STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	C 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE WELLNESS CTR	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the physician of a fall with injury and notify a family regarding a	F 157	The residents found to be affected by the alleged deficient practice have been assessed without negative outcome.	6/30/14

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

Electronically Signed | 06/27/2014

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F 157	Continued From page 1 required hospitalization for 2 of 5 residents reviewed for notification of physician/family (Residents #41 and #4). The findings included: 1. Resident #41 was admitted to the facility on 10/30/07 with diagnosis which included heart failure, dementia, lower leg joint pain, and failure to thrive. The most recent quarterly Minimum Data Set (MDS) dated 03/26/14 indicated Resident #41's cognition was moderately impaired. The MDS assessment further indicated Resident #41 required extensive assistance with bed mobility, transfers, dressing, and personal hygiene but required total assistance for toileting. Record review revealed no documentation that the physician was notified of Resident #41's fall on 05/17/14 which resulted in bruising to both knees, bruising to the right side of the face, and bleeding from the right side of the neck. A telephone interview was conducted on 06/03/14 at 2:59 PM with Nurse #1. He stated on the morning of 05/17/14 around 4:00 AM, he heard Resident #41's roommate calling out for help. He indicated he found Resident #41 between the bed and the wall. He further indicated she was down on her knees with her left arm holding onto the grab bar attached the bed, and her head was resting up against the grab bar. He stated he and another staff member lifted Resident #41 from the floor and put her back into her bed. He stated he documented the discoloration/bruising to her right knee and bruising to the right side of her face, and the moderate amount of bleeding to the right side of Resident #41's neck. He further stated he cleaned the right side of Resident #41's	F 157	100% audit of all incident reports within last 30 days will be was completed by DON to ensure that there has not been any incidents without physician and RP notification. Any identification of discrepancies will be followed up immediately by DON or designee and staff will be educated. 100% audit of all residents' contact information to verify that facility has at least one contact/responsible party/guardian/ legal representative for each resident will be complete by 06/30/2014 by Administrator or designee. Any discrepancies will be followed up immediately by Social Services Director or designee and staff will be educated. Nurses have been in-serviced by the DON as to notify physician and responsible party of all change of conditions. If resident□s responsible party cannot be reached nurses are to notify Social Services Director or DON immediately. QA Nurse or designee will audit 2 charts weekly of residents on each hall that have had change of condition to ensure physician was notified. This auditing will continue for 3 months, then monthly thereafter if compliance is accomplished. The DON or designee will be notified if concerns are noted and staff will be educated immediately if problems have been identified. The DON or designee will provide analysis of the audits to the QA Committee for additional oversight and recommendation. The DON will be responsible for compliance.	

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neck with normal saline and applied steri-strips to the areas. He stated he was unaware he should have called the physician and/or written a note in the physician's communication book at the nurses desk for the physician to evaluate Resident #41 the next time the physician and/or the physician's assistant was at the facility.

An interview was conducted on 06/03/14 at 3:27 PM with the Director of Nursing (DON). She stated she was unaware the physician was not notified on 05/17/14 of Resident #41's fall on 05/17/14. She further stated she was unaware Resident #41 was injured. She indicated she was made aware of Resident #41's fall on 05/19/14. She stated she expected the nursing staff to write a note in the physician's communication book and/or call the physician when there was a fall, an injury, and/or a change in a resident's condition.

An interview was conducted on 06/03/14 at 4:34 PM with Nurse #2. She stated she was unaware the physician was not notified of Resident #41's fall on 05/17/14. She further stated she was made aware of Resident #41's fall and injuries on 05/19/14 after Resident #41's daughter requested an x-ray of the resident's neck.

A telephone interview was conducted on 06/04/14 at 3:38 PM with the physician. He stated he was not notified of Resident #41's fall or her injuries on 05/17/14. He further stated he would have expected to be notified of Resident #41's fall with injuries and he would have expected a note in the communication book for the resident to have been evaluated.

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2. Resident #4 was admitted to the facility 02/05/1998 with diagnoses which included profound mental retardation and seizure disorder. A quarterly Minimum Data Set (MDS) dated 04/15/14 indicated Resident #4's cognition was severely impaired. The MDS specified the resident was totally dependent on staff for all care and received nutrition via a gastrointestinal feeding tube.

A review of Resident #4's medical record revealed a family member was listed as primary contact. Two other family members were listed as second and third contacts to call in case notification of a change in condition was required. All 3 contacts had phone numbers documented by their names.

Continued review of Resident #4's medical record revealed a physician's order dated 05/17/14. The order instructed facility staff to send the resident to the hospital for replacement of a gastrointestinal feeding tube.

An interview was conducted with the Social Worker (SW) on 06/06/14 at 11:15 AM. The SW explained at this time, Resident #4 did not have any contact available to make decisions regarding his care. She stated she attempted to

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F 157	Continued From page 4 call the resident's primary contact and the 2 other contacts listed regarding the resident's 05/17/14 hospital procedure of reinserting the feeding tube. The SW added all 3 phone numbers had been disconnected. She stated consent for the procedure was obtained from 2 physicians that testified the resident needed the feeding tube replacement to promote life. The SW acknowledged she did not notify any Resident #4's contacts requesting permission for his surgical procedure required on 05/17/14. An interview was conducted with the Administrator on 06/06/14 at 2:15 PM. The Administrator stated she was aware there was a history of Resident #4's family contacts not being available. The Administrator stated she expected all residents to have a primary contact that could be reached for notification of changes.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff, resident, family interviews and record review the facility failed to monitor and investigate a pattern of grievances regarding a staff member speaking to residents in a disrespectful way for 3 of 3 residents (Resident #19, #30, and #18). The findings included:	F 166	The residents found to have been affected by the alleged deficient practice have been assessed without negative outcome. No other residents have been found to have been affected by the alleged deficient practice. Staff has been in-serviced by the DON on	7/4/14

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F 166	Continued From page 5 1. Resident #19 was admitted on 05/06/14 with diagnoses including dementia, depression, and debility. The latest annual Minimum Data Set (MDS) assessment dated 04/16/14 revealed Resident #19 was cognitively intact, able to understand and be understood. Interview with the DON on 06/03/14 at 3:27 PM revealed grievances filed by residents and resident families had been going to different personnel according to the nature of the grievance and the staff involved. Interview with Resident #19 on 06/05/14 at 4:15 PM revealed she had reported to staff a concern she had about Nurse Aide (NA) #10 in March, 2014. Resident #19 stated she had observed NA #10 speaking in an inappropriate tone to residents in the main dining room who were cognitively impaired. Resident #19 stated she had also reported NA #10 had turned on music that the residents did not want to hear very loud in the dining room and was yelling over the music to all the residents, which she had felt was rude and disrespectful. Resident #19 stated she had not heard back from staff after she had reported the concern. Review of a Grievance/Complaint report dated 03/26/14 revealed Resident #19 had reported to Social Worker (SW) that NA #10 had used an inappropriate tone of voice to residents, had turned on music on the residents had not wanted to hear very loud, and had talked over the residents in the dining room. The method noted on the form used to notify the resident of the resolution was a one-to-one discussion. The report revealed the Unit Manager (UM) who	F 166	policy and procedures of investigating a grievance/complaint including the newly revised grievance/complaint form. The grievance/complaint report was changed immediately to include staff interviewed, residents interviewed, and family members interviewed. QA Nurse or designee will perform weekly reviews of grievances for 3 months to ensure compliance with facility policy & procedures; ensuring timely follow up and communication of resolution to resident and/or responsible party. Findings will be given to Administrator for additional follow up as needed. The QA nurse will analysis the grievances for trends/patterns and report these to the QA Committee for additional oversight and recommendation. Administrator is responsible for compliance.	

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investigated the complaint observed the noise level in the dining room on two occasions, reminded NAs working in the dining room to be mindful of music level and to speak to residents with respect.

Interview with UM on 06/05/14 at 2:36 PM revealed she had not spoken directly with NA #10 regarding Resident #19's concerns or his tone of voice toward residents. UM stated she was unaware there had been multiple resident concerns expressed regarding NA #10 using a disrespectful tone of voice toward residents.

Interview with the facility Administrator on 06/05/14 at 4:49 PM revealed there had not been a tracking system in place to monitor for patterns of staff interaction concerns. The Administrator stated her expectation was that any pattern of concerns from residents and resident families regarding a nurse aide's disrespectful tone of voice would warrant a full investigation.

2. Resident #30 was admitted on 04/14/09 with diagnoses including dementia, depression, and chronic pain.

Interview with family member of Resident #30 on 06/02/14 at 1:36 PM revealed he had reported to SW in late April a concern about a disrespectful tone of voice he had observed Nurse Aide (NA) #10 using toward the roommate of Resident #30, who was severely cognitively impaired. The family member stated he considered the way NA #10 talked to Resident #30's roommate had been very harsh and rude and he was afraid NA #10 would talk to Resident #30 that way when he was not visiting. The family member stated he was still very concerned about NA #10's ability to

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interact appropriately with cognitively impaired residents because he had never heard any response to his concerns from the SW or anyone else at the facility.

Interview with the Director of Nursing (DON) on 06/03/14 at 3:27 PM revealed grievances filed by residents and resident families had been going to different personnel according to the nature of the grievance and the staff involved.

Interview with SW on 06/05/14 at 8:57 AM revealed she had been told by the UM that the roommate of Resident #30 was hard of hearing which required all nurse aides to speak in loud tones of voice and repeat themselves frequently when working with her. SW stated she had not completed a grievance form regarding the family member of Resident #30's concern or responded to him about his concerns because she had not considered his concerns an official grievance and felt the hearing loss of Resident #30's roommate explained the family member's confusion. SW stated she was not aware of any additional concerns regarding disrespectful or rude interaction between NA #10 and a resident.

Interview with the facility Administrator on 06/05/14 at 4:49 PM revealed there had not been a tracking system in place to monitor for patterns of staff interaction concerns. The Administrator stated her expectation was that any pattern of concerns from residents and resident families regarding a nurse aide's disrespectful tone of voice would warrant a full investigation.

3. Resident #18 was admitted on 12/06/13 with diagnoses including dementia, depression, and neuropathy. The latest annual minimum data set

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(MDS) assessment dated 03/19/14 revealed Resident #18 was cognitively intact, able to understand and be understood.

Interview with Resident #18 on 06/02/14 at 3:03 PM revealed she had reported to the Director of Nursing (DON) in February, 2014 that she had observed Nurse Aide (NA) #10 frequently talking in a very rude tone of voice to residents. Resident #18 stated she had also reported NA #13 rushing residents at the same time she reported her concerns about NA #10. Resident #18 stated NA #10 no longer worked with her but she knew he still worked at the facility so she felt his rudeness had not been handled by the facility staff. Resident #18 stated she had been told by the DON that all nurse aides had been reminded to not rush and to not speak to residents disrespectfully but she did not think anything had been done with the specific nurse aides.

Review of a Grievance/Complaint form filed 02/05/14 revealed Resident #18 had complained about nurse aides treating residents disrespectfully. The staff member filling out the grievance form had not included the names of any specific nurse aides. The report revealed all nurse aides were met with and reminded to treat residents with respect.

