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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING ______ B. WING ______	C 06/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	**2315 HIGHWAY 242 NORTH BENSON, NC 27504**

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observations, family and staff interviews, the facility failed to promote a dignified environment for 2 of 3 cognitively impaired residents (Resident #2 and #3) who required assistance with feeding and toileting. The findings included: 1. Resident #2 was admitted to the facility on 2/18/14 before being readmitted on 6/2/14, diagnosed with paralysis agitans and dysphagia oral phase. Her quarterly MDS, dated 5/24/14 determined that she was cognitively impaired and she displayed inattentiveness and disorganized thinking. She required extensive assistance with eating. Her Care Plan, 3/8/14 stated that she had an activities of daily living (ADL) self-care performance deficit related to dementia and limited mobility. She required total assistance from staff, to eat. Resident #2 was observed reclined in her wheelchair at a dining table with two other residents on 6/7/14 at 12:40 pm. They sat at the table alone, until Nurse Aide (NA #2) sat down at the table to begin feeding two, of the other residents. Resident #2 remained at the table, with a tray of covered food, placed on the table nearby her. Resident #2 was observed looking around the room, watching 17 residents eat their meals,	F 241	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilityl s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected For resident #2 immediately the involved staff were verbally counseled and the nursing facility assisted with feeding her next meal and ensuring proper dining etiquette. For resident #3 immediately the nursing assistant provided incontinent care as soon as it was identified by the state surveyor. Corrective Action for Resident Potentially Affected All current residents were assessed by Unit Manager for feeding assistance needs. This began on June 9, 2014 and will be completed by July 3, 2014. Each	7/3/14

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

Electronically Signed — 06/30/2014

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 241	Continued From page 1 while she waited to get assistance with her lunch. At 1:10 pm, NA #2 completed feeding two residents. She put their trays away, left the dining room and returned at 1:20 pm. Then she sat down next to Resident #2, removed the insulated dome lid from the lasagna and green beans and then began to feed her. On 6/7/14 at 2:30 pm, NA #3 was interviewed. She stated that she worked with Resident #2 often and recently discovered that she was capable of feeding herself, if her tray was set up by staff. She shared that when an aide has to feed residents, they try to place two residents a table, so that they can assist with their meals. If three residents are at a table, then the aide was expected to not start feeding the residents, unless everyone could be fed. However, if she was the only aide at the table with three residents, she explained that she would start feeding the two residents and then wait to feed the last resident. Nurse Aide #2 was interviewed on 6/7/14 at 3:00 pm. She stated that Resident #2 normally had her meals in the restorative dining room, but no one was working in restorative, so someone brought her down to the main dining room to be fed. She explained that this was why they had more residents needing feeding assistance, then available staff. Since she was the only aide sitting at the table with three residents who needed assistance with their meals, she explained that she did the best she could. She acknowledged that she did not reheat the plate of food before offering to Resident #2 who waited forty minutes to be fed, because she felt that the plate was still warm to the touch when she handled it. She commented that Resident #2 ate less than 25% at lunch. Administrative Staff #3 was interviewed on 6/7/14 at 3:18 pm. She stated that if restorative staff	F 241	resident will be identified as being independent or requiring supervision, limited assistance, extensive assistance or total assistance with feeding. Each current resident was further assessed for their preference to eat in the dining room or their room. Based on this information a seating plan was developed for the main dining room. All residents identified as independent requiring no assistance or only set up assistance from staff will be assigned to the independent dining room portion of the main dining room. All other residents that require supervision, limited, extensive or total assistance will be assigned to a nursing assistant for feeding assistance in either the main dining room or their room based on preference. The identified residents requiring assistance with feeding had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their feeding needs. This review was started on June 9, 2014 and ended on July 3, 2014. All current residents were assessed by the nurse management team which includes: staff development coordinator, unit manager, LPN support nurse, MDS nurse and director of nursing for the need for incontinence care. This began on June 9, 2014 and will be completed by July 3, 2014. Each resident will be identified as continent or incontinent. Incontinent residents were also assessed for heavy wetting needs by talking to the CNAI s, RNI s and LPNI s across different shifts that care for the residents. The identified incontinent residents had their care plan reviewed by the MDS Nurse to ensure	

