STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to honor food preferences for 2 of 4 sampled residents reviewed for choices (Resident # 81 and #129). The findings included: 1. Resident #81 was admitted on 03/24/14 with diagnoses including chronic respiratory failure and diabetes mellitus. Review of the annual Minimum Data Set (MDS) dated 03/13/15 revealed Resident #81 had moderately impaired cognition and was able to make his needs known. Review of the medical record revealed a "Diet History/Food Preference List" dated 03/17/15 revealed Resident #81 listed food dislikes as carrots and lima beans. An interview with Resident #81 on 06/01/15 at 11:08 AM revealed he disliked lima beans but was served them in the dining room anyway.	F 242	F242 SS=D Alleged deficient practice in Self -Determination- Right to make choices. 1.On 06/04/2015 The Dietary Manager conducted an interview with Resident #129 regarding food preferences. Resident #129 stated she could eat cooked carrots in some things. Also, Stated she would like to be served Soups, Stews, and Chicken Pot Pies that include carrots. Her preferences were update to reflect that she did not want cooked carrots. The Dietary Manager created food groups in the computer so that Resident #129 would be able to get things like soups stews and chicken pot pie. On 06/04/2015 The DM conducted an Interview with Resident # 81 regarding food preferences. Resident #81 stated he disliked Lima beans, and carrots.. The Dietary manager ensured residents preferences reflected his dislikes.	7/2/15

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

Electronically Signed | 06/26/2015

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F 242	Continued From page 1 Observations in the dining room on 06/02/15 at 12:22 PM revealed Resident #81 eating lunch which included a serving of mixed vegetables that contained carrots and peas. When asked if he was enjoying his lunch Resident #81 stated the lasagna was good but he did not like carrots or peas. An interview was conducted with the Dietary Manager (DM) on 06/04/15 at 10:35 AM. The DM explained food preferences and dislikes were entered into the computer. The DM accessed Resident #81's list of food dislikes in the computer system and noted the list included: sweet potatoes, lima beans, carrots, and oatmeal. The interview further revealed the computer system pulled the disliked food item from the menu but would not pull other foods that contained the disliked food item. The DM further explained mixed vegetables would have to be entered into the computer as a food dislike for Resident #81 and then he would not be served mixed vegetables. 2. Resident #129 was admitted to the facility on 01/30/15 with diagnoses including cerebral vascular accident, hemiplegia, and dysphagia. The physician ordered a mechanical soft diet with no corn or rice on her meal tray. Per dietary notes dated 01/31/15, Resident #129 disliked spinach, greens, cooked cabbage, carrots and oatmeal. The admission Minimum Data Set (MDS) dated 02/11/15 coded Resident #129 as having intact cognition, no behaviors, eating independently with set up, having no mouth or denture problems and needing a mechanically altered diet.	F 242	2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Dietary Manager audited on 6/8/2015 the current resident population to identify that food preferences are documented and updated to reflect accuracy in the food service computer system. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Social Services Director and Dietary Manager conducted in-service/ re-education for Dietary and Nursing Staff regarding the residents' right to make choices consistent with their interests, specifically, honoring choices related to food preferences on 6/24/2015. The Administrator will review concerns during morning stand up meeting to identify opportunities related to providing for resident choices and ensure timely follow-up. The Dietary Manager or Registered Dietician will obtain food likes/dislikes/ preferences during the admission assessment and document the information in the medical record and dietary tray card system. The Admissions Coordinator completes a Comprehensive Preference Worksheet Upon admission that includes plan of care, well being, and food preferences. The facility's Ambassadors (team members who visit with the resident routinely to identify	

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F 242	Continued From page 2 The quarterly MDS dated 04/24/15 coded her as having intact cognition, having no behaviors, requiring supervision during meals and receiving a mechanically altered diet. A nutritional care plan, originally developed 02/10/15 was updated on 04/17/15 to address an acute illness, poor intake and weight loss. One of the interventions included to offer preferred foods and determine individual likes and dislikes. On 06/02/15 at 12:30 PM, Resident #129 was served her meal in her room while sitting in a wheelchair. Her meal included a bowl of mixed vegetables which included squares of carrots. She left the mixed vegetables untouched on her tray. On 06/02/15 at 3:29 PM, Resident #129 was interviewed. She stated that she has told different staff that she does not like cooked vegetables, especially cooked carrots or cabbage, preferring her vegetables to be eaten raw. On 06/04/15 at 9:42 AM, the Dietary Manager (DM) and surveyor, together, reviewed the dietary note dated 01/30/15 which indicated carrots was a disliked. DM stated Resident #129 was on a mechanical soft diet and therefore could not get raw vegetables. When asked why she received mixed vegetables which contained cooked carrots, a documented dislike, DM explained it was a result of the computer system that prints out the tray cards in the kitchen. DM further explained the dislikes, including carrots, was correctly entered into the computer system for Resident #129. The computer would	F 242	concerns/ needs). Will interview 6 random residents weekly for 4 weeks and then 6 random residents every other week for 2 months to include questions regarding preferences such as food choices. The Administrator will review the minutes from Resident Council monthly to identify concerns related to food preferences and provide a timely response to ensure continued compliance. 4.The Administrator and Dietary Manager will review data obtained during food preference audits, concerns, and Ambassador Rounds; analyze the data and report patterns/ trends to the QAPI committee every month for three months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 242	Continued From page 3 automatically print out the alternative vegetable if carrots was the main vegetable of the day. However, if carrots were included in a recipe, such as mixed vegetables, pot pie, etc, the computer would not know that a dislike was being served. The printed tray cards did not contain a list of dislikes for staff to be able to easily check for dislikes mixed in with other foods. The computer just printed on the tray card what items to be provided on the meal tray. DM stated Resident #129 was able to as for alternative foods. On 06/04/15 at 10:01 AM Resident #129 stated she received cooked carrots frequently. DM further stated on 06/04/15 at 11:50 AM that she had to change the computer tracking system to clarify what items contained carrots. On 06/04/15 at 12:10 PM, DM stated that she had spoken to Resident #129 who stated she could eat cooked carrots in some things such as soups and stews. DM stated she had been able to create food groups in the computer so that Resident #129 would get things like vegetable soup but not mixed vegetables with carrot pieces.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep personal care equipment	F 253	F253 SS=E Alleged deficient practice	7/2/15