Interview with the DON on 06/03/14 at 3:27 PM revealed grievances filed by residents and resident families had been going to different personnel according to the nature of the grievance and the staff involved. The DON stated she did not recall Resident #18 naming NA #10 in her concerns about residents being disrespectful or rude. DON stated she had met with all nurse aides after Resident #18's

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F 166	Continued From page 9 grievance was filed but had not met directly with NA #10 at any time to discuss his interaction with residents. DON stated she was only aware of one concern regarding NA #10's interactions with residents. Interview with the facility Administrator on 06/05/14 at 4:49 PM revealed there had not been a tracking system in place to monitor for patterns of staff interaction concerns. The Administrator stated her expectation was that any pattern of concerns from residents and resident families regarding a nurse aide's disrespectful tone of voice would warrant a full investigation.	F 166		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a room with an atmosphere that promoted a homelike quality for 1 of 3 residents reviewed for homelike environment. (Residents #4). The findings included: 1. Resident #4 was admitted to the facility 02/05/1998 with diagnoses which included profound mental retardation and seizure disorder. A quarterly Minimum Data Set (MDS) dated	F 240	The resident found to be affected by the alleged deficient practice has been assessed without negative outcome. Resident's room was decorated to a more homelike environment. A review of rooms of other current residents was conducted and no other residents have been found to have been affected by the alleged deficient practice. Staff has been in-serviced by the DON as to what makes a homelike environment. Activity Director will audit residents' rooms	6/30/14

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F 240	Continued From page 10 04/15/14 indicated the resident's cognition was severely impaired. The MDS specified the resident was totally dependent on staff assistance for all care. Observations on 06/03/14 at 5:38 PM and 06/04/14 at 8:40 AM revealed Resident #4 was in his room lying in bed that was by the door to the hallway. There was no music or television playing and nothing was observed on the walls of his room. His roommate was observed with a mobile over his bed. The curtain was pulled in a manner Resident #4 could not view the roommate's mobile nor see out of the window. On 06/04/14 at 2:50 PM, Resident #4 was observed up in his wheelchair in an activity involving singing. Resident #4 appeared alert and his head was moving back and fort. An observation on 06/05/14 at 1:55 PM revealed Resident #4 in his room lying in bed looking up at the ceiling. There was no music or television playing and the walls in his room were bare. An interview was conducted with the Activities Director (AD) on 06/05/14 at 5:15 PM. The AD stated Resident #4 had no family that visited. She added the resident liked watching the birds in the living room and music. The AD stated Resident #4 was moved to his present room about 6 months ago. In his old room, there were mobiles and stars on the ceiling. She stated she did not realize Resident #4 did not have any decorations in his present room. The AD stated the facility had pictures of Resident #4 with staff members that could be placed on the walls of his room. She added she should have moved the mobiles and ceiling stars when his room was changed but did not think of it at the time.	F 240	quarterly to ensure that rooms are homelike for residents and based on resident and responsible party preference. IDT members will audit 5 rooms weekly for 3 months and any resident's room noted to need further assessment of homelike environment will be brought immediately to the attention of the Administrator. A summary of findings from the audits will be reported to the QA Committee for additional oversight and recommendation. Administrator is responsible for compliance.	

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F 240	Continued From page 11 An interview was conducted with the Administrator on 06/06/14 at 2:15 PM. The Administrator stated the facility should be paying attention so that residents' rooms were maintained with a homelike environment.	F 240		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide residents choices of types and frequency of baths/showers and when they wanted to get up for seven of seven residents sampled for choices (#30, #69, #79, #63, #16, #18, and #50). The findings included: 1. Resident #30 was admitted to the facility on 04/14/09 with diagnoses which included dementia, anxiety, and depression. The most recent Minimum Data Set (MDS) indicated the resident was severely cognitively impaired and required extensive assistance for transfers. Interview with a family member of Resident #30 on 06/02/14 at 1:28 PM revealed Resident #30 had always slept later in the morning and strongly	F 242	The resident found to be affected by the alleged deficient practice has been assessed without negative outcome. 100% audit has been conducted on all residents' choice of bathing preference and when they want to get up. Staff has been in-serviced by the DON on residents' rights to participate in making choices regarding their care. Care plans will be modified to include residents' preferences by 06/30/2014. Tub/Shower list has been modified to indicate residents' preference. 2nd shift Unit Manager will be responsible for ensuring the accuracy of this list. Admitting nurse will ask resident/responsible party upon admit preferences. Preferences will be reassessed with each	6/30/14

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(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 242	Continued From page 12 preferred to sleep until at least 8:30 or 9:00 each morning. The family member stated staff at the facility got Resident #30 up very early each morning, even though she didn't like it. The family member stated he had never been asked by facility staff about her earlier routine or preferences regarding time to wake up, and when he had asked nurse aides if Resident #30 could sleep later in the morning which would fit her previous routines, he had been told in the facility Resident #30 had to be gotten up early so that she was up and ready before breakfast. The family member of Resident #30 stated she often was sleepy during the rest of the day and he felt it was in part because she was awakened before she would choose to wake up. Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents and resident family members were not specifically assessed in the facility for preferences regarding time to get up in the morning. Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed each nursing station had a list of residents that 3rd shift nurse aides were to get up so that 1st shift nurse aides didn't have such a heavy work load. NA #7 stated it was rare residents say they were not ready to get up in the morning when nurse aides entered the room and told them it was time to get up. NA #7 stated she had not asked residents about their preferences regarding time to get up. NA #7 stated all residents got used to the routine after a while and got used to their get up time. Interview with NA #12 on 06/04/14 at 10:35 AM revealed nurse aides began to wake up all residents at 6:00 AM. NA #12 stated if a resident	F 242	quarterly MDS and as need by Activities Director. Monthly, at least 5 random resident/responsible party interviews will be conducted by Social Services Director or designee to ensure preferences is being met. The Director of Nursing or designee will be notified if concerns are noted and staff will be educated if problems have been identified. A summary of findings from the audits will be reported to the QA Committee for additional oversight and recommendation. DON is responsible for compliance.	

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requested to stay in bed longer, nurse aides were to leave them and return a few minutes later to get them up.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed there was a list of residents to get up early each morning. She stated the need was based on those residents' need for breakfast assistance and level of assistance required to get up from bed and get dressed and groomed. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding time to get up.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed 3rd shift nurse aides were instructed to begin waking residents up at 6:00 AM so that all residents could be awake, dressed, and groomed before breakfast. UM stated residents who required the most assistance, like those requiring mechanical lifts and 2 staff, were awakened earliest in the morning to give staff enough time.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding time to get up in morning during the admission process. The Admissions Director stated she understood the nurses reviewed the daily schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding time to get up in the morning. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last

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year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did not talk to residents about the time they wished to get up each morning.

2. Resident #69 was admitted to the facility on 06/28/13 with diagnoses which included kidney failure, circulatory disease, and hypertension. The most recent Minimum Data Set (MDS), a quarterly assessment dated 3/2714, indicated the resident was cognitively intact, was understood and understood others, and was totally dependent with bathing and required the assistance of one staff person, and required limited assistance with one person for transferring.

Interview with Resident #69 on 06/02/14 at 10:06 AM revealed the resident had always taken tub baths about every other day and would prefer to do that at the facility. Resident #69 stated she had never been asked if she would like a tub bath or how often she would like to bathe. Resident #69 stated she had always been told the nurse aides were very busy and could only give each resident showers twice weekly. Resident #69 stated she wasn't sure if the facility had a working tub so she wasn't sure if it was even possible for her to take a tub bath in the facility.

Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding frequency or type of bath/showers.

Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed she had not asked residents

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about their preferences regarding frequency of or type of baths/showers. NA #7 stated a shower list posted at each nurse s station told nurse aides which residents got showers each day, and each resident was provided 2 showers per week based on their room number. NA #7 stated all residents got used to the routine after a while and got used to having 2 showers per week .

Interview with NA #12 on 06/04/14 at 10:35 AM revealed each resident received 2 showers per week based on their room number unless they specifically requested a change to the schedule. NA #12 stated she reminded residents daily whether it was their scheduled shower day or not so they would know when they got up.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed residents' showers were given according to the shower schedule posted at the nursing desks. Nurse #7 stated each resident received 2 showers weekly. Nurse #7 stated even though there was a bathtub in the shower room, she did not know of any residents who received a tub bath, and she believed a physician's order had to be obtained in order for a resident to receive a tub bath. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding frequency or type of bath/showers.

Interview with NA #11, who had worked in the facility for a year and a half, on 06/04/14 at 3:05 PM revealed each resident in the facility received showers twice weekly. NA #11 stated she did not ask residents about their shower preferences regarding type of bath/shower or frequency but did remind residents of the days they were assigned a shower. NA #11 stated she had never known a resident to receive a tub bath and she

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always just told the residents it was time for their shower without asking if they preferred a tub bath.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed each resident was scheduled to receive 2 showers weekly, based on room number, unless the resident or family requested a schedule change. The UM added the facility tried to accommodate requests as much as possible.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding frequency or type of baths/showers during the admission process. The Admissions Director stated she understood the nurses reviewed the daily schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding frequency and type of baths/showers. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did ask residents annually and at admission how important it was for them to choose the type of bath/shower they got, but she did not ask them what type of bath/shower they preferred or how frequently they preferred baths or showers. The AD also stated she understood all residents in the facility received 2 showers per week, and that was what she told residents when they asked. The AD stated she didn't believe it was realistic to think nurse aides could provide

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showers more frequently to residents than twice weekly.

Follow up interview with Resident #69 on 06/05/14 at 11:34 AM revealed Resident #69 never took showers at home and always preferred tub baths because they made her feel so clean and relaxed. Resident #69 stated one of her favorite things to do was to soak in a hot bath tub right before bed, which made her sleep really well. Resident #69 stated in the facility they were told they would get 2 showers a week and that was all.

3. Resident #79 was admitted to the facility on 05/25/14 with diagnoses which included edema, congestive heart failure, and generalized pain. The most recent Minimum Data Set (MDS), a quarterly assessment dated 3/13/14, indicated the resident was cognitively intact, was clearly understood, usually understood others, and was totally dependent with bathing, requiring the physical assistance of one staff person.

Interview with Resident #79 on 06/02/14 at 1:24 PM revealed she had always taken tub baths at home and would prefer to continue taking tub baths at the facility if she had a choice. Resident #79 stated she believed the facility did not have a tub available for residents, she had always been told all residents received showers, and she was unaware residents had the choice of taking a tub bath.

Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding type of bath/showers.

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Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed she had not asked residents about their preferences regarding type of baths/showers. NA #7 stated a shower list posted at each nurse's station told nurse aides which residents got showers each day based on their room number. NA #7 stated all residents got used to the routine after a while and got used to having showers.

Interview with NA #12 on 06/04/14 at 10:35 AM revealed each resident received showers based on their room number unless they specifically requested something different.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed residents were given showers each week according to the shower schedule posted at the nursing desks. Nurse #7 stated even though there was a bathtub in the shower room, she did not know of any residents who received a tub bath, and she believed a physician's order had to be obtained in order for a resident to receive a tub bath. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding type of bath/showers.

Interview with NA #11, who had worked on the 500 hall for a year and a half, on 06/04/14 at 3:05 PM revealed each resident in the facility received showers twice weekly. NA #11 stated she did not ask residents about their shower preferences regarding type of bath/shower but did remind residents of the days they were assigned a shower. NA #11 stated she had never known a resident from the 500 hall to receive a tub bath and she always just told the residents it was time for their shower without asking if they would prefer a tub bath.

