her medical doctor, and the resident committed to learning provision of her own trach.

care. The resident has since refused to participate in her own trach. care and refuses training. We are attempting the training daily. The physician will be informed of her progress on 7/24 and further physician recommendations will be acted upon by the facility staff.

#2 Any resident requesting/ requiring discharge may be affected by this practice. Therefore, on date 7-19-2013 the IDT will evaluate the status of facility residents requesting discharge for needs/services within the community. This information will be documented by the social worker in the medical record and acted upon as needed.

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get intent to return home letter."

Review of Resident #105's quarterly MDS dated 05/23/13 revealed an assessment of moderately intact cognition with the ability to understand others. The quarterly MDS indicated Resident #105's active discharge plan did not have any referrals to an outside agency.

Interview with Resident #105 on 06/24/13 at 10:24 AM revealed she wanted to return home or to a group setting. Resident #105 explained the required care of the tracheotomy was a problem. Resident #105 reported she was afraid she could not learn to take care of the tracheotomy.

Interview with the facility's Social Worker (SW) on 06/26/13 at 2:18 PM revealed Resident #105 would require resident education in the care of her tracheotomy and home health services. The SW described Resident #105's discharge plans as "iffy" since Resident #105 did not think she could manage the tracheotomy independently. The SW reported she thought a staff member had offered to teach Resident #105 but was not certain. The SW reported she did not refer Resident #105 for resident education since Resident #105 expressed reluctance. The SW reported Resident #105's discharge planning was not included in the care plan and she had not contacted local agencies for assistance.

F 272 483.20(b)(1) COMPREHENSIVE
SS=E ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

F 250

#3 On 7-22-13 the regional clinical director will in-service the IDT regarding timely discharge and securing community resources. 08/02/2013

#4 The regional clinical nurse and facility SW will audit resident charts in the active process of discharge planning weekly x 4 weeks then monthly x 3 months to assure timeliness, accuracy, and documentation of the discharge planning process. The social service director will review the result of the audit at the QAPI meeting monthly x 4 months.

F 272

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08/08/2013

A) #1 On 7-24-13 the physician will assess residents #1 and #15 for

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A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
 Identification and demographic information;
 Customary routine;
 Cognitive patterns;
 Communication;
 Vision;
 Mood and behavior patterns;
 Psychosocial well-being;
 Physical functioning and structural problems;
 Continence;
 Disease diagnosis and health conditions;
 Dental and nutritional status;
 Skin conditions;
 Activity pursuit;
 Medications;
 Special treatments and procedures;
 Discharge potential;
 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
 Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
 Based on observations, medical record review, and staff interviews the facility failed to provide

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positioning needs when out the bed to the chair. The IDT will follow MD 08/02/2013 order for positioning.

2 Any resident equiring a restraint will have MD order, consent form, and a pre restraining Evaluation prior to the use of restraint.

The IDT will complete a quarterly re-assessment of the restraint to determine appropriate reduction / maintenance of the restraint.

#3 On 7-22-13 the IDT will be in-serviced by the regional clinical Nurse regarding the process of restraint initiation, documentation and on going assessment requirements for restraint use.

#4 The DON will complete a monthly audit for timely completion of the initial or on going restraint assessments weekly x 12 weeks. Result of the audits will be presented to the QAPI committee by the DON monthly x 3 months.