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F 253	Continued From page 4 stored to prevent contamination, maintain walls in good condition, keep bathrooms in good and clean condition and maintain furnishings in good condition on 4 of 4 halls. The findings included: 1. Personal care equipment was not labeled and stored to prevent contamination as follows: a. Room 205 shared by 2 residents was observed with 2 gray wash basins stacked together on the floor behind the toilet on 06/02/15 at 9:03 AM and 3:57 PM, on 06/03/15 at 11:30 AM, and on 06/04/15 at 9:27 AM. b. Room 401 shared by 3 residents was observed with a unlabeled, uncovered graduated cylinder on the back of the toilet and a unlabeled toothbrush on the back of the toilet on 06/01/15 at 3:21 PM and on 06/02/15 at 9:00 AM. c. Room 503 shared by 2 residents was observed with an unlabeled, uncovered gray wash basin under the sink on the floor on 06/01/15 at 10:17 AM, on 06/02/15 at 8:50 AM and at 9:22 AM. d. Room 506 shared by 2 residents was observed with 2 stacked uncovered, unlabeled gray wash basins with metal shelf supports and screws inside on the floor and an unlabeled, uncovered urine hat on the floor on 06/01/15 at 10:32 AM, on 06/02/15 at 9:06 AM, on 06/03/15 at 9:18 AM and at 4:00 PM. e. Room 510 shared by 2 residents was observed with 2 gray unlabeled uncovered wash basins on the floor behind the commode, one uncovered unlabeled wash basin was on the back of the	F 253	in Housekeeping & Maintenance Services 1 .A. On 06/04/2015 Room 205 The wash basins were disposed of and replaced with new basins labeled, bagged, and stored off of the floor. B. On 06/03/2015 Room 401 Graduated cylinder and toothbrush was disposed of. Replaced with new toothbrush, labeled and in toothbrush holder. Replaced cylinder, labeled, bagged and stored off of floor. C. On 06/03/2015 Room 503 Disposed of wash basin. Replaced with new wash basin, labeled, bagged, and stored off of the floor. D. On 06/03/2015 Room 506 Wash basins, metal shelf supports, screws, and urine hat were disposed of. New wash basins were placed in room. Labeled, bagged, and stored off of the floor. E. On 06/03/2015 Room 510 Wash basins, Hair brush, and toothbrush were disposed of. New wash basins placed. Labeled, bagged, And stored off of the floor. New toothbrush	

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F 253	Continued From page 5 commode on the floor and a unlabeled toothbrush and hair brush was on the sink at 06/01/15 at 11:02 AM and on 06/02/15 at 8:59 AM. f. Room 305 shared by 2 residents was observed with 2 uncovered unlabeled wash basins on the floor under the sink on 06/02/15 at 3:52 PM and on 06/03/15 at 11:32 AM. On 06/03/15 at 1:30 PM housekeeper #2 stated during interview that when she cleans rooms, if she sees personal care equipment on the floor and not covered, she will throw it away. On 06/03/15 at 1:36 PM med aide #1 stated personal care equipment items should bed labeled and keep in resident closets or dressers. On 06/03/15 at 1:38 PM NA #4 was interviewed and stated that personal care equipment should be placed in plastic and stored in drawers or closets and not in the floor. Toothbrushes should be stored in a container and stored in resident drawers in dressers or closets. Hair brushes should be in resident drawers. On 06/03/15 at 3:56 PM NA #2 stated during interview that personal care equipment should be labeled and bagged and stored in resident closet areas. On 06/04/15 at 9:28 AM Nurse Aide (NA) #3 stated the wash basins should be labeled and stored in plastic bags and placed in the closet, not on the floor. On 06/04/15 at 11:17 AM the Director of Nursing (DON) stated personal care equipment in	F 253	Was provided, with label and toothbrush holder. New hair brush provided and labeled. F. On 06/03/2015 Room 305 Wash Basins Were disposed of. New wash basins provided. Labeled, bagged, and stored off of the floor. Walls to be repaired A .Room 304¿s bathroom was stripped, Re-plastered, sanded, and painted. Repairs completedOn 06/25/15. (Cont.) F253 SS=E 1.(Cont.) B. Room 310 area painted. Repair Completed 06/04/15. C. Room 505 scheduled to be Stripped, re-plastered, sanded, and painted. Repair completion date 6/26/15. Commodes Repair/ Cleaning A. Room 401 on 06/04/15 was cleaned By the housekeeping director. The maintenance Director applied caulking to the base of the toilet On 06/04/2015. B. Room 310 on 06/04/15 was cleaned by Housekeeping. Repairs were then	

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F 253	Continued From page 6 resident rooms need to be clean, tabled and stored in a bag and not on the floor. 2. Walls in need of repair included: a. Room 304's bathroom shared by 2 residents was observed with the wall covered with rough plaster and unpainted over a 2 feet by 1 foot section between the commode and mirror and mirror and wall. This was observed on 06/22/15 at 3:55 PM, on 06/03/15 at 11:33 AM, and on 06/04/15 at 10:43 AM. On 06/04/15 at 10:43 AM with the maintenance director who stated about 4 weeks ago the pipes in the wall needed to be replaced and subsequently patched. He stated he just has not gotten back to finish the dry wall work and painting. b. Room 310 shared by 2 residents was observed with a patched unpainted 8 inch square around the call bell box on the wall on 06/02/15 at 3:49 PM and on 06/03/15 at 11:34 AM. c. Room 505 shared by 2 residents was observed with the painted wall paper peeling at each seam across the wall in at least 6 places on 06/02/15 at 3:16 PM, on 06/03/15 at 8:50 AM, and on 06/04/15 at 10:50 AM. On 06/04/15 at 10:50 AM, interview with the maintenance director stated some rooms on this hall have had the painted wall paper removed and this room had not been completed. 3. Commodes in need of cleaning and repair: a. Room 401's toilet, shared by 3 residents, had	F 253	completed By the maintenance director, including new caulking applied to the base of the commode. C. Room 406 on 06/04/15 The maintenance director completed repairs to the base of the commode. Including, new caulking applied. Furnishings A. Room 510 on 06/04/15 The maintenance Director disposed of the over bed table. A New Over bed table was placed at the bedside. B. Room 505 on 06/04/15 The Maintenance Director disposed of the over bed table. A New over bed table was placed at the bedside. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, Maintenance Director, and Housekeeping Director have completed an audit of all patient rooms to be completed by 7/2/2015. (any areas noted or of concern will be corrected Immediately). Audit included personal care equipment stored to prevent	

