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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 observation, record review and staff interviews, the facility failed to notify a resident's physician when the facility was unable to	F 157	It is the intent of the facility to notify residents□ physicians when appointments are missed	3/4/15

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

Electronically Signed

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F 157	Continued From page 1 schedule an ordered urology consult for 1 of 1 (Resident #9) sampled residents. Findings included: Resident #9 was re-admitted to the facility on 12/26/14 with cumulative diagnoses of urinary retention, chronic kidney disease, and cerebrovascular accident (CVA). Resident #9's Quarterly Minimum Data Set (MDS) dated 01/02/15 revealed Resident #9 had short and long term memory problems and was moderately impaired in daily decision making. Resident #9 had an indwelling urinary catheter. Review of the Hospital Discharge Summary for Resident #9 dated 12/26/14 revealed a recommendation for a follow-up with urology for urinary retention and to leave the urinary catheter in place until the follow-up appointment. Review of the 12/26/14-12/31/14 Medication Administration Record (MAR) revealed a hand written entry for a follow-up appointment with urology on 01/27/15 at 3:30 PM. Review of the January 2015 MAR showed a hand written entry for a follow-up appointment with urology on 01/27/15. The entry was initialed as completed. In an observation on 02/03/15 at 11:53 AM Resident #9 was lying in bed. An indwelling urinary catheter with a covered bag was seen hanging from the bed rail. In an observation on 02/03/15 at 2:55 PM Resident #9 was lying in bed. Nursing Assistant (NA) #1 provided urinary catheter care for the resident. In an interview on 02/04/15 at 3:30 PM the Appointment Scheduler indicated she was provided with a copy of the Physician's Order or the Hospital Discharge Summary by the nurses. She then notified the office of the physician or specialist named in the order that a consult	F 157	and/or rescheduled. Resident #9 was rescheduled with Eastern Urology Associates for 2/17/15. Resident was taken to the appointment. No other residents were affected by this alleged deficient practice. Upon admission the Supervisor/licensed nurse will review the discharge summary and transcribe any appointment instructions to the physician□s order sheet and enter on unit appointment calendar. Nursing staff/transport scheduler was in-serviced on 2/18/15, 2/24/15, 2/26/15 on Scheduling Appointments, Missed Appointments and MD Notification. In-services will be completed by 3/4/15. The Director of Nursing/nursing designee will review telephone orders daily and new admission orders within 24 hours of admission during morning meetings Mondays through Fridays. Using a new and updated daily case-mix tool resident appointments will be reviewed daily Mondays through Fridays. Any issues identified will be taken to the Quality Improvement Committee to be	

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F 157	Continued From page 2 appointment was needed. She stated she attempted to make an appointment with the Urologist for Resident #9 but the urology staff refused to make an appointment. The Appointment Scheduler stated she informed the nurse that she was unable to obtain an appointment as ordered. In an interview on 02/05/15 at 12:36 PM Nurse #5 indicated Resident #9 did not have a urinary catheter prior to going out to the hospital on 12/23/14. She stated when Resident #9 returned to the facility on 12/26/14 she had a urinary catheter and a diagnosis of urinary retention. Nurse #5 indicated the Appointment Scheduler had informed her she was unable to make a urology appointment and Nurse #5 initialed the appointment on the MAR. Nurse #5 stated she did not notify Resident #9's physician the facility was unable to make an appointment with the urologist. She indicated she did not place the information on the 24 Hour Report so the missed appointment could be followed up on by the Unit Supervisor. In an interview on 02/05/15 at 4:22 PM the Director of Nursing stated she expected the nurse to notify the referring physician and the facility physician if a specialist consult was not done. She indicated it was her expectation that if the consulting physician had refused an appointment another specialist should have been contacted so the continued use of the indwelling urinary catheter could have been assessed.	F 157	discussed monthly times 2 months. Any Identified problems will be corrected immediately to maintain compliance.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 224		3/4/15

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F 224	Continued From page 3 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent neglect of 1 of 1 sampled residents (Resident #7) as evidenced by not providing hand hygiene of the left hand. The facility failed to assess Resident #7's left hand and failed to prevent the development of a stage 2 pressure ulcer to the fifth digit on the left hand. The facility also failed to monitor and/or assess prevention/protection measures to protect the skin integrity of the severely contracted left hand. Findings included: Resident #7 was admitted to the facility on 06/15/11 and was re-admitted on 01/16/15. Cumulative diagnoses included hypertension, joint contractures, cerebrovascular accident (CVA), pressure ulcer, dementia and diabetes mellitus. Resident #7 also had a history of a pressure ulcer to the thumb of his left hand which healed on 10/08/14. The undated "NURSING INSTRUCTIONS" cardex for Resident #7 noted contractures of the left arm and hand. There was no mention of splinting or protective devices. The "RESTORATIVE NURSING" section was blank. The Quarterly Minimum Data Set (MDS) assessment of 08/06/14 documented Resident #7 was not cognitively intact and required extensive to total assistance for all activities of daily living.	F 224	It is the intent of the facility to prevent neglect of facility residents by providing hand hygiene to resident□s per facility policy and job description. Resident #7 has received appropriate hand hygiene of the left contracted hand as of 02/07/15. OT assessed Resident #7 for appropriate left hand contracture treatment/interventions on 2/19/15. Restorative C.N.A□s were in-serviced on: daily hygiene care of Resident #7□s left hand on 02/23/15. All other nursing staff will be in serviced on neglect related to not providing care and services to prevent decline and/or incident as well as daily hygiene care. In-services started on 2/23/15 to be completed by 3/4/15. Resident #7 will be assessed by nursing for pain prior to ADL care and will receive pain medication at least 30 minutes prior to a.m. care/hand contracture hygiene	

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F 224	Continued From page 4 It was noted that he had the presence of a stage 3 pressure ulcer with no measurements documented. The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living. He had a history of healed pressure ulcers. Resident #7 had a functional limitation in range of motion on one side of the upper extremity and on both sides of the lower extremity. Resident #7's care plan, last reviewed on 11/12/14, identified several problem areas which included: . a problem with being at risk for skin breakdown due to hemi/para/quadriplegia with onset date of 04/23/14. The goal was to remain free from skin breakdown through the next review date. Approaches included keeping the skin clean and dry as well as observing the skin daily. Any abnormalities were to be reported to the nurse. . a problem (with onset date of 05/12/14) with being at high risk for the development of pressure ulcers and the resident had a stage 3 pressure ulcer to the left thumb. Approaches included a daily observation of the skin with routine care and a full skin evaluation weekly with the bath/shower. The problem was reviewed on 11/12/14 and it was noted to continue the POC (plan of care). . a problem with onset date of 08/13/14 with impaired physical mobility, limited range of motion and a potential for worsening contractures. Interventions included PT (physical therapy), OT (occupation therapy) screen/evaluation as indicated. Another intervention was to encourage to participate in range of motion exercises daily	F 224	as needed beginning 2/28/15. Resident #7□s care plan was updated to reflect left hand hygiene contracture care to be provided by restorative nursing daily starting 02/27/15. A 100% contracture audit of all other resident was started on 2/11/15 and completed by 2/13/15 by the therapy department which included hygiene and pain. The MDS nurse/nurse designee will complete a resident contracture assessment upon admission/readmission. All areas identified as contractures will be referred to OT/PT for farther evaluation for treatment, including hygiene and pain, starting 3/2/15. DON/designee will monitor hygiene care of residents with contractures daily times 2 weeks then weekly for 4 weeks then randomly using the compliance rounds tool beginning 2/4/15. Using the daily case mix tool, contractures will be reviewed daily Mondays through Fridays. Any identified problems will be taken to the Quality Improvement Committee to be discussed monthly times 2 months. Any identified problems will be corrected immediately	

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F 224	Continued From page 5 and to encourage to utilize the right static hand splint. There was no mention of prevention measures for the left hand. A daily therapy note of 09/01/14 noted that Resident #7 was supine in bed with a left static hand splint in place. The therapist removed the splint and would replace it tomorrow after passive stretching. It was noted that passive stretch had been completed on the left hand to increase range of motion in order to decrease finger flexion contractures. The therapy discharge summary of 09/17/14 indicated Resident #7 had received treatment for contracture management. A physician's telephone order of 09/17/14 noted that Resident #7 was discharged from occupation therapy and had met the maximum rehabilitation potential. It was noted that nursing was to continue with restorative care for orthotic placement. A physical therapy (PT) screen of 10/21/14 noted Resident #7 had no changes in his contractures and PT was not indicated. An occupation therapy (OT) screen of 11/26/14 indicated the quarterly assessment was conducted with Resident #7. It was noted that he presented with no functional deficits or focus for skilled OT at this time. The December 2014 treatment administration record for Resident #7 included no orders for any treatment that included washing the left hand. There was no January 2015 treatment record found in his active chart. A physician's progress note of 01/15/15	F 224	to maintain compliance.	

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documented to continue with routine wound care, dressing and splinting.

A contracture risk review dated 01/16/15 written by Nurse #6 for Resident #7 documented that a contracture risk care plan was in place. It was noted on the review that a score of 6 or higher indicated was at risk. Resident #7 had a score of 11. It was noted that Resident #7 had joint pain and a history of cerebrovascular accident (CVA) as predisposing factor for contracture development.

A physician's progress note of 01/18/15 made no mention of any contracture management for Resident #7.

A re-admission therapy screen of 01/22/15 noted Resident #7 displayed no current focus for services.

The most recent Quarterly Minimum Data Set (MDS) assessment of 01/23/15 noted Resident #7 required extensive to total care with all activities of daily living. It was documented that he had limitation in range of motion on both sides in both upper and lower extremities. He was identified as at risk for pressure ulcers.

Resident #7 was observed resting in bed on 02/02/14 at 9:40 AM. There was a distinct foul odor noted in the room and the odor smelled strongest when next to Resident #7's bed.

Resident #7 was observed resting in bed on 02/02/15 at 11:45 AM. His left hand was noted to be tightly clenched in the shape of a ball with the thumb pressed underneath the fingers and protruding out the opposite side of the hand. The

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left arm was clenched tightly against his chest. There was no splinting or protection noted in the left hand.

Resident #7 was observed resting in bed while being fed by staff (NA #6) on 02/02/15 at 1:15 PM. The odor remained in the room and no visible splinting/protection devices were noted in either of his hands.

The treatment nurse was observed feeding Resident #7 on 02/02/15 at 5:58 PM. There was no visible splinting/protection devices in place to either of his hands.

Resident #7 was observed resting in bed on 02/03/15 at 8:45 AM. The right hand was underneath the bed covers but the left hand was visible. There was no protective device noted in his left hand. The odor was still detected.

Resident #7 was observed resting in bed on 02/04/15 at 9:15 AM. There was no visible splinting or protection measure in place to either of his hands. The odor was still present.

A bed bath was observed beginning at 9:20 AM on 02/04/15. NA #7 washed, rinsed and dried the right arm and hand. He washed the outer surface of the left contracted hand but made no attempt to open it to wash inside. As NA #7 was completing the bath, he reported that he didn't attempt to open the left hand due to pain on the part of the resident. When questioned about the ability to open the left hand, he attempted to move the fingers very gently away from the palm of the hand. He was able to extend the fingers just enough to allow slight washing of the inside of the hand. There was a very distinct foul odor

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detected as he began to gently extend the fingers from atop the thumb which was positioned across the palm of the hand extending out the far side of the hand. He washed, rinsed and dried the left hand very gently and carefully.

NA #7 was interviewed after the observation on 02/04/15 at 9:50 AM. He stated he hadn't worked with Resident #7 in a while but didn't remember any splinting devices for his hands. He stated there was a distinct odor when he washed the left hand. He reported that he would tell the nurse about the odor.

During an observation of Resident #7, on 02/04/15 at 12:50 PM, the left hand was noted to have a clean dressing in place.