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<p>F 272 Continued From page 12</p> <p>ongoing assessment for use of restraints and failed to assess for the least restrictive restraint or make attempts at reduction of restraints for 2 of 2 sampled residents, (Resident's #1 and #15); assess dental status for 2 of 2 sampled residents, (Resident #54 and # 57); and assess for community discharge for 1 of 3 sampled residents, (Resident #105).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #1 was admitted to the facility on 06/26/97 with diagnoses which included cerebral palsy, seizure disorder and intellect disability. The Annual Minimum Data Set (MDS) dated 01/23/2013 indicated that the resident had short and long term memory problems, had unclear speech, sometimes makes self understood but rarely understands. In addition, the resident was totally dependent on staff for bed mobility, transfer and all activities of daily living (ADL) and non ambulatory. The resident was assessed as having a limited range of motion of upper and lower extremity on one side of her body. The section for Physical Restraints documented that the resident had no physical restraints. The Care Area Trigger (CAT) for this MDS documented under the problem area of falls: "Resident has a seizure disorder and is unable to walk. She has a Velcro belt on her wheelchair to help protect her from falling out the wheelchair if she has a seizure; however given her condition she has a risk of falling" The falls section of the MDS did not document that any falls had occurred. <p>A review of the facility document titled "Restraints; Physical, General Guidelines for the Use of", undated and provided by the</p>	<p>F 272</p> <p>B) #1 On 7-17-2013 Resident #105 was evaluated by her medical doctor. The MD recommendation will be acted up on by the social worker.</p> <p>#2 Any resident requesting/ requiring discharge may be affected by this practice. Therefore, on 7-19-2013 the IDT will evaluate the status of facility residents requesting discharge for needs/services with in the community. This information will be documented by the social worker in the medical record</p> <p>#3 On 7-22-13 the regional clinical director will in-service the IDT regarding timely discharge and securing community resources.</p> <p>#4 The regional clinical nurse and facility SW will audit residents charts in the active process of discharge planning weekly x 4 weeks then monthly x 3 month to assure timeliness, accuracy, and documentation of the discharge</p>	<p>08/02/2013</p>
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 Administrator identified that: "The resident must be physically and cognitively able to self-release devices such as velcro lap trays or tables; seat belts with velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint" Number 12 in the document read: "The need for restraints will be reevaluated at least quarterly to determine if continued restraint use is necessary to treat the resident's medical symptoms. Every effort will be made to eliminate the use of the restraint. Number 13 in the document read: "Requirements: a) Consent Form b) Pre-restraining assessment c) Quarterly restraint assessment or upon change of condition."

The Residents current care plan last updated 04/20/2013 included the problem area: "Risk for injury related to Seizure Disorder" with the approach listed: "Buckle belt when up in wheelchair for prevention of injury secondary, seizure activity, release for ADLs, toileting, repositioning & whenever necessary (PRN)."
 Also: "Risk for falls " with the approach listed: "Velcro belt on while in wheelchair." The problem onset date for both was documented as 10/31/2012.

The resident's current physician orders included the following with origination date as 11/13/2012: "Velcro belt as tolerated in WC (wheelchair) for prevention of injury secondary to seizure."
 Review of the medical record revealed no documentation of a consent form for physical restraint, pre-restraining assessment, quarterly restraint assessment or a care plan in place to meet the specific needs for the resident due to

F 272 planning process. The social service will review the result of the audit at the QAPI committee meeting monthly x 4.

C) Resident #57 is schedule for dental extraction on 7-29-13 with Longterm Care Associates. Inc and #54 as been submitted to Longterm Care Associates Inc for scheduling of the extraction when a time is available.

On 7-17-2013 the DON audited the medical records to assure appointments for dental services have been completed. Any appointment requiring scheduling will be completed by SW by 7-18-2013. The completed audit will be provided to MDS nurse for updating of the care plan by the DON on 7-18-2013. On 7-22-2013 the regional clinical nurse will in-service IDT on scheduling follow up and documentation of dental need in the care plan.

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F 272 Continued From page 14
 the use of the Velcro/buckle belt. Further review revealed no documentation of Resident #1 removing the belt.

Resident #1 was first observed on 06/24/2013 at 12:25 PM in the assistive dining room (ARD) serving herself lunch sitting upright in her wheelchair with her buckle belt in place. On 06/25/2013 at 8:30 AM Resident #1 was observed to be in bed without her buckle belt in place.

Observations throughout the 4 days of the survey revealed Resident #1 independently mobile in her wheelchair the majority of the day sitting upright in her wheelchair to include mealtimes in the ARD. Resident #1 was observed to have her buckle belt on at all times when she was up in her wheelchair to include mealtimes in the ARD. These observations include the following:

06/25/2013 at 9:30 AM Resident #1 was observed rolling up the hall in her wheelchair with buckle belt in place.

06/26/2013 at 12:00 noon Resident #1 was observed in the ARD serving herself lunch sitting upright in her wheelchair with her buckle belt in place.

06/27/2013 at 10:00 AM Resident #1 was observed in the hall outside her room sitting in her wheelchair with her buckle belt in place.

On 06/26/2013 at 2:00 PM interview with the Director of Nurses (DON) revealed no residents in the facility were restrained and Resident #1 was using the belt as a positioning device to hold

F 272 An audit of the outstanding dental 08/02/2013 appointments will be completed weekly x8 weeks for on going scheduling as needed. The report will be presented to the QAPI committee by the administrator x 3 months

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her up in the chair. The DON confirmed the staff member responsible for completing the MDS assessments would do any needed quarterly assessments during her regular MDS paperwork along with the Occupational Therapists who also did an assessment on Resident #1 every six months to look at her positioning. The DON also noted Resident #1 was known to be able to undo her belt if she wanted to although she had not seen her take it off.