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F 253	Continued From page 7 no caulking at the base and was surrounded by discolored brown residue when observed on 06/02/15 at 3:43 PM, at 06/03/15 at 11:36 AM and on 06/04/15 at 10:05 AM. On 06/04/15 at 10:05 AM an interview with the housekeeping supervisor stated it needed to be cleaned with an abrasive. b. Room 310 shared by 2 residents was observed with the base of the commode with very discolored caulking around the base. on 06/02/15 at 3:49 PM, on 06/03/15 at 11:34 AM, and on 06/04/15 at 10:08 AM. On 06/04/15 at 10:08 AM the housekeeping supervisor stated the base of the commode should look cleaner and he could try a stronger solution. On 06/04/15 at 10:09 AM interview with housekeeper #1 revealed she did not think the sprays and wipes she had would get the base of the commode clean as it was probably build up residue. c. Room 406 shared by 3 residents was observed with cracked discolored caulking around the commode base on 06/02/15 at 3:46 PM, on 06/03/15 at 11:37 AM, and on 06/04/15 at 10:06 AM. On 06/04/15 at 10:06 AM interview with the housekeeping supervisor revealed the housekeepers should report if the caulking could not be cleaned with cleaners. 4. Furnishings in disrepair:	F 253	contamination. Checking walls to ensure proper condition. Inspect furnishings, resident rooms and bathrooms to ensure in good repair and proper sanitation. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing, Maintenance Director, and Housekeeping Director conducted an in-service/ re-education for All Staff on 6/25/2015 Regarding Storage and labeling of personal care equipment to prevent contamination. Observation of furnishings, walls, cleanliness of rooms and bathrooms, and appropriate process for reporting needed repairs. The facility's Ambassadors (team members who visit with residents routinely to identify concerns/ needs) will observe and inspect 10 residents room weekly for 4 weeks and then 10 random rooms every other week for 2 months to include observation of walls, personal care equipment stored to prevent contamination, cleanliness of bathrooms/ rooms, and observation of condition of furnishings. 4.The Administrator, Maintenance Director, Director of Nursing, and Housekeeping Director will review data obtained during facility audits	

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F 253	Continued From page 8 a. Room 510 was observed with an over bed table with peeling laminate all around the edges, exposing the wood on 06/02/15 at 3:37 PM, on 06/03/15 at 8:47 AM and on 06/03/15 at 4:02 PM. b. Room 505 was observed with an over bed table with peeling laminate all around the edges, exposing the wood on 06/02/15 at 3:16 PM, on 06/03/15 at 8:50 AM, and on 06/04/15 at 10:50 AM. On 06/03/15 at 4:02 PM, NA #2 stated that she would not know who to report the overbed table to if it needed repair. On 06/04/15 at 10:50 AM the maintenance director stated that the sometimes staff take the overbed tables which were removed from resident use to use for their work and they end up back in resident rooms. He further stated he had replaced 10 last week.	F 253	and rounds; analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272		7/2/15

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F 272	Continued From page 9 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors for 12 of 19 sampled residents reviewed for the most recent comprehensive Minimum Data Set (Residents #9, #17, #30, #46, #52, #68, #80, #81, #90, #95, #111, #129). The findings included: 1. Resident #9 was admitted on 02/01/14 with diagnoses including dementia, congestive heart	F 272	F272 SS=E Alleged deficient practice in Comprehensive Assessments 1.Corrective action has been accomplished for the alleged deficient practice with regard to Residents #9, #17, #30, #46, #68, #80, #81, #90, #95, #111, and #129 by reassessing the Care Area Assessments	

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F 272	Continued From page 10 failure, and osteoarthritis. Review of the most recent comprehensive Minimum Data Set (MDS) dated 01/28/15 revealed Resident #9 had severely impaired cognition and required extensive assistance with transfer. The MDS dated 01/28/15 stated Resident #9 required limited assistance with walking in her room. Further review of the MDS dated 01/28/15 revealed Resident #9 had two falls since the previous assessment. Review of Resident #9's Care Area Assessment (CAA) Summary for Falls dated 02/19/15 revealed it triggered due to physical performance limitations including balance, gait, strength, and muscle endurance. Supporting documentation referenced care tracker entries, the January Medication Administration Record, pain interview, progress/nursing notes, and diagnosis record but gave no details as to the pertinence of this information. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Falls CAA Summary. During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #9's CAA Summary for Falls for the comprehensive MDS completed on 01/28/15. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.	F 272	(CAAs) and making addendum documentation to support the findings. Action could not be taken for Resident #52 due to resident discharged. 2.Residents who have comprehensive assessments completed have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director and MDS Coordinator have reviewed the last 30 days of comprehensive assessments and CAAs to ensure that triggered areas have information present that describes the residents strengths, weaknesses, and functionality. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The District Director of Care Management has conducted in-service/ re-education for the Resident Care Management Director, MDS Coordinator, and Social Services Director regarding CAA completion expectations as described in the RAI manual on 6/24/2015. The Resident Care Management Director will audit at 5 comprehensive assessments and CAAs per month for 6 months to ensure that information addresses the analysis of the resident's strengths, weaknesses, and how these areas affect the resident's	

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F 272	Continued From page 11 2. Resident #68 was admitted to the facility on 10/15/14 with diagnoses including Parkinson's disease. Review of the most recent comprehensive Minimum Data Set (MDS) dated 01/29/15 revealed Resident #68 had severely impaired cognition and required extensive assistance with transfers. The MDS dated 01/29/15 noted she had walked in her room assisted by one person once or twice during the assessment period. Further review of the MDS dated 01/29/15 revealed Resident #68 had 3 falls since the previous assessment. Review of Resident #68's Care Area Assessment (CAA) Summary for Falls dated 02/25/15 revealed supporting documentation which referenced the January Medication Administration Record, nursing notes, hospice, and diagnosis record but gave no details as to the pertinence of this information. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Falls CAA Summary. During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #68's CAA Summary for Falls for the comprehensive MDS completed on 01/29/15. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.	F 272	functionality to ensure continued compliance. 4.The Resident Care Management Director will review data obtained during comprehensive assessment audits, analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified trends/ outcomes to ensure continued compliance.	

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3. Resident #81 was admitted to the facility on 03/24/14 with diagnoses including chronic respiratory failure, diabetes mellitus and seizure disorder. Review of the most recent comprehensive Minimum Data Set (MDS) dated 03/13/15 revealed Resident #81 had moderately impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS dated 03/13/15 also noted Resident #81 was totally dependent on staff for bathing.

Review of Resident #81's Care Area Assessment (CAA) Summary for ADL (Activities of Daily Living) Functional dated 03/24/15 revealed supporting documentation which referenced care tracker entries, the March Medication Administration Record, progress/ nursing notes, and diagnosis record but gave no details as to the pertinence of this information. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Falls CAA Summary.

During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #81's CAA Summary for Falls for the comprehensive MDS dated 03/13/15. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and

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explain things in more depth.
4. Resident #129 was admitted on 01/30/15 with diagnoses including cerebral vascular accident, dysphagia, acute respiratory failure, and hemiplegia.

Review of the admission Minimum Data Set dated 02/06/15 coded her with intact cognition, requiring set up only with eating, having no mouth or denture problems, weighing 223 pounds and receiving a mechanically altered diet.

Review of the Care Area Assessment (CAA) for nutritional status dated 02/10/15 revealed the resident had a recent cerebral vascular accident with left hemiparesis, was able to feed herself, listed her height and weight. Then referred to the flow record and speech therapy notes. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Nutritional Status CAA summary.

During an interview on 06/04/15 at 3:33 PM, the MDS Nurse confirmed she had completed the CAA summary for nutrition for Resident #129. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.