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F 241	Continued From page 2 aren't present then staff should bring residents to the main dining room to be fed. She shared that she was going to explore seating arrangements to ensure that residents were being fed timely and that no one waited for food, while witnessing others eating. She planned to in-service staff on the importance of taking trays off the cart only when they are ready to serve the residents. Administrative Staff #1 was interviewed on 6/17/14 at 4:38 pm by telephone. She commented that she wanted staff to be aware of timeliness of meals of residents in the dining room. She further stated that staff should not offer a resident a cold plate because it was no longer palatable. She stated that she expected staff to get a new plate of food or reheat it, if it sat covered even in a dome for 45 minutes. 2. Resident #3 was admitted to the facility on 1/21/2011 with Alzheimer's disease. The quarterly MDS assessment, dated 4/14/14 determined that she was cognitively impaired and need total assistance from staff for toilet use and extensive assistance for dressing. She was assessed as being always incontinent with her bladder functions. A Care Plan was developed for her on 10/11/13 and was most recently reviewed on 4/12/14. It stated that she had a problem with episodes of incontinence related to impaired mobility and the inability to communicate her needs. Interventions to be used stated that she would be checked frequently and as required for incontinence. Clothing would be changed as needed after incontinent episodes. On 6/7/14 at 11:05 am, Resident #3 was observed in the living area, full of residents and one visitor, sitting in her wheelchair, wearing a shirt and denim capris pants. The area surrounding her crotch as well as her right thigh	F 241	their care plan was current with their incontinent care needs. This review was started on June 9, 2014 and ended on July 3, 2014. Systemic Changes An in-service was conducted on June 16, 18 and July 2 by the staff development coordinator. Those who attended were all RNs, LPNs, and CNAs, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Staff was educated on the main dining room assignments and the expectation of the following: " Beginning meals on time " Dignity and respect during meal time for all residents " Re heating trays as needed " a new tray line schedule was established with the dietary department to align with the facility staffing and resident feeding needs " Opening containers for all residents and cutting up foods as needed or	

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F 241 Continued From page 3

was wet. No staff were present, so assistance was sought for her at the nurse's station. Administrative staff #2 was present at the station and was informed that Resident #3 was incontinent. On 6/7/14 at 11:08 am she responded that Resident #3 hadn't been sitting in the living area that long. She proceeded to say that Resident #3 was a "heavy wetter" and that she would get staff to change her.
At 11:10 am, Nurse Aide #1 was observed wheeling Resident #3 back to her room, where she received incontinence care and was changed into a new clean outfit.
On 6/7/14 at 11:18 am, a family member for Resident #3 was interviewed by telephone. She shared that she visited with Resident #3 yesterday around 11:30 am and discovered Resident #3 in the living room, "soaking wet". She commented that she saw an aide down the hallway in front of the living room and glance through the window to observe Resident #3 but the aide did not enter the room to check if she was incontinent. She stated that she went to the hall, confronted two aides and asked them why Resident #3 wasn't checked during their rounds. The family member shared that she had been visiting in the facility since 10:00 am and did not see any aide approach Resident #3 to determine if she was incontinent.
Nurse Aide # 3 was interviewed on 6/7/13 at 2:29 pm. She stated that she was regularly assigned to Resident #3, who needed staff to anticipate all of her needs. She went on to describe her as a "heavy wetter", which meant that the nursing staff had to change her when they got her up at 7:30 am, after breakfast, about 9:00 am and when making rounds at 11:00 am.
On 6/6/14, she acknowledged that she was giving a bath to another resident around 11 am, when

F 241

requested
" the nursing assistants were provided schedules for feeding residents and dining room attendance to ensure accountability and attendance

Staff was also educated on timely incontinence care and the expectation of the following:
" Staff was educated on the importance of checking residents identified to be incontinent of bowl and/or bladder every 2 hours, as needed and even when family, hospice or other visitors are present.
" Toileting assistance with those residents identified as heavy wetters and frequent rounding in dayrooms

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance
A Quality Assurance monitor titled Feeding Assistance was developed and will be assigned to be completed by the Department Heads according to a schedule. The monitoring will include ensuring meals were being delivered as stated, fed as assigned and provided to residents in a dignified manner. This will continue for a minimum of one meal per day Monday-Friday times three months. In addition to this a Quality Assurance Monitor titled ADL Assistance will be completed daily Monday-Friday times two

