STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	05/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain privacy while providing incontinence care for 1 of 1 sampled resident (Resident #13) receiving care and for 1 of 1 resident (Resident #42) whose window blind had a gap while he was uncovered from the waist	F 164	The blind in the room of Resident #13 & #42 (same room) was replaced by Maintenance personnel on 5/2/14. The privacy curtain for Resident #13 was replaced with one of appropriate width that provides for full visual coverage on	5/21/14

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

Electronically Signed | 05/22/2014

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

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F 164	Continued From page 1 down. Findings included: 1. Resident #13 was admitted to the facility on 10/12/10 with diagnoses of Dementia, Diabetes Mellitus, and Depression. Review of the Resident ' s most recent quarterly Minimum Data Set (MDS) on 3/4/14 revealed he was moderately cognitively impaired. The assessment indicated the resident was sometimes incontinent of urine and required limited one person assistance with toileting. During an observation on 4/30/14 at 9:34 AM Resident #13 was observed walking in his room with the assistance of Nursing Assistant (NA#2). The privacy curtain was closed around the resident with a 2 foot gap at the door entrance. NA#2 assisted the resident with incontinence care. Staff were observed opening the door while Resident #2 received incontinence care. There was no one observed in the hall way. During an interview on 5/2/14 at 10:31 AM NA#2 stated she had helped Resident #13 with changing his brief on 4/30/14. She stated she was aware that the privacy curtain did not close completely and just did not think about it. On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that should be reported to housekeeping. On 5/3/14 at 9:50 AM Nursing Assistant #3 stated he was Resident #13 ' s NA and provided care for	F 164	5/2/14. All other blinds and privacy curtains have been assessed for appropriate placement of intact blinds and curtain width. All staff, including Nursing, Housekeeping/Laundry, Administrative, Social Services, Dietary, Activities, Therapy and Maintenance staff have been inserviced on making sure blinds and privacy curtains are reported to Maintenance or Housekeeping for necessary repairs, cleaning or replacement. Blank Repair Requisitions have been provided in various areas throughout the facility and staff oriented on use to alert housekeeping or maintenance personnel of any occurrences that do not provide for full visual coverage. A Window Blind audit sheet has been put in place and will be performed daily (M-F) by the Maintenance Director or designee for 4 weeks to ensure the deficient practice does not occur. The Housekeeping daily Quality Control Inspection (QCI) sheet will be utilized daily (M-F) for random checks for broken blinds and that privacy curtains are clean and appropriate width for rooms to ensure the deficient practice does not occur. The Window Blind Audit and Housekeeping QCI sheets will be reviewed by Maintenance Director and Housekeeping Supervisor weekly for 4 weeks for results and forwarded to the	

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F 164	Continued From page 2 him. He stated the privacy curtain was not wide enough but whenever he gave the resident care he would make sure to cover the resident if someone were to enter the room. He further stated he thought the privacy curtain had not been wide enough since it was first hung but had not reported it to anyone. 2. Resident #42 was admitted to the facility on 3/18/14 with diagnoses of Cerebrovascular Accident (Stroke), Diabetes Mellitus, Hypertension and Peripheral Vascular Disease. Review of the Resident ' s initial Minimum Data Set (MDS) on 3/25/14 revealed he was moderately cognitively impaired. The assessment indicated the resident was incontinent of urine and required extensive assistance with Activities of Daily Living with one person assistance with toileting. During an observation on 4/29/14 at 11:41 AM the resident ' s window blind was observed with a 3 inches wide by 5 inches long opening with a view to the outside of the parking lot. There was no one observed in the parking lot. Resident #42 was observed in his bed with his covers down past his waist and without a brief. During an observation on 4/30/14 at 9:34 AM Resident #42's resident's window blind was observed with a 3 inches wide by 5 inches long opening with a view to the outside of the parking lot. There was no one observed in the parking lot. Resident #42 was observed in his bed with his covers down past his waist and without a brief. He was observed in the same condition on 4/30/14 at 11:21 AM and on 5/1/14 at 10:07 AM.	F 164	Quality Assurance Committee for further recommendations as necessary. An audit tool has been developed for walking rounds by Administrator and/or Administrative Nursing staff to observe compliance. These audits will be done 1 time per week for 4 weeks and results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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F 164	Continued From page 3 On 5/2/14 at 11:06 AM the Administrator stated the window blinds should not have an opening. Staff that care for him should let maintenance know that the blinds are not closing fully. Also direct care staff should have noticed the window blind was broken and should have reported it to maintenance. On 5/3/14 at 9:50 AM Nursing Assistant (NA#3) stated Resident #42 was assigned to him and he had taken care of him in the past. He stated Resident #42 liked to remain uncovered due to his being so hot natured. NA#3 stated he had not noticed that the window blinds had a gap but would have reported it if he had been aware.	F 164		
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 record review, observations and interviews the facility staff failed to knock on room doors or ask permission to enter resident rooms prior to entering two (2) of two (2) residents observed during an interview and medication pass. (Resident # 124, Resident #17). The findings include: 1. Resident #124 was admitted to the facility on 5/30/12 with diagnoses including Alzheimer ' s disease and Glaucoma. Review of the most	F 241	In-servicing of on-duty staff began immediately by Social Services personnel upon notification of concern by surveyor on 5/1/14. Residents that were identified, (Resident # 124 & #17), upon interview, voiced they felt their right to dignity and respect of individuality had not been violated. To ensure the deficient practice does not occur, in-services have been conducted on Dignity and Respect of Individuality,	5/21/14

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F 241	Continued From page 4 recent quarterly Minimum Data Set (MDS) Assessment dated 2/7/14 identified Resident #124 as cognitively intact and severely impaired visually. During a resident interview on 4/29/14 at 2:05PM Nurse #6 entered Resident #124 ' s room without a knock heard or waiting for the resident to give permission to enter and interrupted the interview asking the resident if a medication given earlier was helpful. During an interview with Nurse #6 on 5/1/14 at 2:30PM she stated it was ingrained in her to always knock on resident doors. She stated she tapped on the door and said, " knock, knock " and then walked in. During an interview on 5/1/14 at 9:40AM Resident #124 stated that due to the blindness in her left eye she could see just a little bit in her right eye and it was good to know when someone was coming in your room. During an interview with the Director of Nursing on 5/1/14 at 3:00PM she stated that staff was expected to knock on resident doors and announce themselves prior to entering a resident ' s room. During an interview with the Administrator on 5/2/14 at 4:00PM she stated knocking on doors was " Nursing 101. " The staff should knock on the residents ' doors and wait for an answer to enter; unless the resident clearly would not respond to the staff. She stated in review of the facility videos, clearly Nurse #6 appeared to have " waved her hand " near the door and then walked in.	F 241	i.e., knocking on doors, to include, Social Services, Nursing, Administration, Maintenance, Housekeeping, Laundry, Dietary, Activities, and Therapy. Nurses and CNA's were in-serviced additionally on 5/13/14 and 5/14/14. On 5/16/14 resident #124 was interviewed by Social Services Director to determine if any concerns with staff respect of privacy related to not knocking on doors. When asked about visitors on 4/29/14, Resident states that she recalls the two ladies in her room and states that the nurse did knock. She states that the nurse always knocks before entering, stating, "Oh yes, they always do." "It makes me feel important because I get to say, "Who is it", and "Come in." States she has no problems or concerns with staff not respecting her privacy or knocking before entering. Explained to resident that the expectation is that staff would knock prior to entering the room. Resident in agreement. On 5/16/14, resident #17 was interviewed by Administrator on 5/16/14 to determine if any concerns with staff respect of privacy and knocking on doors before entering. When asked about nurse reportedly not knocking on his door on 4/30/14, resident #17 states that he did not have a problem with nurse not knocking on his door because he knew she was coming back after having pushed him to his room to administer his medications that day. States that he does not have a problem with staff entering	

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F 241	Continued From page 5 2. Resident #17 was admitted to the facility on 8/8/08 with diagnoses including Multiple Sclerosis. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 4/20/14 identified Resident #17 as cognitively intact. A medication pass was conducted with Resident #17 on 4/30/14 at 11:36AM. Resident #17 was pushed to his room by another staff person and Nurse #7 was observed pushing the medication cart behind the resident to his door and then prepared Resident #17s medications and within minutes turned and walked into the resident ' s room without knocking. During an interview on 5/1/14 at 2:40PM, Nurse #7 she stated that all staff were supposed to knock on a resident ' s door before entering. During an interview with the Director of Nursing on 5/1/14 at 3:00PM she stated that staff was expected to knock on resident doors and announce themselves prior to entering a resident ' s room. During an interview with the Administrator on 5/2/14 at 4:00PM she stated knocking on doors was " Nursing 101. " The Administrator stated the staff should knock on the residents ' doors and wait for an answer to enter; unless the resident clearly would not respond to the staff.	F 241	without knocking depending upon what may be going on at a particular time. Explained to him that the expectation is that staff would knock prior to entering the room. Resident in agreement. The Resident's Rights sign-off sheet for new hires has been updated to include on Item #15,(g) "Staff knock before entering resident room". Visual reminders have been placed throughout the facility to remind staff and visitors to respect the privacy of residents by knocking before entering resident rooms. Social Services staff will monitor for effectiveness by daily (M-F) audits for 2 weeks, then 2 times per week for 2 weeks, then 1 time per week for 2 weeks and forward results to the Quality Assurance Committee for further recommendations. Nursing Administration will perform random daily audits (M-F) for 4 weeks and results will be forwarded to the Quality Assurance Committee for recommendations as necessary. The Administrator will perform weekly random audits 1 time per week for 4 weeks to further monitor compliance. Results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		5/21/14