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Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed each resident was scheduled to receive showers weekly, based on room number, unless the resident or family requested a change, which they tried to accommodate as much as possible.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding type of baths/showers during the admission process. The admissions director stated she understood the nurses reviewed the daily shower schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding type of baths/showers. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did ask residents annually and at admission how important it was for them to choose the type of bath/shower they got, but she did not ask them what type of bath/shower they preferred. The AD also stated she understood all residents in the facility received showers each week, and that was what she told residents when they asked.

Follow up interview with Resident #79 on 06/05014 at 11:25 AM revealed she loved to soak in a bathtub when her muscles were sore, and sometimes that had helped her more than her

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medicine. Resident #79 stated she wished she had that option in the facility but she had to accept what she was offered.

4. Resident #63 was admitted to the facility on 06/02/13 with diagnoses which included dementia, congestive heart failure, and chronic airway obstruction. The most recent Minimum Data Set (MDS), a quarterly assessment dated 3/5/14, indicated the resident was moderately cognitively impaired, usually understood, usually understood others, and required extensive assistance with the assistance of at least two staff persons for bed mobility and transfers.

Interview with Resident #63 on 06/02/14 at 1:08 PM revealed Resident #63 was awakened by staff each morning about 6:00 AM which upset her greatly. Resident #63 stated she had always slept later in the morning and did not like to be awakened so early each morning. Resident #63 stated she had no choice of time to get up because she needed the help of staff to get out of bed. She added when they came in each morning at 6:00 and told her to get up, she thought she had to get up and not ask for more time to sleep.

Review of the "west side get up list" posted at the west hall nursing station revealed Resident #63 was included on a list of residents for 3rd shift staff to get up each morning.

Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding time to get up in the morning.

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Interview with NA #7 on 06/04/14 at 9:58 AM revealed each nursing station had a list of residents that 3rd shift nurse aides were to get up so that 1st shift nurse aides didn't have such a heavy work load. NA #7 stated that it was rare that residents said they weren't ready to get up in the morning when nurse aides entered the room and told them it was time to get up. NA #7 stated she had not asked residents about their preferences regarding time to get up. NA #7 stated all residents got used to the routine after a while and got used to their get up time.

Interview with NA #12 on 06/04/14 at 10:35 AM revealed nurse aides began to wake up all residents at 6:00 AM. NA #12 stated if a resident requested to stay in bed longer, nurse aides were to leave them and return a few minutes later to get them up.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed there was a list of residents to get up early each morning, which was based on those residents' need for breakfast assistance and level of assistance required to get up from bed and get dressed and groomed. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding time to get up.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed 3rd shift nurse aides were instructed to begin waking residents up at 6:00 AM so that all residents could be awake, dressed, and groomed before breakfast. UM stated residents who required the most assistance, like those requiring mechanical lifts and 2 staff, were awakened earliest in the morning to give staff enough time.

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Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding time to get up in morning during the admission process. The Admissions Director stated she understood the nurses reviewed the daily schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding time to get up in the morning. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did not talk to residents about the time they wished to get up each morning.

Follow up interview with Resident #63 on 06/05/14 at 11:25 AM revealed Resident #63 felt she was tired all the time because she needed more sleep in the mornings. Resident #63 stated she had tried to tell staff she needed to sleep later when they got her up, but when she did, they would leave and come back a minute later, tell her she had to get up then so she felt she had no choice but to get up.

5. Resident #16 was admitted to the facility on 04/18/14 with diagnoses which included edema, chronic pain, and osteoarthrosis. The most recent Minimum Data Set (MDS), 30 day assessment dated 5/16/14 indicated the resident was cognitively intact, able to understand and be understood, and required extensive assistance with transfers and physical help with bathing.

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Interview with Resident #16 on 06/02/14 at 10:28 AM revealed she was told on admission that she could have two showers each week. Resident #16 stated she much preferred a tub bath but had never been asked if she preferred tub baths or been offered a tub bath. Resident #16 stated she required a lot of help to get around, and was unsure if the staff could safely get her in and out of a bathtub, but if possible, she would feel much more comfortable soaking in a hot tub rather than getting a shower.

Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding type of bath/showers.

Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed she had not asked residents about their preferences regarding type of baths/showers. NA #7 stated a shower list posted at each nurse's station told nurse aides which residents get showers each day, and each resident was provided showers each week based on their room number. NA #7 stated all residents got used to the routine after a while and got used to having showers.

Interview with NA #12 on 06/04/14 at 10:35 AM revealed each resident received showers each week based on their room number unless they specifically requested a change. NA #12 stated she reminded residents daily whether it was their shower day or not so they would know when they got up.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed residents' showers were given according

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to the schedule posted at the nursing desks. Nurse #7 stated each resident received showers weekly. Nurse #7 stated even though there was a bathtub in the shower room, she did not know of any residents who received a tub bath, and she believed a physician's order had to be obtained in order for a resident to receive a tub bath. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding type of bath/showers.

Interview with NA #11, who had worked in the facility for a year and a half, on 06/04/14 at 3:05 PM revealed each resident in the facility received showers weekly. NA #11 stated she did not ask residents about their shower preferences regarding type of bath/shower. NA #11 stated she had never known a resident from the 500 hall to receive a tub bath and she always just told the residents it was time for their shower without asking if they would prefer a tub bath.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed each resident was scheduled to receive showers weekly, based on room number, unless the resident or family requested a change, which they tried to accommodate as much as possible.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding type of baths/showers during the admission process. The Admissions Director stated she understood the nurses reviewed the daily schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was

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the Activities Director (AD) who assessed resident preferences regarding type of baths/showers. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did ask residents annually and at admission how important it was for them to choose the type of bath/shower they got, but she did not ask them what type of bath/shower they preferred. The AD also stated she understood all residents in the facility received showers each week, and that was what she told residents when they asked.

Follow up interview with Resident #16 on 06/05/14 at 1:34 PM revealed Resident #16 felt she would not have been able to take a tub bath at home because it would be dangerous for her to get in and out of the tub alone. Resident #16 stated she didn't know if while at the facility they had safe ways of getting her in and out of a tub, but she would love to find out if she had that option. Resident #16 stated she didn't know because no one had ever told her about their tub baths, only their showers.

6. Resident #18 was admitted to the facility on 06/05/13 with diagnoses which included dementia, chronic respiratory failure, and chronic airway obstruction. The most recent Minimum Data Set (MDS), a quarterly assessment dated 3/27/14, indicated the resident was moderately cognitively impaired, understood others and was understood, and required physical assistance with bathing with the assistance of one staff person.

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Interview with Resident #18 on 06/02/14 at 10:08 AM revealed the resident felt she was not getting washed well enough and needed more showers per week. Resident #18 stated she had been told by staff each resident received only 2 showers each week but she would prefer to have at least 3 showers each week. Resident #18 stated she had never been asked by staff how many showers she would like to have each week.

Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding frequency of baths/showers.

Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed she had not asked residents about their preferences regarding frequency of baths/showers. NA #7 stated a shower list posted at each nurse's station told nurse aides which residents got showers each day, and each resident was provided 2 showers per week based on their room number. NA #7 stated all residents got used to the routine after a while and got used to having 2 showers per week.

Interview with NA #12 on 06/04/14 at 10:35 AM revealed each resident received 2 showers per week based on their room number unless they specifically requested a change to the schedule. NA #12 stated she reminded residents daily whether it was their scheduled shower day or not so they would know when they got up.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed residents' showers were given according to the shower schedule posted at the nursing desks. Nurse #7 stated each resident received 2

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showers weekly. Nurse #7 stated she was unaware of who, if anyone, assessed resident preferences regarding frequency of bath/showers.

Interview with NA #11, who had worked in the facility for a year and a half, on 06/04/14 at 3:05 PM revealed each resident in the facility received showers twice weekly. NA #11 stated she did not ask residents about their shower preferences regarding frequency but did remind residents of the days they were assigned a shower.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed each resident was scheduled to receive 2 showers weekly, based on room number, unless the resident or family requested a schedule change, which they tried to accommodate as much as possible.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding frequency of baths/showers during the admission process. The Admissions Director stated she understood the nurses reviewed the daily schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding frequency of baths/showers. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did ask residents annually and at admission how important it was for them to

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choose the type of bath/shower they got, but she did not ask them how frequently they preferred baths or showers. The AD also stated she understood all residents in the facility received 2 showers per week, and that was what she told residents when they asked. The AD stated she didn't believe it was realistic to think nurse aides could provide showers more frequently to residents than twice weekly.

Follow up interview with Resident #18 on 06/05/14 at 11:18 AM revealed she didn't like to feel she wasn't very clean, and she felt very uncomfortable when waiting several days for another shower. Resident #18 stated she had asked nurse aides before if she could have more showers, and they had told her when her scheduled shower days were. Resident #18 stated she hadn't been given a choice.

7. Resident #50 was admitted to the facility 01/13/14 with diagnoses which included history of stroke with left side hemiplegia (a form of paralysis), muscle weakness, and joint pain. An admission Minimum Data Set (MDS) dated 02/10/14 indicated the resident was able to express ideas and wants, understood verbal content, and the resident s cognition was intact. The MDS specified the resident required extensive staff assistance for bathing and personal hygiene.

An interview was conducted with Resident #50 on 06/02/14 at 1:44 PM. Resident #50 stated she would prefer a tub bath. The resident added no facility staff ever asked her or offered a tub bath and she was unaware a tub was available.

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Interview with the MDS Coordinator on 06/04/14 at 9:21 AM revealed residents were not specifically assessed in the facility for preferences regarding type of bath/showers.

Interview with Nurse Aide (NA) #7 on 06/04/14 at 9:58 AM revealed she had not asked residents about their preferences regarding type of baths/showers. NA #7 stated a shower list posted at each nurse's station told nurse aides which residents got showers each day based on their room number. NA #7 stated all residents got used to the routine after a while and got used to having showers.

Interview with NA #12 on 06/04/14 at 10:35 AM revealed each resident received showers based on their room number unless they specifically requested something different.

Interview with Nurse #7 on 06/04/14 at 11:34 AM revealed residents were given showers each week according to the shower schedule posted at the nursing desks. Nurse #7 stated even though there was a bathtub in the shower room, she did not know of any residents who received a tub bath. She stated she believed a physician's order had to be obtained in order for a resident to receive a tub bath. Nurse #7 stated she was unaware of whom, if anyone, assessed resident preferences regarding type of bath/showers.

An interview was conducted with NA #11 on 06/04/14 at 3:05 PM. NA #11 stated she had worked on the 500 hall for a year and a half. She stated residents in the facility received showers twice weekly. NA #11 stated she does not ask residents about their shower preferences regarding type of bath/shower but did remind

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residents of the days they were assigned a shower. NA #11 stated she had never known a resident from the 500 hall to receive a tub bath and she always just told the residents it was time for their shower without asking if they would prefer a tub bath.

Interview with Unit Manager (UM) on 06/04/14 at 5:03 PM revealed each resident was scheduled to receive showers weekly, based on room number, unless the resident or family requested a change. UM added the facility tried to accommodate as much change requests as possible.

