STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician to obtain treatment orders for an unstageable pressure	F 157	Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider with the	10/23/15

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

Electronically Signed | 10/16/2015

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F 157	Continued From page 1 ulcer noted on a newly admitted resident for 1 of 4 residents reviewed for notification of changes (Resident #153). The findings included: Resident #153 was admitted to the facility 09/21/15 with diagnoses which included severe depression, diabetes mellitus, catatonia, and anxiety. A review was conducted of a nursing admission assessment dated 09/21/15 at 5:30 PM. Nurse #2 signed the assessment with a notation she had conducted all sections of the assessment. Skin assessment documentation in the nursing admission assessment included a 3 centimeter (cm) by 2 cm opening in the coccyx area described as a pressure ulcer. Nurse #1 documented in an admission nurse's note the "decub" on the buttocks measured 3 cm by 2 cm. Further documentation specified the area was cleaned with normal saline and a dressing applied. No other information was provided regarding the pressure ulcer. A review of Resident #153's medical record on 09/23/15 revealed no physician's order for treatment of the pressure ulcer was provided. Nurse #1 was the nurse on Resident #153's hall on 09/23/15. This nurse was interviewed at 1:19 pm on this day. Nurse #1 was unaware of any skin condition regarding Resident #153. Nurse #1 confirmed there were no treatment orders for wound care in the resident's medical record or on the resident's treatment administration record. In an interview on 09/23/15 at 3:28 PM, the Director of Nursing (DON) confirmed Resident	F 157	statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #153 did have physician orders obtained by the Director of Clinical Services for treatment of the unstageable pressure ulcer on 9/23/15. Resident #153 has been receiving treatments as ordered by the physician since 9/23/15. Newly admitting residents have the potential to be affected by the same alleged deficient practice. Current residents, inclusive of newly admitted residents, had a skin assessment completed 9/24/15 - 9/25/15 by the Minimum Data Assessment Nurse and Wound Nurse to ensure that any prior, or currently identified skin impairments, had appropriate existing treatment orders and/or new orders were obtained for treatment and services. The Director of Clinical Services provided education to licensed nurses on 10/1/15 regarding the notification of the physician to obtain treatment orders for any newly admitted resident with identified skin impairment, or for any existing residents who develops skin impairment requiring treatment. Newly hired licensed nurses will receive education upon hire. Licensed Nurses will notify the resident's physician and responsible party upon identification of skin impairment, and obtain treatment orders as indicated and document	

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F 157	Continued From page 2 #153 was admitted with an unstageable pressure ulcer. The DON stated she assessed the wound on this day. She stated the wound measured 3 cm by 2 cm and the base of the wound was covered in yellow slough. The DON stated the admission nurse should have notified the physician of this wound when it was found during the nurse's admission assessment. The DON added a treatment order should have been obtained from the physician when the wound was found. An interview was conducted with Nurse #2 on 09/23/15 at 3:46 PM. Nurse #2 stated she did Resident #153's nurse's admission assessment on 09/21/15. Nurse #2 stated she did assess the wound and document in her notes that the resident had a pressure ulcer. Nurse #2 explained she intended to obtain a wound treatment order from the physician who was scheduled to be in the facility the following day, but forgot to notify him.	F 157	notification in the medical record. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring of residents to ensure that any necessary treatment orders were obtained timely for any identified skin impairments. Quality Improvement Monitoring will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 12 weeks, and/or until substantial compliance is obtained using a sample size of 5 residents. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	

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F 157	Continued From page 3	F 157	Date of Completion: October 23, 2015	
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 record reviews and resident and staff interviews the facility failed to implement a smoking policy that did not violate safe smokers rights and honor the rights of residents to smoke without supervision and at non-designated times for 2 of 4 sampled residents deemed safe smokers (Resident #14, #149). The findings included: The facility Smoking Policy dated 11/30/2014 provided by the Director of Nursing (DON) read: Policy: The Company facilities are an established non-smoking facility, unless allowed by state and local regulations. Residents are notified on admission that the facility is a non-smoking facility or allowed to smoke only in designated areas, and that they must adhere to the Smoking Policy. Each resident will be assessed on admission and quarterly to determine if the resident is a safe smoker. Procedure: Residents will be evaluated for safety regarding smoking upon admission and quarterly. The facility will maintain a list of all smokers	F 242	Resident #14 no longer resides at the facility Resident #149¿s care plan and safe smoking evaluation was completed by the licensed nurse on 10/15/15 to reflect the resident¿s current smoking status and ability. Other residents who smoke are at risk of the alleged deficient practice. The Director of Clinical Services (DCS) reviewed residents who smoke by 10/15/15 to determine their individual ability to safely smoke. The DCS created a ¿Resident Smokers¿ list on 10/16/15 that is kept at the nurses station to alert staff of the each residents designation as either a safe smoker allowed to smoke without supervision or assistance, or an unsafe smoker requiring assistance by staff. The DCS posted the staff-assisted smoking times for those residents who	10/23/15