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F 253	Continued From page 6 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to maintain a clean and orderly environment by failing to clean privacy curtains for 3 of 3 rooms (rooms #504, #102 and #109), failed to replace broken window blinds in 2 of 2 rooms (rooms #112 and #115) and failed to clean stained bathroom floors and caulking around toilets in rooms (rooms #102, #109, #112, #313, #315, #316, #317,# 401 and #405). Findings included: 1. During an observation on 5/1/14 at 8:48 AM brown stain matter was observed on the upper portion of a privacy curtain dividing bed 1 and bed 2 in room 504. During an observation on 5/2/14 at 8:48 AM brown stain matter was observed on the upper portion of a privacy curtain dividing bed 1 and bed 2 in room 504. During an observation on 5/2/14 at 9:50 AM brown stain matter was observed on the upper portion of a privacy curtain dividing bed 1 and bed 2 in room 504. During an observation on 5/2/14 at 10:52 AM brown stain matter was observed on the upper portion of a privacy curtain dividing bed 1 and bed 2 in room 504. On 5/3/14 at 10:01 AM the Housekeeping	F 253	The privacy curtains in rooms 504, 102 and 109 were cleaned on 5/2/14. The blinds in rooms 112 and 115 were replaced on 5/2/14. The toilet bases in rooms 102, 109, 112, 313, 315 & 317 (adjoining bathroom), 316, 401 and 405 have been cleaned and/or recaulked as of 5/20/14. All other areas with the potential for the same deficient practice have been audited for compliance. All staff, including, Maintenance, Housekeeping, Laundry, Dietary, Nursing, Administration, Social Services, Therapy and Activities have been inserviced on using Repair Requisitions to notify Maintenance or Housekeeping of blinds needing replacement/repair or privacy curtains needing to be cleaned or not operating properly, i.e. not sliding in the track, to provide for full visual coverage, as well as, to report stained toilet bases or tiles. Housekeeping staff are to inspect rooms daily, as they are cleaning, to include privacy curtains, blinds and toilets to ensure a sanitary, orderly and comfortable interior and prompt repairs/replacement as needed. A Window Blind audit sheet has been put	

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F 253	Continued From page 7 Supervisor stated he had been at the facility for only a week. He stated the housekeeping staff should pull the curtains daily to check if there are any stains. If the privacy curtains are stained, then they need to take them down and clean them. 2. On 4/29/14 at 11:00 AM an observation in room 109 revealed the privacy curtain was soiled with streaks of a dark substance on the base of the curtain 3 feet long and 1 foot high. The privacy curtain was also observed with a white substance on the right edge that was 6 inches long by 1 inch wide. Also, observed was the toilet in the bathroom of 109 with a dark brown stain at the base of the toilet. On 5/3/14 at 10:01 AM an observation in room 109 revealed the privacy curtain was soiled with streaks of a dark substance on the base of the curtain 3 feet long and 1 foot high. The privacy curtain was also observed with a white substance on the right edge that was 6 inches long by inch wide. Also, observed was the toilet in the bathroom of 109 with a dark brown stain at the base of the toilet. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated he had been at the facility for only a week. He further stated he was in the process of going though out the facility to identify what needed to be repaired. He stated each housekeeper had a deep cleaning day and toilets with brown rings staff would remove the brown caulking and replace with fresh caulking. He stated that housekeeping staff should look at the privacy curtains daily and take them down and clean them if they are dirty.	F 253	in place and will be performed daily (M-F) by the Maintenance Director for 4 weeks to ensure the deficient practice does not occur. The Housekeeping Quality Control Inspection (QCI) sheet will be utilized to identify broken blinds, privacy curtain issues and ensure toilet bases in random rooms are clean daily (M-F) for 4 weeks. These sheets will be reviewed weekly by Maintenance Director and Housekeeping Supervisor and Quality Assurance Coordinator/SDC to ensure compliance. Results will be forwarded to the Quality Assurance Committee for further recommendations as necessary. An audit tool has been developed for walking rounds by Administrator and/or Administrative Nursing staff to observe compliance. These audits will be done 1 time per week for 4 weeks and results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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F 253	Continued From page 8 3. On 5/1/14 at 3:18 PM an observation of room 102 revealed the window blind had a 1 inch wide by 5 inches long opening. Also, observed was the toilet in the resident ' s bathroom with a dark brown stain at the base of the toilet. On 5/2/14 at 11:28 AM an observation of room 102 revealed the window blind had a 1 inch wide by 5 inches long opening. Also, observed was the toilet in the resident ' s bathroom with a dark brown stain at the base of the toilet. On 5/2/14 at 11:28 AM the Administrator stated her Housekeeping Supervisor had resigned last week without a notice and she was not aware that the window blind was broken or that the toilet had dark brown stains in room 102. She stated all staff when they identify a problem should fill out a repair requisition and place it in the maintenance box on the hall. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated he had been at the facility for only a week. He further stated he was in the process of going though out the facility to identify what needed to be repaired. He stated each housekeeper had a deep cleaning day and toilets with brown rings staff would remove the brown caulking and replace with fresh caulking. He stated staff should identify if the blinds were broken and fill out a repair requisition and place it in the maintenance box on the hall. He stated he picked up the repair requisitions and fixed what needed to be repaired. 4. On 4/29/14 at 11:41 AM an observation of room #112 revealed the window blinds had 3 inches wide by 5 inches long opening. Also observed was the toilet in the resident ' s	F 253		

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F 253	Continued From page 9 bathroom with a dark brown stain at the base of the toilet. On 4/30/14 at 9:34 AM an observation of room #112 revealed the window blinds had a 3 inches wide by 5 inches long opening . Also, observed was the toilet in the bathroom of room 112 with a dark brown stain at the base of the toilet. On 5/2/14 at 11:06 AM an observation of room #112 revealed the window blinds had a 3 inch wide by 5 inches long opening. Also, observed was the toilet in the bathroom of room 112 with a dark brown stain at the base of the toilet. On 5/2/14 at 11:06 AM the Administrator stated the window blind in room 112 should not have an opening. Staff that care for the resident should let maintenance know that the blinds are not closing fully. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated he had been at the facility for only a week. He further stated he was in the process of going though out the facility to identify what needed to be repaired. He stated each housekeeper had a deep cleaning day and toilets with brown rings staff would remove the brown caulking and replace with fresh caulking. He stated staff should identify if the blinds were broken and fill out a repair requisition and place it in the maintenance box on the hall. He stated he picked up the repair requisitions and fixed what needed to be repaired immediately. 5. On 4/29/14 at 11:36 AM an observation of room 115 revealed the window blind was broken in both windows.	F 253		

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F 253	Continued From page 10 On 5/2/14 at 11:06 AM the Administrator stated the window blinds should not have an opening. Staff that care for the residents should let maintenance know that the blinds are broken. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated he had been at the facility for only a week. He further stated he was in the process of going though out the facility to identify what needed to be repaired. He stated staff should identify if the window blinds were broken and fill out a repair requisition and place it in the maintenance box on the hall. He stated he picked up the repair requisitions and fixed what needed to be repaired. 6. On 4/29/14 at 9:30 AM the bathroom floor in room 316 was observed with dark brown grout around the base of the commode. The bathroom door and door frame leading into the bathroom was observed with multiple scratches at wheel chair height. Further observations of this bathroom in room #316 on 4/30/14 at 9:28 AM, 5/1/14 at 11:33 AM and 5/2/14 at 11:24 AM revealed the conditions remained the same as observed on 4/29/14. On 5/3/14 at 12:22 PM the Administrator stated staff did identify that the privacy curtains were not wide enough within the last 3 months. The Housekeeping Supervisor informed the Administrator the curtains were not wide enough and when we looked at the order the width should have been 180 inches and we received 108 inches. The facility ordered curtains to replace the short ones and failed to install the curtains. The Administrator stated she did not check behind the Housekeeping Supervisor to make	F 253		