5. Resident #95 was admitted to the facility on 08/16/14 with diagnoses including muscle

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weakness, urinary tract infection, post traumatic stress disorder, and dysphagia.

The admission Minimum Data Set (MDS) dated 05/23/14, coded him with intact cognition, feeling down, feeling tired, moving so slowly someone might notice, having verbal and other behaviors 1 to 3 days in the assessment period, requiring extensive assistance with most activities of daily living skills (ADLS), receiving antidepressants, antianxiety and antipsychotic medications over the last 7 days.

The Care Area Assessments dated 09/08/14 had no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the triggered areas as follows:
*Cognitive Loss/Dementia CAA stated the resident had a diagnosis of post traumatic stress disorder, depression, anxiety, and he was able make needs known and understand others.
*ADL CAA stated he had a fall at home, resulting in a hip fracture, was at risk for further falls, incontinence, pressure ulcers due to needing extensive assistance with bed mobility, transfers, and toileting. It also noted he had a history of a cerebral vascular accident with left hemiplegia and was nonambulatory.
*Psychosocial Wellbeing CAA had no summary and just referred to undated nursing and social notes.
*Psychotropic drug use CAA stated he had diagnoses of anxiety, depression and post traumatic stress disorder and referred to nonspecific notes and the August MAR.

During an interview on 06/04/15 at 3:33 PM, the MDS Nurse confirmed she had completed the

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CAA summary for nutrition for Resident #129. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.

6. Resident #17 was admitted to the facility on 02/18/15 with diagnoses including altered mental status, congestive heart failure, acute frontal lobe infarct, gastrointestinal bleed, diabetes, and bilateral below the knee amputation.

The admission Minimum Data Set dated 02/18/15 coded her with intact cognition, requiring extensive assistance with most areas of activities of daily living skills (ADLs), being frequently incontinent and having no pressure ulcers.

The Care Area Assessments (CAA) dated 03/09/15 had no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the triggered areas as follows:
*ADL CAA stated she had a recent hospitalization for acute frontal lobe infarct, a recent gastrointestinal bleed, listed additional diagnoses, being a bilateral amputee, having incontinence requiring extensive assistance with ADLs, and participating in therapy with plans to return home with family.
*Incontinence CAA stated that she was frequently incontinent of bladder, was continent of bowel at this time and directed the reader to see the ADL

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CAA.
*Pressure ulcer CAA stated she had no skin breakdown was was at risk due to needing extensive assistance with ADLS, incontinence and having diagnoses of peripheral vascular disease, diabetes, and bilateral amputation.

During an interview on 06/04/15 at 3:33 PM, the MDS Nurse confirmed she had completed the CAA summary for nutrition for Resident #129. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.

7. Resident #46 was admitted to the facility on 01/20/15 with diagnoses including dementia, diabetes, and chronic kidney disease.

The admission Minimum Data Set dated 01/30/15 coded her with intact cognition (scoring a 9 out of 15 on the brief interview for mental status), requiring extensive assistance for bed mobility, dressing, toileting and being unsteady but able to stabilize herself.

The Care Area Assessment related to Activities of Daily Living Skills (ADLs) dated 02/16/15 stated she required limited to extensive assistance with ADLs, ambulated using a rollator walker, had incontinent episodes and previously lived with family until she needed more assit with ADLs. There was no description of the problem, causes

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and contributing factors, or related risk factors included in the analysis of findings for the Nutritional Status CAA summary.

During an interview on 06/04/15 at 3:33 PM, the MDS Nurse confirmed she had completed the CAA summary for nutrition for Resident #129. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.

8. Resident #30 was admitted to the facility on 07/10/12. Diagnoses included dementia with behavioral disturbance and Alzheimer's disease. Resident #30's annual Minimum Data Set (MDS) dated 04/10/15 indicated Resident #30 had both short and long-term memory problems and severely impaired cognitive skills for daily decision making. The annual MDS revealed Resident #30 received antipsychotic and antidepressant medications daily during the 7 day look back period. Care Area Assessments (CAA) triggered from the annual MDS included: Psychotropic Drug Use.

Review of the CAA Summary for Psychotropic Drug Use dated 04/10/15 indicated Resident #30 triggered due to the use of anti-psychotic and anti-depressant medications. There was no description of the problem, causes, contributing factors, related risk factors or any other information in the analysis of findings for the CAA Summary.

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During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #30's CAA Summary for Psychotropic Drug Use for the annual MDS completed on 04/10/15. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.

9. Resident #52 was admitted to the facility on 08/17/12. Diagnoses included Parkinson's disease, anxiety, depressive disorder and dementia with psychosis. Resident #52's quarterly Minimum Data Set (MDS) dated 04/12/15 indicated Resident #52 had both short and long-term memory problems and moderately impaired cognitive skills for daily decision making. The quarterly MDS revealed Resident #52 received antianxiety, antipsychotic and antidepressant medications daily during the 7 day look back period. Care Area Assessments (CAA) triggered from the annual MDS included: Psychotropic Drug Use.

Review of the CAA Summary for Psychotropic Drug Use dated 04/14/15 indicated Resident #52 triggered due to the use of anti-anxiety, anti-psychotic and anti-depressant medications. There was no description of the problem, causes, contributing factors, related risk factors or any other information in the analysis of findings for the CAA Summary.

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During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #52's CAA Summary for Psychotropic Drug Use for the quarterly MDS completed on 04/12/15. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. The MDS nurse further stated she did not usually go into much detail when completing the analysis of findings for CAA Summaries. The interview further revealed the Corporate MDS Nurse reviewed CAA Summaries last month and had instructed the MDS Nurse to analyze more and explain things in more depth.
10. Resident #90 was admitted to the facility on 06/22/12 with diagnoses of heart failure and cerebral vascular accident. The annual Minimum Data Set (MDS) dated 004/24/15 revealed Resident #90 had 2 falls since the last assessment and received antipsychotic, anti-depression and antianxiety medications during the 7 day look back period. Care Area Assessments (CAA) triggered from the annual MDS included falls and psychotropic drug use.

Review of the CAA summary for falls dated 05/21/15 stated Resident #90 triggered for falls due to a history of falls and a continued risk for falls due to intermittent confusion. The summary further stated Resident #90 ambulated with a rolling walker, wore oxygen via nasal cannula,had incontinent episodes and refused to have a pad alarm on her bed. The CAA summary for psychotropic drug use stated Resident #90 triggered due to physician order for depression, antianxiety and antipsychotic medications. The summary further stated no behaviors were noted during the assessment period. There was no

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description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for any of these CAA Summaries.

During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #90's CAA summary for falls and psychotropic drug use. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA Summaries. She further stated the Corporate MDS Nurse reviewed her CAA summaries recently and informed her they needed to be more in-depth and comprehensive.