During an interview with the treatment nurse on 02/04/15 at 1:00 PM, she stated NA #7 had asked her to look at Resident #7's hand. She stated the hall nurse had also reported to her that Resident #7 was experiencing pain in the left hand and asked her to assess it. The treatment nurse stated she noticed an odor when she washed the left hand today. She also reported she had placed gauze between his fingers and a gauze roll inside the hand followed by wrapping the hand with rolled gauze. She added that while she was washing the left hand, she found a stage 2 pressure ulcer to the inside of the left pinky finger where it was pressed against the fourth digit (ring finger). She commented that the hall nurses completed weekly skin checks. The treatment nurse added that Resident #7 had a history of healed pressure ulcers to the left hand. She remarked that she would speak with the physician about possibly obtaining an order for antibiotics. The treatment nurse also commented Resident

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#7 might need pain management prior to the wound care. The treatment nurse denied that she had been washing Resident #7's left hand prior to discovery of the stage 2 pressure ulcer.

A wound assessment of 02/04/15 for the left little finger of Resident #7's left hand noted a stage 2 pressure ulcer. The open wound measured 0.5 centimeters by 0.5 centimeters by 0.2 centimeters with 100% granulation tissue noted. It was noted that Resident #7 experienced pain with the treatment. It was documented in the notes section of this assessment that the hall nurse had notified her of the breakdown to resident's left hand. The treatment nurse also documented that the area was painful to touch with a scant amount of drainage. She washed Resident #7's left hand with soap and water and applied [brand name] ointment to the wound. She covered the area with a dry dressing and placed a gauze hand roll into the palm of the left hand with gauze placed between his fingers and secured the dressing with rolled gauze. She also documented that she had notified the family. The treatment nurse also documented she had paged the physician for treatment orders.

A screen from the therapy department of 02/04/15 noted that Resident #7 was screened due to left upper extremity contracture. It was noted that the resident's spasticity was severe with pain noted as a 9 on a scale of 1-10 during passive range of motion. It was noted that there had been attempts in the past to address his contracture. No services could address the tone in the left hand without surgical intervention at this time.

A physician's telephone order of 02/04/15 at

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12:00 PM noted to wash Resident #7's left hand with soap and water daily. It noted to clean the wound to the left pinky fingers with normal saline and apply [brand name] ointment with a dry dressing daily.

Another physician's telephone order of 02/04/15 noted to insert a gauze hand roll to the left hand daily until assessed by therapy. It also noted to insert gauze between the fingers on the left hand daily until assessed by therapy.

During an interview with Nurse #2 who worked on Resident #7's hall, on 02/05/15 at 9:58 AM, she stated Resident #7 had been transferred to her hall about a month ago from another hall in the facility. She stated she had worked with him previously and he had a history of skin breakdown to his left hand. Nurse #2 reported that she had gone into his room yesterday during rounds to reposition him and while turning him he complained about pain in his left hand. She stated the open area was discovered at that time.

The rehabilitation manager was interviewed on 02/05/15 at 10:05 AM. She stated Resident #7 had been evaluated. She stated Resident #7 did have a splint to his left hand at one time but he developed a wound from it and the splint was stopped until the area healed. She commented that once the area healed, the contracture had worsened to the point that splinting couldn't be done. The manager stated when he was discharged from therapy he was to have a wash cloth for protection to the left hand or a hand roll. The manager also stated that the recommendation upon discharge was for the thumb to be amputated or a tendon release to help relax the fingers but both were refused. She

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stated he should have been discharged to the restorative program for splinting of both hands. The manager reported that when Resident #7 was discharged from therapy the orders were not written properly and Resident #7 was never referred to restorative for his splinting needs.

The treatment nurse and the acting Director of Nurses (DON) were observed providing treatment to Resident #7 on 02/05/15 at 10:50 AM. The treatment nurse reported Resident #7 had been pre-medicated for pain about 20 minutes ago. She removed the old dressing and began to wash the left hand with soap and water. There was a very distinct foul odor detected as the fingers were gently separated. The DON held the hand while the treatment nurse maneuvered to wash inside the severely contracted hand. The fingers were contracted on top of each other overlapping the thumb making it difficult for her to wash them. The treatment nurse was not able to use the wash cloth to cleanse inside the palm of the hand due to the inability to extend the fingers far enough to get the wash cloth inside. The treatment nurse moistened dry gauze with water and utilized a q-tip to gently wash inside the hand. Once she had washed the hand, she dried the inside of his hand with dry gauze and a clean q-tip. There was an approximate dime size open area to the little "pinky" finger that had white raised edges and a sunken dark pink center. The treatment nurse applied the [brand name] ointment using a q-tip. She placed folded gauze between each finger and a gauze hand roll into the palm of the left hand. She wrapped the hand with rolled gauze.

The treatment administration record for Resident #7 indicated that as of 02/05/15 the left hand was

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to be washed with soap and water. The wound to the left "pinky" finger was to be cleansed with normal saline, [brand name] ointment was to be applied and there was to be a gauze hand roll placed in the left hand.

On 02/05/15 at 10:20 AM, an interview was conducted with Nurse #4 who was identified as being responsible for the restorative program. She stated Resident #7 was not currently on restorative caseload. She reported that he did have a splint in the past to the left hand but he developed a wound from the splint and it was discontinued. Nurse #4 reported that Resident #7 had been in the restorative program in the past for passive range of motion and splinting. She also reported that when a resident was in restorative any splinting needs would be included on the resident's cardex so all staff would be aware of his needs. Nurse #7 reported that when Resident #7 was discharged from therapy last September 2014 he was not referred back to restorative for splinting or contracture management services.

NA #7 reported on 02/05/15 at 11:20 AM that he had informed the treatment nurse on 02/04/15 about the odor noted in Resident #7's left hand yesterday. He stated if he found any issues with a resident's skin he would report it to the nurse.

On 02/05/25 at 11:40 AM, Nurse #4 stated that the rehabilitation manager had updated Resident #7's care plan today. She reported that she would ask therapy to evaluate the appropriateness of splinting for Resident #7.

Nurse #2 and Nurse #5 were interviewed on 02/05/15 at 2:15 PM. Nurse #2 stated skin

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checks were completed by the second shift nurses and if a new area was discovered it was assessed and the appropriate treatment started. Nurse #5 stated that the skin checks had been discontinued when the new management came and the nurse aides were given the responsibility to do the skin checks during showers. Nurse #5 stated the aide was to report any skin changes found to the nurse for evaluation.

NA #9 was interviewed on 02/05/15 at 2:25 PM. She stated she was unsure as to whether Resident #7 had splinting devices or not. She stated she had worked with him in the past and thought restorative had applied splints but she wasn't sure which hand they were placed in.

The restorative aide (RA) who had worked with Resident #7 was interviewed on 02/05/15 at 3:07 PM. She stated she had worked with him for passive range of motion to his left lower extremity but had never worked with him in regards to splinting of the upper extremity.

Nurse #6 was interviewed about the contracture risk review form on 02/05/15 at 4:00 PM. She stated she was new at the facility and it was just a form that needed to be completed when a resident was admitted or re-admitted to the facility. She wasn ' t sure what happened to it once it was completed.

Nurse #1 was interviewed on 02/05/15 at 4:10 PM. She stated that she had been in Resident #7's room and there was a definite odor detected to his left hand. She stated that the aides should have been placing a rolled up wash cloth in Resident #7's left hand on a daily basis to protect his hand.

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F 224	Continued From page 14 Resident #7's care plan was updated on 02/05/15 to include a problem with impaired physical mobility, limited range of motion and potential for worsening contractures. Interventions included therapy screens/evaluations as indicated, encourage to participate in range of motion exercises, and utilize a right palmar splint to decrease risk of further contracture. His care plan also identified a problem with having a high risk for the development of pressure ulcers (onset date of 05/12/14) and had a stage 2 pressure ulcer to the fifth digit of the left hand. There was a handwritten note that documented "updated 2/5/15". A handwritten note of 02/05/15 indicated to cleanse the site with normal saline, apply [brand name] ointment and cover with a dry dressing. It was noted in the approach section that the skin was to be observed daily with routine care and a full skin evaluation was to be done weekly with the bath and/or shower.	F 224		
F 253 SS=D	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, record review and staff interviews, the facility failed to provide housekeeping services to control urine odors in 4 of 4 resident's bathrooms (Rooms 111, 200/201, 212/213 and 214/215) where foul urine odors were detected. Findings included:	F 253	It is the intent of the facility to provide housekeeping services to control urine odors. Soiled bathroom floors in rooms 111, 214/215, 212/213 were cleaned on 2/3/15.	3/4/15

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F 253	Continued From page 15 The maintenance supervisor provided information that indicated back in October of 2014 there was painting to be done on the 300 hall. Hand written on the body of the information was Room 212 along with 3 other room numbers. There were no details as to what repairs needed to be performed in Room 212. During an observation of the resident's shared bathroom in Room 212/213, on 02/02/15 at 9:55 AM, the entire surface of the flooring was noted to be very darkened and discolored. The baseboards were resting on the floor exposing the bare walls on all 4 sides of the room. There were several irregular shaped holes noted in the walls where the baseboards had been. There was a very strong urine odor detected. The appearance of the bathroom remained unchanged when observed again at 4:15 PM on 02/02/15. On 02/02/15 at 10:00 AM, the resident's shared bathroom in Room 214/215 was noted to have a large yellowish liquid area noted on the floor near the toilet. There was a very strong urine odor detected in the room. There was no change noted in the odor or appearance of the bathroom when observed again at 4:30 PM on 02/02/15. During an observation of the shared resident's bathroom in Room 214/215 on 02/02/15 at 11:40 AM, there was an approximate 1 inch to 2 inch dark brownish area that appeared damp noted on the floor around the base of the toilet. There was a dinner plate size wet area noted on the floor in front of the toilet with a very foul urine odor detected in the room. The wall where the sink was located had a large dried area where the soap had dripped down the wall from the hand	F 253	Bathroom in room 214/215 floor tiles have been replaced; wall repaired and painted. Bathroom in room 212/213 floor tiles have been replaced, baseboard repaired; wall repaired and painted. Bathroom in room 200/201 have been thoroughly cleaned and floor tiles replaced. Bathroom in room 111 has been thoroughly cleaned. Housekeeping Staff will be in-Serviced on cleaning schedules by 3/4/15. Housekeeping Manager will continue to use/follow the deep cleaning schedule. Housekeeping Manager/Designee will monitor bathrooms daily times 2 weeks, weekly times 4 weeks then monthly Any identified problems will be taken to the Quality Improvement Committee to be discussed monthly times 2 months. Any identified problems will be corrected immediately to maintain compliance.	

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F 253	Continued From page 16 soap dispenser. Another observation was conducted in the shared bathroom in Room 212/213 on 02/03/15 at 9:15 AM. The baseboard pieces were still resting on the floors and the strong urine odor remained unchanged. The resident's shared bathroom in Rooms 200/201 was observed to be in need of cleaning on 02/02/15 at 1:35 PM. There was a very strong urine odor detected in the room. There were several smears of brown material noted on the floor near the entrance into Room 200. There were brown smears noted on the toilet porcelain. On 02/03/15 at 9:50 AM, the resident's shared bathroom in Room 214/215 remained the same as the observation of 02/02/15. The strong urine odor was still present and there was a large puddle of yellowish liquid noted on the floor in front of the toilet. On 02/03/15 at 9:55 AM, the resident's shared bathroom in Room 200/201 was noted to have a very strong urine odor with numerous smears of brown material noted on the floor. There was yellowish liquid noted on the floor in front of the toilet. The wall next to the sink had a large amount of dried soap drippings from the hand soap dispenser. On 02/03/15 at 10:05 AM, the resident's bathroom in Room 111 was noted to be in need of cleaning. There was a very strong urine odor detected and the floor tiles were discolored and stained. On 02/03/15 at 10:10 AM, the administrator	F 253		

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reported that she had placed the painting of the 300 hall on hold until she had some place to move the residents. She stated she had not toured every bathroom in the facility but she depended upon housekeeping to clean them. She reported that she had identified some housekeeping issues with the current contract service and had spoken with the manager about the overall cleanliness of the facility upon her arrival to the facility back in January 2015. She stated evidently she would need to re-address the issue. She observed the resident's shared bathroom in Room 214/215 on 02/03/15 beginning at 10:15 AM. There was a puddle of yellow liquid on the floor in front of the toilet and an incredibly foul urine odor detected. The dark brown matter was still noted on the floor around the base of the toilet. The administrator stated the bathroom needed to be cleaned and she would have it done today. She went into the bathroom in Room 200/201 at 10:15 AM and agreed additional cleaning was needed. She went into the bathroom in Room 212/213 at 10:20 AM and stated the tiles needed to be replaced and there was a foul odor in the room. The administrator then went into Room 111 at 10:25 AM which was not a shared bathroom. She stated the tiles on the floor needed to be replaced and the floor was in need of cleaning to remove the odor.