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F 253	Continued From page 11 sure the curtains were installed. 7. On 4/29/14 at 9:35 AM the bathroom floor in room 313 was observed with a stained tile floor and darkened grout around the base of the commode. Further observations of this bathroom in room #313 on 5/1/14 at 11:30 AM and on 5/2/14 at 11:44 AM revealed conditions remained the same as observed on 4/29/14. On 5/3/14 at 12:22 PM the Administrator stated staff did identify that the privacy curtains were not wide enough within the last 3 months. The Housekeeping Supervisor informed the Administrator the curtains were not wide enough and when we looked at the order the width should have been 180 inches and we received 108 inches. The facility ordered curtains to replace the short ones and failed to install the curtains. The Administrator stated she did not check behind the Housekeeping Supervisor to make sure the curtains were installed. 8. The bathroom between rooms 315 and 317 was observed with a stained tile floor and darkened grout around the base of the commode on 4/29/14 at 10:50 AM. Further observations of the bathroom in room between room #315 and 317 on 5/1/14 at 11:35 AM and 5/2/14 at 9:32 AM revealed conditions remained the same as observed on 4/29/14. On 5/3/14 at 12:22 PM the Administrator stated staff did identify that the privacy curtains were not wide enough within the last 3 months. The Housekeeping Supervisor informed the Administrator the curtains were not wide enough and when we looked at the order the width should have been 180 inches and we received 108	F 253		

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F 253	Continued From page 12 inches. The facility ordered curtains to replace the short ones and failed to install the curtains. The Administrator stated she did not check behind the Housekeeping Supervisor to make sure the curtains were installed. 9. The bathroom between room 403 and 405 was observed with a dark brown stain around the base of the commode at floor level on 4/29/14 at 11:01 AM. Further observations of the bathroom in room # 403 and 405 on 5/1/14 at 8:56 AM revealed conditions remained the same as observed on 4/29/14. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated he had been at the facility for only a week. He further stated he was in the process of going though out the facility to identify what needed to be repaired. He stated each housekeeper had a deep cleaning day and toilets with brown rings staff would remove the brown caulking and replace with fresh caulking.	F 253		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to maintain comfortable sound levels by allowing a resident with behaviors to yell out at night for 5 of 5 residents (Residents # 138, 116, 56, 67, 11) who complained of unwanted noise.	F 258	To address the issue of maintaining comfortable sound levels for residents identified, (residents #138, 116, 56, 67, (resident #11 has been discharged), possible options have been offered by Social Services Director, including room	5/21/14

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F 258	Continued From page 13 The Findings included: 1. Resident # 138 was admitted to the facility on 6/22/13 with diagnosis that included Chronic obstructive pulmonary disorder, Hypertension and Depression. Review of the most recent Quarterly Minimum Data Set Assessment dated 3/14/14 revealed resident # 138 did not have any cognitive impairment or behaviors coded. During an interview with Resident # 138 on 4/29/14 at 2:30 PM the resident stated that he had a concern with his roommate yelling out at night. Resident # 138 stated that he had, " told everyone " his roommate hollers and staff had told him the roommate was " sicker than you " and needed to be closer to the nurses ' station. During an interview on 5/2/14 at 9:08 AM with Resident # 138 he stated that the other night his room mate was hollering for water. The Resident stated that he did not have to tell staff his roommate was yelling he could be heard up to the front hall. During an interview with Nurse # 1 on 5/2/14 at 2:54 PM she stated that on 4/15/14, Resident # 138 said he had told the Social Worker (SW) that his room mate yells out at night. Nurse # 1 revealed that normally she would go tell the SW however she stated that Resident # 138 indicated he had reported his roommate yelling to the SW. The Social Worker was interviewed on 5/2/14 at 3:03 PM she stated that neither the resident nor Nurse # 1 had spoken to her about any resident	F 258	changes, closing their doors and/or ear plugs. All have acknowledged right to shut or have their doors shut to minimize uncomfortable sound levels. All have declined relocation and ear plugs at this time. Residents with behaviors that may have contributed to uncomfortable sound levels have been identified through 1:1 interviews with those residents affected. Staff were also asked for their input to further identify any residents with behaviors that may be contributing to uncomfortable sound levels. Nursing staff, including LPN's, RN's, and CNA's, as well as, the Interdisciplinary Team (IDT), have been advised on the survey findings, and, making sure that residents who yell out are being monitored to ensure proper documentation so that behaviors contributing to uncomfortable sound levels can be appropriately addressed. Audits are being performed by Social Services Director or designee daily (M-F) for 4 weeks to determine if sound levels are improving. Administrative Nursing staff will audit comfortable sound levels on a random basis daily (M-F) for 4 weeks. Administrator will audit 1 time per week (M-F) for 4 weeks during random walking rounds to monitor compliance with comfortable sound levels. All results will be forwarded to the Quality Assurance Committee for further	

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F 258	Continued From page 14 yelling. During an interview with Nurse # 2 on 5/2/14 at 3:16 PM she stated that she heard the resident yelling in the morning but not at night as her shift ended at 11:00 PM. Nurse # 2 stated when the resident did yell out, she would try to see what he needed or wanted. The Nurse stated that she had not reported his yelling as he usually stops after she asked what he needed. 2. Resident # 116 was admitted to the facility on 2/10/12 with diagnosis that included Dementia, Hypertension and Kidney disease. A review of the most recent Quarterly Minimum Data Set Assessment dated 3/11/14 revealed the resident did not have any cognitive impairment or behaviors coded. During an interview with Resident # 116 on 5/2/14 at 10:29 AM he stated that he heard people yell on most nights. The Resident stated that he told the nurse but that not much happened to stop the noise. 3. Resident # 56 was admitted to the facility on 12/22/10 with diagnosis that included Diabetes Mellitus, Hypertension and Congestive Heart Failure. A review of the most recent Quarterly Minimum Data Set Assessment dated 4/25/14 revealed the resident did not have any cognitive impairment or behaviors coded. During an interview with Resident # 56 on 5/2/14 at 10: 31 AM she stated that she heard people yell all night. The resident stated that she had told the nurse but that it did no good. 4. Resident # 67 was admitted to the facility on	F 258	recommendations as necessary.	

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8/21/14 with diagnosis that included Depression, Hypertension and Spinal stenosis. A review of the Annual Minimum Data Set Assessment dated 2/24/14 coded the resident as having moderately impaired cognition with no behaviors present.

During an interview with Resident # 67 on 5/2/14 at 10:40 AM she stated that there is a man here who yelled every night. The resident stated that you can tell the nurse but it did no good, no one stopped the yelling.

During an interview with the Director of Nursing (DON) on 5/2/14 at 4:43 PM she stated that a few months ago they had a grievance of noise at night and the facility addressed the issue.

On 5/3/14 at 11:08 AM the Director of Nursing stated she would expect staff to go to the resident that was yelling and find out what was going on. She stated staff should check for pain or if they could not sleep provide an intervention. The DON further stated she would expect her staff go to the other residents down the hall and ask them if they would like staff to shut their door.

5. Resident #11 was admitted to the facility on 3/28/14 with diagnoses including Anxiety, Dementia and Chronic Obstructive Pulmonary Disease (COPD).

Resident ' s initial Minimum Data Set (MDS) summary dated 4/4/14 revealed she was cognitively intact and had no behaviors.

On 5/1/14 at 1:41 PM Resident #11 stated that a resident across the hall was screaming and crying out at night so that she could not sleep. She stated she had not been able to sleep and

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F 258	Continued From page 16 was afraid she could not get better and heal unless she got some sleep. Resident #11 stated she was counting the days when she could go home and sleep in peace and quiet. She stated she had not told staff but she did not feel the need to since she knew they could also hear the resident making all the noise. On 5/3/14 at 11:08 AM the Director of Nursing stated she would expect staff to go to the resident that was yelling and find out what was going on. She stated staff should check for pain or if they could not sleep provide an intervention. The DON further stated she would expect her staff go to the other residents down the hall and ask them if they would like staff to shut their door.	F 258		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 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;	F 272		5/22/14

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F 272	Continued From page 17 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 record review, observations and staff interviews, the facility failed to complete a quarterly minimum data set (MDS) assessment accurately by failing to include Active Diagnoses (Resident #92) and failed to assess a resident with behaviors (Resident #111). The findings included: 1. Resident #92 was admitted to the facility on 8/4/11 and re-admitted on 1/10/14 with diagnoses including Dry Eye Syndrome, Macular Degeneration, Peripheral Vascular Disease (PVD), Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Hyperlipidemia, Peptic Ulcer Disease (PUD), Dementia, Anxiety and Chronic Pain.	F 272	The Quarterly MDS dated 4/11/14 for resident #92 has been modified to include all active diagnosis in Section I on 5/2/14. A Comprehensive Assessment for resident #111 is in process. All other residents will have their diagnosis reviewed by the Interdisciplinary Team with each MDS as it comes due and added to the MDS if active. All residents with identified behaviors will have MDS reviewed to ensure Section E, is coded. A Comprehensive Assessment tool has been put in place to be utilized by the Interdisciplinary Team to assure that Sections E and I accurately reflect the residents.	