On 06/26/2013 at 4:10 PM interview with MDS Coordinator #1 revealed the facility documents available to her for assessment use did not include a restraint form on her computer or that could be printed out. The MDS Coordinator #1 confirmed the MDS documented no restraints were used on Resident #1 however she confirmed Resident #1 was restricted by the belt and would come out of her wheelchair without it. The MDS Coordinator #1 noted she had seen Resident #1 take her belt off but could find no written documentation in the chart.

On 06/27/2013 at 10:55 AM interview with Nurse Aide #2 (NA#2) revealed she had never seen Resident #1 take her belt off. NA#2 confirmed the resident care instructions were to take off the belt when Resident #1 was in the bed or the shower. NA#2 noted she was told it was for positioning, balance and trunk stability.

On 06/27/2013 at 11:00 AM NA#2 was observed to ask Resident #1 several times to remove her belt, however, Resident #1 was unable to follow directions and did not remove the belt.

On 06/27/2013 at 11:15 AM interview with the

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F 272	Continued From page 16 DON confirmed there were no restraint consent documents for Resident #1 since she did not have a restraint. On 06/27/2013 at 2:40 PM interview with the DON revealed there had been MDS staff changes on the hall where Resident #1 resided and the assessments just weren't done as a result. 2. Resident # 57 was admitted to the facility on 06/23/2011 with diagnoses of chronic kidney disease dysphagia, vascular dementia and convulsions. The Annual Minimum Data Set (MDS) dated 06/20/2012 documented the resident had short and long term memory problems and unclear speech. In addition, the resident was not ambulatory and required extensive assistance for personal hygiene which included brushing teeth. The MDS documented under the section for dental status that Resident # 57 had no dental problems. Review of the Care Plan (origination date 06/23/2011) last updated 06/19/2013; revealed no Problem/Need in place for Oral Hygiene with interventions in place. Observed at the bottom of the page for ADL care was handwritten " oral hygiene daily and PRN, Dentist PRN ", it was undated. On 06/25/2013 at 10:04 AM Resident #57 was observed sitting up in his wheelchair watching TV in his room. When spoken to Resident #57 smiled and said "Yes"; at that time it was observed he had missing and broken teeth.	F 272		
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 Review of Resident #57's medical record revealed documentation of the following facility onsite dental care/follow-up:

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- 09/14/2011: "Recommend removal of broken teeth and better brushing, no complaints and no treatment wanted."
- 04/24/2012: "Extract root tops in hospital."
- 10/23/2012: "Brush and mouthwash."
- 04/09/2013: "Extractions needed but must be done in hospital."

On 06/27/2013 at 2:30 PM interview with MDS Coordinator #1 confirmed Resident #57 did not have dental care marked on his MDS which would in turn trigger the Care Plan to be updated. The MDS Coordinator #1 also revealed the hall where Resident #57 resided was the hall where there had been several MDS staff changes over the last year.

On 06/27/2013 at 2:40 PM interview with the DON confirmed MDS assessments just weren't done as a result of MDS Coordinator staff turnover.

3. Resident #105 was admitted to the facility on 02/26/2013 with diagnoses which included recent respiratory failure with insertion of a tracheotomy. Resident #105's admission Minimum Data Set (MDS) dated 03/05/2013 indicated intact cognition with the ability to understand others. The admission MDS indicated an active discharge plan was in place for Resident #105.