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F 241	Continued From page 4 she was notified that Resident #3's family member discovered her wet. She admitted that she changed her on her 7 am rounds but don't know who might have handled Resident #3 thereafter. The other aide working on her hall told her that he checked Resident #3 sometime after breakfast. Nurse Aide #2 was interviewed on 6/7/14 at 3:00 pm. She stated that NA#2 and her checked on Resident #1 after breakfast (about 9:00 am) and she was dry. Then they returned her to the living room between 9:30-9:45 am. Neither aide made rounds again before 11 am. On 6/7/14 at 4:38 pm, Administrative Staff #1 was interviewed by telephone. She commented that one day, she was approached by a family member for Resident #3 who was upset about finding her clothes with urine on it. Administrative Staff #1 said that she felt that a voiding program would benefit Resident #3 because staff knew the times she was likely to void and could assist her to a toilet or bedpan, which would allow her to have dignity and prevent skin conditions.	F 241	weeks then weekly times three months. The monitor will include verifying that that timely perineal care is being provided. Both monitors will be completed for a minimum of three months or until resolved by QOL/QA committee. See attachment titled QA review complaint survey June 6, 2014. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Social Service, and Dietary Manager.	
F 312 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews, the facility failed to attend to	F 312	The statements made on this plan of correction are not an admission to and do	7/3/14

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F 312	Continued From page 5 the needs of 1 of 3 cognitively impaired residents (Residents #1), requiring extensive feeding assistance at meals as well as failed to assure that 1 of 3 cognitively impaired residents (Resident #3), requiring total assistance with toileting; received routine rounds, to ensure that she did not sit in urine, once incontinent. The findings included: 1. The facility's October 1, 2001 Feeding the Resident (Dependant Eating) policy was reviewed. It stated its purpose was to assist the resident with feeding as necessary and to provide adequate nutrition. Nursing staff were expected to play tray directly in front of resident. Cut or divide food into small portions and give resident a small amount at a time. Solid food and liquids would be alternated. Resident #1 was admitted to the facility on 4/5/14, diagnosed with Alzheimer's disease, anxiety and was recently admitted to Hospice. A significant change Minimum Data Set (MDS) assessment, dated 5/22/14 determined that he had cognitive impairments and displayed inattentiveness and disorganized thinking. He needed extensive assistance from staff while eating. On q 4/9/14 Dietician Nutritional Assessment, it was noted that Resident #1 had a history of pocketing his food in his mouth. The Care Plan, dated 5/29/14 identified that Resident #1 had unplanned/unexpected weight loss related to poor food intake due to a recent hospitalization. The interventions to be used included monitoring his food intake at each meal. On 6/6/14 at 6:00 pm, Resident #1 was observed in the main dining room, sitting a table with two residents and Administrative Staff #1. He sat with a tray of food in front of him, holding a spoon in his right hand. His two cups of drinks were set in front of his tray and his fork was placed on the	F 312	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilityl s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected For resident #1 immediately the involved staff were verbally counseled and the facility staff ensured on his next meal he received the feeding assistance required for his care needs. For resident #3 immediately the nursing assistant provided incontinent care as soon as it was identified by the state surveyor. Corrective Action for Resident Potentially Affected All current residents were assessed by Unit Manager for feeding assistance needs. This began on June 9, 2014 and will be completed by July 3, 2014. Each resident will be identified as being independent or requiring supervision, limited assistance, extensive assistance or total assistance with feeding. Each current resident was further assessed for their preference to eat in the dining room or their room. Based on this information a seating plan was developed for the main dining room. All residents identified as independent requiring no assistance or only set up assistance from staff will be assigned to the independent dining room	

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F 312	Continued From page 6 tray, to his left. He had a plate of ground chicken tenders, sweet potato fries, green beans and melon slices. Repeatedly he was seen using his spoon to try to slice his food and using a butter knife to load food on his utensil, then lift to his mouth to eat. He was able to successfully place food in his mouth a few times and was noted to take a long time to swallow the food, chewing it for several minutes. During the meal, Resident #1 played with his silverware, twirling his knife inside of the insulated dome lid bowl and then dropping his knife on the floor. Although, he had two cups of tea near his tray, he was never observed to take any sips of fluids. Administrative Staff #1 focused her attention on feeding Resident #3, who sat to her left and did not turn toward Resident #1, to redirect him or verbally and physically cue him, as assistance during his meal, until 6:18 pm. At that time, she was observed to move his cups closer to his right hand, encouraging him to take sips, which he did not. At 6:20 pm, it was noted that Resident #1 had completed less than 25% of his meal, as most of the residents began to empty out of the dining room. On 6/7/14 at 12:40 pm, Resident #1 was observed sitting in the main dining room, with Resident #2 near his side. He sat at the table, with his meal tray covered and placed across from him. He was observed three times, trying to drink tea from a cup, that had plastic wrap covering the mouth of the container. Next, he picked up a bowl of sliced fruit, placing it up to his mouth, trying to eat it, but was unsuccessful, because it also had plastic wrap covering the food. Resident #1 did this for several minutes, until a nurse aide approached him, moved his tray in front of him, removing all wrappers and	F 312	portion of the main dining room. All other residents that require supervision, limited, extensive or total assistance will be assigned to a nursing assistant for feeding assistance in either the main dining room or their room based on preference. The identified residents requiring assistance with feeding had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their feeding needs. This review was started on June 9, 2014 and ended on July 3, 2014. All current residents were assessed by the nurse management team which includes: staff development coordinator, unit manager, LPN support nurse, MDS nurse and director of nursing for the need for incontinence care. This began on June 9, 2014 and will be completed by July 3, 2014. Each resident will be identified as continent or incontinent. Incontinent residents were also assessed for heavy wetting needs by talking to the CNAI s, RNI s and LPNI s across different shifts that care for the residents. The identified incontinent residents had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their incontinent care needs. This review was started on June 9, 2014 and ended on July 3, 2014. Systemic Changes An in-service was conducted on June 16, 18 and July 2 by the staff development coordinator. Those who attended were all RNs, LPNs, and CNAs, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide	