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F 272	Continued From page 18 A review of the quarterly Minimum Data Set (MDS) dated 4/11/14 revealed Section I (Active Diagnoses) was incomplete. Section I failed to include diagnoses of Anxiety, DM, Hyperlipidemia, PUD, COPD, Dementia, Macular Degeneration and Dry Eye Syndrome. Section Z0500 (Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion) was observed signed by the MDS Coordinator and dated 4/18/14. Review of the Medication Administration Record for January 2014 through April 2014 documented Resident #92 received medication for the following diagnoses: Diabetes Mellitus, Hyperlipidemia, Dementia, Anxiety, Chronic Obstruction Pulmonary Disease, Dry Eyes, Macular Degeneration and Peptic Ulcer Disease. During an interview with MDS Nurse on 5/2/14 at 2:05PM she stated she typically reviews the Admission orders with the Diagnoses and codes the MDS from this review. She stated she did not know why the section was incomplete. During an interview with the Administrator on 5/2/14 at 4:00PM she stated she did not understand why the MDS was incomplete, stating the MDS should be a reflection of each current diagnosis. 2. Resident # 111 was admitted to the facility on 12/3/12 and re-entered on 8/5/13 with diagnoses of altered mental status, Metastatic Breast Cancer to the lymph nodes, lungs, and bones, Anxiety, Depression, Hemiplegic, Cerebrovascular Accident (stroke), Anemia,	F 272	A medical record of 1 (one) random sample will be reviewed weekly for accuracy of entries in Sections E and I on the MDS by the Director of Nursing or designee for 4 weeks. The Comprehensive Assessment tools and random sample results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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Hypertension, Congestive Heart Failure (CHF), Diabetes, Chronic kidney disease, Chronic Obstructive Pulmonary disease and end of life Hospice.

A review of the significant change Minimum Data Set (MDS) assessment dated 6/13/13 and the quarterly MDS dated 3/5/14 revealed Section E (Behavior) had no symptoms identified. Section Z0500 (Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion) was observed signed by the MDS Coordinator and dated 03/18/2014.

Review of the Progress Notes by the Social Worker assistant dated 9/9/13 revealed Resident #111 " Hasn ' t had anything but minimal behaviors during assessment reference period i.e. yelling out for attention frequently per nursing documentation. "

Review of the resident's care plan dated 9/9/13 revealed problem #4 was that the resident was severely impaired for daily decision making based on short and long term memory deficits. The resident yelled out for attention. There were no goals or approaches on the care plan.

Review of the Progress Notes by the Social Worker assistant dated 12/5/13 revealed Resident #111 had no behaviors during the assessment reference period per nursing documentation and staff interviews related to behaviors. The notes did indicate the resident had a history of " yelling out at times to nursing staff for no apparent reason. "

Review of the Interdisciplinary Progress Notes dated 2/17/14 revealed Resident #111, " yells out

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at times for staff. "

A review of the Progress Notes from Resident #111 ' s Psychiatrist dated 2/28/14 revealed the purpose of her initial visit was, " To recognize and cope with feelings of depression. " She was assessed as depressed and agitated with a flat affect. Resident #111 ' s response to the therapist was that she became frustrated with staff and would spend a great deal of time during the day, " yelling for staff. " Resident #111 discussed with the therapist her " Feelings of depression and being lonely and her lack of contact with others. "

A review of the Progress Notes from Resident #111 ' s Psychiatrist dated 3/4/14 revealed the resident was assessed under mood as being depressed. She discussed with her therapist that she was frustrated over not being allowed to wear her breathing treatment mask all the time. She believed that just wearing the mask with out the machine would help her breathe better and how it might just give her comfort to wear it.

Review of the Progress Notes by the Social Worker assistant dated 3/5/14 revealed Resident #111 had no behaviors during her assessment reference period per nursing documentation and staff interviews related to behaviors.

During an observation on 4/30/14 at 2:45 PM Resident #111 was observed yelling out loudly, " I want my bed out, I want my bed out continuously. Staff nurse #11 was observed going down the hall during a medication pass. Resident #111 continued yelling out " I want my bed out; I want my bed out .... " Nurse #11 was observed down the hall and called out to the resident that she

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was coming in her room in just a minute and stated to the resident from down the hall, " Can you wait? " Resident #111 responded with, " OK, " and then began to yell out again, " I want my bed out, I want my bed out. "

During an interview on 5/1/14 at 9:40 AM the Hospice Nursing Assistant stated Resident #111 usually yells out the whole time she is giving her care. She stated she lets the nurse know and asks her if she has any medications to calm her. The Hospice NA stated the resident usually gets stuck on a word and keeps repeating it over and over. She stated she is really loud and sometimes it will last for hours and she will not stop. The Hospice NA further stated she will ask the resident what is wrong and Resident #111 will say she does not know.

During an interview on 5/1/14 at 9:54 AM, facility Nurse #7 stated within the last couple of months Resident #111 has started " yelling out the same word non-stop. " Nurse #7 stated she will ask the resident if there is something she can do for her, but Resident #111 will not stop yelling. The nurse further stated, " What ever gets stuck in her mind she just keeps repeating it for hours. "

During an interview on 5/1/14 at 2:00 PM a family member stated Resident #111 would holler out at anyone so they could help her. The family member stated Resident #111 was so loud that when she entered the building she could hear her yelling out. She stated that Resident #111 had cancer and the facility and hospice thought that the yelling was due to the cancer had gone to her brain.

On 5/2/14 at 8:51 AM the Social Worker assistant

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F 272	Continued From page 22 stated she had completed Resident #111 ' s assessment on 3/5/14. She stated during the 7 day look back she was not having behaviors. She stated she reviewed the progress notes and interviewed the nurses during the assessment look back. She stated the resident did yell but it was because, " She just wants attention. " During an interview on 5/2/14 at 9:14 AM the MDS Coordinator stated during care plan meetings staff have talked about Resident #111 hollering out a lot but she did not trigger for behaviors. She stated the Social Workers did the behaviors and cognition and mood part of the MDS and they sign off that it is accurate. That is their section and they put that information in the MDS. The MDS coordinator further stated that everyone signs off on their part and then she signs off that it is complete. During an interview on 5/2/14 at 9:38 AM, with the Social Worker, the facility consultant and the assistant to the Social Worker stated that Social Workers filled out the MDS part for cognition, mood and behaviors. The Social Worker stated she had identified the resident was yelling out for attention on the 9/9/13 assessment but failed to put goals and approaches into the care plan. She stated because of the yelling out she had arranged for psych visits in February 2014. She stated on the 3/4/14 quarterly MDS assessment she still had not assessed the resident as having behaviors.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		5/23/14

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F 280	Continued From page 23 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 record review, observations and staff interviews, the facility failed to individualize and update a care plan with goals and approaches after identifying that 1 of 3 residents reviewed for pressure ulcers (Resident #30) refused to change positions in bed so as to promote healing of Stage IV pressure Ulcers. The findings included: Resident #30 was originally admitted to the facility on 5/31/13 and readmitted on 9/17/13 with diagnoses including, Paraplegia and Pressure Ulcers. According to the most recent Quarterly Minimum Data Set dated 2/1/14, Resident #30's cognition was intact. He required extensive assistance to total dependence in most areas of	F 280	Resident #30□s Care Plan has been individualized to include refusal of resident to accept repositioning and/or staying repositioned once assistance has been provided and appropriate interventions to address the risks associated with refusal/noncompliance. The risks/benefits have been explained to resident regarding his refusal to remain repositioned and he acknowledges understanding. All other residents with pressure ulcers who refuse care will have Care Plans reviewed and revised if necessary for individualization related to refusal of care. The risks and benefits will be discussed with each resident so that they make an	

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F 280	Continued From page 24 activities of daily living. In the area of bed mobility, he required extensive assistance with one person physical assistance. In the area of transfers, the activity occurred with two person physical assistance. In the areas of toileting and personal hygiene he was totally dependent with one person physical assistance. On the MDS Resident #30 had two stage 3 pressure ulcers and one stage 4 pressure ulcers that were present upon admission to the facility on 9/17/13. Review of the treatment record dated 4/28/14 revealed that Resident #30 had one stage 4 pressure ulcer on his right gluteal fold, a stage 4 ulcer on his left gluteal fold and a stage 4 pressure ulcer on his sacrum. Review of Resident # 30's Care Plan, quarterly update, 2/26/14, read in part, "Problem start date: 6/14/13, Has impaired skin integrity related to resident, has multiple wounds to gluteal fold, etc. At risk for further skin breakdown related to decreased mobility and bowel incontinence. Goal target date: 5/10/14. Wounds will show no sign/symptoms of infection and will improve as evidenced by decrease in size by next review. Approach start date: 6/14/13. Pressure relief mattress and chair cushion. Weekly weights. Measure and document on wound progress or decline weekly. Goal Target date: 5/10/14. Will reduce the risk of further skin breakdown through the next review. Approach start date: 6/14/13. Assist resident to turn and reposition on each NA (Nursing Assistance) round and as needed. Provide incontinence care as needed. Position to protect pressure points. Keep head of bed less than 30 degrees unless eating or tube feed running. Therapy will be notified for evaluation and	F 280	informed decision regarding refusal of care. The Director of Nursing and Wound Care Nurse (WCN) met to discuss identifying alert and oriented residents who have pressure ulcers and those that choose to refuse repositioning or pressure relieving interventions/ treatments in order to provide for individualization of their Care Plans. The Point of Care module has been programmed for documentation/alerts of refusal of care related to repositioning and will be monitored daily (M-F) by the Unit Managers/Coordinators or designees and communicated to the Interdisciplinary Team to identify residents who are noncompliant with pressure relieving interventions/treatments ongoing so that individualization of care plan may be accomplished. The Director of Nursing or Designee will perform random audits of the care plans for newly identified residents who have been identified as noncompliant with pressure relief interventions/treatments to determine if care plan addresses this issue for 4 weeks. Audit results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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intervention or treatment approaches and protective and positioning devices as necessary."