Interview with Admissions Director on 06/05/14 at 9:14 AM revealed she did not assess resident preferences regarding type of baths/showers during the admission process. The Admissions Director stated she understood the nurses reviewed the daily shower schedule with new residents and their families.

Interview with the Director of Nursing (DON) on 06/05/14 at 3:09 PM revealed she believed it was the Activities Director (AD) who assessed resident preferences regarding type of baths/showers. The DON stated nursing used to complete the preference assessment but that duty had been passed to the AD within the last year.

Interview with the AD on 06/05/14 at 4:30 PM revealed she did ask residents annually and at admission how important it was for them to choose the type of bath/shower they got, but she did not ask them what type of bath/shower they preferred. The AD also stated she understood all residents in the facility received showers each

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F 242	Continued From page 31 week, and that was what she told residents when they asked.	F 242		
F 246 SS=D	. 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review, the facility failed to provide a wheelchair that met the needs of 1 of 1 resident reviewed for accommodation of resident's needs. (Resident #50). The findings included: Resident #50 was admitted to the facility 01/13/14 with diagnoses which included history of stroke with left side hemiplegia (a form of paralysis), muscle weakness, and joint pain. An admission Minimum Data Set (MDS) dated 02/10/14 indicated the resident was able to express ideas and wants, understood verbal content, and the resident's cognition was intact. The MDS specified the resident required extensive staff assistance for transfers and was non-ambulatory. A Care Area Assessment included Resident #50's sitting balance was adequate when in the wheelchair, but was noted to lean to the left at	F 246	The resident found to be affected by the alleged deficient practice has been assessed without negative outcome. An accommodating wheelchair has been delivered and is in use based on recommendations by the seating clinic. Restorative CNA's have been in-serviced by Therapy Director on how to measure residents' for appropriate sized wheelchairs. Restorative CNA's will measure all residents to ensure the wheelchair they are using is a suitable fit based on their height & weight by 07/04/2014. RN MDS Coordinator to assess residents to ensure accuracy of measurements. Residents that have additional positioning concerns will be screened by therapy. Restorative CNAs will measure all residents upon admit for proper fitting of wheelchair. RN	6/30/14

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F 246	Continued From page 32 times. A review of Resident #50's medical record revealed a nursing note dated 04/01/14. The note specified the resident had returned from a physician's office visit with orders for a referral to an Outpatient Physical Therapy Seating Clinic. A physician's order dated 04/01/14 was noted in the medical record for this referral. A review was conducted of an Initial Evaluation / Examination document dated 05/29/14 and signed by Physical Therapist (PT) #1 employed by the Outpatient Physical Therapy Seating Clinic. The document specified the referral was made by a physician specializing in neurology. PT #1's documented assessment of Resident #50 specified the resident was 5 feet 8 inches tall and weighed 331 pounds. The resident's posture in her present chair that was provided by the facility was affected by her thighs being off the front of the seat by 6 inches. The resident's left arm was flaccid and the left leg partially flaccid and not functional. PT #1 documented Resident #50 was utilizing a facility wheelchair that was too small for her and causing pain in her left leg due to lack of proper support. The seat contained a 4 inch foam cushion that was compressed to 1 inch when she sat in it. Placed behind her back was a wooden board with a black cover. The board was too short causing edges to dig into her torso. Continued document review revealed the clinic's long term goal was to provide a wheelchair with full support to correct her posture and distribute pressure to facilitate postural control and prevent sliding out of the wheelchair. The wheelchair would fit the resident, be comfortable, stable, safe, and provide independent mobility to the resident.	F 246	MDS Coordinator to assess residents to ensure accuracy of measurements. Residents will be reassessed by the RN MDS Coordinator during quarterly review to ensure that their wheelchair a suitable fit based on height and weight. During environmental rounds by IDT the task has been added to check for proper positioning of resident. Any discrepancies will be brought to the attention of the Administrator for follow up and analysis of trends/patterns. Findings from audits will be reported to the QA Committee for additional oversight and recommendation. Administrator is responsible for compliance.	

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F 246	Continued From page 33 An interview was conducted with Resident #50 on 06/02/14 at 1:49 PM. The resident was observed sitting in a wheelchair with a left arm and a left foot rest. Resident #50 stated the wheelchair was too small and caused back pain when sitting in the chair. She also explained the left arm rest was uncomfortable. Resident #50 described a board she placed between her back and the back of the wheelchair. She stated without it, she had back pain, but the board was very uncomfortable and caused pain when used a long period of time. The resident stated she had not been referred to the facility therapy department since admission. She stated she had asked facility management staff for a wheelchair that fit and did not cause her pain when she used it. The resident stated that never happened. She stated when she had an appointment a few weeks ago with her neurologist, he wrote an order referring her to the outpatient seating clinic. She stated she had been to the clinic this past Friday. The resident explained the clinic had ordered her a wheelchair to be delivered at a later date. An observation at this time revealed the wheelchair seat extended to mid thigh leaving the remaining part of her thighs unsupported. Resident #50's left arm was supported by the left arm rest. That arm rest was so close to the chair the resident had to hold her flaccid left arm very close to her body in an unnatural way to support her arm. An interview with the Therapy Manager (TM) on 06/03/14 at 9:52 AM revealed he was the manager of the facility's therapy department. He stated it was common to get referrals from the facility regarding positioning. The TM stated he had no referrals from the facility regarding Resident #50.	F 246		

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An interview with the MDS Coordinator on 06/04/14 at 8:46 AM revealed she attended Resident #50's first care plan meeting that was held after her admission. The care plan meeting date was 02/27/14. The MDS Coordinator stated Resident #50 and 2 family members attended. She stated the family members had several requests one of which was a wheelchair that fit Resident #50. The MDS Coordinator explained the usual way positioning for residents was handled was to get the facility's therapy department involved. From therapy's evaluation, physician orders would be initiated for wheelchairs or positioning devices required to fit the resident's needs.

An interview was conducted with the Director of Nursing (DON) on 06/04/14 at 11:14 AM. The DON explained Restorative Nurse Aide (RNA) #1 had measured Resident #50 for her present wheelchair. She stated several adjustments had been made to the wheelchair to make it more comfortable for the resident. One adjustment included adding a foot rest. The DON was unaware of how the resident's left arm was positioned in her present chair or that the resident's thighs extended beyond the wheelchair seat.

An interview was conducted with Restorative Nurse Aide (RNA) #1 on 06/05/14 at 8:56 AM. RNA #1 stated one of his duties was to provide facility residents with wheelchairs. He explained when a new resident was admitted to the facility, he got the resident's height and weight from the admissions or medical record departments. He looked over the facility's stock of wheelchairs and attachments to find the one he thought would

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F 246	Continued From page 35 meet the residents' needs. RNA #1 stated this was the procedure he utilized for Resident #50. According to her height and weight provided on admission, he chose a wheelchair he thought would be suitable for her. He stated the resident complained it was too small. He returned to the facility stock and found the largest wheelchair they had. He also placed a second armrest on this chair in attempt to meet the resident's needs. RNA #1 was unaware the resident's thighs extended further than the wheelchair seat. He stated he had not been trained how to measure a resident for a wheelchair. .	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 staff interviews, the facility failed to replace stained or dirty privacy curtains on 4 of 5 halls (200, 300, 400 and 500) and broken window blinds on 1 of 5 halls (200). The findings included: 1. Observations during the survey revealed the privacy curtains in rooms 212, 301, 303, 403, 410 and 508 were stained and soiled. a. Observations of room 212 on 06/02/14 at 8:30 AM and 06/06/14 at 9:45 AM and 10:30 AM revealed the privacy curtain had multiple small brown smears and stains. b. Observations of room 301 on 06/02/14 at 8:20	F 253	The residents found to be affected by the alleged deficient practice have been assessed without negative outcome. The soiled/stained privacy curtains were changed immediately and the broken blind was replaced on 06/20/2014. 100% audit has been completed on all resident rooms to identify any other similar alleged deficient practice. Staff has been in-serviced by DON and Environmental Services Director to report soiled/stained privacy curtains and broken blinds to Environmental Services Director	6/30/14

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F 253	Continued From page 36 AM and 06/06/14 at 9:50 AM and 10:32 AM revealed the privacy curtain had 2 large round brown stains. c. Observations of room 303 on 06/02/14 at 8:22 AM and 06/06/14 at 9:52 and 10:34 AM revealed the privacy curtain to have multiple brown stains near the bottom of the curtain. d. Observations of room 403 on 06/02/14 at 9:00 AM and 06/06/14 at 9:58 AM and 10:45 AM revealed the privacy curtain to have multiple stains. e. Observations of room 410 on 06/02/14 at 9:10 AM and 06/06/14 at 10:00 and 11:00 AM revealed the privacy curtain to have multiple brown stains. f. Observations of room 508 on 06/02/14 at 9:16 AM and 06/06/14 at 10:05 and 11:05 AM revealed the privacy curtain to have multiple brown stains. An interview with Housekeeper #1 on 06/06/14 at 9:43 AM revealed privacy curtains were taken down and washed by halls once per week. During an interview on 06/06/14 at 10:04 AM the Housekeeping Director stated it was the housekeeper's responsibility to examine the privacy curtains for stains and soiling each time the resident's room was cleaned. He stated if a privacy curtain needed to be changed the housekeeper should let the floor tech know and he would change out the curtain. The Housekeeping Director stated it was unacceptable to have soiled/stained privacy curtains. 2. Observations during the survey revealed room 212 had broken window blinds. An interview with a family member of Resident #30, room 212 B, on 06/03/14 at 3:00 PM revealed Resident #30 enjoyed looking out the window but could not due to the blinds being broken. The family member stated the broken blinds had been reported to the nurse but had not	F 253	immediately. Environmental Services Director will audit privacy curtains and blinds for being soiled or stained and ensure blinds are working properly 3 times a week for 3 months then weekly thereafter if compliance is accomplished. During random environmental rounds, the IDT will check for soiled/stained curtains & broken blinds. Any discrepancies will be brought to the attention of the Administrator for follow up and analysis of trends/patterns. Findings of audits will be reported to QA Committee for additional oversight and recommendation. Environmental Services Director is responsible for compliance.	