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F 312	Continued From page 7 cut up his food. Nurse Aide #1 (NA #1) sat down at his table, where she mainly fed Resident #3, but offered cueing to him. Resident #1, attempted to feed himself, but was not able to focus on his meal, often rolling his wheelchair away from the table, staring at other residents, around the room. Resident #1 continued to take a long time to chew the food in his mouth, before he swallowed the contents. He had to be redirected several times by NA #1, to return to the table and eat his meal. At 1:20 pm, it was observed that he only ate 3 bites of lasagna, bit off a piece of bread and did not try to drink from his cups again. Overall, he consumed less than 25 of his meal. A phone interview was conducted with a family member for Resident #1 on 6/7/14 at 11:18 am. She stated that she visited at least weekly and was concerned that she has often discovered a tray of food, left unattended with Resident #1, who required feeding assistance. She shared that she has brought her concerns to the attention of the nurse aides as well as a nurse. During an interview with Nurse Aide # 3 on 6/7/14 at 2:29 pm, she shared that she was regularly assigned to Resident #1 who was capable of feeding himself at times. She mentioned that he had a sitter who cared for him weekdays, who was able to get him to eat 75-100% of his meals, but that she had never attempted to feed him. Administrative Staff #3 was interviewed on 6/7/14 at 3:18 pm. She mentioned that even if Resident #1 had a sitter and received Hospice services, their nurse aides were still responsible for providing care to the residents. She shared that they would revisit the seating arrangements in the dining room to ensure that residents were being fed timely. A phone interview was conducted with Administrative Staff #1 on 6/7/14 at 4:38 pm. She	F 312	training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Staff was educated on the main dining room assignments and the expectation of the following: " Beginning meals on time " Dignity and respect during meal time for all residents " Re heating trays as needed " a new tray line schedule was established with the dietary department to align with the facility staffing and resident feeding needs " Opening containers for all residents and cutting up foods as needed or requested " the nursing assistants were provided schedules for feeding residents and dining room attendance to ensure accountability and attendance Staff was also educated on timely incontinence care and the expectation of the following: " Staff was educated on the importance of checking residents identified to be incontinent of bowl and/or bladder every 2 hours, as needed and even when family, hospice or other visitors are present.	

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F 312	Continued From page 8 acknowledged that she assisted with feeding Resident #3, yesterday during dinner. She explained that Resident #1 was capable of independently feeding himself and only needed cueing during meals. By allowing him to feed himself, promoted his dignity. She stated that Resident #3 was at risk for aspiration, so she wanted to closely monitor her while feeding her supper. She shared that toward the end of the dining experience, once less residents were in the dining room, she noticed that Resident #1 did better feeding himself and was able to consume up to 50% of his meal. She thought it might be attributed to him being more overly stimulated earlier during the meal. 2. Resident #3 was admitted to the facility on 1/21/2011 with Alzheimer's disease. The quarterly MDS assessment, dated 4/14/14 determined that she was cognitively impaired and need total assistance from staff for toilet use and extensive assistance for dressing. She was assessed as being always incontinent with her bladder functions. A Care Plan was developed for her on 10/11/13 and was most recently reviewed on 4/12/14. It stated that she had a problem with episodes of incontinence related to impaired mobility and the inability to communicate her needs. Interventions to be used stated that she would be checked frequently and as required for incontinence. Clothing would be changed as needed after incontinent episodes. On 6/7/14 at 11:05 am, Resident #3 was observed in the living area, full of residents and one visitor, sitting in her wheelchair, wearing a shirt and denim Capri pants. The area surrounding her crotch as well as her right thigh was wet. No staff were present, so assistance was sought for her at the nurse's station.	F 312	" Toileting assistance with those residents identified as heavy wetters and frequent rounding in dayrooms This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance A Quality Assurance monitor titled Feeding Assistance was developed and will be assigned to be completed by the Department Heads according to a schedule. The monitoring will include ensuring meals were being delivered as stated, fed as assigned and provided to residents in a dignified manner. This will continue for a minimum of one meal per day Monday-Friday times three months. In addition to this a Quality Assurance Monitor titled ADL Assistance will be completed daily Monday-Friday times two weeks then weekly times three months. The monitor will include verifying that that timely perineal care is being provided. Both monitors will be completed for a minimum of three months or until resolved by QOL/QA committee. See attachment titled QA review complaint survey June 6, 2014. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Social Service, and Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING ______ B. WING ______	C 06/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 9	F 312		