During an observation on 5/1/14 at 2:15 PM, Resident # 30 was observed lying on his back in bed watching television.

During an observation on 5/1/14 at 3:15 PM, Resident # 30 was observed lying on his back in bed watching television.

During an interview on 5/1/14 at 2:55 PM, Nursing Assistant #5 stated Resident # 30 had a pressure sore located on his buttocks. She revealed that she kept him turned from side to side and she put a pillow under his feet to keep pressure off his feet.

During an interview on 5/1/14 at 3:46 PM, Nursing Assistant #6 revealed Resident #30 preferred to lie on his back and he was adamant about the way he laid in bed. She stated he would lie on his back with a pillow propped up on his right side and arm.

Review of the record revealed that there was no documentation of how long Resident #30 was reluctant to stay off his back.

During an interview on 5/1/14 at 3:20 PM, Resident # 30 revealed his pressure ulcers developed in the hospital. He revealed staff had talked to him about the risk of developing pressure ulcers, treatment, and how they planned to reduce the risk of pressure sores. Resident # 30 revealed that staff repositioned him, but he could also reposition himself.

During an observation on 5/2/14 at 9:50 AM,

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Resident # 30 was observed lying on his back in bed watching television.

During an interview on 5/2/14 at 11:10 AM, Nursing Assistant # 7 stated she worked with Resident # 30 ninety per cent of the time. She revealed that they try to reposition him however, he does not like to be turned so they prop pillows on his sides.

During an interview on 5/2/14 at 11:25 AM, the facility Treatment Nurse revealed Resident # 30 had eight pressure sores when he was first admitted to the facility. She stated he currently had two pressure sores on his gluteal fold and one on his sacrum. The Treatment Nurse revealed Resident # 30 was at risk for pressure sores because he does not have any feeling and cannot move from waist down. She reported that no wounds started in the facility, however, one wound closed and reopened. The Treatment Nurse revealed that they had talked to Resident # 30 about positioning in reference to his pressure sores, but he still preferred to lie on his back, but he would allow a pillow to be propped on his right side and arm however she stated that she felt it was not enough to keep the pressure off. The treatment nurse did not indicate any other approaches had been put in place to encourage repositioning.

During an observation on 5/2/14 at 10:52 AM, Resident # 30 was lying in bed on his back watching television.

During an interview on 5/2/14 at 2:28 PM, the MDS (Minimum Data Set) Coordinator stated that Resident # 30's care plan was updated every quarter and every time an assessment was due.

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F 280	Continued From page 27 She further revealed that the Nurse and Unit Manager updated the care plan between the time that she updated the care plan quarterly. During an interview on 5/3/14 at 10:30 AM, the Director of Nursing revealed she reviewed Resident # 30's Care Plan and she was not able to find anything about encouraging the resident to reposition to get off his back or to get up from bed. She stated Resident # 30 was alert and oriented and would let staff know what he wanted to do. Review of the record revealed no documentation of Resident #30's refusals to reposition to relieve pressure nor was there documentation of efforts to counsel Resident #30 regarding lying on his back could be detrimental to making progress in healing the pressure sores. There was no documentation in the record of other measures to get Resident #30 to turn and reposition. During an interview on 5/3/14 11:30 AM the Administrator stated that Resident # 30 had a low air mattress and he was happy and content watching television. She said he had come a long way with his wounds but she could not identify planned approaches to encourage repositioning for Resident #30.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		5/22/14

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F 312	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide nail care for 2 of 2 residents (#100 and 133) and remove chin hairs for 1 of 1 residents (#100) needing total assistance with Activities of Daily Living. The Findings include: 1. Resident # 100 was admitted to the facility on 2/16/10 with diagnosis including Dementia with behavior disturbances, Hyperthyroidism, Schizophrenia, Depression and Arthritis. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 4/18/14 assessed resident #100 as moderately impaired for cognition. She required extensive one person physical assist with personal hygiene and had impairment of her upper extremities which included her shoulder, elbow, wrist and hand. Review of the Care Plan dated 11/7/13 for Activities of Daily Living (ADL ' s) documented resident # 100 needed assist with ADL ' s and staff would provide showers weekly and nail care prn (as needed.) During the initial tour on 4/29/14 at 9:25 AM resident # 100 was observed in her Geri chair in the day room watching TV. Resident # 100 was observed to have multiple chin hairs ½ inches or longer. The left hand pinky finger and index finger nails were observed broken and with jagged edges. The resident ' s right hand pinky finger and middle finger nails were observed broken and with jagged edges.	F 312	Resident #100 and #133 both had their nails trimmed and filed on 5/1/14. Resident #100 also had her chin hairs removed on 5/1/14. All other in-house residents needing total assistance with Activities of Daily Living (ADL's) were checked for nail care and facial hairs and assistance provided as necessary on 5/1/14. Informal in-servicing began immediately on 5/1/14 and a formal in-service for Nursing staff, including RN's, LPN's, CNA's, were in-serviced on 5/13/14 and 5/14/14 on the expectation to provide ADL assistance to dependent residents upon shower days and as needed. Administrative Nursing staff will perform daily random audits (M-F) of residents needing total assistance for nail care and facial hairs times 4 weeks. Results will be reviewed for effectiveness and forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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F 312	Continued From page 29 On 4/30/14 at 9:15 AM Resident # 100 was observed in her Geri chair in the day room watching TV. Resident # 100 was observed to have multiple chin hairs ½ inches or longer. The left hand pinky finger and index finger nails were observed broken and with jagged edges. The resident ' s right hand pinky finger and middle finger nails were observed broken and with jagged edges. During an observation on 5/1/14 at 8:56 AM resident # 100 was observed in her Geri chair in the day room watching TV. The resident was observed to have multiple chin hairs ½ inches or longer. The left hand pinky finger and index finger nails were observed broken and with jagged edges. The resident ' s right hand pinky finger and middle finger nails were observed broken and with jagged edges. During an interview with nursing assistant (NA) # 1 on 5/1/14 at 2:36 PM she stated that the resident was a total assist with her ADL ' s. She stated that the resident does not refuse her bath or shower and had never refused care with her. NA # 1 stated the resident would let her trim her nails and sometimes would ask her to remove her chin hairs. During an interview with the Director of Nursing (DON) on 5/1/14 at 3:30 PM she stated that staff are suppose to do nail care with ADL ' s. She stated nails may be long but should not have rough or jagged edges. She stated she would expect staff to do nails on bath days and to look at a resident ' s nails and file them if they are jagged.	F 312		

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2. Resident # 133 was admitted to the facility on 3/18/14 with diagnosis including Hypertension, Dementia and Diabetes Mellitus.

Review of the Admission Minimum Data Set Assessment dated 3/25/14 assessed Resident #133 as severely impaired for cognition. She required extensive one person physical assist with personal hygiene.

Review of the Care Plan dated 4/2/14 for Activities of Daily Living documented resident # 133 requires total assistance with ADL ' s related to diagnosis of dementia and staff were to provide for the resident ' s personal hygienic needs.

On 4/30/14 at 9:00 AM Resident # 133 was observed in bed. The residents right hand index and middle fingernails were observed broken and had jagged edges.

During an observation on 5/1/14 at 8:52 AM Resident # 133 was observed in bed. The residents right hand index and middle fingernails were observed broken and had jagged edges. The residents left hand pinky and pointer finger was observed broken and had jagged edges.

In an interview with NA #1 on 5/1/14 at 2:19 PM NA # 1 stated that Resident # 133 was unable to do for herself and needed total assistance with ADL ' s. The NA stated that fingernail care was usually done on shower days.