A floor technician was observed using a large blow dry machine in the bathroom in Room 214/215 on 02/03/15 at 2:30 PM. He reported he had stripped the floor and was drying it. When questioned how often resident's bathroom floors were stripped, he responded he stripped and waxed the residents bathrooms when told to do so by the account manager. He stated he would

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go in all of the bathrooms every day before leaving to make sure they were clean. He remarked that he had not been in this bathroom in about a week.

The housekeeper responsible for cleaning the 200 hall was interviewed on 02/03/15 at 2:35 PM. She stated she conducted a walk through in the mornings looking for debris on the floor, food on the floor, trash or any spills. She stated she emptied the trash and swept and mopped the resident's floors including the bathroom floors daily. The housekeeper stated the resident adjoining bathrooms in Rooms 213 and 214 always had urine odors and she had reported it to the account manager. When questioned about the cleaning performed daily, she responded she wiped the walls and mirrors as well as the doors. The housekeeper stated she wiped the aluminum strip behind the handrails and cleaned the toilets and sinks. She stated she had a scraper to remove the dark matter from the floors around the toilets and the baseboards. The housekeeper stated she swept and mopped the floors daily. The housekeeper stated the resident who occupied Room 215 had complained to her in the past about the foul urine odor in the bathroom. She commented a long time ago the manager had told her she could use a spray that would eliminate the odors but she hadn't used it. The housekeeper added that the 200 hall required heavier cleaning than the other halls in the building.

An observation was conducted in the bathroom in Room 111 on 02/03/15 at 2:50 PM. The floor had been mopped and the urine odor had resolved.

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F 253	Continued From page 19 The account manager for housekeeping services for the facility was interviewed on 02/04/15 at 11:10 AM. He stated he was aware of some of the resident's bathrooms which needed additional cleaning. The manager stated there was a schedule for stripping and waxing resident rooms/bathrooms which averaged out to be about every 6 months. He added that timeframe probably wasn't sufficient for the problem bathrooms. He stated he had turned in several work orders for the staining of the tile in several bathrooms which included the shared bathroom in Room 212/213 but the work had not been completed. He reported that the floor in Room 212/213 had been identified as needing to be replaced back in January of 2014. The manager reported he had not followed up on any of the work orders and wasn't sure who he would need to speak with to get the work approved. He was unable to provide any of these work orders for review. The manager reported that he conducted a tour of the building twice daily. When questioned what he was looking for when he toured, he responded that he looked to make sure the trash had been emptied and that the soap and paper towel dispensers had been filled. He stated he looked for cleanliness of the sinks and toilets. He stated he didn't take notice of odors but if he noticed the odors he would spray. The manager reported there were some bathrooms that required additional cleaning due to resident's habits. He stated there was a [brand name] enzymatic spray that the housekeepers could spray to help with the odors and was safe to use. The manager reported that the housekeeping staff left daily at 2:45 PM and any incidents/accidents after that usually waited til they arrived back the next morning at 7:45 AM. He commented that he felt the observations had	F 253		

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F 253	Continued From page 20 been conducted before the housekeeper had the opportunity to clean the bathroom. He agreed that better cleaning could be performed to help with the strong odors. The manager also reported that the nurse aides were supposed to clean urine and stool from the floors and call housekeeping to come sanitize afterwards. The manager remarked that the floor in Room 111 was stripped and waxed yesterday and smelled much better. He also stated he had brought in additional staff to do some additional cleaning today.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		3/4/15

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F 279	Continued From page 21 by: Based on observation, record review and staff interviews, the facility failed to develop a comprehensive care plan for the ongoing use of an indwelling urinary catheter for 1 of 1 (Resident #9) sampled residents. Findings included: Resident #9 was re-admitted to the facility on 12/26/14 with cumulative diagnoses of urinary retention, chronic kidney disease, and cerebrovascular accident (CVA). Resident #9 ' s Quarterly Minimum Data Set (MDS) dated 01/02/15 revealed Resident #9 had short and long term memory problems and was moderately impaired in daily decision making. Resident #9 had an indwelling urinary catheter. Review of the 12/26/14-12/31/14 Physician Orders revealed indwelling urinary catheter orders. Review of the Physician Orders for January 2015 revealed an order to keep Resident #9 ' s indwelling urinary catheter in place until the urology follow-up appointment on 01/27/15. Review of Resident #9 ' s Care Plan updated 01/15/15 at the most recent Care Plan meeting, showed no mention of an indwelling urinary catheter. In an observation on 02/03/15 at 11:53 AM Resident #9 was lying in bed. An indwelling urinary catheter with a covered bag was seen hanging from the bed rail. In an observation on 02/03/15 at 2:55 PM Resident #9 was lying in bed. Nursing Assistant (NA) #1 provided urinary catheter care for the resident. In an interview on 02/05/15 at 11:55 AM the MDS Coordinator indicated he went through each resident ' s chart and reviewed the MDS, physician orders, and notes prior to each Care Plan Meeting to review what areas needed to be	F 279	It is the intent of the facility to develop and maintain a comprehensive care plan on each resident with a indwelling catheter. Resident #9 was assessed by MDS nurse and the care plan updated to reflect the resident□s current status on 02/06/15. DON completed an audit on 2/28/15 on current residents with indwelling catheters to ensure care plans were reflective of the resident□s status. No other residents were affected by this alleged deficient practice. MDS nurse will complete a weekly audit X 2 weeks then, monthly X 2 months to ensure that all residents with indwelling catheters are appropriately care planned starting 2/28/2015. Any identified problems will to be The Quality Improvement Committee to be discussed times 2 months. Any identified problems will be corrected immediately to maintain compliance.	

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F 279	Continued From page 22 addressed in the care plan. He stated during the Care Plan Meeting each discipline would discuss the problems and needs of each resident and develop or update the care plan. The MDS Coordinator stated an indwelling urinary catheter care plan should have been developed for Resident #9. In an interview on 02/05/15 at 12:05 PM Nurse #4 stated care plans were checked to make sure they were still current and applicable to the resident. She indicated she visually assessed the residents and saw that Resident #9 had an indwelling urinary catheter. She stated she did not bring up the use of the catheter during the Care Plan Meeting and that a care plan should have been developed on admission and updated during the most recent Care Plan Meeting.	F 279		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide hand hygiene for 1 of 4 sampled residents (Resident #7) whose bed bath was observed. The facility failed to provide incontinent care for 1 of 1 sampled residents (Resident #10) whose personal hygiene care was observed. The facility also failed to provide finger nail care for 2 of 4 sampled residents (Resident #9 and Resident #6)	F 312	It is the intent of the facility to provide care and services to maintain grooming, personal and oral hygiene to the residents in the facility. Hand hygiene was provided for resident #7. Proper incontinence care was provided to Resident #10.	3/4/15

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F 312	Continued From page 23 and oral care for 1 of 4 sampled residents (Resident #9) whose morning care was observed. Findings included: 1. Resident #7 was admitted to the facility on 06/15/11 and was re-admitted on 01/16/15. Cumulative diagnoses included hypertension, joint contractures, cerebrovascular accident (CVA), dementia and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living including bathing. Resident #7's care plan identified several problem areas which included a problem requiring extensive to total assistance from staff for all activities of daily living. It was noted Resident #7 preferred bed baths. Resident #7 needed one person to totally assist with bathing, grooming and hygiene. This problem was last reviewed on 11/12/14. A bed bath was observed beginning at 9:20 AM on 02/04/15. NA #7 assisted by NA #2 prepared a basin of water and used numerous pumps to the hand dispenser to obtain soap. NA #7 began the bath by washing Resident #7's face, arms, chest and the right hand. He washed the outer top surface of the left hand but made no attempt to wash inside the hand. He continued bathing Resident #7. As he was finishing the bath, he was questioned as to the ability to extend the fingers on the left hand to allow washing inside the hand. NA #7 responded that it was painful for Resident #7 so he didn't bother the hand. NA #7 extended the fingers of the left hand very gently but was unable to move the thumb. As he	F 312	Oral care was provided to resident #9. Nail care was provided to residents #9 and resident #6. C.N.A.□s were in-serviced beginning on 2/6/15on the following: Nail care, Peri care/Incontinent care, Foley Catheter care, Personal Hyigene, Bed baths oral care to be completed on 3/4/15. 100% audit was completed on nail care on 2/25/15 and 2/26/15. Nails were cut, trimmed or filed as needed. Residents will be provided with personal hygiene care, oral care, incontinent care, Foley care routinely and as needed per facility policy. The DON/Administrative nurse will monitor nail care, oral care, incontinent care and contracture care for the current residents daily X 2 weeks; then, weekly X 6 weeks; then, monthly X 2 months starting 03/4/15. Any identified problems will be taken to the Quality Improvement Committee for to be discussed monthly times 2 months. Any identified problems will be corrected immediately to maintain compliance.	

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extended the fingers, a very foul odor was detected. He used the tip of the wash cloth to carefully reach inside as best he could to wash the skin. All four fingers were noted to have long fingernails which extended past the tips of the fingers. He washed, rinsed and dried the left hand very gently and carefully.

NA #7 was interviewed following the observation at 9:55 AM on 02/04/15. He stated he didn't attempt to open the hand due to causing pain for Resident #7. When questioned as to hand hygiene, he stated the treatment nurse was responsible for washing the hand on a daily basis. NA #7 confirmed that there was a definite odor detected upon washing the hand. NA #7 stated he would inform the nursing staff about the odor.

During an interview with the treatment nurse on 02/04/15 at 1:00 PM, she stated NA #7 had asked her to look at Resident #7's hand. She stated the hall nurse had also reported to her that Resident #7 was experiencing pain in the left hand and asked her to assess it. The treatment nurse stated she noticed an odor when she washed the left hand today. She also reported she had placed gauze between his fingers and a gauze roll inside the hand followed by wrapping the hand with rolled gauze. When questioned about washing Resident #7's left hand daily, she responded that she had not been washing his hand on a routine basis but now that the pressure ulcer was present she would be providing daily treatment which included hand washing.