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F 253	Continued From page 37 been repaired. An interview with Nurse #5 revealed she was not aware the blinds in room 212 were broken. She stated she would place a work order for maintenance to repair them. Nurse #1 stated work orders were kept at the nurse's desk and maintenance picked them up daily. During an interview with the Assistant Maintenance Director on 06/06/14 at 8:55 AM stated he was not aware the blinds in room 212 were broken. He reported the nurse should have completed a work order and left it on the clip board to be picked up by maintenance. The Assistant Maintenance Director stated he conducted weekly rounds of the facility but had not seen the broken blinds. An interview was conducted with the Administrator on 06/06/14 at 11:30 AM. The Administrator stated she was aware of the broken blinds in room 212 but had not reported it to maintenance. She stated she should have completed a work order when she observed the broken blinds.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 309	The resident found to be affected by the	6/30/14

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F 309	Continued From page 38 record review, the facility failed to position a resident in a geri chair in a manner that promoted comfort and well being for 1 of 3 residents reviewed for positioning. (Resident #12). The findings included: Resident #12 was admitted to the facility 10/06/13 with diagnoses which included dysphagia, anorexia, debility, history of deep vein thrombosis, and dementia. A quarterly Minimum Data Set (MDS) dated 04/11/14 indicated the resident's cognition was severely impaired. The MDS specified the resident required extensive staff assistance for all activities of daily living including transfers and eating. The MDS assessment further indicated the resident's balance and transfers were described as not steady and the resident was only able to stabilize with staff assistance. No care plan was available that addressed positioning for this resident. Review of Resident #12's medical record revealed no care plan regarding use of positioning devices required when the resident was up in the geri chair. A review of an undated resident status sheet the nurse aides utilized for resident needs contained no instruction for use of pillows/positioning devices for Resident #12. An observation of lunch was conducted on 06/02/14 at 12:05 PM in the assisted dining room. Resident #12 was observed in a geri chair seated at a table that was chin high to the resident. The chair was leaning slightly back. Resident #12 was observed leaning over the left arm of the geri chair so that her head was over the left geri chair arm. There were no pillows or positioning devices observed in use for Resident #12. When	F 309	alleged deficient practice has been assessed without negative outcome. The resident was immediately repositioned and a therapy referral was made for positioning. 100% of all residents will be assessed by IDT to ensure there are no other positioning needs. The residents plan of care and status sheet has been updated to reflect positioning guidelines for the resident. Staff has been in-serviced by DON on proper positioning of residents. Any recommendations from IDT will be forwarded to Restorative Nurse for follow up. Residents will be assessed quarterly by Restorative Nurse to ensure resident has proper positioning to promote comfort and well being. Quality Assurance Nurse or designee will audit positioning at meals 3 times a week for 3 months then weekly thereafter if compliance is accomplished. The Director of Nursing or designee will be notified if concerns are noted and staff will be educated if problems have been identified. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. DON is responsible for compliance.	

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the meal was served, Resident #12 was reaching up to her tray. She was unable to visualize her food and was observed attempting to pick up meat covered with gravy with her hands. Resident #12 maintained the described position throughout the meal.

An observation of Resident #12 sitting in her geri chair in her room was conducted on 06/03/14 at 10:27 AM. The geri chair was leaning slightly back. Resident #12 was observed leaning over the left arm of the geri chair using her left hand to hold up her head. No support cushions or devices were in use. The resident's sock covered feet were hanging off the seat of the geri chair seat with her toes pointed toward the floor and not touching the floor.

During lunch on 06/03/14 at 12:14 PM, Resident #12 was observed in the geri chair leaning slightly back but not leaning to her left. A pillow was observed behind her back. She was sitting at the same table. With the present positioning, the table was upper chest high to the resident. The resident continued to reach up in attempt to get liquids off her tray.

An interview with Nurse Aide (NA) #4 on 06/03/14 at 12:45 PM revealed the residents in assisted dining do not have a seating arrangement. The staff attempted to keep certain residents apart during the meal to promote a quieter atmosphere. No further explanations were provided.

An interview with Nurse #3 was conducted on 06/04/14 at 12:55 PM. Nurse #3 stated she noticed Resident #12 was leaning on 06/02/14. She stated she straightened the resident so she was not leaning to the left and placed a pillow

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behind her back. Nurse #3 acknowledged the resident did not have any supporting pillows on 06/02/14.

An interview was conducted with NA #5 on 06/05/14 at 10:00 AM. NA #5 stated Resident #12 was supposed to have pillows to her head, back, and sides when up in the geri chair. She stated the resident will throw them out at times. NA #5 did acknowledge Resident #12 had no pillows for support earlier this week. She did not provide a reason.

An interview was conducted with NA #3 on 06/05/14 at 10:10 AM. NA #3 stated she usually was assigned to the assisted dining room for meals. She stated she had asked the nurse aides bringing Resident #12 to the dining room to use pillows to the resident's back and sides. NA #3 added Resident #12 continued to be brought to the dining room with no supporting pillows in use and leaning to the left.

An interview was conducted with the MDS Coordinator on 06/05/14 at 2:55 PM. The MDS Coordinator stated she was responsible for updating the resident status sheets utilized by nurse aides regarding residents' needs. She stated she relied on orders from the facility's therapy department for the use of positioning aides. The MDS Coordinator acknowledged she had no therapy orders relating to positioning for Resident #12.

An interview was conducted with Physical Therapist (PT) #2 on 06/06/14 at 1:58 PM. PT #2 stated Resident #12 had been referred to therapy on 06/04/14 regarding her positioning in the geri chair. She added her plan was to try a high

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F 309	Continued From page 41 backed wheelchair for Resident #12. She stated the chair would prevent the resident from leaning back and to the left. An interview was conducted with the Director of Nursing (DON) on 06/06/14 at 2:15 PM. She stated all nurses should ensure residents were properly positioned in geri chairs and wheel chairs. The DON added she expected all residents to be positioned properly.	F 309		
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. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to provide necessary personal care (fingernails free of debris, oral care, and trimming of chin hairs) to 2 of 3 sampled residents dependent on staff to carry out activities of daily living (Resident #6 and #71). The findings included: 1. Resident #6 was admitted to the facility on 10/31/02 with diagnosis which included Alzheimer's disease, heart disease, and cerebral vascular disease. Resident #6's care plan dated 05/16/14 specified staff were to check nail length, trim, and clean the fingernails as necessary and	F 312	The residents found to be affected by the alleged deficient practice have been assessed without negative outcome. The personal care needs of the residents' identified were immediately addressed. No other residents have been found to have been affected by this alleged deficient practice. Staff has been in-serviced by DON on providing necessary personal care including trimming fingernails and shaving facial hair. QA Nurse or designee will audit trimming fingernails, oral care, and shaving facial hair of residents 3 times a week for 3 months then weekly thereafter if	6/30/14

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F 312	Continued From page 42 staff were to perform oral care every morning and every evening. The care plan identified the resident was dependent on staff and would have her personal hygiene needs met daily. The most recent quarterly Minimum Data Set (MDS) dated 05/22/14 specified Resident #6 had severe cognitive impairment and was dependent on staff assistance for personal hygiene. a) On 06/02/14 at 8:17 AM Resident #6 was observed in her room. Her fingernails were observed and noted to have brown debris underneath all five of her fingers on the left hand. Subsequent observations of Resident #6's fingernails revealed the following: On 06/02/14 at 12:47 PM Resident #6 was observed eating her lunch in the assisted dining room being assisted at times and picking up her food with her fingers. On 06/02/14 at 4:12 PM Resident #6 was seated in her wheelchair in the hall and her fingernails were observed visibly dirty with brown debris underneath all five fingernails on the left hand and under the fingernails of the middle and ring fingers of her right hand. On 06/04/14 at 2:38 PM Resident #6 was laying in her bed and brown debris was observed under all ten fingernails, brown debris all on her left hand, on her left cheek, forehead, and in her hairline. On 06/04/14 at 3:07 PM Resident #6 was laying in her bed and brown debris was observed under all five fingernails of her left hand and under three fingernails of her right hand.	F 312	compliance is accomplished. The DON or designee will be notified if concerns are noted and staff will be educated if problems have been identified. During random environmental rounds the IDT will also identify any need for trimming of fingernails, oral care, and shaving of facial hair. Any discrepancies will be brought to the attention of the administrator for follow up. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. DON is responsible for compliance.	

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F 312	Continued From page 43 On 06/04/14 at 3:22 PM the Director of Nursing (DON) was interviewed and observed the condition of Resident #6's fingernails and confirmed the brown debris needed to be cleaned out from under the fingernails. The DON stated she expected the nursing assistants to have trimmed and cleaned under the resident's fingernails. b) On 06/02/14 at 8:17 AM Resident #6 was observed in her room. Her teeth were observed and noted to have white matter accumulated along the gum line. Subsequent observations of Resident #6's teeth revealed the following. On 06/02/14 at 4:12 PM Resident #6 was seated in her wheelchair in the hall and her teeth were observed visibly dirty with white matter accumulated along the gum line. On 06/04/14 at 3:07 PM Resident #6 was laying in her bed and her teeth were observed visibly dirty with white matter accumulated along the gum line. On 06/05/14 at 2:14 PM Nursing Assistant (NA) #3 was interviewed and reported she was assigned to care for Resident #6. NA #3 reported she typically got the resident up in the morning and provided her with a partial bed bath, washed her face and combed her hair. The NA was asked if she brushed Resident #6's teeth and she reported she did not always brush her teeth. She explained she had cleaned the resident's teeth on 06/03/14 with a pink tipped swab but not with the resident's toothbrush. NA #3 had no explanation	F 312		

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F 312	Continued From page 44 for using the swabs in place of the resident's toothbrush. She indicated Resident #6 had 2 toothbrushes and toothpaste but she would choose to use the pink tipped swabs instead. NA #3 stated she was expected to brush a resident's teeth in the morning and the nurse aides working in the evenings were expected to brush a resident's teeth in the evening. On 06/05/14 at 5:03 PM the Director of Nursing (DON) was interviewed and reported the nursing assistants were expected to provide oral care daily in the mornings and in the evenings. The DON stated she expected the NA's to brush Resident #6's teeth daily. 2. Resident #71 was admitted to the facility on 08/28/13 with diagnoses of heart failure, muscle weakness, abnormality of gait and lack of coordination. A quarterly Minimum Data Set (MDS) dated 02/12/14 revealed Resident #71 was cognitively intact and was able to make her needs known. The quarterly MDS further revealed Resident #71 required extensive assistance with personal hygiene and rejection of care was not noted. Review of a care plan for activities of daily living (ADL) dated 03/06/14 revealed Resident #71 required extensive assistance with ADL due to a history of generalized weakness, poor activity intolerance and impulsivity with high fall risk. The stated goal was for Resident #71 to have her ADL needs met with staff assistance until the next review date. Interventions included: assist with dressing, grooming and personal hygiene daily. An observation of Resident #71 was made on	F 312		

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F 312	Continued From page 45 06/03/14 at 11:25 AM which revealed black and gray chin hairs on her neck and jaw line. The black and gray hairs were approximately 3/8 of an inch long and very noticeable. During an interview on 06/04/14 at 3:59 PM Resident #71 stated she required staff assistance to shave her chin hairs. Resident #71 stated she did not like for her chin hairs to be long. An interview with Nurse Aide (NA) #1 on 06/04/14 at 4:40 PM revealed chin hairs should be trimmed on the resident's shower days or anytime they are observed to need trimming. NA #1 stated Resident #71's shower was not given on 06/03/14 as scheduled due to staff being busy. NA #1 stated Resident #71's chin hairs needed to be trimmed. An interview was conducted with the Director of Nursing (DON) on 06/04/14 at 4:55 PM. During the interview the DON stated she expected nurse aides to keep chin hairs trimmed and showers to be given as scheduled.	F 312		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		6/30/14

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F 325	Continued From page 46 by: Based on observations, record reviews, and staff interviews the facility failed to allow the resident to finish her meals after taking her to the bathroom and failed to inform dietary and medical staff of changes of the frequency of meal refusals and decreased meal intake which related to weight loss for 1 of 4 residents reviewed for weight loss. (Resident #58). The findings included: Resident #58 was admitted to the facility on 06/10/13 with diagnoses which included depression, generalized osteoarthritis, vascular dementia with delusions, stroke, loss of weight, oral dysphagia (difficulty swallowing), debility, depressive disorder, anxiety, and lack of coordination. The most recent annual Minimum Data Set (MDS) dated 03/19/14 indicated Resident #58 had short and long term memory loss and was severely impaired cognitively for daily decision making skills. The MDS further indicated Resident #58 required extensive assistance with eating and drinking. The care plan for Resident #58 last updated 05/23/14 addressed the potential for nutritional problems and weight loss with a goal for no avoidable weight loss. The care plan interventions included: 1. obtain and monitor lab work 2. monitor for signs and symptoms of dysphagia 3. refusing to eat 4. provide and serve diet as ordered 5. monitor intake and record each meal 6. Registered Nutritionist (RD) to evaluate and make diet change recommendations as needed. 7. meals to be provided in main dining room for	F 325	The resident found to be affected by the alleged deficient practice has been assessed by the IDT. Changes have been made to plan of care with involvement from MD, RD, and POA. No other residents have been identified as being affected by this alleged deficient practice. Residents will be interviewed by staff to validate they are able to finish meals as desired. Any negative findings will be brought to the attention of the Administrator for follow up. Staff has been in-serviced by DON on need for residents to complete meals. Random dining room observations will occur by DON or designee to ensure that residents that request to leave are being offered meals in their rooms. All residents will be reviewed for consistent decreases/meal refusals of their usual meal intake. This will be done weekly by DON or designee for 3 months then monthly thereafter per facility policy. Any consistent decreases in intake/meal refusal will prompt immediate investigation by IDT and notification to MD. Dietary interventions will be implemented and close monitoring will take place. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. Administrator will be responsible for compliance.	