During an interview with the Director of Nursing (DON) on 5/1/14 at 3:30 PM she stated that staff are suppose to do nail care with ADL ' s. She stated nails may be long but should not have rough or jagged edges. She stated she would

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F 312	Continued From page 31 expect staff to do nails on bath days and to look at a resident ' s nails and file them if they are jagged. In an interview with the Hospice Nurse on 5/2/14 at 1:45 PM she stated that she would expect the Hospice NA to clean and file her nails.	F 312		
F 320 SS=E	483.25(f)(2) NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, family and staff interviews the facility failed to implement effective interventions for a resident (Resident #111) displaying an increase in behaviors (yelling out) for 1 of 2 sampled residents with behaviors. The findings included: Resident # 111 was admitted to the facility on 12/3/12 and re-entered on 8/5/13 with diagnoses of altered mental status, Metastatic Breast Cancer to the lymph nodes, lungs, and bones, Anxiety, Depression, Hemiplegia, Cerebrovascular Accident (stroke), Congestive Heart Failure (CHF), Diabetes, Chronic kidney	F 320	The Care Plan for Resident #111 was initially reviewed by the Social Services Director and Director of Nursing and on 5/2/14 to review interventions and possible modifications as necessary. Per request of the facility, the hospice provider involved with the care of this resident was consulted for input. Other possible contributing factors have been explored and follow-up is ongoing. The Care Plan was further revised by the Interdisciplinary Team (IDT) on 5/15/14. Behavior monitoring tools are in place and being reviewed daily to determine effectiveness of current interventions.	5/22/14

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F 320	Continued From page 32 disease, Chronic Obstructive Pulmonary disease and end of life Hospice. Review of the significant change Minimum Data Set assessment (MDS) dated 6/13/13 and the most recent quarterly MDS dated 3/5/14 revealed Resident #111 was moderately to severely impaired for daily decision making. The hearing, speech section of the assessment revealed she only had minimal difficulty with hearing; her speech was clear and was able to express her ideas and wants. She was also able to understand others. The behavior section of the assessment revealed she did not have verbal behaviors of disruptive sounds or did not exhibit vocal screaming. Resident #111 was assessed as being totally dependent on staff for bed mobility and transfers. Review of the Progress Notes by the Social Worker assistant dated 9/9/13 revealed Resident #111 " Hasn ' t had anything but minimal behaviors during assessment reference period i.e. yelling out for attention frequently per nursing documentation. " Review of the resident's care plan dated 9/9/13 revealed problem #4 was that the resident was severely impaired for daily decision making based on short and long term memory deficits. The resident yells out for attention. There were no goals or approaches on the care plan. Review of the Progress Notes by the Social Worker assistant dated 12/5/13 revealed Resident #111 had no behaviors during the assessment reference period per nursing documentation and staff interviews related to behaviors. The notes did indicate the resident	F 320	All other residents identified with behaviors are being reviewed by the Interdisciplinary Team to determine effectiveness of current interventions and modifications made as necessary. To ensure the deficient practice does not occur, the facility Electronic Health Record/Point of Care (EHR/POC) module has been reprogrammed to include behavior monitoring on all residents. The contracted Mental Health provider has been consulted regarding assistance with input related to effective interventions and a communication tool has been put in place to ensure timely information exchange. Inservicing to LPN's, RN's and Administrative Nursing staff related to recognizing behaviors and exercising interventions was performed on 5/13/14 and 5/14/14. Behavior monitoring tool reports will be reviewed weekly for 4 weeks by Director of Nursing and Social Services Director or designees to monitor effectiveness of current interventions. EHR/POC System alerts will be reviewed weekly for 4 weeks by Social Services Director and Director of Nursing or designees to monitor for effectiveness of interventions as evidenced by decreasing incidents of behaviors. Results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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had a history of " yelling out at times to nursing staff for no apparent reason. "

Review of the Interdisciplinary Progress Notes dated 2/17/14 revealed Resident #111, " yells out at times for staff. "

A review of the Progress Notes from Resident #111 ' s Psychiatrist dated 2/28/14 revealed the purpose of her initial visit was, " To recognize and cope with feelings of depression. " She was assessed as depressed and agitated with a flat affect. Resident #111 ' s response to the therapist was that she became frustrated with staff and would spend a great deal of time during the day, " yelling for staff. " Resident #111 discussed with the therapist her " Feelings of depression and being lonely and her lack of contact with others. "

A review of the Progress Notes from Resident #111 ' s Psychiatrist dated 3/4/14 revealed the resident was assessed under mood as being depressed. She discussed with her therapist that she was frustrated over not being allowed to wear her breathing treatment mask all the time. She believed that just wearing the mask with out the machine would help her breathe better and how it might just give her comfort to wear it.

Review of the Progress Notes by the Social Worker assistant dated 3/5/14 revealed Resident #111 had no behaviors during her assessment reference period per nursing documentation and staff interviews related to behaviors.

Review of the Interdisciplinary Progress Notes dated 3/7/14 at 8 PM revealed Resident #111, " Resident continuously yelling/screaming during

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F 320	Continued From page 34 entire shift. Redirected several times with no success. Will continue to monitor behavior. " Review of the Interdisciplinary Progress Notes dated 3/12/14 at 3:00 AM revealed Resident #111 yelled out at times and wanted staff to be with her in her room. Review of the Interdisciplinary Progress Notes dated 3/19/14 at 5 PM revealed Resident #111 had yelling episodes. Review of the Interdisciplinary Progress Notes dated 3/20/14 at 4 AM revealed Resident #111 was constantly yelling throughout the night. The nurse administered a sleeping pill for insomnia and medication for anxiety. Resident #111 slept from 12 AM until 3 AM but she woke up and started yelling out again. Review of the Interdisciplinary Progress Notes dated 3/21/14 at 6:45 PM revealed Resident #111 was cursing and yelling at staff during the evening shift. Staff tried to redirect her with no positive outcome. Review of the Progress Notes from Resident #111 ' s Psychiatrist dated 4/9/14 revealed the goal was for her to recognize and cope with feeling of depression and his assessment was she was depressed with a flat affect. Resident #111 stated she was concerned about her health. She felt she was getting worse, " but no one is telling me anything. " Review of the Interdisciplinary Progress Notes dated 4/22/14 revealed the hospice nurse was notified concerning " continuous yelling out all the time. "	F 320		

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F 320	Continued From page 35 During an observation on 4/30/14 at 2:45 PM Resident #111 was observed yelling out loudly, " I want my bed out, I want my bed out continuously. Staff nurse #11 was observed going down the hall during a medication pass. Resident #111 continued yelling out " I want my bed out; I want my bed out .... " Nurse #11 was observed down the hall and called out to the resident that she was coming in her room in just a minute and stated to the resident from down the hall, " Can you wait? " Resident #111 responded with, " OK, " and then began to yell out again, " I want my bed out, I want my bed out. " On 4/30/14 at 3:00 PM Resident #111 stopped yelling out when she was interviewed. She stated she wanted her bed out. Resident was observed yelling out again, " I want my bed out ..... " after the interview was ended. During an interview on 5/1/14 at 9:40 AM the hospice Nursing Assistant stated Resident #111 usually yells out the whole time she is giving her care. She stated she lets the nurse know and asks her if she has any medications to calm her. The hospice NA stated the resident usually gets stuck on a word and keeps repeating it over and over. She stated she is really loud and sometimes it will last for hours and she will not stop. The hospice NA further stated she will ask the resident what is wrong and Resident #111 will say she does not know. During an interview on 5/1/14 at 9:54 AM, the resident ' s primary Nurse #7 stated within the last couple of months Resident #111 has started " yelling out the same word non-stop. " Nurse #7 stated she will ask the resident if there is	F 320		

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something she can do for her, but Resident #111 will not stop yelling. The nurse further stated, " Whatever gets stuck in her mind she just keeps repeating it for hours. "

During an interview on 5/1/14 at 2:00 pm a family member stated Resident #111 would holler out at anyone so they could help her. The family member stated Resident #111 was so loud that when she entered the building she could hear her yelling out. She stated that Resident #111 had cancer and the facility and hospice thought that the yelling was due to the cancer had metastasized to her brain. The family member stated she noticed that when her mother would have a urinary tract infection that was when she would start yelling out. The family member stated her mother had a UTI and that she had just been started on some antibiotics and was not yelling. She further stated that the only intervention she knew staff had done was to give her medications to calm her.