Review of Resident #105's care plan conference

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F 272	<p>Continued From page 18</p> <p>summary dated 05/15/2013 revealed documentation of a meeting with Resident #105 to discuss discharge plans. "Resident states she plans to return to local apartment. SW (Social Worker) to get intent to return home letter." There was no documentation of an assessment of Resident #105's requirements for discharge.</p> <p>Review of Resident #105's quarterly MDS dated 05/23/2013 revealed an assessment of moderately intact cognition with the ability to understand others. The quarterly MDS indicated Resident #105's active discharge plan did not have any referrals to an outside agency.</p> <p>Interview with Resident #105 on 06/24/2013 at 10:24 AM revealed she wanted to return home or to a group setting. Resident #105 explained the required care of the tracheotomy was a problem. Resident #105 reported she was afraid she could not learn to take care of the tracheotomy.</p> <p>Interview with the facility's Social Worker (SW) on 06/26/2013 at 2:18 PM revealed Resident #105 required training in the care of her tracheotomy before discharge could occur. The SW described Resident #105's discharge plans as "iffy" since Resident #105 did not think she could manage the tracheotomy independently. The SW could not provide a reason for the lack of a comprehensive assessment of Resident #105's discharge requirements.</p> <p>4. Resident #54 was admitted to the facility on 10/17/2006 with diagnoses which included dysphagia and dementia.</p> <p>Review of Resident #54's annual Minimum Data</p>	F 272	
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F 272	Continued From page 19 Set (MDS) dated 09/28/2012 revealed no problems with oral or dental problems. The MDS indicated impairment of Resident #54's short and long term memory. Review of a dental consultation dated 10/23/2012 revealed decayed teeth with the recommendation of teeth extraction in a hospital setting. Review of Resident #54's speech therapy discharge dated 01/21/2013 revealed Resident #54 was to receive a mechanical soft diet with pureed meat. The speech therapist documented Resident #54's teeth were brown with black spots and many were broken. Review of Resident #54's quarterly MDS dated 03/22/2013 revealed Resident #54 had no dental problems. Review of a dental consult dated 04/09/2013 revealed an assessment of missing teeth with a recommendation for teeth extraction in a hospital setting. Review of Resident #54's care plan dated 06/19/2013 revealed staff direction to assist with dental care daily. Review of a care plan conference dated 06/19/2013 with Resident #54's family member revealed discussion of Resident #54's teeth and reluctance for dental surgery. Observation on 06/25/13 at 9:05 AM revealed Resident #54's teeth were gray and black with several missing teeth.	F 272		
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F 272	<p>Continued From page 20</p> <p>Interview with Nurse Aide (NA) #1 on 06/26/2013 at 10:55 AM revealed Resident #54 required use of a soft swab for teeth brushing. NA #1 explained Resident #54 did not open her mouth completely for oral care.</p> <p>Interview with Nurse #4 on 06/26/2013 at 1:35 PM revealed Resident #54 did not appear to have mouth pain and was not aware of any dental plans. Nurse #1 explained the MDS nurse would conduct oral assessments.</p> <p>Interview with MDS Coordinator #1 on 06/26/2013 at 2:41 PM revealed she did not indicate on the MDS an assessment of Resident #54's oral and dental status. MDS Coordinator #1 explained the assessment omission was an error.</p> <p>Interview with the Director of Nursing on 06/26/2013 at 3:39 PM revealed she expected the MDS Coordinator to perform a complete oral and dental assessment.</p> <p>5. Resident #15 was admitted to the facility on 12/13/2004 with diagnoses which included cerebral palsy, seizure disorder and intellect disability. The Annual Minimum Data Set (MDS) dated 08/20/2012 indicated that the resident had short and long term memory problems, had unclear speech, sometimes made self understood and sometimes understood. In addition, the resident required assistance from staff for bed mobility, transfer and all activities of daily living (ADL) and uses a wheelchair. The resident was assessed as having a limited range of motion of upper and lower extremity on both sides of his body. The section for Physical Restraints documented that the resident had no physical restraints. The Care Area Trigger (CAT)</p>	F 272	

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F 272	<p>Continued From page 21</p> <p>for this MDS documented under the problem area of falls: "Potential risk for falls due to Cerebral Palsy, Intellect disability, seizure disorder, use of psychotropic medications, and gait instability. Resident continues with bed in low position, floor mat, and sensor alarms. Table top continues while in w/c related to Cerebral Palsy, Poor posture and trunk control - Released for ADLs, activities, repositioning and as needed. "</p> <p>A review of the facility document titled "Restraints; Physical, General Guidelines for the Use of", undated and provided by the Administrator identified that: "The resident must be physically and cognitively able to self-release devices such as velcro lap trays or tables; seat belts with velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint" Number 12 in the document read: "The need for restraints will be reevaluated at least quarterly to determine if continued restraint use is necessasry to reat the resident's medical symptoms. Every effort will be made to eliminate the use of the restraint. Number 13 in the document read: "Requirements: a) Consent Form b) Pre-restraining assessment c) Quarterly restraint assessment or upon change of condition."</p> <p>The Residents current care plan included the problem area: "Potential for fall and fall-related injury related to history of fall, limited ROM hemiparesis, incontinence, seizure disorder, gait instability, dementia, use of psychotropic medication and restraint" with the approach listed: "Tabletop to wheelchair as ordered, release for ADLs, repositioning and prn."</p>	F 272	