Administrative staff #2 was present at the station and was informed that Resident #3 was incontinent. On 6/7/14 at 11:08 am she responded that Resident #3 hadn ' t been sitting in the living area that long. She proceeded to say that Resident #3 was a " heavy wetter " and that she would get staff to change her.
At 11:10 am, Nurse Aide #1 was observed wheeling Resident #3 back to her room, where she received incontinence care and was changed into a new clean outfit.
On 6/7/14 at 11:20 am, a follow up conversation was held with Administrative Staff #2. She stated that Resident #3 had only been in the living room for about 15-20 minutes. She had checked on her then because she was known to exhibit a certain behavior, which required monitoring. When she saw her at that time, she shared that Resident #3's clothing was dry.
On 6/7/14 at 11:18 am, a family member for Resident #3 was interviewed by telephone. She shared that she visited with Resident #3 yesterday around 11:30 am and discovered Resident #3 in the living room, "soaking wet" . She commented that she saw an aide down the hallway in front of the living room and glance through the window to observe Resident #3 but the aide did not enter the room to check if she was incontinent. She stated that she went to the hall, confronted two aides and asked them why Resident #3 wasn't checked during their rounds. The family member shared that she had been visiting in the facility since 10:00 am and did not see any aide approach Resident #3 to determine if she was incontinent.
Nurse Aide # 3 was interviewed on 6/7/13 at 2:29 pm. She stated that she was regularly assigned to Resident #3, who needed staff to anticipate all of her needs. She went on to describe her as a

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F 312	Continued From page 10 "heavy wetter", which meant that the nursing staff had to change her when they got her up at 7:30 am, after breakfast, about 9:00 am and when making rounds at 11:00 am. Then again, after lunch, when they lay her down. She shared that during her shift, she finds Resident #3 to be incontinent 3 to 4 x out of 5. She stated that when she's incontinent, her briefs are saturated with urine. Normally after breakfast, she would find her soaked through her brief. She stated that she usually made her rounds every two hours and had about 10 residents on her assignment, although on the hall, their were 20 residents, that she shared caring for along with the other assigned aide. She explained that after Resident #1 completed her breakfast in the main dining room, whichever aide assigned the dining room, brought her to the living room area, where she would sit during the morning, if she wasn't already wet. Then on her next round, she usually took Resident #1 back to her room, to check her for incontinence and change her. On 6/6/14, she acknowledged that she was giving a bath to another resident around 11 am, when she was notified that Resident #3 ' s family member discovered her wet. She admitted that she changed her on her 7 am rounds but don ' t know who might have handled Resident #3 thereafter. The other aide working on her hall told her that he checked Resident #3 sometime after breakfast. Nurse Aide #2 was interviewed on 6/7/14 at 3:00 pm. She stated that NA#2 and her checked on Resident #1 after breakfast (about 9:00 am) and she was dry. Then they returned her to the living room between 9:30-9:45 am. Neither aide made rounds again before 11 am. NA #2 stated that Resident #3 had a history of being wet right before their lunch break at 11:30 am. On 6/7/14 at 4:38 pm, Administrative Staff #1 was	F 312		

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F 312	Continued From page 11 interviewed by telephone. She commented that one day, she was approached by a family member for Resident #3 who was upset about finding her clothes with urine on it. She summoned the nurse aide , who got her cleaned up. She emphasized that when Resident #3 wets, the floor gets wet beneath her, as well as her clothes. She shared that Resident #3 was on a diuretic. Administrative Staff #1 said that she felt that a voiding program would benefit Resident #3 because staff knew the times she was likely to void and could assist her to a toilet or bedpan, which would allow her to have dignity and prevent skin conditions.	F 312		