On 5/2/14 at 8:51 AM the Social Worker assistant stated she had completed Resident #111 ' s assessment. She stated during the 7 day look back she was not having behaviors. She stated she reviewed the progress notes and interviewed the nurses during the assessment look back. She stated the resident did yell but it was because, " She just wants attention. "

During an interview on 5/2/14 at 9:38 am, with the Social Worker, the facility consultant and the assistant to the Social Worker stated that Social Workers filled out the MDS part for cognition, mood and behaviors. The Social Worker stated she had identified the resident was yelling out for attention on the 9/9/13 assessment but failed to

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F 320	Continued From page 37 put goals and approaches into the care plan. She stated because of the yelling out she had arranged for the Psychiatrist to see Resident #111 in February 2014. The Social Worker stated she did not get the notes from the Psychiatrist until 3 weeks later and had not had time to address the resident ' s concerns. On 5/2/14 at 12:00 noon the Hospice Nurse stated Resident # 111 did have episodes of yelling out. She stated staff would go in and try to comfort her, but as soon as they would walk out she would start yelling out again. She stated the hospice team had coordinated her plan of care and she thought Resident #111 ' s cancer had metastasized to the brain causing her to yell out. She stated the physician had also tried different medications to calm her and recently she had a UTI which could also cause her behavior.	F 320		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		5/22/14

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F 329	Continued From page 38 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to monitor the use of an anti-anxiety medication for one (1) of five (5) sampled residents (Resident #92) reviewed for unnecessary medications. The findings included: Resident #92 was admitted to the facility on 8/4/11 and re-admitted on 1/10/14 with diagnoses that included Anxiety. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 4/11/14 identified Resident #92 as moderately impaired cognitively. Resident #92 The MDS indicated Resident #92 had no mood or behavior concerns. She received anti-anxiety medication daily. Review of the most recent Care Plan dated 10/30/13 and updated on 5/1/14 the Problem read, in part, resident is at risk for falls related to the use of anti-anxiety and antidepressant medication; resident is at risk for adverse reactions to anti-anxiety and antidepressant medication. The listed approaches, in part, to meeting the goal of not exhibiting adverse effects	F 329	A Behavior Monitor was initiated on 4/15/14 for resident #92 for use of anti-anxiety medication, Klonopin, and continues to be monitored daily. All residents at risk for the same deficient practice have been reviewed to ensure that daily monitors are in place. New orders or order changes for existing residents and all new admission orders will be reviewed daily (M-F) by administrative nursing staff for orders medications requiring monitoring. Additionally, the Pharmacy Consultant will continue to review monthly to verify monitoring tools are in place and communicate findings to appropriate facility staff. Nurses were inserviced 5/13/14 on making sure the appropriate monitoring tools were initiated upon the receipt of new orders or order changes. Administrative Nursing will audit new orders and order changes daily (M-F) for	

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F 329	Continued From page 39 from the anti-anxiety and anti-depressant included monitoring behavioral flow sheets every shift. Review of the Physician ' s Order dated 2/4/14 documented an order for Klonopin 0.25milligrams (mg) by mouth, once daily for Anxiety control. Review of the Physician ' s Progress note dated 2/21/14 documented Resident #92 had been complaining of worsening anxiety and Klonopin was started on 2/2/14. Review of the electronic Medication Administration Record (eMAR) for February 2014 through May 2014 documented the resident received Klonopin 0.25 mg daily. Review of the Nursing Notes dated January 2014 through May 2, 2014 showed no documentation related to Anxiety. There were no additional notes in the medical record related to Anxiety. Review of the Pharmacist Consultant note dated 2/18/14 documented under behaviors: anxiety noted; the note dated 3/17/14 documented under behaviors: (blank); and the note dated 4/22/14 documented under behaviors: anxiety x 0. An observation was made of Resident #92 on 4/30/14 at 11:25AM she was resting in her room. The resident was unavailable for an interview. During an interview on 5/1/14 at 11AM, the Administrator stated there was no documentation in the computer system to show that Resident #92 had any behavior monitoring. During an interview with the Director of Nursing	F 329	4 weeks to ensure appropriate monitoring tools have been initiated where necessary. Results will be forwarded to the Quality Assurance Committee for recommendations as necessary.	

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(DON) on 5/1/14 at 11:30AM she stated in mid February the facility realized if a resident was re-admitted to the facility or if they had a change in their anti-anxiety medication than the " behavior button " on the eMAR needed to be manually added back into the eMAR in order for the behavior monitoring tool to reappear on the eMAR screen. The DON stated the nurses were in-serviced on this on 2/19/14. She further stated the eMAR behavior button was not re-set for Resident #92 until 4/15/14 and this is the reason the behavior monitoring sheets were not appearing for the nursing staff to complete. The DON stated the facility staff chart by exception and if the resident would have had periods of anxiety this would have been indicated in the nursing notes or on the eMAR.

An observation was made on 5/1/14 at 1:35PM she was observed in her room sleeping.

During a follow up interview with the DON on 5/1/14 at 2:30PM she stated that it was expected that anti-anxiety medications be monitored. The DON was unable to provide any documentation to show there had been behavior monitoring to support the need for the use of the anti-anxiety medication prior to 4/15/14.

During an interview with the Pharmacy Consultant on 5/2/14 at 4:49PM she stated there is no one set form required to monitor anti-anxiety medications. She stated that the facility would monitor using nursing notes, psychiatric evaluations and/or behavior sheets. She stated she would read the nursing notes or physician progress notes if behavior sheets are not on the eMAR. The Pharmacist did not confirm where she had seen the behavior monitoring in Resident

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F 329	Continued From page 41 #92 ' s record.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by failing to clean the face of 2 of 2 fans blowing towards the food preparation areas of the kitchen. The findings included: During the initial kitchen sanitation inspection on 4/29/14 at 9:00 AM a floor fan was observed near the hand sink pointed towards a food preparation table. The fan was not turned on. The face of the floor fan cage was observed covered with grey dust particles. On 4/30/14 at 11:12 AM the same fan was turned on and blowing towards a food cart that blocked the food preparation table. The face of the floor fan cage was observed covered with grey dust particles.	F 371	Both of the fans cited were cleaned by Maintenance personnel on 5/1/14. No other fans are present in the dietary kitchen or any other food preparation areas. A daily cleaning schedule for routine cleaning of the fans in the dietary kitchen has been created to include wiping down the fans daily in the a.m. and p.m. by dietary staff. If buildup is noted on the inside or on the blades, the dietary personnel will notify maintenance for a thorough cleaning. In addition, Maintenance Director will ensure that fans are taken apart weekly and the insides and blades thorough cleaned. Dietary Staff were inserviced on the importance of daily cleaning and oriented	5/21/14

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F 371	Continued From page 42 During a follow up tour of the kitchen area on 5/1/14 at 9:42 AM the same fan was turned on and blowing towards the food preparation table and stove top where eggs were observed boiling on the stove. A large round floor fan was observed to the left side of the tray line turned on and pointed towards the stove where eggs were boiling. The face of the round floor fan was covered with grey dust particle strings that were observed blowing past the fan cage towards the stove top. During an interview with the Certified Dietary Manager on 5/1/14 at 9:46 AM she stated the maintenance man is responsible for cleaning the fans and fans should be cleaned once a week. She stated that she would remove the fans from the kitchen immediately. During an interview with the maintenance man on 5/1/14 at 3:16 PM he stated that he had cleaned the fans two weeks ago but would now clean weekly by taking them apart and using a brush to clean grease and dust off the fan cages.	F 371	to the new cleaning schedules for fans on 5/5/14. Dietary Supervisor or designee will inspect fans daily for 4 weeks (M-F) then 3 times per week for 2 weeks to ensure compliance and will initial on the daily cleaning sheet. Administrator will audit 1 time per week for 4 weeks. Results will be forwarded to the Quality Assurance Committee for further recommendations if necessary.	
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced	F 460		5/21/14

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F 460	Continued From page 43 by: Based on observations, staff and resident interviews the facility failed to provide full visual privacy for residents whose privacy curtains did not fully close for 3 of 5 halls observed. The findings included: 1. On 5/2/14 at 11:59 AM observation of the privacy curtain in room 410 Bed A, revealed a 3 foot gap so that the curtain did not provide complete privacy around the resident ' s bed. In an interview with Resident # 135 on 5/1/14 at 11:59 AM she stated that it would be great to have full privacy as the curtain does not cover me completely. " 2. On 5/1/14 at 12:06 PM an observation of the privacy curtain in room 415 Bed A, revealed a 3 foot gap so that the curtain did not provide complete privacy around the resident ' s bed. 3. Observation of room 406 on 5/1/14 at 12:07 PM revealed the privacy curtain for Bed B had a 4 foot gap so that the curtain did not reach the window and did not completely provide privacy around the resident ' s bed. 4. Observation of room 317 on 5/1/14 at 12:09 PM revealed the privacy curtain for Bed B had a 4 foot gap so that the curtain did not reach to the wall and did not completely provide privacy around the resident ' s bed. 5. During an observation on 4/30/14 at 9:34 AM Room # 112 was observed with the privacy curtain closed around the resident with a 2 foot	F 460	Privacy curtains of appropriate width for beds 410A (Resident #135), 415A, 406B, 422A & B, 501B, 502A & B, 504A, 506B, 317B, 202A, 112A (Resident #13) were replaced or hooks straightened in the tracks to allow closure for full visual privacy as of 5/3/14. All other rooms that have the potential to be affected have been audited for compliance. All staff, including Nursing, Housekeeping/Laundry, Administrative, Social Services, Dietary, Activities, Therapy and Maintenance have been inserviced on the expectation that full visual coverage for residents be maintained during personal cares and treatment and the importance of reporting concerns timely to Maintenance or Housekeeping as appropriate. Blank Repair Requisitions have been provided in various areas throughout the facility and staff oriented on use to alert housekeeping or maintenance personnel of the need for interventions should full visual privacy be compromised. The Housekeeping Supervisor and Maintenance Director have developed a list that contains the appropriately sized privacy curtain for each resident room. This list will be maintained by the Housekeeping Supervisor to ensure that the appropriately sized privacy curtain is in each resident room.	