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	<p>F 272 Continued From page 22</p> <p>Review of the medical record revealed no physician order for a secured lap buddy, no documentation of a consent form for physical restraint, pre-restraining assessment, quarterly restraint assessment or a care plan in place to meet the specific needs for the resident due to the use of the secured lap buddy. Further review revealed no observation had been made of Resident #15 being able to remove the secured lap buddy since 12/17/2012.</p> <p>Resident #15 was first observed on 06/24/2013 at 12:19 PM in his bedroom sitting upright in his wheelchair with his lap buddy in place.</p> <p>Observations throughout the 4 days of the survey revealed Resident #15 independently mobile in his wheelchair the majority of the day sitting upright in his wheelchair to include mealtimes in the assisted dining room (ADR). Resident #15 was observed to have his secured lap buddy on at all times when he was up in his wheelchair to include mealtimes in the ADR. These observations include the following:</p> <p>06/24/2013 at 1:04 PM Resident #15 was observed sitting in the ADR in his wheelchair with secured lap buddy in place, being served lunch by a nurse aide.</p> <p>06/24/2013 at 3:50 PM Resident #15 was observed in the hall near the facility front door, independently ambulating around the halls sitting upright in his wheelchair with his secured lap buddy in place.</p> <p>06/25/2013 at 9:15 AM Resident #15 was</p>	F 272	

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F 272	Continued From page 23 observed in the hall outside his room sitting in his wheelchair with his secured lap buddy in place. On 06/25/2013 at 11:30 AM Resident #15 was observed in the ADR, independently ambulating around the room sitting upright in his wheelchair with his secured lap buddy in place. On 06/25/2013 at 4:15 PM Resident #15 was observed in the hallway next to the 100 hall nursing station sitting in his wheelchair with his secured lap buddy in place. On 06/26/2013 at 10:20 AM Resident #15 was observed in the hallway outside the conference room independently ambulating around the hallways sitting upright in his wheelchair with his secured lap buddy in place. On 06/26/2013 at 1:40 PM Resident #15 was observed in the ADR, sitting upright in his wheelchair at the table with his secured lap buddy in place. On 06/27/2013 at 9:15 AM Resident #15 was observed in the 200 hallway independently ambulating around the hallways sitting upright in his wheelchair with his secured lap buddy in place. On 06/27/2013 at 10:50 AM Resident #15 was observed ambulating independently outside the conference room sitting upright in his wheelchair with his secured lap buddy in place. An interview with the Director of Nurses (DON) on 06/26/2013 at 2:00 PM revealed no residents in the facility were restrained and Resident #15 was	F 272		
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F 272	Continued From page 24 using the lap buddy as a positioning device to hold him up in the chair. The DON confirmed the staff member responsible for completing the MDS assessments would do any needed quarterly assessments during his regular MDS paperwork along with the Occupational Therapists who also did an assessment on Resident #15 every six months to look at his positioning. The DON also noted Resident #15 was known to be able to undo his lap buddy if he wanted to although she had not seen him take it off. An interview with Nurse #5, who reported she worked regularly with Resident #15, on 06/26/2013 at 11:30 AM revealed Resident #15 could not remove the secured lap buddy and that it was used to protect him from falling and to keep him positioned upright in the wheelchair. An interview on 06/26/2013 at 3:36 PM with Physical Therapist #1 (PT #1) revealed the secured lap buddy was used for Resident #15 for function, positioning, and to prevent falls. PT #1 reported the most recent restraint screen completed by the therapy department for Resident #15 was from 2010 and involved a hard lap tray and not the soft lap buddy Resident #15 was currently using. On 06/26/2013 at 4:10 PM interview with MDS Coordinator #1 revealed the facility documents available to her for assessment use did not include a restraint form on her computer or that could be printed out. The MDS Coordinator #1 confirmed the MDS documented no restraints were used on Resident #15 however she confirmed Resident #15 was restricted by the lap buddy and would come out of his wheelchair	F 272		
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F 272	Continued From page 25 without it. The MDS Coordinator #1 noted she had not seen Resident #15 take his lap buddy off and she stated that he would not be able to remove it when asked to remove it. On 06/27/2013 at 9:55 AM interview with Nurse Aide #4 (NA#4) revealed she had never seen Resident #15 remove his secured lap buddy. NA #4 stated she only removed the lap buddy when Resident #15 was transitioned out of the wheelchair to toilet or to lay in bed. NA#4 also stated Resident #15 would fall or slide out of the wheelchair if staff removed the secured lap buddy. On 06/27/2013 at 10:10 AM NA#4 was observed to ask Resident #15 several times to remove his lap buddy, however, Resident #15 was unable to follow directions and did not remove the belt. On 06/27/2013 at 11:15 AM interview with the DON confirmed there were no restraint consent documents for Resident #15 since he did not have a restraint. On 06/27/2013 at 2:40 PM interview with the DON revealed there had been MDS staff changes on the hall where Resident #15 resided and the assessments just weren't done as a result.	F 272		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 #1 Residents #64 and #69 are receiving their medications as order by the MD, on dialysis days. Resident #15 is receiving a stool softener per MD order and has a bowel protocol in place.	08/02/2013