Nurse #1 was interviewed on 02/05/15 at 4:00 PM. She stated the nurse aide was expected to wash the resident's hands even if the hand was contracted while providing the morning bath. She

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F 312	Continued From page 25 stated if for some reason the aide was unable to provide care they should report it to the hall nurse. She added that she had been in Resident #7's room and there was a definite odor detected to his left hand. The acting Director of Nurses (DON) was interviewed on 02/05/15 at 5:45 PM. She stated the nurse aides should be washing all parts of the body including the hands. She stated there was more than one way to wash a contracted hand. She stated it could be placed in warm soapy water and then dried gently. The DON stated she noticed that Resident #7's hand had a foul odor when she assisted the treatment nurse with wound care. 2. Resident #10 was admitted to the facility on 04/06/12 with cumulative diagnoses of hemiplegia, gout, and hypertension. Resident #10's Quarterly Minimum Data Set (MDS) dated 01/29/15 revealed that Resident #10 needed the extensive assistance of one person for toilet use and hygiene. Resident #10 was moderately cognitively impaired. In an observation on 02/03/15 at 12:23 PM, Resident #10 was sitting in a wheelchair in his room. The T-shirt and sweat pants Resident #10 was wearing were visibly saturated with urine from approximately the umbilicus to the bottom of the groin and from hip to hip. The wet T-shirt was removed and Resident #10 was assisted to stand using a mechanical lift. The wet sweat pants were pulled down to the ankles and the saturated brief was removed. Nursing Assistant (NA) #5 cleansed Resident #10's groin and buttocks. She made no attempt to cleanse the urine from the	F 312		

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lower abdomen, upper thighs, or hips. When questioned regarding the care she had provided, NA #5 again cleansed Resident #10's groin and buttocks with no attempt to cleanse the lower abdomen, upper thighs, or hips. A dry brief was applied and Resident #10 was lowered into the wheelchair. The wet sweat pants were removed and a dry pair of pants and a dry T-shirt were placed on Resident #10.
In an interview on 02/03/15 at 12:30 PM, NA #5 stated the last time she had checked Resident #10 was at 8:30 AM. She stated she had not checked Resident #10 because she had gotten busy. She indicated she should check all her residents every two hours to make sure they remain clean and dry.
In a follow-up interview on 02/03/15 at 2:35 PM, NA #5 indicated she was a new NA and was still getting used to the time management portion of the job. She stated when she provided care to Resident #10 she should have washed the skin anywhere it had been in contact with urine.
In an interview on 02/05/15 at 3:30 PM, Nurse #1 (Staff Development Coordinator) stated it was her expectation that if a resident was found soaking wet, all areas the urine had touched should be washed, not just the groin and buttocks.
3. Resident #9 was re-admitted to the facility on 12/26/14 with cumulative diagnoses of hemiplegia, dysphagia and hypertension.
Resident #9's Quarterly Minimum Data Set (MDS) dated 01/02/15 revealed that Resident #9 was totally dependent on one person for hygiene needs. Resident #9 had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making.
In an observation on 02/02/15 at 10:05 AM, Resident #9 was lying in bed. Dark brown matter was noted under the fingernails.

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F 312	Continued From page 27 In an observation on 02/03/15 at 11:53 AM, Nursing Assistant (NA) #1 verified she would be providing a bed bath and AM care for Resident #9. NA #1 completed the bed bath and left the room to get more supplies. NA #1 came back to the room and changed the top sheet on Resident #9's bed and tidied the room. When asked, NA #1 stated she had completed AM care for Resident #9 except for catheter care which she would perform later in the day. Fingernail and oral care were not offered or provided. In an observation on 02/03/15 at 2:55 PM, Resident #9 still had dark brown matter underneath the fingernails. Catheter care was provided and NA #1 stated she had completed Resident #9's AM care. In an interview on 02/04/15 at 2:50 PM, NA #1 stated she had not performed oral care or fingernail care for Resident #9 the previous day. NA #1 stated she should provide both nail care and oral care to the residents in her care every day. In an interview on 02/05/15 at 4:22 PM, Nurse #1 stated it was her expectation that fingernail care be provided daily with AM care. She indicated it was not acceptable that Resident #9's nails had not been cleaned and that oral care had not been provided. Nurse #1 stated that even if a resident did not have teeth to be brushed it was still necessary to provide daily oral care with AM care. 4. Resident #6 was readmitted to the facility on 10/26/07 with cumulative diagnoses of muscle weakness, chronic pain, and osteoporosis. Resident #6's Annual MDS dated 01/08/15 revealed Resident #6 was totally dependent on one person for hygiene needs. Resident #6 was moderately cognitively impaired. In an observation on 02/02/15 at 12:15 PM, Resident #6 was lying in bed. Dark brown matter	F 312		

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F 312	Continued From page 28 was noted under Resident #6's fingernails. In an observation on 02/04/15 at 11:30 AM, NA #2 verified she would be providing a bed bath and morning care for Resident #6. NA #2 completed the bed bath and offered oral care to Resident #6. After combing Resident #6's hair NA #2 stated AM care had been completed. In an interview on 02/04/15 at 12:20 PM, NA #2 stated fingernail care should be provided during AM care or sometimes in the afternoon. She indicated after looking at Resident #6's fingernails that they needed to be cleaned. After soaking Resident #6's fingernails in warm water she proceeded to clean the dark brown matter from underneath the fingernails. In an interview on 02/05/15 at 4:22 PM, Nurse #1 stated it was her expectation that fingernail care be provided daily with AM care. She indicated it was not acceptable that Resident #6's nails had not been cleaned during AM care.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess the skin	F 314	It is the intent of the facility that residents that are admitted	3/4/15

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F 314	Continued From page 29 integrity of the left hand and also failed to prevent the development of a pressure ulcer to the fifth digit (left little finger) of the contracted left hand for 1 of 3 sampled residents (Resident #7). Findings included: Resident #7 was admitted to the facility on 06/15/11 and was re-admitted on 01/16/15. Cumulative diagnoses included hypertension, joint contractures, cerebrovascular accident (CVA), pressure ulcer, dementia and diabetes mellitus. Resident #7 had a history of a healed pressure ulcer to the thumb of his left hand which healed on 10/08/14. The Quarterly Minimum Data Set (MDS) assessment of 08/06/14 noted that Resident #7 had a stage 3 pressure ulcer with slough. There were no measurements documented. The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living. He had a history of healed pressure ulcers. Resident #7's care plan identified several problem areas which included a problem with being at risk for skin breakdown due to hemi/para/quadriplegia with an onset date of 04/23/14. The goal was to remain free from skin breakdown through the next review date. Approaches included keeping the skin clean and dry as well as observing the skin daily. Any abnormalities were to be reported to the nurse. This problem was last reviewed on 11/12/14. Another area (with onset date of 05/12/14) identified a problem of being at high risk for the	F 314	without pressure ulcers not develop pressure ulcers unless their condition demonstrates it is unavoidable. A skin assessment on 2/6/15 was completed for resident #7. A treatment plan was implemented. Resident #7□s pressure wound on his left little finger healed as of 02/19/15. C.N.A. were in serviced on Nail Care Starting on 2/6/15 to be completed on 3/4/15. On 2/6/15 a 100% skin audit for all other residents was implemented and completed on 2/18/15. Resident with identified problems were treated appropriately. Skin assessments have been re-implemented weekly and completed by the 3-11 nurses following the posted Assignment Sheet. The DON/Designee will monitor the skin assessment documentation weekly X 4 weeks and then randomly. Any identified problems will be taken to the The Quality Improvement Committee to be discussed monthly for 2 months.	

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F 314	Continued From page 30 development of pressure ulcers due to having a stage 3 pressure ulcer to the left thumb. This problem was last reviewed on 11/12/14 and it was noted to continue with the plan of care. There were no treatment orders noted on the December 2014 treatment administration record for Resident #7 in regards to routine washing of the left hand. There was no January 2015 treatment administration rcord found in Resident #7's chart. The most recent Quarterly Minimum Data Set (MDS) assessment of 01/23/15 noted Resident #7 required extensive to total care with all activities of daily living. Resident #7 was observed resting in bed at 11:45 AM on 02/02/15. A very foul odor was detected in his room. A bed bath was observed beginning at 9:20 AM on 02/04/15. As NA #7 was completing the bath, he reported that he didn't attempt to open the left hand due to pain on the part of the resident. When questioned about the ability to open the left hand, he attempted to move the fingers very gently away from the palm of the hand. He was able to extend the fingers just enough to allow slight washing of the inside of the hand. There was a very distinct foul odor detected as he began to gently extend the fingers from atop the thumb which was positioned across the palm of the hand extending out the far side of the hand. He washed, rinsed and dried the left hand very gently and carefully. NA #7 was interviewed following the observation at 9:55 AM on 02/04/15. He reported that he had	F 314	Any identified problems will be corrected immediately to maintain compliance.	

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not worked with Resident #7 in a while as he floated from hall to hall. When questioned about hygiene care of the left hand, he stated the treatment nurse was responsible for washing the hand on a daily basis. NA #7 confirmed that there was a definite odor detected upon washing the hand and he would report it to the nurse.

A physician's telephone order of 02/04/15 at 12:00 PM indicated to wash the left hand with soap and water daily. It was noted to clean the wound to the left pinky finger with normal saline, apply [brand name ointment] ointment and cover with a dry dressing daily. It was also noted to insert a gauze hand roll into the left hand and insert gauze between the fingers on the left hand daily until assessed by therapy.

During an observation of Resident #7, on 02/04/15 at 12:50 PM, the left hand was noted to have a gauze wrapped around the entire surface of the hand.

During an interview with the treatment nurse on 02/04/15 at 1:00 PM, she stated NA #7 had asked her to look at Resident #7's hand. She stated the hall nurse had also reported to her that Resident #7 was experiencing pain in the left hand and asked her to assess it. The treatment nurse stated she noticed an odor when she washed the left hand today. She also reported she had placed gauze between his fingers and a gauze roll inside the hand followed by wrapping the hand with rolled gauze. She added that while she was washing the left hand, she found a stage 2 pressure ulcer to the inside of the left pinky finger where it was pressed against the fourth digit (ring finger). She commented that the hall nurses completed weekly skin checks. The treatment

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nurse added that Resident #7 had a history of healed pressure ulcers to the left hand. She remarked that she would speak with the physician about possibly obtaining an order for antibiotics. The treatment nurse also commented Resident #7 might need pain management prior to the wound care. When questioned about washing Resident #7's left hand daily, she responded that she had not been washing his hand on a routine basis but now that the pressure ulcer was present she would be providing daily treatment which included hand washing.

A wound assessment of 02/04/15 for the left little finger of Resident #7's left hand noted a stage 2 pressure ulcer. The open wound measured 0.5 centimeters by 0.5 centimeters by 0.2 centimeters with 100% granulation tissue noted. It was noted that Resident #7 experienced pain with the treatment. It was documented in the notes section of this assessment that the hall nurse had notified her of the breakdown to resident's left hand. The treatment nurse also documented that the area was painful to touch with a scant amount of drainage. She washed Resident #7's left hand with soap and water and applied [brand name] ointment to the wound. She covered the area with a dry dressing and placed a gauze hand roll into the palm of the left hand with gauze placed between his fingers and secured the dressing with rolled gauze. She also documented that she had notified the family. The treatment nurse also documented she had paged the physician for treatment orders.

During an interview with Nurse #2 who worked on Resident #7's hall, on 02/05/15 at 9:58 AM, she stated Resident #7 had been moved to her hall about a month ago from another hall. She stated

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she had worked with him previously and he had a history of skin breakdown to his left hand. Nurse #2 reported that she had gone into his room yesterday during rounds to reposition him and while turning him he complained about pain in his left hand. She stated the open area was discovered at that time.

The treatment nurse and the acting Director of Nurses (DON) were observed providing wound treatment to Resident #7 on 02/05/15 at 10:50 AM. The treatment nurse reported Resident #7 had been pre-medicated for pain about 20 minutes ago. She removed the old dressing and began to wash the left hand with soap and water. There was a very distinct foul odor detected as the fingers were gently separated. The DON held the hand while the treatment nurse maneuvered to wash inside the severely contracted hand. The fingers were contracted on top of each other overlapping the thumb making it difficult for her to wash them. The treatment nurse was not able to use the wash cloth to cleanse inside the palm of the hand due to the inability to extend the fingers far enough to get the wash cloth inside. The treatment nurse moistened dry gauze with water and utilized a q-tip to gently wash inside the hand. Once she had washed the hand, she dried the inside of his hand with dry gauze and a clean q-tip. There was an approximate dime size open area to the little "pinky" finger that had white raised edges and a sunken dark pink center. The treatment nurse applied the [brand name] ointment using a q-tip. She placed folded gauze between each finger and a gauze hand roll into the palm of the left hand. She wrapped the hand with rolled gauze.

The treatment administration record for Resident

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#7 indicated that as of 02/05/15 the left hand was to be washed with soap and water. The wound to the left "pinky" finger was to be cleansed with normal saline, [brand name] ointment was to be applied and there was to be a gauze hand roll placed in the left hand.