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frequent cueing table
8. allow adequate time to eat
9. maintain adequate nutritional status

The height recorded in the medical record for Resident #58 was 66 inches. Review of weights (measured in pounds) recorded in the medical record for Resident #58 included the following:
09/06/13 130
10/08/13 129
11/12/13 128
01/13/14 125
02/05/14 128
03/04/14 126
04/08/14 122
05/09/14 120

Physician progress notes for Resident #58 dated 03/12/14, 04/11/14, 04/25/14, and 5/28/14 did not address weight loss. Review of the medical record of Resident #58 from 08/21/13 through current revealed she remained on a pureed diet with nectar thick liquids.

The Registered Dietician (RD) progress note dated 01/21/14 revealed Resident #58 was on a pureed diet with nectar thick liquids and continued to feed herself in the main dining room eating an average of 50% of her meals. Further review of the progress note revealed Resident #58 received a nutritional supplement with lunch and supper and 60 milliliters (ml) of med pass (a nutritional drink) 3 times daily with medications since 07/19/13. The note further revealed continued monitoring of Resident #58's weight and oral intake and no dietary changes were made. The most recent RD progress note dated 06/04/14 indicated Resident #58 had decreased weights since 02/2014. The note further indicated

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Resident #58 received Remeron (a medication utilized as an appetite stimulant) at night since 11/15/13 and continued to receive the nutritional supplements.

A review of the Dietary Manager (DM) progress note dated 04/11/14 noted a 3% weight loss. The note indicated Resident #58 ate meals in the restorative dining room and consumed 25-50% of meals. The DM note further indicated Resident #58 received a nutritional supplement with lunch and supper and 60 cc of med pass 3 times daily with medications. The note further revealed continued monitoring of Resident #58's weight and oral intake and no dietary changes were made.

A review of the resident's medical record revealed Resident #58 required assistance for feeding on the restorative dining area with no notes of behaviors during meal times until 06/04/14.

A review of the meal intake records revealed the following:
March 2014 18 meals consumed 0-25% 6 meals refused
April 2014 26 meals consumed 0-25% 6 meals refused
May 2014 46 meals consumed 0-25% 22 meals refused
June 3, 2014 lunch meal consumed 0-25%

On 06/03/14 at 12:50 PM Resident #58 was observed in the dining room assisted by Nurse Aide (NA) #4. The meal plate had a few bites taken out of each entrée item. And ½ of the nectar thickened tea was consumed. NA #4 stated Resident #58 was taken back to her room because she didn't want to eat. Resident #58 was

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observed during the meal asking to go to the bathroom. The meal tray was not sent to the resident's room.

On 06/03/14 at 5:16 PM Resident #58 was observed in the dining room assisted by NA #6 with her meal. A few minutes later Resident #58 was no longer in the dining room and her tray was untouched and not eaten. NA#6 stated the Resident #58 was done eating, was taken back to her room to the bathroom and she notified NA#9 on the resident's hall. At 5:58 PM Resident #58 was observed in her room. NA#9 stated she was unaware that the resident had been brought back to her room and had not eaten her meal. The meal intake record noted 0-25% meal consumed for this meal.

On 06/04/14 at 5:06 PM an interview was conducted with Nurse #4. Nurse #4 stated Resident #58 required more one on one staff assistance for feeding due to her verbal behaviors and agitation when over stimulated in the dining room. Nurse #4 stated if she had been made aware yesterday that Resident #58 was brought back to her room during dinner, she would have made sure her meal tray had been brought with her. Nurse #4 further stated she was aware of Resident #58 decreased eating but was unaware of weight loss. Nurse #4 explained Resident #58 often would not continue eating in the dining room because of her agitation from the over stimulation in the dining room.

On 06/05/14 at 3:14 PM an interview was conducted with the Medical Director (MD). The MD stated he would want to be notified if a resident was not eating or refusing their meals especially if their weight was declining. The MD

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explained that he or the Geriatric Nurse Practitioner (GNP) should have been notified if the resident had increased refusals of meals and weight loss.

On 06/06/14 at 10:15 AM an interview was conducted with the DM. The DM revealed she received meal intake information from the computer that the nurse aides enter for each resident or verbal communication from the nurses or the nurse aides of any resident nutrition problems. The DM further revealed the computer also does alerts to the dietary department for weight losses starting at 3% from their previous weight. The DM stated she, the RD, and the Director of Nursing (DON) all received copies of weight reports. The DM stated the weight reports were reviewed in a meeting and nutritional concerns were reported to the physician for new orders. The DM explained she was unaware Resident #58 was refusing meals and had declining intake of her meals. The DM further explained she had not received any communication from nurses or nurse aides of any nutritional concerns for Resident #58 of not eating or refusing meals. The DM revealed Resident #58 was receiving a pureed diet and a nutritional supplement with her lunch and dinner meals but that was recorded as part of the meal percentage consumption.

On 06/06/14 at 11:17 AM an interview was conducted with NA#5. NA #5 stated when Resident #58 was brought back to her room from the dining room her meal trays were rarely sent with her. NA # 5 explained the meal consumption was written on the tray cards in percentages which included the nutritional supplement and then were entered in the computer.

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On 06/06/14 at 11:30 AM an interview was conducted with NA#4. NA#4 demonstrated the recording of this morning's breakfast tray card consumption. During the demonstration the computer record showed 0-25% but the tray card read 'R' for refused. NA#4 stated she was unaware Resident #58 refused her meal. If she had known, she would have tried to assist her again in her room with breakfast. NA#4 further stated that Resident #58 liked being in her room and was often more agreeable there.

On 06/06/14 at 12:29 PM an interview was conducted with NA#8. NA #8 stated she was in the assisted dining room this morning and helped Resident #58 with her meal. NA #8 further stated Resident #58 ate a few bites and refused to eat anything else so she was taken back to her room. NA#8 explained she was not sure of what the normal procedure was for what to do for residents who refused their meals.

On 06/06/14 at 1:52 PM an interview was conducted with the GNP. The GNP revealed she was aware of Resident #58 being challenging for providing care but was unaware of any weight loss or decline in her meal intake. The GNP explained she would have liked information of weight loss and meal refusals communicated in order to reevaluate Resident #58 for nutritional and hydration status.

On 06/06/14 at 1:52 PM an interview was conducted with the DON. The DON stated the normal practice for nutritional concerns was for nurse aides to report concerns to the nurses, and nurses reported to the MD, DM, RD and the DON. The DON further stated the weight reports

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F 325	Continued From page 52 were reviewed by the DON, DM, and the RD, and recommendations were provided to the MD for new orders. The DON explained her expectation was for the nurse aides to assist Resident #58 with meals and if she refused to attempt feeding her in her room, and report continued refused meals and poor intake verbally to the nurses. The DON further explained she expected nurses to then communicate information to the DON, MD and the RD either verbally or written and document in the nurses notes. The DON verified Resident #58 was not receiving the extra assistance needed for dining and the nurse aides and nurses were not communicating Resident #58's declined meal consumption and frequent meal refusals.	F 325		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews the facility failed to monitor and communicate proper fluid intake for 5 of 5 sampled residents reviewed for hydration. (Resident #58, #6, #40, #41, and #66). The findings included: 1. Resident #58 was admitted to the facility on 06/10/13 with diagnoses which included depression, generalized osteoarthritis, vascular dementia with delusions, stroke, oral dysphagia	F 327	All residents in the alleged deficient practice have been assessed without further negative outcome. No other residents have been identified as having this alleged deficient practice. 100% hydration audit will be conducted by QA Nurse or designee on all residents by 07/04/2014. Any negative findings from this audit will be communicated to MD and RD immediately for follow up. Nursing staff has been in-serviced by DON on the appropriate hydration pass time for each	7/4/14

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F 327	Continued From page 53 (difficulty swallowing), debility, depressive disorder, anxiety, and lack of coordination. The most recent annual Minimum Data Set (MDS) dated 03/19/14 indicated Resident #58 had short and long term memory loss and was severely impaired cognitively for daily decision making skills. The MDS further indicated Resident #58 required extensive assistance with eating and drinking. The care plan for Resident #58 last updated 05/23/14 addressed the potential for nutritional problems related to a mechanically altered diet. The care plan goal was to consume at least 75% of meals daily and interventions which included: 1. obtain and monitor lab work 2. monitor for signs and symptoms of dysphagia 3. provide puréed diet with nectar thickened liquids 4. provide and serve diet as ordered 5. monitor intake and record each meal 6. Registered Nutritionist (RD) to evaluate and make diet change recommendations as needed. 7. maintain adequate nutritional status Review of fluid intake records revealed the following: How much fluid in milliliters (ml) the resident drank. April 2014 average fluid intake 720 ml per day May 2014 average fluid intake 615 ml per day June 1, 2014 360 ml today June 2, 2014 360 ml today June 3, 2014 120 ml today Further review of fluid intake reveals 48 days out of 64 days Resident #58 received 800 ml or less of fluid per day. A review of the resident's medical record revealed	F 327	shift and the importance of offering hydration between meals. Nursing staff has been in-serviced by DON on the need to ensure residents receive proper hydration. Hydration audit tool has been implemented by QA nurse to be conducted on 5-10 residents weekly for 3 months, variances will be investigated and responsible staff will be re-educated. Findings from the audits will be reported to the DON for analysis of trends/patterns and a summary of the QA Committee. QA committee will then determine the need for further monitoring. Results of the audits will be communicated to DON. MD will be notified immediately if dehydration symptoms are present for further follow up. During environmental rounds by IDT availability of fluids and offering of fluids will be reviewed. Any discrepancies will be brought to the attention of the Administrator for follow up. DON or designee will review fluid consumption intake weekly for 3 months then monthly thereafter, any consistent decreases in fluid intake will prompt immediate investigation by IDT and notification to MD. Dietary interventions will be implemented and close monitoring will take place. DON will be responsible for compliance of this deficiency.	