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F 309	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to administer medications as per physician order on dialysis days for 2 of 3 hemo-dialysis residents (Resident #64 and #79) and failed to follow a bowel protocol for 1 of 5 residents sampled for constipation(Resident #15) The findings included: 1. Resident #64 was re-admitted on 04/05/13 with diagnoses to include end stage renal disease. An Annual Minimum Data Set dated 06/05/13 documented Resident #64 was cognitively intact and received dialysis services. Review of Resident #64 medical record revealed he received dialysis Monday, Wednesday and Friday. Review of the plan of care dated 04/24/13 documented he required hemo-dialysis and was at risk for decrease in cardiac output with an intervention to administer medications as ordered. Review of Resident #64's June 2013 physician order sheet revealed orders for the following medications: Celexa (antidepressant) 10 milligrams (mg) one daily at 9:00 AM Reglan (antiemetic) 5mg one four times a day (qid) before meals and at bedtime (hs) scheduled at 7:30 AM, 11:30 AM, 4:30 PM and 9:00 PM	F 309	# 2 Any resident that requires dialysis or requiring assistance with bowel needs can be affected by this practice. On 7-15-2013 the DON reviewed the MARS of dialysis residents to assure that there is no conflict between medication administration time and dialysis time. On 6-28-2013 the SDC queried the resident record for any resident not having a BM in 3 days. Any resident requiring interventions had initiation of the bowel protocol. #3 On 6-28-2013 The Staff Coordinator in- serviced nursing staff regarding the importance of documentation of BMs and the initiation of the bowel protocol. #4 The BM exception report will be pulled 5 times a weeks for 16 weeks by the SDC. Any resident flagging on the exception report will have their MAR evaluated for initiation of the bowel protocol. Any new resident	08/02/2013

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F 309	Continued From page 27 Lopressor (antihypertensive) 100mg twice a day (bid) at 8:00 AM and 9:00 PM Renvela (phosphate binder) 800mg five tablets three times a day (tid) with meals at 8:00 AM, 12:00 PM and 5:00 PM Renvela 800mg two tablets with snack tid at 9:30 AM, 1:00 PM and 9:00 PM Procardia (antihypertensive) 30mg daily at 9:00 AM Azopt (glaucoma medication) eye drop bid at 9:00 AM and 9:00 PM. Review of Resident #64's blood pressure (B/P) log for the month of June revealed a B/P on 06/5/13 of 186/90; on 06/7/13 of 182/90; 06/12/13 of 178/94; on 06/14/13 of 160/90 and on 06/24/13 of 180/72. Review of Resident #64's Medication Administration Record (MAR) for June 2013 revealed the following medications scheduled for either 7:30 AM, 8:00 AM, 9:00 AM, 11:30 AM or 12:00 PM: Celexa 10mg; Lopressor 100mg; Renvela 800mg 2 tablets; Procardia 30mg, Renvela 2 tablets, Reglan 5mg and Azopt drops were initialed and circled as not administered or had an " OOF " (out of facility) written in the box for the following days 06/03/2013; 06/05/2013, 06/07/2013, 06/10/2013, 06/12/2013, 06/14/2013, 06/17, 06/19/2013, 06/21/2013, and 06/24/2013. During an interview with Nurse #1 on 06/26/13 at 2:55 PM, she stated she did not administer Resident #64's morning medications on dialysis days because Resident #64 left for dialysis at 6:15 AM. Nurse #1 added she would sign the MAR and circle her initials to indicate the medication was not administered. Nurse #1	F 309	receiving dialysis will have their medication times and dialysis time evaluated to assure delivery of their routine medications. The result of the audit will be presented to the QAPI committee by SDC for 5 months.	08/02/2013	

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reported the 11:00 PM to 7:00 AM nurse would report in the morning that the medications had been administered but would not sign the MAR. Nurse #1 also added the medication times should have been changed.