NA #7 reported on 02/05/15 at 11:20 AM that he had informed the treatment nurse on 02/04/15 about the odor noted in Resident #7's left hand. He stated if he found any issues with a resident's skin he would report it to the nurse. NA #7 commented that he had not worked with this resident in a while due to being a floater about the facility.

Nurse #2 and Nurse #5 were interviewed on 02/05/15 at 2:15 PM. Nurse #2 stated skin checks were completed by the second shift nurses and if a new area was discovered it was assessed and the appropriate treatment started. Nurse #5 stated that the skin checks had been discontinued when the new management came and the nurse aides were given the responsibility to do the skin checks during showers. Nurse #5 stated the aide was to report any skin changes found to the nurse for evaluation.

Nurse #1 was interviewed on 02/05/15 at 4:00 PM. She stated that nurse aides were expected to observe the resident's skin during showers and complete a skin sheet if any areas of concern were identified. Nurse #1 reported the nurse would then assess the skin concern and provide appropriate treatment. She added that she had been in Resident #7's room and there was a definite odor detected to his left hand.

During an interview with the acting Director of

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F 314	Continued From page 35 Nurses (DON), on 02/05/15 at 5:45 PM, she stated the nurse aides should be reporting any issues with a resident's skin to the nurses. She stated there was a definite foul odor detected when the left hand was washed during wound care. The DON added that the floor nurses were responsible for completing weekly skin checks. There were no skin checks found for the month of January/February 2015. Resident #7's updated care plan of 02/05/15 identified a problem with being at high risk for the development of pressure ulcers due to the development of a stage 2 pressure ulcer to the fifth digit on the left hand. A handwritten note of 02/05/15 indicated to cleanse the site with normal saline, apply triple antibiotic ointment and cover with a dry dressing. It was noted in the approach section that the skin was to be observed daily with routine care and a full skin evaluation was to be done weekly with the bath and/or shower.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		3/4/15

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F 315	Continued From page 36 by: Based on observation, record review and staff interviews, the facility failed to provide ongoing medical justification for the use of an indwelling urinary catheter following a recent hospital admission for 1 of 1 (Resident #9) sampled residents. Findings included: Resident #9 was re-admitted to the facility on 12/26/14 with cumulative diagnoses of urinary retention, chronic kidney disease, and cerebrovascular accident (CVA). Resident #9's Quarterly Minimum Data Set (MDS) dated 01/02/15 revealed Resident #9 had short and long term memory problems and was moderately impaired in daily decision making. Resident #9 had an indwelling urinary catheter. Review of the Hospital Discharge Summary for Resident #9 dated 12/26/14 revealed a recommendation for a follow-up with urology for urinary retention and to leave the urinary catheter in place until the follow-up appointment. Review of the 12/26/14-12/31/14 Medication Administration Record (MAR) revealed a hand written entry for a follow-up appointment with urology on 01/27/15 at 3:30 PM. Review of the January 2015 MAR showed a hand written entry for a follow-up appointment with urology on 01/27/15. The entry was initialed as completed. In an observation on 02/03/15 at 11:53 AM Resident #9 was lying in bed. An indwelling urinary catheter with a covered bag was seen hanging from the bed rail. In an observation on 02/03/15 at 2:55 PM Resident #9 was lying in bed. Nursing Assistant (NA) #1 provided urinary catheter care for the resident. In an interview on 02/04/15 at 3:30 PM the Appointment Scheduler indicated she was	F 315	It is the intent of the facility that residents will not use an indwelling catheter unless the resident□s condition demonstrates the catheterization is necessary. Attending Physician was notified On 2/5/15, obtained orders for In And Out Catheterization times 3 for Post void residual. Resident #9 Foley was discontinued on2/5/15. Resident #9 was seen by Eastern Urological Associates on 02/17/15 for evaluation of urinary retention. Diagnosis resolved. Care plan updated to reflect resident #9□s current status. Resident #9□s catheter was discontinued on 2/5/15. Upon admission the licensed nurse will verify the orders/diagnosis for any resident arriving with an indwelling catheter and contact the attending MD for evidence supporting urinary retention. If diagnose is not supported by Post Void Residual the Foley Catheter will be discontinued. Any identified problems will be taken to The Quality Improvement Committee to be discussed times 2 months. Any identified problems will be corrected immediately to maintain compliance.	

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F 315	Continued From page 37 provided with a copy of the Physician's Order or the Hospital Discharge Summary by the nurses. She then notified the office of the physician or specialist named in the order that a consult appointment was needed. She stated she attempted to make an appointment with the Urologist for Resident #9 but the urology staff refused to make an appointment. The Appointment Scheduler stated she informed the nurse that she was unable to obtain an appointment as ordered. She indicated she made no further attempt to make the urology appointment. In an interview on 02/05/15 at 12:05 PM Nurse #4 stated that the goal was to keep residents off urinary catheters. She indicated Resident #9 did not have a urinary catheter when she went to the hospital but had one on re-admission. In an interview on 02/05/15 at 12:36 PM Nurse #5 indicated Resident #9 did not have a urinary catheter prior to going out to the hospital on 12/23/14. She stated when Resident #9 returned to the facility on 12/26/14 she had a urinary catheter and a diagnosis of urinary retention. Nurse #5 indicated the Appointment Scheduler had informed her she was unable to make a urology appointment and Nurse #5 initialed the appointment on the MAR. Nurse #5 stated she did not notify Resident #9's physician the facility was unable to make an appointment with the urologist or place the information on the 24 hour Report. Nurse #5 indicated if it had not been brought to the attention of the facility she did not feel an appointment with the urologist would have been made and Resident #9 could have had the catheter in place for an extended amount of time. In an interview on 02/05/15 at 4:22 PM the Director of Nursing stated she expected the nurse to notify the referring physician and the facility	F 315		

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F 315	Continued From page 38 physician if a specialist consult was not done. She indicated it was her expectation that if the consulting physician had refused an appointment another specialist should have been contacted so the continued use of the indwelling urinary catheter could have been assessed.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide splinting services for contracture management to 1 of 1 sampled residents (Resident #7) who had a right hand contracture. The facility also failed to provide protective interventions/measures to 1 of 1 sampled residents (Resident #7) who had a severely contracted left hand. Findings included: Resident #7 was admitted to the facility on 06/15/11 and was re-admitted on 01/16/15. Cumulative diagnoses included hypertension, joint contractures, cerebrovascular accident (CVA), dementia and diabetes mellitus. The August 2014 physician's order sheet included orders to apply the right static hand splint daily. It was noted that a hand roll was to be placed in the	F 318	It is the intent of the facility to to provide splinting and protective intervention measures to resident with contractures. OT completed a contracture assessment on Resident #7 and began OT therapy for contracture management and supportive devices on 02/09/15. 100% contracture audit was completed by OT and PT starting 02/11/15 and completed 02/13/15. Identified contractures were evaluated and treated by OT/PT for supportive devices and contracture care starting 02/15/15 and completed	3/4/15

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F 318	Continued From page 39 left hand when the splint was not in place. It was noted to observe the skin integrity of the right hand and to monitor the left hand for redness and/or breakdown. A screen from the physical therapy department of 08/04/14 noted that Resident #7 denied pain. His contracture management had been addressed in the past. No physical therapy was indicated as there was no decline in function. a. An occupation therapy (OT) discharge summary of 09/17/14 noted that Resident #7 had been treated for contracture management. A physician's telephone order of 09/17/14 noted that OT had discharged Resident #7 as he had met the maximum rehabilitation potential. "Nursing to continue (symbol for with) restorative care for orthotic placement." The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living. It was documented that there was functional limitation in range of motion on one side of the upper extremity and on both sides of the lower extremities. Resident #7's care plan identified several problem areas which included a problem with an onset date of 08/13/14 which noted impaired physical mobility and limited range of motion with a potential for worsening contractures. Interventions included the utilization of a right static hand splint. A physical therapy (PT) screen of 10/21/14 noted	F 318	02/20/15. The facility will continue to completed a contracture assessment per policy on admission/readmission and quarterly. SDC nurse in-serviced CNAs on contracture care during ADLs starting 02/06/15 with completion date to be 03/04/15. DON/Administrative nurses will monitor care of residents with contractures 2 X weekly for 4 weeks; then, weekly X 8 week starting 03/04/15. Any identified problems will be taken to the Quality Improvement Committee to be discussed times 2 months. Any identified problems will be corrected Immediately to maintain compliance.	

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Resident #7 had no changes in his contractures and PT was not indicated.

An occupation therapy (OT) screen of 11/26/14 indicated the quarterly assessment was conducted with Resident #7. It was noted that he presented with no functional deficits or focus for skilled OT at this time.

A contracture risk review dated 01/16/15 written by Nurse #6 for Resident #7 documented that a contracture risk care plan was in place. It was noted on the review that a score of 6 or higher indicated was at risk. Resident #7 had a score of 11. It was noted that Resident #7 had joint pain and a history of cerebrovascular accident (CVA) as predisposing factor for contracture development.

Nurse #6 was interviewed about the contracture risk review form on 02/05/15 at 4:00 PM. She stated she was new at the facility and it was just a form that needed to be completed when a resident was admitted or re-admitted to the facility. She wasn t sure what happened to it once it was completed.

The most recent Quarterly Minimum Data Set (MDS) assessment of 01/23/15 noted Resident #7 required extensive to total care with all activities of daily living. The resident had functional limitation in range of motion on both sides in the upper and the lower extremities.

Resident #7 was observed resting in bed on 02/02/15 at 11:45 AM. The right hand was closed and no splinting was observed.

During the lunch meal observation on 02/02/15 at

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1:15 PM, the treatment nurse was observed feeding Resident #7. There were no splinting devices or protective devices noted in the right hand.

Another meal observation was conducted with the dinner meal on 02/02/15 at 5:58 PM. The treatment nurse was observed feeding Resident #7. There was no splinting device noted in his right hand.

Resident #7 was observed resting in bed on 02/03/15 at 9:15 AM. There was no splinting device noted in the right hand.

NA #7 was interviewed on 02/04/15 at 9:55 AM. He stated he floated and didn't have a routine assignment but he had worked with Resident #7 in the past. He stated he didn't remember any splinting for this resident other than the specialty boot.

Resident #7's care plan, last updated 02/05/15, identified a problem with impaired physical mobility, limited range of motion and the resident had a potential for worsening contractures. It was noted that he was to utilize a right palmar splint to decrease the risk of further contracture but no time frame was noted.

A physician's telephone order written by the occupation therapy department of 02/05/15 noted to refer Resident #7 to restorative for splinting of the right upper extremity splint/hand roll. It was noted to donn the splinting before breakfast and doff after lunch daily.

During an interview with Nurse #2 who worked on Resident #7's hall, on 02/05/15 at 9:58 AM, she

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stated Resident #7 was transferred from a different hall about a month ago. She stated she had worked with him previously and remembered he had a splint but thought it was discontinued due to skin breakdown. Nurse #2 commented she had not seen any splinting devices since he was moved to her hall.

The rehabilitation manager was interviewed on 02/05/15 at 10:05 AM. She stated Resident #7 had been evaluated. The manager reported that when Resident #7 was discharged from therapy back in September 2014 the orders were not written properly and Resident #7 was never referred to restorative for his splinting needs. She added that she had found the splint for his right hand in his drawer and had placed it on the right hand.

On 02/05/15 at 10:20 AM, an interview was conducted with Nurse # 4 who was identified as being responsible for the restorative program. She stated Resident #7 was not currently on restorative caseload. Nurse #4 reported that Resident #7 had been in the restorative program in the past for passive range of motion and splinting. She also reported that when a resident was in restorative any splinting needs would be included on the resident's cardex so all staff would be aware of his needs.