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Resident #58 required assistance for feeding on the restorative dining area with no notes of behaviors during meal times until 06/04/14.

A review of the meal intake records revealed the following:
March 2014 18 meals consumed 0-25% 6 meals refused
April 2014 26 meals consumed 0-25% 6 meals refused
May 2014 46 meals consumed 0-25% 22 meals refused
June 3, 2014 lunch meal consumed 0-25%

A review of dietary notes revealed no notes addressing Resident #58's decreased fluid intake.

A review of the Registered Dietician (RD) progress notes dated 06/04/14 revealed daily fluid intake requirement of 1600 ml. The last quarterly review RD progress note dated 01/02/14 revealed Resident #58 was on a puréed diet with nectar thickened liquids. The RD note further indicated Resident #58 was feeding herself in the main dining room and received nutritional supplements with her meals. No changes were indicated on her current diet regimen.

On 06/03/14 at 9:51 AM a cooler was observed on the Resident #58's bedside table with 3 warm 4 ounce (oz) containers of thickened liquid drinks with a warm to the touch ice pack in the cooler.

On 06/03/14 at 12:38 PM Resident #58 was observed lying in her bed with the cooler with 3 warm drinks and a warm ice pack in the cooler on the bedside table. The staff was not observed offering fluids.

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On 06/03/14 at 2:58 PM Resident #58 was observed in her bed and the cooler remained on the bedside table. The cooler was observed to have 3 containers of warm thickened liquid and a warm ice pack in the cooler.

On 06/03/14 at 3:16 pm a nursing assistant (NA) was observed passing ice and water pictures to resident's rooms.

On 06/03/14 at 4:00 PM the NA completed passing ice water. Resident #58's cooler was observed to remain unchanged. The cooler contained 3 warm thickened liquid drinks and a warm ice pack. The staff was not observed offering fluids.

On 06/04/14 at 8:14 AM Resident #58 was observed in the assistive dining room eating her breakfast. She was observed drinking thickened orange juice from a cup. Resident was transported back to her room after eating 50% of her meal and drinking 120 ml of orange juice. She was observed in her bed at 8:40 am and a cooler was on her bedside table. The cooler contained 4 containers of thickened liquids with a cold ice pack in the cooler.

An interview was conducted on 06/04/14 at 12:31 PM with the RD. The RD explained Resident #58 required 1600 cc of fluid daily and was on a purred diet with nectar thickened liquids. The RD reviewed the fluid intake records and stated Resident #58 was not receiving her required fluid intake on a daily basis according to the records. The RD further stated she would want communication from the nursing department of Resident #58's decreased fluid consumption.

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An interview was conducted with Nurse #4 on 06/04/14 at 5:06 PM. Nurse #4 stated the process for filling ice water pictures and coolers with thickened liquids was completed by the nurse aides every day at the beginning of every shift. She further explained the nurse aides were supposed to offer liquids between meals and every time they do rounds.

An interview was conducted with NA#6 on 06/05/14 at 3:42 PM. NA #6 stated ice and water pictures were passed every day each shift and the coolers were restocked with cold ice packs and thickened liquids. NA#6 stated she worked this week the 2nd shift (3-11 pm) and was passing the ice and water today. She explained another NA passed the ice water on Monday and Tuesday but could not remember who it was.

On 06/05/14 at 3:14 PM an interview was conducted with the Medical Director (MD). The MD stated he wanted to be notified if a resident was not eating and drinking or refusing their meals. The MD explained that he or the Geriatric Nurse Practitioner (GNP) should have been notified if the resident had increased refusals of meals and fluid intake.

On 06/06/14 at 1:52 PM an interview was conducted with the GNP. The GNP revealed she was aware of Resident #58 being challenging for providing care but was unaware of any decline in her meal or fluid intake. The GNP explained she would have liked information regarding decreased fluid and meal intake and communication in order to reevaluate Resident #58 for nutritional and hydration status.

On 06/06/14 at 1:52 PM an interview was

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conducted with the Director of Nursing (DON). The DON stated the normal practice for nutritional and hydration concerns were for nurse aides to report concerns to the nurses, and nurses reported to the MD, DM, RD and the DON. The DON further stated the meal and fluid intake records were reviewed by the DON, DM, and the RD, and recommendations were provided to the MD for new orders. The DON explained her expectation was for the nurse aides to assist Resident #58 with meals and drinking fluids and fluids should be offered in-between meals and during nurse aide rounds. The DON further explained she expected nursing to communicate information to the DON, MD and the RD either verbally or written and document in the nurses notes. The DON verified Resident #58 was not receiving the extra assistance needed to provide oral intake during dining and the nurse aides and nurses were not communicating Resident #58's decreased meal and fluid consumption.

2. Resident #6 was admitted to the facility on 10/31/02 with diagnosis which included Alzheimer's disease, cerebral vascular disease, and diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) dated 05/22/14 specified Resident #6 had severe cognitive impairment and required extensive assistance with cueing from staff for eating and drinking. The most recent Care Area Assessment (CAA) Summary dated 02/14/14 indicated Resident #6 was incapable to perform her activities of daily living (ADL) without significant physical assistance. The plan of care last updated 05/16/14 indicated there was a problem/need as, "Incontinent of bowel and bladder with poor re-training potential due to impaired cognition and

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decreased mobility: skin breakdown and urinary tract infection." One of the interventions for this problem/need was listed as, "Encourage fluids frequently during the day."

Observation of the resident on 06/02/14 at 8:17 AM revealed her sitting in a wheelchair beside her bed. At the foot of the bed against the wall on a bedside nightstand was a water pitcher that was warm (room temperature) and full of water. She was observed to have dry lips, but the mucosa of her mouth was moist. The resident stated she was thirsty and could not get any water.

Observations on 06/04/14 at 8:12 AM revealed the resident in the assisted dining room with her breakfast meal tray in front of her. She had 1 four ounce glass of thickened cranberry juice, 1 four ounce glass of a thickened shake, and an 8 ounce carton of milk poured into a glass. The resident consumed all of her milk, ½ of her thickened shake, and ¾ of her cranberry juice. Her meal tray was observed to be picked up by a nursing assistant at 9:24 AM. Another observation of the resident on 06/04/14 at 10:43 AM revealed resident was in her room with room temperature water in the water pitcher, the pitcher was full of water, and no straw was in the water pitcher located on the nightstand at the foot of her bed against the wall. At 2:38 PM on 06/04/14 she was observed to have a room temperature water pitcher without a straw on the floor at her bedside. The nursing assistant was in the room, picked up the water pitcher out of the floor, and put it on top of the resident's nightstand at the foot of her bed against the wall.

Interview with a family member of Resident #6 on 06/04/14 at 4:38 PM revealed she frequently had

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to get the resident water when she visited. Continued interview revealed when she visited she found the resident's water pitcher to be warm (room temperature), full of water, without a straw, and always located on the nightstand at the foot of the bed against the wall. The family member revealed the resident was occasionally incapable of asking for water and it had to be offered to her and she needed a straw in the pitcher for her to suck the water from the water pitcher. Further interview with the family member revealed the resident could suck the water through a straw if the water was offered to her. The family member further revealed she frequently finds the resident's water pitcher without a straw and always setting on the nightstand against the wall at the foot of the resident's bed.

Interview with the Nursing Assistant (NA) #3 on 06/05/14 at 2:14 PM revealed they were to pass out ice and water to their residents every day and on every shift. Continued interview revealed no response as to why Resident #6 did not have fresh water nor a straw in her water pitcher.

3. Resident #40 was admitted to the facility on 06/08/10 with diagnoses which included cerebral vascular accident, dementia, and anemia. On the most recent annual Minimum Data Set (MDS) dated 04/24/14 specified Resident #40 was coded as having short and long term memory problems and having modified independence for cognitive skills of daily decision making. On the plan of care last updated 05/07/14 had a problem/need listed as, "Nutritional problem leaves 25% or more of food uneaten." One of the interventions for the problem/need was to, "Provide and serve supplements as ordered: Magic Cup twice daily with meals and med pass

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F 327	Continued From page 60 60 milliliters (ml) three times per day." An observation of breakfast on 06/04/14 at 8:17 AM she had 4 ounces of orange juice and 8 ounces of coffee in a cup on her meal tray. She consumed ½ of her coffee and none of the orange juice. Her meal tray was taken up at 8:58 AM without any of the orange juice being offered or consumed. During the lunch observation on 06/05/14 at 12:39 PM she had tea on her meal tray, she was encouraged to drink the tea and the meal tray was taken up at 1:23 PM without her consuming any of the tea. Observation of the resident again on 06/04/14 at 4:12 PM during care revealed she had a water pitcher in her room and full of room temperature water and no water from the water pitcher had been consumed. Interview with the NA #2 on 06/05/14 at 9:40 AM revealed they are to pass out ice and water to their residents every day and on every shift. Continued interview revealed NA #2 had no response as to why Resident #40's water pitcher was warm, full of water, and no water had been offered to Resident #40. NA #2 further stated "we are very busy and I just forget to offer her water when I am in the room." 4) Resident #41 was admitted to the facility on 10/30/07 with diagnoses which included dementia, pain in the joints, and pneumonia. On the most recent quarterly Minimum Data Set (MDS) dated 03/26/14 specified Resident #41 was coded as having short and long term memory problems and having modified independence for cognitive skills of daily decision making. On the plan of care last updated	F 327		

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05/20/14 had a problem/need listed as, "Pneumonia requiring antibiotic therapy: acute episode." One of the interventions for the problem/need was to, "encourage fluids frequently throughout the day." Another problem/need listed on the plan of care last updated on 06/03/14 listed as, "Skin tear of upper arm related to fragile skin." One of the interventions for the problem/need was to, "Encourage good nutrition and hydration in order to promote healthier skin."

Observation of the resident on 06/02/14 at 10:38 AM revealed her to be lying in her bed. On the top shelf of the dresser drawers setting beside the television was a water pitcher full of room temperature water.

On 06/02/14 at 10:40 AM during an observation the resident's family member came to visit. She stated she visits the resident about 4 times a week and "they sometime get water but not fresh ice and water every day." She further stated you have to tell the staff you need water. She indicated she can ask an NA to get her water and they will tell you they don't have time. She further indicated if you get fresh water from the staff, they don't put the water pitcher where the resident can reach it. She stated, "If a resident can't ask for water then they don't get any water." The family member indicated when she comes to visit she will feed the resident so she knows the resident has ate and drank all of her fluids. She further indicated the resident's lips remained dry and cracked most all of the time and she will apply lip balm to keep the resident's lips moist.

Interview with the NA #3 on 06/05/14 at 2:14 PM revealed they are to pass out ice and water to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE WELLNESS CTR	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

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F 327	Continued From page 62	F 327		

their residents every day and on every shift. Continued interview revealed no response as to why Resident #41's water pitcher was full of room temperature water and no water had been offered to Resident #41. NA #2 further indicated she had been very busy and had not put fresh water or ice in the resident's water pitchers.