During a telephone interview with Nurse #2 on 06/26/13 at 4:38 PM, Nurse #2 explained she sometimes did and sometimes did not administer Resident #64's scheduled morning medications (7:30 AM, 8:00AM and 9:00 AM) on his dialysis days during her shift. Nurse #2 added she would usually report to the day nurse whether she had given the scheduled morning medications or not. Nurse #2 also explained there were times she would not sign the MAR because she had forgotten and if she remembered after the fact she would call the morning nurse and inform her.

A telephone interview was conducted with the Medical Director (MD) on 06/27/13 at 12:17 PM. The MD stated he was unaware Resident #64 was not receiving some of his scheduled medications due to being out at dialysis. The MD expressed he would have expected the staff to have notified him that the Resident was not receiving medications on dialysis days. The MD also added Resident #64 has a diagnosis of cardiovascular disease and should have been receiving his medications to manage his B/P and heart rate. The MD added he believed no harm was done due to the Resident being clinically stable but would thoroughly review Resident #64's medical record to ensure there had been no impact.

During an interview with the Director of Nursing (DON) on 06/27/13 at 12:35 PM, the DON stated

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F 309	<p>Continued From page 29</p> <p>she would have expected the nurses to have contacted the MD immediately and have the medication times changed to meet Resident #64's needs. The DON added Resident #64 should have never gone without his medications.</p> <p>2. Resident #79 was re-admitted 04/22/13 with diagnosis to include end stage renal disease. A quarterly Minimum Data Set dated 04/01/13 documented Resident #79 was receiving dialysis. Resident #79's medical record revealed he received dialysis on Monday, Wednesday and Friday.</p> <p>Review of Resident #79's June 2013 physician order sheet revealed orders for the following medications: Simethicone (gas relief) 80milligrams.(mg) one tablet after meals at 9:00 AM, 1:00 PM, 6:00 PM and 9:00 PM Renvela (phosphate binder) 800mg two tablets three times a day (tid) with meals at 8:00 AM, 12:00 PM and 5:00 PM Vistaril (anti-anxiety) 25mg one capsule every 6 hours at 6:00 AM, 12:00 PM, 6:00 PM and 12:00 AM Deep sea mist four times a day (qid) at 6:00 AM, 12:00 PM, 5:00 PM and 10:00 PM.</p> <p>Review of Resident #79's medication administration record (MAR) for June 2013 revealed the following medications scheduled for 12:00 PM and 1:00 PM: Simethicone 80mg; Renvela 800mg, Vistaril 25mg and Deep sea mist were initialed and circled as not administered on the following days 06/07/2013, 06/10/2013,</p>	F 309		

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F 309	Continued From page 32 Review of the Medication Administration Records for the month of June 2013 revealed Resident #15 had not received any milk of magnesium suspension, dulcolax suppository, or fleets enema. There was no documentation revealing the physician had been contacted regarding constipation during the month of June, 2013. An interview was conducted on 06/27/2013 at 1:01 PM with Nurse Aide #4 (NA #4), who reported she worked regularly with Resident #15. NA #4 stated she sits Resident #15 on the commode every day after lunch and documented on the computer each day he had a BM. NA #4 stated Resident #15 gets very agitated when constipated and had shown signs of agitation frequently during the month of June. NA #4 stated that when Resident #15 goes 3 days without a BM, the nurse gives him a laxative. NA #5 revealed Resident #15's BMs are consistently extra large. An interview was conducted on 06/27/13 at 1:03 PM with Nurse #5, who reported she worked regularly with Resident #15. Nurse #5 stated if nurse aides did not document a BM for Resident #15 in three days, the computer would alert nursing staff that the bowel protocol must be initiated. Nurse #5 reviewed Resident #15's June 2013 MAR and confirmed he did not receive any prn medications for constipation. She said all nurses and nurse aides are told to document every bowel movement and if no documentation of a bowel movement exists, they are to follow the established protocol for bowel movements. Nurse #5 also stated Resident #15 shows signs of agitation when constipated and had shown	F 309			