11. Resident #111 was admitted to the facility on 05/05/14 with diagnoses of difficulty walking and non-Alzheimer's dementia. The annual Minimum Data Set (MDS) dated 04/16/15 revealed Resident #111 had 1 fall since the last assessment and had problems with coughing and choking during meals when swallowing. Care Area Assessments (CAA) triggered from the annual MDS included falls and nutritional status.

Review of the CAA summary for falls dated 05/20/15 stated Resident #111 triggered for falls due to being at risk for falls due to impaired cognition, incontinence and needing extensive assistance with activities of daily living. The CAA summary for nutritional status stated Resident #111 triggered due to being on a mechanical soft diet with honey thickened liquids. Resident #111 was able to feed self. There was no description of the problem, causes and contributing factors,

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or related risk factors included in the analysis of findings for any of these CAA Summaries.

During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #111's CAA summary for falls and nutritional status. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA summaries. She further stated the Corporate MDS Nurse reviewed her CAA summaries recently and informed her they needed to be more in-depth and comprehensive.

12. Resident #80 was admitted to the facility on 04/23/14 with diagnoses of renal failure and dysphagia. The annual Minimum Data Set (MDS) dated 04/10/15 revealed Resident #80 received a mechanically altered diet and went to hemodialysis three times a week. Care Area Assessments (CAA) triggered from the annual MDS included nutritional status.

Review of the CAA summary for nutritional status dated 04/27/15 stated Resident #80 triggered for nutritional status due to being on a mechanical soft diet with nectar thickened liquids, having a history of dysphagia (trouble swallowing), and being recommended to be on a pureed diet but she and family were noncompliant. The resident and family were educated concerning her swallowing problems. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for any of these CAA Summaries.

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F 272	Continued From page 22 During an interview on 06/04/15 at 3:30 PM the MDS Nurse confirmed she had completed Resident #80's CAA summary for nutritional status. The MDS Nurse stated she received training in MDS 3.0 a few years ago but didn't recall an in-depth session on writing CAA summaries. She further stated the Corporate MDS Nurse reviewed her CAA summaries recently and informed her they needed to be more in-depth and comprehensive.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		7/2/15

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F 278	Continued From page 23 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (comprehensive assessments) for 2 of 19 residents whose assessments were reviewed. (Residents #95 and #129). The findings included: 1. Resident #95 was admitted to the facility on 08/16/14 with diagnoses including muscle weakness, a fractured hip, and post traumatic stress disorder (PTSD). The admission Minimum Data Set (MDS) dated 05/23/14 coded Resident #95 with intact cognition, feeling down and tired, moving or speaking so slowly it could be noticed, having verbal and other behaviors 1 to 3 times in the assessment period, requiring extensive assistance with most activities of daily living skills and receiving antipsychotic medication, antianxiety medication and antidepressant medication. On the identification section of the MDS, staff marked "NO" in the section asking if the resident was evaluated by Level II Preadmission Screening and Resident Review (PASRR) and determined to have a serious mental illness, mental retardation or related condition. On 06/03/15 at 12:01 PM, the Social Worker and	F 278	F278 SS=D Alleged deficient practice in Assessment Accuracy/ Coordination/ Certified. 1.Corrective action has been accomplished for the alleged deficient practice with regard to resident #95, and #129. The assessments will be modified/ corrected by 07/02/15. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director and MDS Coordinator have reviewed all assessments completed in the last 30days to ensure coding accuracy as well as proper coding for all diagnosis to include Level II PASSAR. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The District Director of Care Management has conducted in-service/ re-education for the Resident Care Management Director, MDS Coordinator, and Social Services Director on 6/24/2015 regarding	

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F 278	Continued From page 24 surveyor reviewed the FL 2 (form identifying the level of care a person requires) dated 08/14/14. The FL 2 contained a PASRR number ending in "F" which indicated he was assessed a Level 2 PASRR and required nursing care but was only approved on a time limited basis. Administration provided a web site print out form the NC Uniform Screening Tool dated 06/03/15 showing resident history information. This form noted that Resident #95 was approved on 08/13/14 as a PASRR level II for mental illness approved for 60 days. On 06/04/15 at 4:24 PM, MDS nurse and the Administrator were interviewed. They stated Resident #95 was admitted to the facility with a PASRR number ending in "F" (indicating a nursing home stay was only valid for 30, 60 or 90 days). MDS nurse stated that she knew he did not have a diagnosis of mental retardation which would indicate PASRR Level II, but was not sure of a mental illness. She did not consider PTSD a mental illness and therefore did not mark the correct section on the MDS. The Social Worker stated during interview on 06/04/15 at 4:32 PM, that she was under the impression that an evaluation was not completed on Resident #95 to indicate if he was a PASRR Level I or II and that determination would be made when his time limitation was ready to be reviewed again. 2. Resident #129 was admitted to the facility on 01/30/15 with diagnoses including cerebral vascular accident, hemiplegia, acute respiratory failure and dysphagia.	F 278	MDS Accuracy and proper coding for all Diagnosis to include what constitutes level II PASSAR as described in the RAI manual. The Resident Care Management Director will audit 10 assessments per month for 3 months to ensure accurate coding of ADL¿s and to include proper coding of all diagnosis. 4.The Resident Care Management Director will review data obtained during assessment audits, analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 278	Continued From page 25 The admission Minimum Data Set (MDS) dated 02/11/15 coded Resident #129 as having intact cognition, no behaviors, requiring extensive assistance of 2 persons for bed mobility, toileting, and hygiene. She required total assistance of 2 persons for transfers, was nonambulatory and required human assistance to balance. This MDS coded her at being independent with dressing with set up. The quarterly MDS dated 04/24/15 coded Resident #129 as requiring extensive assistance of 2 persons for dressing. Resident #129 was observed on 06/01/15 at 10:55 AM sitting in a high back wheelchair, with a left foot pedal under her left foot which had a splint in place, her left arm rested on a pillow and she had a palm guard in her left hand. On 06/04/15 at 4:22 PM, MDS nurse stated she had miscoded the dressing and showed the survey the activity of daily living sheets which documented Resident #129 needed extensive assistance of 2 persons for dressing during the assessment period ending 02/11/15. She further stated that the facility has a system in place to check a sampling of MDS's to ensure MDS accuracy, but not every MDS was checked for accuracy.	F 278		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		7/2/15