On 02/05/15 at 11:40 AM, Nurse #4 stated that the rehabilitation manager had updated Resident #7's care plan today. She reported that she would ask therapy to evaluate the appropriateness of splinting for Resident #7. She added that she never received a referral for restorative for Resident #7 when the order was written to discharge by the therapy department

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F 318	Continued From page 43 back in September 2014. NA #9 was interviewed on 02/05/15 at 2:25 PM. She stated she was unsure as to whether Resident #7 had splinting devices or not. She stated she had worked with him in the past and thought restorative had applied splints but she wasn't sure which hand they were placed in. b. The undated "NURSING INSTRUCTIONS" cardex for Resident #7 noted contractures of the left arm and hand. There was no mention of splinting or protective devices. The "RESTORATIVE NURSING" section was blank. The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living. It was documented that there was functional limitation in range of motion on one side of the upper extremity and on both sides of the lower extremities. Resident #7's care plan identified a problem with an onset date of 08/13/14 which noted impaired physical mobility. There was no intervention for protection of the skin to the left hand contracture. A physical therapy (PT) screen of 10/21/14 noted Resident #7 had no changes in his contractures and PT was not indicated. An occupation therapy (OT) screen of 11/26/14 indicated the quarterly assessment was conducted with Resident #7. It was noted that he presented with no functional deficits or focus for skilled OT at this time.	F 318		

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A contracture risk review dated 01/16/15 written by Nurse #6 for Resident #7 documented that a contracture risk care plan was in place. It was noted on the review that a score of 6 or higher indicated was at risk. Resident #7 had a score of 11. It was noted that Resident #7 had joint pain and a history of cerebrovascular accident (CVA) as predisposing factor for contracture development.

Nurse #6 was interviewed about the contracture risk review form on 02/05/15 at 4:00 PM. She stated she was new at the facility and it was just a form that needed to be completed when a resident was admitted or re-admitted to the facility. She wasn't sure what happened to it once it was completed.

The most recent Quarterly Minimum Data Set (MDS) assessment of 01/23/15 noted Resident #7 required extensive to total care with all activities of daily living. The resident had functional limitation in range of motion on both sides in the upper and the lower extremities.

Resident #7 was observed resting in bed on 02/02/15 at 11:45 AM. His left hand was noted to be tightly clenched in the shape of a ball with the thumb pressed underneath the fingers and protruding out the opposite side of the hand. The left arm was clenched tightly against his chest. There was no protective device noted in the left hand.

Another meal observation was conducted with the dinner meal on 02/02/15 at 5:58 PM. The treatment nurse was observed feeding Resident #7. His left hand was observed to be tightly clenched and his left arm and hand were pressed

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tightly against his chest.

Resident #7 was observed resting in bed on 02/03/15 at 9:15 AM. There was no protective device noted in the left hand.

A bed bath was observed being provided to Resident #7 on 02/04/15 at 9:20 AM. Nurse Aide #7 (NA #7) washed the resident's face, arms and chest. He washed the right hand but washed over the top of the left hand. He made no attempt to wash the inside of the left hand. As he was completing the bath, he was questioned as to the ability to extend the fingers to wash inside the closed hand. NA #7 commented that he didn't attempt to open the hand due to it being painful for the resident. He lifted the fingers very gently from where they were positioned over the thumb. The fingers were lifted just enough for him to proceed to wash the inside of the hand. NA #7 commented that he was not aware of any upper extremity splinting for this resident.

A screen from the therapy department of 02/04/15 noted that Resident #7 was screened due to left upper extremity contracture. It was noted that the resident's spasticity was severe with pain noted as a 9 on a scale of 1-10 during passive range of motion. It was noted that there had been attempts in the past to address his contracture. No services could address the tone in the left hand without surgical intervention at this time.

During an interview with the treatment nurse on 02/04/15 at 1:00 PM, she stated NA #7 had asked her to look at Resident #7's hand. She stated the hall nurse (Nurse #2) had also reported to her that Resident #7 was experiencing pain in the left

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hand and asked her to assess it. The treatment nurse stated she noticed an odor when she washed the left hand as well as a stage 2 pressure ulcer today. She also reported she had placed gauze between his fingers and a gauze roll inside the hand followed by wrapping the hand with rolled gauze. The treatment nurse remarked that she was in the process of writing a physician's telephone order to ask therapy to evaluate his splinting needs.

During an interview with Nurse #2 who worked on Resident #7's hall, on 02/05/15 at 9:58 AM, she stated Resident #7 was transferred to her hall about a month ago from a different hall. She stated she had worked with him previously and remembered he had a splint but thought it was discontinued due to skin breakdown. Nurse #2 commented she had not seen any splinting devices since he was moved to her hall. She also commented that she had gone into his room yesterday to reposition him and while turning him he complained about pain in his left hand.

The rehabilitation manager was interviewed on 02/05/15 at 10:05 AM. She stated Resident #7 had been evaluated. She stated Resident #7 did have a splint to his left hand at one time but he developed a wound from it and the splint was stopped until the area healed. She commented that once the area healed, the contracture had worsened to the point that splinting couldn't be done. The manager stated when he was discharged from therapy he was to have a wash cloth or a hand roll for protection to the left hand. The manager also stated that the recommendation upon discharge was for the thumb to be amputated or a tendon release to help relax the fingers but both were refused. She

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stated he should have been discharged to the restorative program for splinting of both hands. The manager reported that when Resident #7 was discharged from therapy the orders were not written properly and Resident #7 was never referred to restorative for his splinting needs.

Resident #7's care plan, last updated 02/05/15, identified a problem with impaired physical mobility, limited range of motion and the resident had a potential for worsening contractures. There was no intervention for protection of the skin integrity of the severely contracted left hand.

On 02/05/15 at 10:20 AM, an interview was conducted with Nurse # 4 who was identified as being responsible for the restorative program. She stated Resident #7 was not currently on restorative caseload. She reported that he did have a splint in the past to the left hand but he developed a wound from the splint and it was discontinued. Nurse #4 reported that Resident #7 had been in the restorative program in the past for passive range of motion and splinting. She also reported that when a resident was in restorative any splinting needs would be included on the resident's cardex so all staff would be aware of his needs.

On 02/05/15 at 11:40 AM, Nurse #4 stated that the rehabilitation manager had updated Resident #7's care plan today. She reported that she would ask therapy to evaluate the appropriateness of splinting for Resident #7. She added that she never received a referral for restorative for Resident #7 when the order was written to discharge by the therapy department back in September 2014.

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F 318	Continued From page 48 NA #9 was interviewed on 02/05/15 at 2:25 PM. She stated she was unsure as to whether Resident #7 had splinting devices or not. She stated she had worked with him in the past and thought restorative had applied splints but she wasn't sure which hand the splint was placed in. The restorative aide (RA) who had worked with Resident #7 in the past was interviewed on 02/05/15 at 3:07 PM. She stated she had worked with him for passive range of motion to his left lower extremity but had never worked with him in regards to splinting of the upper extremity. Nurse #1 was interviewed on 02/05/15 at 4:00 PM. She stated that she had been in Resident #7's room and there was a definite odor detected to his left hand. She stated that the aides should have been placing a rolled up wash cloth in Resident #7's left hand on a daily basis to protect the skin integrity of his hand.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide continuous supervision for 1 of 1 residents (Resident #1) who was placed on	F 323	Past noncompliance: no plan of correction required.	

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one-on-one supervision as an intervention for falls and behaviors, resulting in the resident sustaining an acute subdural hematoma. Findings included:

Resident #1 was admitted to the facility on 10/20/14, readmitted on 10/26/14, and expired in the facility on 10/30/14. The resident's documented diagnoses included end stage renal disease with hemodialysis, history of cerebrovascular disease, history of transient ischemic attacks, and difficulty walking.

An interim plan of care dated 10/20/14 identified falls as an area of concern for Resident #1. Interventions included keeping the call light in reach, encouraging use of the call light, safe footwear, instruct resident about safety precautions, therapy referral as needed, placement of a wander alarm, and fall mat to the bedside.

A 10/21/14 physician progress note documented dialysis was to be discontinued for Resident #1 due to her non-compliance with the procedure.

Nurse's notes for 10/21/14 and 10/22/14 documented Resident #1 made statements that she wanted to go home, refused to stay in bed at night, was trying to get out of bed and her chair without assistance, was disrobing, and was removing items from her roommate's dresser.

A 10/22/14 Report of Resident Fall documented Resident #1 was found lying on the floor of her room at 8:30 PM. It was documented the resident's last known location was her wheelchair, and it was discovered that the resident's wheelchair was not locked. The resident

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F 323	Continued From page 50 sustained no injuries from the fall. A 10/22/14 Report of Resident Fall documented Resident #1 was found sitting on the floor in front of her wheelchair, partially disrobed, at 11:30 PM. It was documented the resident slid out of her chair, and only had one gripper sock on when found by staff. The resident sustained no injuries from the fall. A 10/23/14 2:10 AM Nurse's Note documented Resident #1 was placed at the nurse's station where the nurse was charting because the resident kept trying to get up unassisted. On 10/23/14 the resident's care plan documented poor safety awareness put the resident at great risk for falls, with actual falls experienced on 10/22/14. Interventions to this problem included the addition of anti-roll backs, placing the wheelchair in the locked position when the resident was not in motion, and concentration on safe transfers from the wheelchair and positioning in the wheelchair during therapy sessions which were initiated on 10/20/14. A 10/24/14 Report of Resident Fall documented Resident #1 was found on the floor by her bed at 8:15 AM, and was placed on one-on-observation to prevent further falls. The resident sustained no injuries from the fall. A 10/24/14 5:31 PM nurse's note documented Resident #1 was being sent to the emergency room (ER) with abdominal distention and suspected fluid overload due to no dialysis for almost a week. A hospital discharge summary documented	F 323		

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Resident #1 was hospitalized from 10/24/14 until 10/26/14. Documented discharge diagnoses included hyperkalemia, dyspnea related to fluid overload, flash pulmonary edema, acute encephalopathy, and abdominal distention. The summary also documented the resident was placed on comfort care per family wishes.

10/26/14 nurse's notes documented Resident #1 was readmitted to the facility on comfort care, was placed on one-on-one nursing assistant (NA) supervision due to the resident's combativeness and lack of safety awareness, was placed in a geri-chair, and had a fall mat at the bedside.

A 10/29/14 Report of Resident Fall documented the resident was found on the floor at 8:30 AM after the NA providing her one-on-one supervision (NA #4) left the resident's room to obtain the resident's breakfast tray. The report also documented the one-on-one NA was instructed to let the hall NA bring the meal tray into the resident's room. Neuro-checks and vital signs were normal. The primary physician ordered close observation of the resident.

Nurse's notes documented around 10:00 AM on 10/29/14 Resident #1 experienced increase lethargy and did not respond to verbal or physical stimuli. A physician order was obtained to send the resident to the ER.

10/29/14 hospital computed tomography scans of Resident #1's head documented, "There is a large acute subdural hematoma along the left lateral convexity measuring up to 2.3 centimeters (cm) in thickness. Low attenuation within the collection could represent active bleeding. Acute parenchymal hemorrhage within the inferior left

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frontal lobe measuring up to 4.8 cm. Moderate focal mass effect. Severe left-to-right midline shift measuring 1.2 cm. Moderate left uncal herniation. Mild to moderate hydrocephalus from entrapment."

A 10/29/14 nurse's note documented Resident #1 returned to the facility at 6:40 PM. She was unresponsive with brown secretions coming from her mouth and nose, had labored breathing, and was suctioned for comfort. The physician called to remind the facility the resident was comfort care, do not resuscitate, and do not hospitalize.

A 10/30/14 nurses' note documented the resident showed no signs of life at 12:07 AM.

At 2:03 PM on 02/02/15 Nurse #1 stated Resident #1 had behaviors including resistance to care, tried to get up unassisted from the chair and the bed, and had poor safety awareness which made her at risk for falls. This nurse reported fall interventions put in place for the resident included low bed, fall mat by bed, wheelchair, geri-chair, having the family come visit and talk with the resident, moving the resident to the nurse's station or commons area for closer observation, activities (which did not work too well), and one-on-one observation.