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F 460	Continued From page 44 gap at the door entrance. During an interview on 5/2/14 at 10:31 AM NA#2 stated she had helped Resident #13 with changing his brief on 4/30/14. She stated she was aware that the privacy curtain did not close completely and just did not think about it. On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that should be reported to housekeeping. On 5/3/14 at 9:50 AM Nursing Assistant #3 stated he was Resident #13 ' s NA and provided care for him. He stated the privacy curtain was not wide enough but whenever he gave the resident care he would make sure to cover the resident if someone were to enter the room. He further stated he thought the privacy curtain had not been wide enough since it was first hung but had not reported it to anyone. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain. On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are	F 460	The Housekeeping Quality Control Inspection (QCI) sheet will be performed daily (M-F) for 4 weeks by Housekeeping Supervisor in random rooms to ensure that curtains are in good repair and clean. These sheets will be reviewed weekly by Housekeeping Supervisor and Quality Assurance Coordinator/SDC to ensure compliance. Results will be forwarded to the Quality Assurance Committee for further recommendations as necessary. Nursing Administration will perform random audits daily (M-F) for 4 weeks. Administrator or designee will randomly audit resident rooms 1 time per week for 4 weeks to ensure compliance. Results will be forwarded to the Quality Assurance Committee for further recommendations as necessary.	

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F 460	Continued From page 45 not wide enough and that should be reported to housekeeping. 6. On 5/3/14 at 11:55 AM room # 202 the privacy curtain at the end of the bed closest to the door was observed with a 3 foot wide gap. The privacy curtain was observed to not be wide enough to provide full visual privacy when it was closed around the bed. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain. On 5/3/14 at 12:22 PM the Administrator stated staff did identify that the privacy curtains were not wide enough within the last 3 months. The Housekeeping Supervisor informed the Administrator the curtains were not wide enough and when we looked at the order the width should have been 180 inches and we received 108 inches. The facility ordered curtains to replace the short ones and failed to install the curtains. The Administrator stated she did not check behind the Housekeeping Supervisor to make sure the curtains were installed.	F 460		

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F 460	Continued From page 46 7. During an observation on 5/2/14 at 12:01 PM, room 502's privacy curtains did not provide full visual privacy. An observation revealed when 502 bed 1's privacy curtain was pulled to provide privacy, half of the bed was still visible when observed from the door entrance. When 502 bed 2's privacy curtain was pulled to provide privacy, the curtain did not extend to the full length of the bed. On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that it should be reported to housekeeping. During an interview on 5/3/14 9:30 AM, the Administrator revealed that the new Housekeeping person had started work in the facility this past Monday. She stated that she found that when they ordered the privacy curtains, they were supposed to be 180 inches and they turned out to be 108 inches. She revealed the numbers got transposed and there was a problem with the order. The Administrator explained that the company was contacted and they sent some curtains. She revealed some privacy curtains in some rooms were fixed however, some of the curtains were too short in some rooms. She showed some of the privacy curtain addendums that needed to be added to the shorter curtains. She stated that she thought the privacy curtains had been fixed, however she found the out the previous Housekeeping person did not put up the curtains. She stated she knew there was a problem two months ago. She revealed her expectation was for the Housekeeping person to ensure the curtains were put up correctly.	F 460		

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F 460	Continued From page 47 On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain. 8. During an observation on 5/2/14 at 12:03 PM, room 504, bed 1's privacy curtain did not provide full visual privacy. When the curtain was pulled it did not provide privacy between bed 1 and bed 2 because the curtain got stuck at the tracks at the top of the curtain. On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that it should be reported to housekeeping. During an interview on 5/3/14 9:30 AM, the Administrator revealed that the new Housekeeping person had started work in the facility this past Monday. She stated that she found that when they ordered the privacy curtains, they were supposed to be 180 inches and they turned out to be 108 inches. She revealed the numbers got transposed and there was a problem with the order. The Administrator explained that the company was contacted and they sent some curtains. She revealed some privacy curtains in some rooms were fixed however, some of the curtains were too short in	F 460		

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	345185	A. BUILDING _____ B. WING _____	05/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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some rooms. She showed some of the privacy curtain addendums that needed to be added to the shorter curtains. She stated that she thought the privacy curtains had been fixed, however she found the out the previous Housekeeping person did not put up the curtains. She stated she knew there was a problem two months ago. She revealed her expectation was for the Housekeeping person to ensure the curtains were put up correctly.

On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain.

9. During an observation on 5/2/14 at 12:06 PM, room 506, bed 2 did not provide full visual privacy. An observation revealed that when bed 2's privacy curtain was pulled, the curtain got stuck at the top of the curtain track and failed to provide full visual privacy between bed 1 and bed 2.

On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that it should be reported to housekeeping.

During an interview on 5/3/14 9:30 AM, the Administrator revealed that the new

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Housekeeping person had started work in the facility this past Monday. She stated that she found that when they ordered the privacy curtains, they were supposed to be 180 inches and they turned out to be 108 inches. She revealed the numbers got transposed and there was a problem with the order. The Administrator explained that the company was contacted and they sent some curtains. She revealed some privacy curtains in some rooms were fixed however, some of the curtains were too short in some rooms. She showed some of the privacy curtain addendums that needed to be added to the shorter curtains. She stated that she thought the privacy curtains had been fixed, however she found the out the previous Housekeeping person did not put up the curtains. She stated she knew there was a problem two months ago. She revealed her expectation was for the Housekeeping person to ensure the curtains were put up correctly.

On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain.

10. During an observation on 5/2/14 at 12:06 PM, room 501 bed 2's privacy curtain did not provide full visual privacy. An observation revealed that bed 2's privacy curtain failed to provide full visual privacy between bed 1 and bed

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2, because the privacy curtain was stuck at the top of the curtain track and would not extend the distance between bed 1 and bed 2 to provide full visual privacy.

On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that it should be reported to housekeeping.

During an interview on 5/3/14 9:30 AM, the Administrator revealed that the new Housekeeping person had started work in the facility this past Monday. She stated that she found that when they ordered the privacy curtains, they were supposed to be 180 inches and they turned out to be 108 inches. She revealed the numbers got transposed and there was a problem with the order. The Administrator explained that the company was contacted and they sent some curtains. She revealed some privacy curtains in some rooms were fixed however, some of the curtains were too short in some rooms. She showed some of the privacy curtain addendums that needed to be added to the shorter curtains. She stated that she thought the privacy curtains had been fixed, however she found the out the previous Housekeeping person did not put up the curtains. She stated she knew there was a problem two months ago. She revealed her expectation was for the Housekeeping person to ensure the curtains were put up correctly.

On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180

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inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain.

11. During an observation on 5/2/14 at 12:10 PM, room 422 bed 1's privacy curtain did not provide full visual privacy. An observation revealed that 422 bed 1's privacy curtain was too short and did not extend to provide full visual privacy between bed 1 and bed 2. Further observation revealed that 422 bed 2's privacy curtain did not extend the full length of the bed, when the privacy curtain was pulled toward the bedroom window. The curtain was almost two feet too short and did not provide full visual privacy.

On 5/02/14 at 11:28 AM the Administrator stated as direct care staff that care for the resident and housekeeping should notice that the curtains are not wide enough and that it
should be reported to housekeeping.

During an interview on 5/3/14 9:30 AM, the Administrator revealed that the new Housekeeping person had started work in the facility this past Monday. She stated that she found that when they ordered the privacy curtains, they were supposed to be 180 inches and they turned out to be 108 inches. She revealed the numbers got transposed and there was a problem with the order. The Administrator explained that the company was contacted and they sent some curtains. She revealed some privacy curtains in some rooms were fixed

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F 460	Continued From page 52 however, some of the curtains were too short in some rooms. She showed some of the privacy curtain addendums that needed to be added to the shorter curtains. She stated that she thought the privacy curtains had been fixed, however she found the out the previous Housekeeping person did not put up the curtains. She stated she knew there was a problem two months ago. She revealed her expectation was for the Housekeeping person to ensure the curtains were put up correctly. On 5/3/14 at 10:01 AM the Housekeeping Supervisor stated that when the curtains were ordered they were the wrong size. The correct width of the curtains should have been 180 inches but the ones that were hung were only 108 inches. When staff hung the privacy curtains they noticed they were not wide enough and the company was notified and corrected the problem with adding additional 72 inches. The previous Housekeeping Supervisor failed to hang the correct size curtain.	F 460		