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F 311	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide restorative services as ordered to improve or maintain the residen s functional status for 3 of 3 resident's reviewed for restorative services (Resident #90, #111 and #58). The findings included: 1. Resident #90 was admitted to the facility on 06/22/12 with diagnoses of heart failure, cerebral vascular accident, peripheral vascular disease, chronic obstructive pulmonary disease and non-Alzheimer's dementia. The annual Minimum Data Set (MDS) dated 04/24/15 revealed Resident #90 was cognitively intact and required limited assistance with bed mobility, dressing and personal hygiene. Review of the Physical Therapy (PT) assessment summary dated 04/14/15 revealed Resident #90 was evaluated for PT services due to a recent fall. The summary stated Resident #90 did not need skilled PT services but was referred to the restorative nursing program for lower extremity exercises and gait to maintain her current level of function. Review of the Rehab to Restorative Transition Record revealed Resident #90 was referred by PT to the restorative nursing program on 04/14/15. The goals for Resident #90 were for her to tolerate lower extremity exercises seated and standing for 15 minutes at a time and ambulate 350 to 500 feet 6 times per week for 16 weeks. Review of the Rehabilitation/Restorative Service	F 311	F311 SS=D Alleged deficient practice in Treatment/ Services To Improve / Maintain ADL's 1.Resident #90 showed no sign of functional decline on 6/4/2015. Resident ambulates with rollator walker ad lib. Resident #111 showed no sign of functional decline on 6/4/2015. Resident #58 showed no sign of functional decline on 6/4/2015. 2. All residents in the Restorative Nursing Program have the potential to be affected by the same deficient practice; therefore, The Director of Nursing in-serviced/ re-educated all nursing staff on the process for using PRN staff for call outs and med aides to assist in performing modalities and documentation for restorative nursing on 6/11/2015. The Director of Nursing and Assistant Director of Nursing Will complete a 100% Audit of all residents receiving Restorative Nursing for the past 30days. Audit to ensure Restorative Nursing provided per plan of care. If audit reveals Restorative was not provided per plan of care will refer resident to	

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F 311	Continued From page 27 Delivery Records revealed Resident #90 received restorative services 3 times during the week of 04/01/15 , 4 times the week of 04/05/15, 3 times the week of 04/12/15, 4 times the week of 04/27/15, 5 times the week of 05/04/15, 4 times the week of 05/11/15, 3 times the week of 05/18/15 and 3 times the week of 05/25/15. An interview was conducted with the Restorative Nurse on 06/03/15 at 2:39 PM. She stated restorative were not being provided as ordered due to restorative staff being pulled to work as medication aides or nurse aides on the floors. She further stated administration was in the process of hiring staff on an as needed basis to help with the restorative nursing program. Interview conducted with Restorative Aides #1 and #2 on 06/03/15 at 3:09 PM revealed there were 4 restorative aides scheduled to cover restorative services 7 days a week 12 hours a day. They stated if they were pulled to the floor to work a nurse aide or medication aide assignment, they tried to provide the restorative services for the resident's residing on their assigned hall but may not be able to complete the restorative workload. They stated they had made the Restorative Nurse, Assistant Director of Nursing and the Director of Nursing (DON) aware that restorative services were not always being provided as scheduled. During an interview conducted with the Corporate Director of Clinical Training and the Administrator on 06/04/15 at 1:30 PM they revealed problems with the Restorative Program were identified and a quality assurance plan was developed which included the hiring of new staff and cross training existing Medication Aides to complete restorative	F 311	therapy to screen for any possibly decline or to change any part of their restorative nursing program. Audit will be completed by 7/2/2015. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing hired additional PRN Staff to utilize for direct care coverage. All Nursing Staff will be trained in modules of Restorative care, including documentation by 07/02/15. The DON, ADON, and Unit Manager will audit to ensure proper documentation , and residents receive restorative nursing per plan of care. Will audit 6 residents receiving restorative nursing weekly for 4 weeks and then 6 residents every other week for 2 months. 4.The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/ trends to the QAPI committee every month for three months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based	

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F 311	Continued From page 28 programs. A follow up interview was conducted with the Corporate Director of Clinical Services on 06/04/15 at 1:53 PM. She stated medication aides were trained to provide restorative services to be completed prior to or following medication pass. An interview conducted on 06/04/15 at 3:34 PM with the Restorative Nurse revealed when restorative services were provided by medication aides, that service was not captured in the restorative services documentation. An interview with Medication Aide #1 on 06/04/15 at 4:26 PM revealed when has completed restorative services, he has asked the restorative nurse, restorative aide, DON or therapy manager what tasks needed to be performed. An interview with Medication Aide #3 on 06/04/15 at 4:27 PM revealed if the restorative aides were pulled to the floor to work she was responsible for providing restorative services. She stated she did not follow the restorative plan of care for the residents but provided range of motion (ROM), and walked them to the bathroom. An interview with Medication Aide #4 on 06/04/15 at 4:31 PM revealed she provided restorative services to residents if the restorative aide was pulled to the floor to work. She stated she did not follow the restorative plan of care for the resident but would help them dress, do ROM exercises and walk them to the bathroom. 2. Resident #111 was admitted to the facility on 05/05/14 with diagnoses of difficulty in walking and non-Alzheimer's dementia. The annual	F 311	on identified trends/ outcomes to ensure continued compliance.	

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Minimum Data Set (MDS) dated 04/16/15 revealed Resident #111 had severely impaired cognitive skills and required extensive assistance for bed mobility, transfers, dressing, toileting and personal hygiene.

Review of the Physical Therapy (PT) discharge summary, dated 02/24/15 revealed Resident #111 was discharged from PT to the restorative nursing program. Per the PT discharge summary Resident #111 was to receive lower extremity exercises, ambulation using a rolling walker and transfers with standing balance activities to maintain his current level of performance and in order to prevent decline.

Review of the Rehab to Restorative Transition Record revealed Resident #111 was referred by PT to the restorative program on 02/24/15. The goals of the interventions were to tolerate active range of motion of both lower extremities for 15 minutes consistently for 6 to 7 days a week for 90 days, tolerate transfer activities for 15 minutes consistently for 6 to 7 days a week for 90 days and ambulate for a goal of 100 to 130 feet 6 to 7 days a week for 90 days.

Review of the Rehabilitation/Restorative Service Delivery Records for April and May 2015 revealed Resident #111 only received restorative services 4 times the week of 04/05/15, 4 times the week of 04/12/15, 3 times the week of 04/19/15, 1 time the week of 04/26/15, 5 times the week of 05/03/15, 4 times the week of 05/10/15, 2 times the week of 05/17/15 and 2 times the week of 05/24/15.

An interview was conducted with the Restorative Nurse on 06/03/15 at 2:39 PM. She stated

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restorative were not being provided as ordered due to restorative staff being pulled to work as medication aides or nurse aides on the floors. She further stated administration was in the process of hiring staff on an as needed basis to help with the restorative nursing program.

Interview conducted with Restorative Aides #1 and #2 on 06/03/15 at 3:09 PM revealed there were 4 restorative aides scheduled to cover restorative services 7 days a week 12 hours a day. They stated if they were pulled to the floor to work a nurse aide or medication aide assignment, they tried to provide the restorative services for the resident ' s residing on their assigned hall but may not be able to complete the restorative workload. They stated they had made the Restorative Nurse, Assistant Director of Nursing and the Director of Nursing (DON) aware that restorative services were not always being provided as scheduled.