At 4:12 PM on 02/02/15 Nurse #2 reported she was working the morning of 10/29/14, and she could not get Resident #1 to take her medications around 8:00 AM. She explained the resident was lethargic, would not respond to verbal stimuli, and would move just a little bit when touched. However, she reported this was the resident's baseline since returning from the hospital on 10/26/14. She reported passing by Resident

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#1's room around 8:30 AM on 10/29/14 and finding the resident alone in the room on the floor. According to Nurse #2, the resident was in a geri-chair earlier the same morning when she attempted to administer medications. When she looked behind her the nurse commented she saw NA #4 walking down the hall with what turned out to be Resident #1's breakfast tray. Nurse #2 stated Resident #1 was supposed to be supervised one-on-one since her most recent hospitalization. This nurse reported vital signs and neuro-checks were within normal limits for Resident #1 when she was assessed post-fall. However, by 10:00 AM that same morning the nurse stated the resident was basically totally non-responsive, and was sent to the ER.

At 1:05 PM on 02/04/15 NA #4 stated she left Resident #1's room on the morning of 10/29/14 even though she was assigned to watch the resident one-on-one. She explained she thought the resident's lips and mouth looked dry so she wanted to get her some hydration, and rather than wait for the hall NA to bring the resident's meal tray in, she obtained it herself. The NA reported that even though the meal cart was not right outside Resident #1's room, it was just down the resident's hall about mid-way. According to the NA, when she left the resident the resident was sitting in her geri-chair. When returning to the room, the NA stated she saw the resident lying on the floor in front of her geri-chair.

Record review revealed the facility designed an action plan on 10/29/14 to prevent further falls when residents were assigned one-on-one supervision. When Resident #1 returned from the ER on 10/29/14 she was placed back on one-on-one supervision, and those nurses and

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NAs assigned to her were in-serviced about the new policy concerning one-on-one supervision. This new policy required the nurse on duty to design a schedule for NAs assigned to provide one-on-one supervision, and designate a back-up staff member. The assigned direct care NA and his/her back-up completed a sign on/off log to make sure the resident received around the clock one-on-one supervision. The assigned NA and the back-up had to notify each other via use of the call bell system or hand bell system when one of them needed to take a break, eat a meal, or leave the resident room for any other reason. They were in-serviced that one could not leave the room before the other arrived in the room to provide relief.

Also beginning on 10/29/14 and running through 11/03/14 fall risk assessments were completed on all residents currently in the building. Fall risk assessments were deemed necessary upon admission, quarterly, and following falls.

In-servicing was provided to all staff members between 11/03/14 and 11/07/14 regarding the new policy for one-on-one resident supervision. Review of sign-in sheets revealed all staff members attended the on-site in-servicing or received education about the policy via phone no later than 11/07/14. Interviews with eighteen staff members who worked assorted shifts and held various positions revealed all had attended in-servicing or been informed about the facility's new one-on-one supervision policy.

Beginning the week of 11/03/14 Patient at Risk meetings began to focus more precisely on individual residents with falls, analysis of causative factors, and development of

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F 323	Continued From page 55 interventions which were documented on resident care plans and care guides. This emphasis on falls in the Patient at Risk meetings has been ongoing. Weekly fall audit tools were utilized beginning the week of 11/03/14 to randomly select residents with falls to make sure interventions were developed and carried out correctly (including one-on-one supervision) following Patient at Risk meetings. These audits were completed weekly during a three month period. Audit results and the implementation of the new one-on-one supervision policy were documented in quality assurance (QA) meetings on 12/16/14 and 01/19/15. Review of Reports of Resident Falls and resident care plans revealed no residents were placed on one-on-one supervision since 10/30/14 when Resident #1 expired. The facility's alleged compliance date of 11/07/14 for their one-on-one supervision action plan was verified by the survey team.	F 323		
F 353 SS=E	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	F 353		3/4/15

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F 353	Continued From page 56 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 duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide qualified nursing staff in sufficient numbers to assure residents were provided necessary care and services for 3 of 3 (Resident # 9, Resident # 6, and Resident # 11) sampled residents reviewed for Activities of Daily Living. Findings included: This tag is cross referenced to: 1. F312: Activities of Daily Living (ADL): Based on observation, record review and staff interviews, the facility failed to provide hand hygiene for 1 of 4 sampled residents (Resident #7) whose bed bath was observed. The facility failed to provide incontinent care for 1 of 1 sampled residents (Resident #10) whose personal hygiene care was observed. The facility also failed to provide finger nail care for 2 of 4 sampled residents (Resident #9 and Resident #6) and oral care for 1 of 4 sampled residents (Resident #9) whose morning care was observed. Findings included: In an interview on 02/05/15 at 2:30 PM the Director of Nursing (DON) stated she thought some of the staffing problems occurred after	F 353	It is the intent of the facility to provide nursing staff in sufficient numbers to assure residents receive necessary care and services. Based on the resident acuity, the C.N.A. assignments were re-arranged on 2/6/15 and will be adjusted daily as needed to meet the needs of the residents. Nursing staff will be recruited as needed. The DON/Administrative nurse will monitor residents medical acuity and ADL direct care needs daily by reviewing the resident 24 hour report starting 03/04/15. Any identified problems will be taken to the Quality Improvement Committee	

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F 353	Continued From page 57 residents were moved off a hall which was being refurbished. She explained most of these residents were relocated to a hall already populated with residents requiring total care from the staff. The DON commented it was possible staffing needed to be readjusted after these room changes. In an interview on 02/05/15 at 3:48 PM the Administrator stated she and the DON had questioned the equality of NA assignments based on the level of care required by the residents in the assignments, but had not had a chance to address this problem yet. 2. F364: Palatable Food: Based on observation, staff interview, and record review the facility failed to preserve food palatability for 1 of 2 residents (Resident #11) observed at a lunch meal who were dependent on staff for eating. The facility allowed food to remain in the meal cart for an hour without heating the food before feeding it to Resident #11. At 1:18 PM on 02/02/15 NA #3 stated she did the best she could with passing out meal trays on her assigned hall by herself. She reported being short of staff on the hall made things stressful, and she did not use her best judgement when she attempted to feed Resident #11 cold food. She commented another NA assigned to the hall went home to change clothes, and another staff member (the transporter/scheduler) was late getting to the hall to provide help feeding residents. At 12:12 PM on 02/05/15 the transporter/scheduler stated on 02/02/15 she was requested to help assist residents in the main	F 353	to be discussed for 2 months. Any identified problems will be corrected Immediately to maintain compliance.	

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dining room at lunch because the facility was short the four staff members required to supervise residents eating there during meals. She commented she was delayed getting to the hall on which NA #3 was assigned where she was supposed to help feed residents eating in their rooms.

At 12:04 PM on 02/05/14 NA #10, who was also assigned to the same hall as NA #3, stated she worked on one of two halls in the building where most of the residents lived who required at least extensive assistance with their activities of daily living (ADLs). She reported she started work at 7:00 AM, and breakfast trays for her hall arrived around 7:40 AM. According to NA #10, eight residents on her hall had to be fed by the staff at the breakfast meal. The NA commented this workload caused some of her residents to have to wait until after lunch to receive their baths. She stated unfortunately this also meant she was not always able to provide oral care care and nail care with every bath.

At 2:30 PM on 02/05/15 the director of nursing (DON) stated she thought some of the staffing problems occurred after residents were moved off a hall which was being refurbished. She explained most of these residents were relocated to a hall already populated with residents requiring total care from the staff. The DON commented it was possible staffing needed to be readjusted after these room changes.

At 3:48 PM PM on 02/05/15 the administrator stated she and her DON had questioned the equality of NA assignments based on the level of care required by the residents in the assignments, but had not had a chance to

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F 353	Continued From page 59 address this problem yet.	F 353		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to preserve food palatability for 1 of 2 residents (Resident #11) observed at a lunch meal who were dependent on staff for eating. The facility allowed food to remain in the meal cart for an hour without heating the food before feeding it to Resident #11. Findings included: Resident #11 was admitted to the facility on 07/23/12. Her documented diagnoses included dementia, aphasia, heart failure, and hypertension. The resident's most recent minimum data set (MDS), a 11/19/14 quarterly MDS assessment, documented she had impaired short and long term memory, her decision making skills were moderately impaired, she was dependent on a staff member for eating, she received a mechanically altered diet, and she was 52 inches tall and weighed 79 pounds. On 02/02/15 the lunch meal cart arrived on Resident #11's hall at 12:09 PM. It was 12:22 PM	F 364	It is the intent of the facility to provide palatable foods by serving at the right temperatures. Dietary re-scheduled the delivery times to ensure nursing personnel can provide timely delivery. Resident # 11□s meal tray delivery and assistance with meal has been completed timely since 02/06/15. A new assist restorative dining program was implemented by nursing on 2/13/15. Upon admission the licensed nurse will assess the meal assist needs of the resident and communicate this to the CNAs verbally and on the CNA care cards. The DON/Administrative nurse will audit meal delivery daily times 2 weeks; then, weekly times	3/4/15

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F 364	Continued From page 60 before nursing assistant (NA) #3 began passing trays on the hall. She was the only NA passing meal trays on Resident #11's hall. The door to the cart was left open periodically as the NA was going in and out of the cart and taking trays to resident rooms. At 12:44 PM on 02/02/15 NA #3 stated another NA working on the hall had to rush home to change clothes. She also reported she thought another staff member (the transporter/scheduler) was supposed to be helping pass trays and feed residents on her hall, but this staff member had not shown up yet. NA #3 commented she had provided all residents on the hall who were able to feed themselves with trays. According to the NA, there were two trays left in the cart for residents that needed to be fed by staff. At 12:46 PM on 02/02/15 NA #3 began passing out trays on an adjoining hall. At 12:50 PM on 02/02/15 the transporter/scheduler retrieved 1 of 2 meal trays left for Resident #11's hall, and began feeding a resident. At 12:58 PM on 02/02/15 Resident #11's meal tray was the only tray left in the hall's cart. NA #3 stated she thought the transporter/scheduler had finished feeding all residents on the original hall where she was passing trays. At 1:09 PM on 02/02/15 NA #3 took Resident #11's tray out of the cart, and carried it into the resident's room. She reported she had to feed the resident. At 1:12 PM on 02/02/15 NA #3 fed Resident #11 a	F 364	2 weeks; then, monthly X 1 month starting 03/04/15. Any identified problems will be taken to the Quality Improvement Committee to be discussed for 2 months. Any identified problems will be corrected Immediately to maintain compliance.	