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F 309	Continued From page 33 signs of agitation frequently during the month of June. Nurse #5 had no explanation for why computer alerts had not been noticed by nurses or why nurses had not initiated bowel protocol for Resident #15 in June. An interview was conducted with the Director of Nursing (DON) on 06/27/13 at 3:07 PM. The DON stated she expected nurses and nurse aides to follow the established bowel protocol for all residents without exception. The DON revealed the bowel protocol for Resident #15 was for all BMs to be documented in the computer. When Resident #15 had gone 3 days with no bowel movement, the resident was to receive 30 ccs of Milk of Magnesium orally. If no bowel movement occurred in one shift, Resident #15 was to receive a dulcolax suppository. If no bowel movement occurred in one shift, Resident #15 was to receive a fleets enema. If not effective in one shift, the physician was to be notified immediately. Each of these steps were to be documented in the prn medication administration record in the computer by the nurse when completed.	F 309			
F 412	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412	F412 Resident #57 is schedule for dental extraction on 7-29-13 with Longterm Care Associate Inco. and #54 has been submitted to Longterm Care Associates Inc. for scheduling of a dental extraction when a time is available.	08/02/2013	

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F 412	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide recommended dental care to 1 of 2 sampled residents (Resident #57). The findings included: Resident #57 was admitted to the facility on 06/23/2011 with diagnoses of chronic kidney disease dysphagia, vascular dementia and convulsions. The Annual Minimum Data Set (MDS) dated 06/20/2012 documented the resident had short and long term memory problems and unclear speech. In addition, the resident was not ambulatory and required extensive assistance for personal hygiene which included brushing teeth. The MDS documented under the section for dental status that Resident #57 had no dental problems. Review of the Care Plan (origination date 06/23/2011) last updated 06/19/2013; revealed no Problem/Need in place for Oral Hygiene with interventions in place. Observed at the bottom of the page for ADL care was handwritten "oral hygiene daily and PRN, Dentist PRN ", it was undated. On 06/25/2013 at 10:04 AM Resident #57 was observed sitting up in his wheelchair watching TV in his room. When spoken to Resident #57 smiled and said "Yes"; at that time it was	F 412	On 7-17-2013 the DON audited the medical records to assure appointments for dental services have been completed. Any appointment requiring scheduling will be completed by SW by 7-18-2013. The completed audit will be provided to MDS nurse for updating of the care plan by the DON on 7-18-2013. On 7-22-2013 the regional clinical director will in-service the IDT on scheduling, follow up and documentation of dental needs in the care plan. An audit of the needed dental appointments will be completed weekly x8 weeks by the administrator for on going scheduling as needed. The report will be reviewed at the QAPI committee by the administrator x 3 months.	08/02/2013	

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F 412	Continued From page 35 observed he had missing and broken teeth. Review of Resident #57's medical record revealed the following documentation written by the onsite Dentist when he provided care at the facility to Resident #57 on the following dates: 09/14/2011: "Recommend removal of broken teeth and better brushing, no complaints and no treatment wanted." 04/24/2012: "Extract root tops in hospital" 10/23/2012: "Brush and mouthwash." 04/09/2013: "Extractions needed but must be done in hospital." On 06/27/2013 at 2:30 PM interview with MDS Coordinator #1 confirmed Resident #57 did not have dental care marked on his MDS which would in turn have triggered the Care Plan to be updated to include dental care/oral hygiene interventions to be put into place. On 06/27/2013 at 10:10 AM interview with the Transportation Aide revealed she had been in this position for many years but had never been told to make Resident #57 an evaluation appointment for dental extractions. Further interview revealed she had now been told today, 06/27/2013, to make Resident #57 an appointment and he now had scheduled for July a dental evaluation appointment. On 06/27/2013 at 10:15 AM interview with the Social Worker (SW) revealed Resident #57 had seen the onsite dentist who came to the facility for cleaning since his admission on a regular basis but the new appointment in July would be able to get him a referral to a surgical office that	F 412		
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F 412	Continued From page 36 could perform the recommended teeth extractions. On further interview the SW stated she knew Resident #57 had mouth problems but she had just missed sending him out. On 06/27/2013 at 2:40 PM interview with the Director of Nurses (DON) revealed once the onsite Dentist leaves the facility the assessments are collected by the SW and she was responsible to separate out those that needed further follow up before they are given to medical records to be filed on the charts. On further interview the DON confirmed her expectations were the SW would follow up on the dental recommendation as was her responsibility.	F 412		