During an interview conducted with the Corporate Director of Clinical Training and the Administrator on 06/04/15 at 1:30 PM they revealed problems with the Restorative Program were identified and a quality assurance plan was developed which included the hiring of new staff and cross training existing Medication Aides to complete restorative programs.

A follow up interview was conducted with the Corporate Director of Clinical Services on 06/04/15 at 1:53 PM. She stated medication aides were trained to provide restorative services to be completed prior to or following medication pass.

An interview conducted on 06/04/15 at 3:34 PM

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with the Restorative Nurse revealed when restorative services were provided by medication aides, that service was not captured in the restorative services documentation.

An interview with Medication Aide #1 on 06/04/15 at 4:26 PM revealed when has completed restorative services, he has asked the restorative nurse, restorative aide, DON or therapy manager what tasks needed to be performed.

An interview with Medication Aide #3 on 06/04/15 at 4:27 PM revealed if the restorative aides were pulled to the floor to work she was responsible for providing restorative services. She stated she did not follow the restorative plan of care for the residents but provided range of motion (ROM), and walked them to the bathroom.

An interview with Medication Aide #4 on 06/04/15 at 4:31 PM revealed she provided restorative services to residents if the restorative aide was pulled to the floor to work. She stated she did not follow the restorative plan of care for the resident but would help them dress, do ROM exercises and walk them to the bathroom.

3. Resident #58 was originally admitted to the facility on 03/07/14 and readmitted to the facility on 02/07/15 following a hospitalization. His diagnoses included dysuria, dementia, diabetes, cerebral vascular accident, unsteady gait and muscle weakness.

The annual Minimum Data Set dated 02/21/15 coded Resident #58 with severely impaired cognitive skills, requiring extensive assistance of

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F 311	Continued From page 32 2 staff for bed mobility and transfers, being non-ambulatory, having unsteadiness during transfers requiring human assistance to stabilize himself and receiving occupational and physical therapies. Review of the Physical Therapy (PT) discharge summary, dated 03/21/15, revealed Resident #58 was discharged from PT on 03/20/15 having met his maximum potential. Per the discharge summary, Resident #58 was discharged to the restorative nursing program to facilitate the resident maintaining his current level of performance and to prevent decline. The discharge summary stated that the development and instruction for active range of motion and transfers was developed and completed. Review of the Rehab to Restorative Transition Record revealed Resident #58 was referred by PT to the restorative program on 03/20/15. The goals of the intervention were for strengthening his lower extremities and transfers. Activities to be performed with the resident included: *therapeutic exercises of assisted active range of motion to the lower left extremity and active range of motion to the right lower extremity with resistance; and *transfer training at side rail, sit to stand if possible or at least partial stand. These were to be performed 6 times per week for 12 weeks. Review of the Rehabilitation/Restorative Service Delivery Records revealed Resident #58 received no restorative services after 04/20/15 until	F 311		

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05/01/15. Interview with the Restorative Nurse on 06/03/15 at 1:47 PM revealed therapy sets up a restorative referral. Further interview on 06/03/15 at 2:39 PM revealed the restorative nurse made an error when services ended 04/20/15. She subsequently caught her error and re-established the restorative program for Resident #58 on 05/01/15.

Review of the May 2015 Rehabilitation/Restorative Service Delivery Record revealed Resident #58 only received restorative services 5 times per week during the weeks of 05/11/15 and 05/18/15.

On 06/02/15 at 3:14 PM Resident #58 was observed being transferred from the wheelchair to bed via 2 staff and a sit to stand lift. He required 2 staff as he complained of leg pain remained in a squatted position during the transfer.

Interview with the restorative nurse on 06/03/15 at 2:39 PM revealed that services were not provided as scheduled 6 times per week due to restorative staff being pulled to work on the floors. She further stated administration was in the process of hiring as staff on an as needed basis to help with restorative services.

Interview with Restorative Aides #1 and #2 on 06/03/15 at 3:09 PM revealed there were 4 restorative aides scheduled to cover restorative services 7 days per week. They stated that if they were pulled to the floor to work a nurse aide

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assignment, they tried to provide the restorative services for the resident's residing on their assigned hall but may not be able to complete the restorative workload. They stated they have made the restorative nurse, Assistant Director of Nurses and the Director of Nurses (DON) aware that restorative services were not always being provided as scheduled.

Interview with DON on 06/04/15 at 1:30 PM revealed problems with the restorative program was identified and a quality assurance plan was developed including the hiring of new staff and in servicing existing staff to also complete restorative programs.

During an interview conducted with the Corporate Director of Clinical Training and the Administrator on 06/04/15 at 1:30 PM they revealed problems with the Restorative Program were identified and a quality assurance plan was developed which included the hiring of new staff and cross training existing Medication Aides to complete restorative programs.

A follow up interview was conducted with the Corporate Director of Clinical Services on 06/04/15 at 1:53 PM. She stated medication aides were trained to provide restorative services to be completed prior to or following medication pass.

An interview conducted on 06/04/15 at 3:34 PM with the Restorative Nurse revealed when restorative services were provided by medication aides, that service was not captured in the restorative services documentation.

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	345080	A. BUILDING _____ B. WING _____	C 06/04/2015

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F 311	Continued From page 35 An interview with Medication Aide #1 on 06/04/15 at 4:26 PM revealed when has completed restorative services, he has asked the restorative nurse, restorative aide, DON or therapy manager what tasks needed to be performed. An interview with Medication Aide #3 on 06/04/15 at 4:27 PM revealed if the restorative aides were pulled to the floor to work she was responsible for providing restorative services. She stated she did not follow the restorative plan of care for the residents but provided range of motion (ROM), and walked them to the bathroom. An interview with Medication Aide #4 on 06/04/15 at 4:31 PM revealed she provided restorative services to residents if the restorative aide was pulled to the floor to work. She stated she did not follow the restorative plan of care for the resident but would help them dress, do ROM exercises and walk them to the bathroom.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide nail care for a dependent resident for 1 of 3 residents reviewed for activities of daily living	F 312	F312 SS=D Alleged deficient practice in ADL Care Provided for Dependent	7/2/15