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F 364	Continued From page 61 bite of mechanical soft beef stew. At 1:13 PM on 02/02/15, after surveyor intervention, the dietary manager (DM) used a calibrated thermometer to check the temperature of the beef stew. The thermometer only registered 60 degrees Fahrenheit. The bottom of the plate was barely warm, and the beef stew was congealed. At this time the DM stated it was not acceptable to feed a resident food which sat in a meal cart for longer than fifteen minutes without warming it up. She reported the temperature upon feeding and appearance of the food did not meet facility expectations. According to the DM, the last time she was informed of problems with cold food was a couple of months ago on another hall. She commented she thought the cold food issue had been resolved. At 1:18 PM on 02/02/15 NA #3 stated she should have told the nurse or a supervisor that the facility was short of staff on her hall when resident meal trays appeared, and she should have reheated Resident #11's food or called to get another tray which was hot from the kitchen before feeding the resident. She explained she thought the transporter/scheduler was going to feed the residents dependent on staff for eating so she moved to the other hall on which she was expected to pass trays. At 12:12 PM on 02/05/15 the transporter/scheduler stated on 02/02/15 she was requested to help assist residents in the main dining room at lunch before she went to help feed residents on the halls.	F 364		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		3/4/15

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F 367	Continued From page 62 Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide fortified foods as part of a therapeutic diet ordered as a weight loss intervention for 3 of 7 sampled residents (Resident #3, #6, and #7) who were reviewed for weight loss. Findings included: 1. Resident #3 was admitted to the facility on 12/02/11 and readmitted on 09/09/13. Her documented diagnoses included cerebrovascular accident, hypertension, and dysphagia. A 04/07/14 physician order placed Resident #3 on Remeron 7.5 milligrams (mg) nightly for appetite stimulation. On 04/27/14 "I am at risk for alteration in nutrition r/t (in regard to dementia, depression, and chronic kidney disease" was identified as a problem on Resident #3's care plan. Interventions included consulting the registered dietitian (RD) as needed, provide diet as ordered, and provide provide supplements as ordered. Resident #3's weight record documented she weighed 120 pounds on 05/07/14. A 05/16/14 physician order placed Resident #3 on fortified foods at all meals. Resident #3's weight record documented she weighed 110 pounds on 07/18/14.	F 367	It is the intent of the facility to provide the residents with fortified foods as part of a therapeutic diet. Dietary Manager did 100% audit of residents on Fortified Foods on 2/24/15. Dietary cards were revised with correct Fortified foods to ensure cards can be easily read by the dietary personnel. Resident #3, #6, and #7 has received fortified foods X 3 meals daily as ordered since 02/6/15 Upon admission the Dietary Manager will assess resident for dietary needs and preference. On Dietary Manager will complete the new resident□s diet card and review resident□s orders, needs and preferences, including fortified foods, with dietary personnel. Dietary Manager in-serviced the dietary personnel on: using the new diet cards and providing fortified foods on trays on 2/12/15 and 2/27/15. Dietary manager/designee will monitor	

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F 367	Continued From page 63 A 07/28/14 physician order provided Resident #3 with one can of liquid nutrition supplement between meals three times daily (TID). A 08/08/14 RD progress note documented the resident experienced significant weight loss over the last 90 days. A 09/26/14 RD progress note documented nursing staff informed the RD that Resident #3 was not eating well. A 09/26/14 physician order provided the resident with two nutrition shakes at each meal. Resident #3's weight record documented she weighed 116.7 pounds on 09/29/14. The resident's 12/08/14 quarterly minimum data set (MDS) documented her short and long term memory were impaired, she was moderately impaired in decision making, she had not experienced any recent significant weight loss, she required limited assistance by a staff member with eating, and she weighed 114 pounds. Resident #3's weight record documented she weighed 108 pounds on 01/19/15. A 01/20/15 physician order clarified Resident #3 was to continue to receive fortified foods at every meal. At 12:38 PM on 02/02/15 Resident #3 was eating lunch in her room. There were no fortified foods on her meal tray (see interview with dietary manager).	F 367	tray line for residents with fortified foods daily times 2 weeks , then weekly X 4 weeks; then, monthly X 1 month to ensure residents receive fortified foods as ordered started 3/4/15. Any identified problems will be taken to the Quality Improvement Committee for review for 2 months. Any identified problems will be corrected Immediately to maintain compliance.	

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F 367	Continued From page 64 At 6:12 PM on 02/02/15 Resident #3 was eating supper in her room. There were no fortified foods on her meal tray (see interview with dietary manager). At 9:18 AM on 02/03/15 the dietary manager (DM) stated the fortified food provided at the 02/03/14 breakfast meal was oatmeal, and the fortified foods provided at the 02/02/15 lunch and supper meals were pudding or mashed potatoes (neither of which Resident #3 received at lunch or supper on 02/02/15). She reported there was a dietary employee on each tray line who was supposed to make sure the tray slips matched the foods/supplements going out to residents on the meal trays. The DM also commented that she and her assistant randomly checked the tray slips against the food/supplements leaving the kitchen. At 10:28 AM on 02/04/15, during a follow-up interview with the DM, she stated she thought part of the problem with the facility not providing fortified foods as ordered was the current tray slip system. She explained when residents had a lot of supplements/nutrition interventions ordered they were spread out in three possible locations on the tray slips including the diet order section, special requests section, and tray aides section. According to the DM, she thought the cluttered tray cards made it difficult for dietary staff to distinguish between key interventions and supplements ordered for weight loss and food likes identified by residents and family members. At 10:40 AM on 02/04/15, during a telephone conversation, RD #1 stated she agreed that the clutter on the tray slips may have contributed to residents not receiving fortified foods on their	F 367		

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F 367	Continued From page 65 meal trays. She stated it was important to discontinue ineffective weight loss interventions before replacing them with interventions which would hopefully prove to be more effective. 2. Resident #7 was admitted to the facility on 06/15/11 and was re-admitted on 01/16/15. Cumulative diagnoses included hypertension, joint contractures, cerebrovascular accident (CVA), dementia and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment of 10/30/14 indicated Resident #7 had severely impaired cognition. He required extensive to total assistance for all activities of daily living including eating. His weight was documented as 181 pounds with no weight loss noted. Resident #7's care plan identified several problem areas which included: . Resident #7 had a problem with being at risk for nutrition less than or greater than body requirements. Handwritten notes indicated Resident #7 received a regular puree diet with fortified foods, sugar free shakes, double portions and 1.7 Kcal supplement four times daily. Approaches included the following to provide diet as ordered. This problem was last updated on 10/31/14. Resident #7 weighed 184 pounds on 12/06/14. The January 2015 physician's order sheet for Resident #7 included a mechanical soft diet with	F 367		

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thin liquids, fortified meals and double portions with each tray. He was also to receive a sugar free shake with each tray.

A dietary note of 01/06/15 from the registered dietician (RD) noted Resident #7 had a gradual weight loss over the past 180 days. His current body weight was noted as 176.9 pounds. He was receiving a regular mechanical soft diet with sugar free shakes, double portions and fortified foods with every tray. He was also receiving 240 ml (milliliters) of a 1.7 kcal product as a supplement four times daily. Resident #7 was also receiving a multivitamin.

A diet order slip of 01/16/15 for Resident #7 noted the resident was to receive double portions, fortified foods and a sugar free shake with every tray.

A physician's telephone order of 01/16/15 indicated Resident #7 was to receive a mechanical soft diet and a sugar free shake with fortified foods and double portions.

A nutrition screening/assessment of 01/20/15 indicated Resident #7 had gained weight. His current body weight was 181.2 pounds. He was receiving a mechanical soft diet with fortified foods, double portions with shakes. He was also receiving 240 ml of a supplement (1.7 kcal) four times daily. It was noted that Resident #7 was taking 75% of the meals and 100% of the supplements. It was also noted that the estimated caloric need was 2060 calories with 82 grams of protein and 2060 ml of fluid daily. His total intake which included the supplements provided a total of 4032 calories, 175 grams of protein and 2160 ml of fluids.

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The most recent Quarterly Minimum Data Set (MDS) assessment of 01/23/15 noted Resident #7 required extensive to total care with all activities of daily living including eating. His weight was documented as 181 pounds with no weight loss noted.

During a lunch meal observation on 02/02/15 at 1:15 PM, Nurse Aide #6 (NA #6) was observed feeding Resident #7. His meal tray consisted of beef stew, cooked carrots, apple cake, bread and a sugar free shake. It was noted on the tray slip that Resident #7 was to receive double portions, fortified foods and sugar free shakes. NA #6 stated he had received a double portion of the beef stew.

Another meal observation was conducted with the dinner meal on 02/02/15 at 5:58 PM. The treatment nurse was observed feeding Resident #7. His meal tray consisted of 2 fish sandwiches on hamburger buns, vegetable barley soup, one and a half hash brown patties, raspberry peaches, a sugar free shake and two 8 ounce glasses of liquids.

During an interview with the dietary manager (DM), on 02/03/15 at 9:18 AM, the DM stated pudding and mashed potatoes were the fortified foods provided at the 02/02/15 lunch and dinner meals. Resident #7 received neither of these food items on his tray for lunch or dinner on 02/02/15. She reported there was a dietary employee on each tray line who was supposed to make sure the tray slips matched the foods/supplements going out to residents on the meal trays. The DM also commented that she and her assistant randomly checked the tray slips

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F 367	Continued From page 68 against the food/supplements leaving the kitchen. A follow-up interview was conducted with the DM on 02/04/15 at 10:28 AM. She stated she thought the current tray slip system was part of the problem with the facility not providing fortified foods as ordered. She explained when residents had a lot of supplements/nutrition interventions ordered they were spread out in three possible locations on the tray slips including the diet order section, special requests section, and "tray aids" section. According to the DM, she thought the cluttered tray cards made it difficult for dietary staff to distinguish between key interventions and supplements ordered for weight loss and food likes identified by residents and family members. The tray slip for Resident #7 was reviewed on 02/04/15 at 10:30 AM. It was noted that "FORTIFIED FOODS, DOUBLE PORTIONS, SHAKE PLUS w/EVERY TRAY" was listed in the "Tray Aids" section. It was also noted that "SF SHAKE" also appeared in the "Special Request" section of the tray slip. During a telephone interview with the registered dietician (RD), on 02/04/15 at 10:40 AM, it was stated that the clutter on the tray slips may have contributed to residents not receiving fortified foods on their meal trays as ordered. 3. Resident #6 was re-admitted to the facility on 10/26/07 with cumulative diagnoses of diabetes mellitus, malnutrition, and chronic pain. Resident #6's Annual Minimum Data Set (MDS) dated 01/08/15 revealed that Resident #6 had no swallowing disorders and had a weight of 147	F 367		

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pounds.
Review of the weight/wound note dated 01/02/15 revealed Resident #6 weighed 139 pounds and had a gradual weight loss over the past 30 days. Resident #6's weight record revealed a weight of 144.4 pounds on 01/09/15, 147 pounds on 01/12/15, and 146 pounds on 01/19/15.
Review of the Care Plan updated 01/22/15 revealed Resident #6 was "at risk for nutrition less than body requirements related to therapeutic diet. Diet: Regular Concentrated Sweets (RCS) fortified foods."
Review of the Physician's Telephone Order dated 01/02/15 revealed an order for a Regular Concentrated Sweets diet with fortified foods on every tray and ice cream with lunch and dinner for Resident #6.
In an observation on 02/02/15 at 1:10 PM Resident #6 was sitting up in bed eating lunch. The lunch tray consisted of beef stew, green salad with dressing, a bread stick and a slice of apple cake. The tray also contained ice cream, milk, cranberry juice and water. Resident #6's Lunch Meal Card showed Fortified Foods listed after Tray Aids.
In an observation on 02/02/15 at 6:05 PM Resident #6 was sitting up in bed eating dinner. The dinner tray consisted of a fish patty on a bun, a hash brown patty, fruit, and a broth based vegetable soup. The tray also contained ice cream, milk, and 2 glasses of cranberry juice. Resident #6's Dinner Meal Card showed Fortified Foods listed after Tray Aids.
In an observation on 02/03/15 at 8:25 AM Resident #6 was sitting up in bed eating breakfast. The breakfast tray consisted of 2 slices of bread, bacon, grits, and a banana. The tray also contained milk, cranberry juice and hot chocolate. Resident #6's Breakfast Meal Card

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F 367	Continued From page 70 showed Fortified Foods listed after Tray Aids. In an interview on 02/03/15 at 9:18 AM the Dietary Manager (DM) stated the fortified food provided at the 02/03/14 breakfast meal was oatmeal, and the fortified foods provided at the 02/02/15 lunch and supper meals were pudding or mashed potatoes. She reported there was a dietary employee on each tray line who was supposed to make sure the tray slips matched the foods/supplements going out to residents on the meal trays. The DM also commented that she and her assistant randomly checked the tray slips against the food/supplements leaving the kitchen. In a follow-up interview on 02/04/15 at 10:28 AM the DM, stated she thought part of the problem with the facility not providing fortified foods as ordered was the current tray slip system. She explained when residents had a lot of supplements/nutrition interventions ordered they were spread out in three possible locations on the tray slips including the diet order section, special requests section, and tray aides section. According to the DM, she thought the cluttered tray cards made it difficult for dietary staff to distinguish between key interventions and supplements ordered for weight loss and food likes identified by residents and family members. In a telephone interview on 02/04/15 at 10:40 AM Registered Dietician (RD) #1 stated she agreed that the clutter on the tray slips may have contributed to residents not receiving fortified foods on their meal trays.	F 367		