5. Resident #66 was admitted to the facility on 06/30/09 with diagnosis which included Alzheimer's disease and Diabetes Mellitus Type II. On the most recent quarterly Minimum Data Set (MDS) dated 05/14/14 specified Resident #66 was coded as having severe cognitive impairment and required extensive assistance with eating and drinking. On the plan of care last updated 05/14/14 had a problem/need listed as, "Frequently incontinent of bowel and bladder related to progressive cognitive decline." One of the interventions for the problem/need was to, "Encourage fluids frequently throughout the day." Another problem/need listed on the plan of care was, "Nutritional problem related to mechanically altered diet, leaves 25% or more of food uneaten, significant weight loss." One of the interventions for the problem/need was to, "Provide and serve supplements as ordered: Magic cup twice daily with meals, mighty shake twice daily with meals, and med pass 90 milliliters (ml) three times per day."

Observation of the resident on 06/02/14 at 8:23 AM revealed her to be lying in her bed with raised bilateral side rails and her water pitcher setting on the over bed table pushed up against the wall underneath the window and out of the resident's reach. The water pitcher was full of room temperature water. Further observation of Resident #66 revealed her to have dry, cracked

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F 327	Continued From page 63 lips. Observation of breakfast on 06/04/14 at 8:17 AM she had 4 ounces of milk in a glass and 4 ounces of orange juice in a glass on her meal tray. She poured the milk into her bowl of cereal and consumed 4 or 5 bites of the cereal and drank all 4 ounces of the orange juice. Her meal tray was taken up at 8:58 AM without any of the milk being consumed from the bowl of cereal. Observation of the resident on 06/04/14 at 1:38 PM during transfer from her wheelchair into her bed revealed she had a water pitcher in her room located on the over bed table full of room temperature water and no water had been consumed. Another observation on 06/04/14 at 4:18 PM she was observed to have dry lips, and the mucosa of her mouth was moist. The resident stated she was always thirsty and no one would bring her any water. Interview with the NA #4 on 06/05/14 at 9:40 AM revealed they are to pass out ice and water to their residents every day and on every shift. Continued interview revealed no response as to why Resident #66's water pitcher was full of room temperature water. She further stated she had not offered Resident #66 any water and she had not placed fresh ice and water into her water pitcher.	F 327		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		6/30/14

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F 333	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews the facility failed to notify the Physician of a resident's medication allergy when an antibiotic was ordered via telephone resulting in a medication error for 1 of 6 residents reviewed for unnecessary medications. (Resident #55). The findings included: Resident #55 was admitted to the facility on 03/18/08 and readmitted on 03/05/14 with diagnoses which included muscle weakness, depressive disorder, diabetes, anxiety, nausea with vomiting, and dementia. The most recent quarterly Minimum Data Set dated 04/02/14 indicated Resident #55 was severely impaired cognitively for daily decision making skills. A review of Resident #55's medical record revealed a medication allergy to Bactrim (an antibiotic medication) was noted on a History and Physical dated 12/12/13. A review of the Admission Nursing Evaluation dated 12/24/13 listed a medication allergy to Bactrim. A review of the monthly physician orders dated 01/01/14 through 01/31/14 revealed an allergy listed for Bactrim (an antibiotic medication). A review of the Medication Administration Record (MAR) dated 01/01/14 through 01/31/14 revealed an allergy listed for Bactrim. The MAR further listed a new med order dated 01/18/14 for Bactrim 1 tablet by mouth twice daily for 7 days.	F 333	The resident found to be affected by the alleged deficient practice was assessed at the time of the error with no further negative outcome. The physician was notified immediately of the error of allergy to medication given and a different antibiotic was ordered. No other residents have been found to have been affected by the alleged deficient practice. Nurses have been in-serviced by DON to always read allergies to physicians when getting an order for a drug. DON will be notified of all medication errors and all nurses will be educated as to why the error occurred and what measures will be put into place to prevent error from occurring again. QA Nurse will perform allergy checks with any drug taken from E-kit to ensure there is no allergy to ordered medication for 3 months. Any negative findings will be brought to the attention of the DON for follow up with Medical Director and nurses will be educated. Pharmacy will continue to notify facility of any drug allergy interaction as they have previously prior to dispensing. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. DON is responsible for compliance.	

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A review of Physician Progress notes dated 01/02/14 and 01/15/14 listed a medication allergy to Bactrim.

A review of physician orders dated 01/18/14 written by Nurse #6 revealed a new order for Bactrim 1 tablet by mouth twice daily for 7 days for infection.

A review of nursing notes dated 01/19/14 indicated Nurse #6 called the physician and reported the administration of one dose of bactrim and received the verbal order to discontinue the bactrim due to allergy.

On 06/04/14 at 4:42 PM an interview was conducted with the Medical Director (MD). The MD stated he was not notified of the medication allergy when he ordered the Bactrim via telephone. The MD further stated he remembered being notified of the medication error and was certain that it was ordered without knowing of any medication allergies. The MD explained the standard practice in giving verbal orders was to have communication from the nursing staff of a resident's allergies prior to giving an order. The MD added Resident #55 was not harmed from the medication error but was sent to the hospital for evaluation due to previous abnormal lab results.

On 06/05/14 at 3:55 PM an interview was conducted with Nurse #6. Nurse #6 verified she received a verbal order via telephone for Bactrim for Resident #55 and had not read the Residents' allergies to the MD prior to taking the order. Nurse #6 stated she notified the MD of the medication administration error and the residents' allergies the next day prior to giving the morning

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F 333	Continued From page 66 dose of Bactrim. ON 06/06/14 at 1:52 PM an interview was conducted with the Director of Nursing (DON). The DON revealed the Nurse # 6 received a verbal order for Bactrim for Resident #55 and failed to read the medication allergies to the physician prior to receiving the order. The DON verified the nurse also failed to read the allergy list on the MAR prior to administering the medication. The DON stated it was her expectation for nurses to always read the allergies listed on the MAR to the physician prior to receiving orders and prior to administering medications.	F 333		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		6/30/14

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F 353	Continued From page 67 duty. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide adequate staffing to assist residents that were dependent on staff to eat their meals during dining room observations of 2 of 4 meals in the assisted dining room. The findings included: An observation was conducted in the assisted dining room on 06/02/14 at 12:05 PM. Nurse Aide (NA) #1 was observed in the room with 14 residents. NA #1 brought lunch trays to 2 residents sitting at a half-moon shaped table to the far left of the dining room. One resident was sitting in a geri-chair, had arm contractures and incapable of feeding himself. The other resident was sitting in a wheelchair with no interest and/or attempts to feed herself. NA #1 started assisting the 2 residents with their lunch. The other 12 residents were arranged so that they were sitting at 1 large table. At 12:13 PM, NA #3 and NA #4 came into the dining room and started putting clothing protectors on the other 12 residents and wiping their hands with hand wipes. Afterward these 2 nurse aides started serving lunch trays to the remaining 12 residents. Residents were observed sitting in geri-chairs or wheelchairs attempting to feed themselves with their hands picking up pieces of chopped meat with gravy, while 4 residents sitting in wheelchairs at a half-moon shaped table to the far right of the dining room had no staff assistance and made no attempts to feed themselves. At 12:42 PM, NA #4 started helping a resident at the end of the	F 353	Residents found to have been affected by the alleged deficient practice have been assessed with no negative outcome. A fourth person was immediately added to the assisted dining room. No other residents have been found to have been affected by this alleged deficient practice. Staff has been in-serviced by DON that one CNA needs to be at each table to serve no more than 4 residents. Dining room arrangements was conducted by DON and modifications were made to further accommodate resident needs. Staff Development Coordinator will audit assisted dining room 3 times a week for 3 months then monthly thereafter if compliance is accomplished. Any identified areas of deficient practice will be corrected immediately. The DON or designee will be notified if concerns are noted for further follow up if needed. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. DON is responsible for compliance.	

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table where 4 residents were sitting unattended. During this time NA #3 was attempting to assist 6 residents at once. One of the residents was asking for water while 1 resident was yelling "What do I do next?" and another resident yelling "What is this?" The 2 nurse aides were observed not only talking among themselves but answering the 2 resident's questions as well as talking to the other residents into taking a bite of food. All while, the nurse aides rolled on a stool; on the opposite side of the table, assisting each resident with one bite at a time.

An observation was conducted in the assisted dining room on 06/03/14 from 12:33 PM until 12:55 PM. NA #3 and NA #4 were observed assisting 11 residents with their lunch meals. Two residents were observed yelling out "What do I do?". NA #3 was observed raising her voice talking to the residents in attempt to answer their question. NA #3 and NA #4 were observed rolling back and forth to each resident sitting across the table from them and talking loudly to each resident in an attempt to get their attention to take a bite of food. NA #4 commented they needed help assisting these residents. At 12:55 PM the Director of Nursing (DON) entered the dining room. She stated the nurse aides were supposed to assist 6 residents each with eating and they were supposed to give each resident a bite then go back and start over again. The DON observed the 2 nurse aides at the same end of the table talking. The DON stated NA #3 was not supposed to be at the end of the table where NA #4 was assisting her 6 residents with eating. She agreed the noise level was loud and stated she was not in the dining room often and was unaware of all of the distractions.

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F 353	Continued From page 69 An additional interview was conducted with the DON on 06/05/14 at 5:03 PM. She stated approximately 2 to 3 months ago she had the tables put together thinking 2 nursing assistants could handle feeding the resident's. The DON explained she was unaware of the noise, confusion, and lack of assistance provided to the residents during the meal.	F 353		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and family and staff interviews the facility failed to provide screens to prevent pests from entering 2 opened resident windows observed on 2 of 5 halls. (Halls 200 and 500). The findings included: Observations on 06/03/14 at 3:30 PM revealed room 212 to have the window opened with no screen covering the window. Observations on 06/03/14 at 4:45 PM revealed 2 flies in room 408 landing on Resident #116 water cup multiple times. During an interview on 06/03/14 at 3:00 PM, Resident #30's family member reported he had killed several bees in Resident #30's room over the past year. He stated Resident #30 enjoyed the fresh air from having the window open but there was no screen to keep the bugs out. Observations on 06/04/14 at 3:24 PM and	F 469	The residents found to be affected by the alleged deficient practice have been assessed without negative outcome. Screens were immediately placed on the windows. 100% audit has been completed on all resident rooms to identify any other unscreened windows. Any unscreened window that was found during audit has been identified and replacement screens have been ordered. Identified unscreened windows will not be opened until screens are in place. No other residents have been found to have been affected by the deficient practice. Staff has been in-serviced by DON and Environmental Services Director that all windows that open must have a screen for	7/4/14

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F 469	Continued From page 70 06/06/14 at 9:30 AM revealed room 504 to have the window opened with no screen covering the window. An interview with the Assistant Maintenance Director on 06/06/14 at 9:32 AM revealed he was not aware that rooms 212 and 504 did not have screens on the windows. He stated the window should not be opened without a screen due to bugs coming in the facility through the open window. An interview with the Administrator on 06/06/14 at 11:30 AM revealed she was not aware rooms 212 and 504 did not have screens over them. The Administrator stated it was not acceptable for windows to be opened without screens to keep the bugs out.	F 469	pest control. Environmental Services Director or designee will audit weekly for 3 months then monthly thereafter if compliance is accomplished. The Administrator will be notified if concerns are noted and staff will be educated. During environmental rounds by IDT windows are checked for screens. Any discrepancy will be brought up to the attention of the Administrator for follow up. Findings from the audits will be reported to the QA Committee for additional oversight and recommendation. Administrator is responsible for compliance.	