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F 312	Continued From page 36 (Resident #81). The findings included: Resident #81 was admitted to the facility on 03/24/14 with diagnoses including chronic respiratory failure, diabetes mellitus and seizure disorder. Review of an annual Minimum Data Set (MDS) dated 03/13/15 revealed Resident #81 had moderately impaired cognition and required extensive assistance with personal hygiene and was totally dependent on staff for bathing. Review of a care plan for activities of daily living (ADL) dated 03/24/15 stated Resident #81 required extensive assistance of 1 to 2 staff members for the completion of ADL needs. The goal was for Resident #81 to have all his ADL needs identified and met with staff assistance while maintaining the highest level of independent function to include: brushing hair, washing face and hands, and brushing teeth daily. Observations of Resident #81's right hand on 06/01/15 at 11:08 AM revealed black debris under all four fingernails. During an interview on 06/01/15 at 11:08 AM Resident #81 observed his right hand and stated he would need to ask the nurse aide (NA) to clean under his fingernails. Subsequent observations of Resident #81 revealed the following: - On 06/02/15 at 10:00 AM black debris was noted under all four fingernails. - On 06/03/15 at 3:17 AM black debris was noted	F 312	Residents 1.Resident #81 on 06/04/15 RN assessed residents nails for cleanliness. Left hand nails were neat and trimmed with no debris. Right hand 3rd digit nail length long with some debris under nail. Nail Care provided including trimming 3rd digit nail, with residents permission. Resident Stated he was growing his nails out however, agreed to have nail cleaned and trimmed. 2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, and Unit Manager will complete a 100% Audit of all current residents to include cleanliness and length of nails. Audit to be completed by 6/25/2015. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing, and Assistant Director of Nursing completed an In-service/ re-education for all Nursing staff on 06/11/2015. Including Resident Care, showers, nail care to be provided at time of shower and PRN. Educated on and initiated bath worksheet to be completed on shower days and signed off by the nurse. Including	

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F 312	Continued From page 37 under all four fingernails. - On 06/04/15 at 10:53 AM black debris was noted under all four fingernails. An interview with NA #5 on 06/03/15 at 2:59 PM revealed nail care, including cleaning under resident's fingernails, was provided during showers and as needed. A follow up interview with Resident #81 on 06/04/15 at 10:53 AM revealed he had been assisted with a shower earlier in the morning but the NA had not cleaned under the fingernails on his right hand. Resident #81 could not recall if he asked the NA to clean under his fingernails during his shower and stated he did like to be a bother. An interview was conducted with the Director of Nursing (DON) on 06/04/15 at 10:57 AM. The DON stated she expected resident's fingernails to be cleaned with showers and as needed when NAs were providing care. The DON was accompanied to Resident #81's room on 06/04/15 at 11:04 AM to observe his right hand and confirmed the debris should have been cleaned out from under the fingernails on his right hand. During a follow up interview on 06/04/15 at 3:05 PM NA #5 stated she was assigned to Resident #81 that day but NA #6 from the night shift had completed his shower. NA #5 could not recall if Resident #81's fingernails needed cleaning this week.	F 312	nail care provided at time. The DON/ ADON/ UM will randomly audit 6 residents weekly for 4 weeks and then 6 random resident every other week for 2 months to ensure nails are trimmed and clean. 4.The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/ trends to the QAPI committee every month for three months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328		7/2/15

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F 328	Continued From page 38 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to secure a compressed oxygen cylinder in a resident's room and failed to change the contaminated oxygen tubing for a resident for 2 of 2 resident's reviewed with oxygen therapy (Residents #90 and #139). The findings included: 1. Review of the facility policy Transport of a Resident with Oxygen with an origin date of 12/2005 and a revised date of 12/2009 read in part: 5. Oxygen cylinders/containers must be secured as follows: · Oxygen related equipment must be securely mounted or fastened to the wheelchair, vehicle seat or floor during transit. · Compressed gas oxygen cylinders should be secured to prevent movement. · Liquid oxygen containers should be secured in an upright position to prevent leakage. Resident #90 was admitted to the facility on 06/22/12 with diagnoses of chronic obstructive	F 328	F328 SS=D Alleged deficient practice in Treatment/ Care For Special Needs 1.Resident #90 Portable oxygen cylinder holder was secured to the residents walker by the Maintenance Director 06/01/2015. Resident # 139 Nasal Cannula was replaced on 06/01/15. 2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, and Assistant Director of Nursing, Will complete a 100% Audit on all Residents requiring Oxygen to include proper cylinder storage, tubing clean, with in date, and stored appropriately by 7/2/2015. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing, and Assistant Director of Nursing	

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F 328	Continued From page 39 pulmonary disease. The annual Minimum Data Set (MDS) dated 04/24/14 revealed Resident #90 was cognitively intact. An observation made on 06/01/15 at 12:05 PM revealed an unsecured portable oxygen cylinder with the gauge reading ½ full in a black unzipped cloth bag lying on the seat of Resident #90's rolling walker. During an interview conducted on 06/01/15 at 12:05 PM with Resident #90 she stated her portable oxygen cylinder was always stored on her rolling walker so she could wear her oxygen when she ambulated. An interview was conducted on 06/01/15 at 12:07 PM with nurse aide (NA) #1. She stated Resident #90's portable oxygen cylinder was always kept on the seat of her rolling walker. An observation of the unsecured portable oxygen cylinder lying in Resident #90's seat of her rolling walker and interview was conducted with the Administrator on 06/01/15 at 12:08 PM. The Administrator confirmed the portable oxygen cylinder was not secured in the seat of the rolling walker and should not have been lying in the seat but secured to the walker. 2. Resident #139 was admitted to the facility on 05/22/15 with diagnoses including delirium tremors, altered mental status and chronic airway obstruction. Physician orders originating on 05/22/15 included oxygen to be administered at 2 liters per minute via nasal cannula to maintain saturation levels greater than 88%.	F 328	completed an in-service/ re-education to all nursing staff on Oxygen safety and storage, including infection control practices on 6/1/2015. The facility's Ambassadors (team members who visit with residents routinely to identify concerns/ needs) will observe 5 residents who use oxygen weekly for 4 weeks and then 5 residents every other Week for 2 months to include observation of portable oxygen cylinder, stored securely, and tubing clean, with in date, and stored appropriately to prevent contamination. 4.The Administrator, and Director of Nursing, will review data obtained during facility audits and rounds; analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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On 06/01/15 at 12:49 PM, Resident #139 was observed sitting on the edge of his bed, the oxygen concentrator was running but the nasal cannula was on the floor by the bed. Resident #139 stated he was uncomfortable and could not locate his oxygen. The surveyor encouraged him to activate his call light. Medication Aide #2 entered the room and assisted him get repositioned. At 12:55 PM, Medication Aide #2 picked his nasal cannula off the floor and reapplied it to his nostrils and face without any cleaning. When Medication Aide #2 left the room, she was interviewed. Medication Aide #2 stated that Resident #139 continually removes his oxygen and this was the third time this date she replaced it. She further stated she was taught to replace the tubing when it was soiled and she should have replaced the tubing after it had been on the floor, before reapplying to the resident's face.

Interview with Nurse #1 on 06/02/15 at 10:36 AM revealed oxygen tubing was to be changed weekly and as needed which included if it was soiled or on the floor. She further stated if a resident dropped the nasal cannula on the floor, staff should replace it with a new one and new tubing.

During interview on 06/04/15 at 11:25 AM, the Director of Nursing stated the oxygen tubing should be changed weekly and whenever it made contact with the floor as it was then considered contaminated.