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F 242	Continued From page 4 identifying them as safe or unsafe smokers. The facility will establish Smoking Times for residents. The facility will post the Smoke Times throughout the facility. The posting will also be present in the room of each resident who is identified as a smoker. Designated staff will supervise smoke times for residents needing supervision. The facility will establish a schedule of who will supervise the posted smoke times. A resident will be allowed to smoke without supervision if they are deemed appropriate by the care plan. Unsafe smokers will wear smoking aprons while smoking. 1. Review of the facility smoking policy revealed it was for safe and unsafe smokers. The policy violated the safe smokers right to smoke whenever they wanted. During an interview on 09/25/15 at 4:24 PM the Administrator acknowledged the facility smoking policy did not differentiate between safe and unsafe smokers. The Administrator stated she did not realize safe smoking meant the resident had the choice to smoke whenever they wanted. 2. Resident #14 was admitted to the facility on 06/23/15 with diagnoses of hypertension, diabetes, fracture and chronic obstructive pulmonary disorder. The significant change Minimum Data Set (MDS) dated 08/18/15 revealed Resident #14 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Review of the care plan dated 06/30/15 revealed Resident #14 had the potential for injury related to smoking. Interventions included safe smoking assessment on admission and quarterly. Instruct the resident on smoking protocol, keep smoking materials locked at nurse's station. Provide	F 242	have been identified as unsafe. Facility smokers have a posting in their room indicating the times that the facility will provide staff assistance for unsafe smokers. The Director of Clinical Services/ Social Services Director will be responsible for updating the ¿Resident Smokers¿ list with any changes of resident smoking designation of either safe or unsafe requiring assistance. Newly admitting residents choosing to smoke will be evaluated upon admission and then at least quarterly thereafter utilizing the Admission and Quarterly Data Collection tool and the Safe Smoking Evaluation. Any resident who smokes will be evaluated as needed in addition to quarterly, and the determination of the assessment may render change to the existing classification of either Safe or Unsafe Smoker requiring staff assistance. Residents will be re-evaluated upon any observation/report of unsafe smoking. The Executive Director reeducated current facility staff on resident¿s rights to self choice by 10/16/15. The Director of Clinical Services reeducated Department Managers and Licensed Nurses by 10/16/15 regarding the facility assessment and evaluation for determination of Safe Smokers, and on the completion of the Admission/Readmission and Quarterly Data Collection Tools, and the Safe Smoking Evaluation. The Director of Clinical Services educated facility staff by 10/16/15 on the ¿Resident Smoker¿ list posted at the nurses station to ensure	

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F 242	Continued From page 5 designated area for smoking for residents. Monitor for continued safe smoking. Provide scheduled staff supervised smoking times. Redirect resident during non-smoking times. Review of the Nursing Admission Assessment dated 06/23/15 under safety revealed Resident #14 was a safe smoker and only smoked occasionally. During an interview conducted on 09/25/15 at 1:47 PM Resident #14 stated she began smoking again when she was admitted to the facility because she liked to sit outside and socialize with the other residents. She stated there had been times when she wanted to smoke and couldn't due to having to wait for the supervised smoking times even though she was a safe smoker. The Administrator was interviewed on 09/25/15 at 10:16 AM. The Administrator stated a smoking assessment was completed upon admission and residents were informed that all smoking materials were kept at the nursing station. The Administrator stated she expected staff to visually watch a resident smoke when completing the smoking assessment. She stated all smokers, safe and unsafe had set staff supervised smoking times. The Administrator stated since the facility didn't have to offer smoking she thought it was at their discretion to have all residents supervised during smoke breaks. 3. Resident #149 was admitted to the facility on 08/24/15 with diagnoses of right leg fracture, difficulty walking and muscle weakness. The admission Minimum Data Set (MDS) dated 08/31/15 revealed Resident #149 was cognitively intact and required limited assistance with transfers, toileting and personal hygiene. Review of the care plan dated 09/01/15 revealed Resident #149 had the potential for injury related to smoking. Interventions included safe smoking	F 242	staff understanding of the designation of either Safe or Unsafe Smoker. Safe Smoker designation will allow the resident freedom of choice to smoke at times they prefer without supervision. A designation of Unsafe Smoker will require staff assistance at designated times which are posted at the nurses station and in each residents room that chooses to smoke. Education also included the facility designated area for smoking and the utilization of safety devices such as smoking aprons. Newly hired facility staff will be educated upon hire. Licensed Nurses and Department Managers will assess any resident wishing to smoke upon admission, readmission, at least quarterly, and upon any change in condition or report of unsafe smoking. Those residents who are assessed to be safe smokers, will be allowed to smoke as they desire and as deemed appropriate per their care plan. Those residents who are assessed as unsafe smokers will be provided a list of staff supervised smoking periods, and provided assistance at those times by a staff member. The Director of Clinical Services/Nurse Manager/Executive Director/ Social Services Director/Activity Director will conduct Quality Improvement Monitoring of residents who smoke to validate compliance that each resident is provided freedom of choice in regards to independence with smoking as deemed appropriate per the residents care plan	

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F 242	Continued From page 6 assessment on admission and quarterly. Instruct the resident on smoking protocol, keep smoking materials locked at nurse's station. Provide designated area for smoking for residents. Monitor for continued safe smoking. Provide scheduled staff supervised smoking times. Redirect resident during non-smoking times. Review of the Nursing Admission Assessment dated 08/24/15 under safety revealed Resident #149 was assessed as a safe smoker. During an interview conducted on 09/25/15 at 4:05 PM with Resident #149 revealed he would like to go out and smoke whenever he wanted to. He stated he did not like having to wait for the smoke breaks. The Administrator was interviewed on 09/25/15 at 10:16 AM. The Administrator stated a smoking assessment was completed upon admission and residents were informed that all smoking materials were kept at the nursing station. The Administrator stated she expected staff to visually watch a resident smoke when completing the smoking assessment. She stated all smokers, safe and unsafe had set staff supervised smoking times. The Administrator stated since the facility didn't have to offer smoking she thought it was at their discretion to have all residents supervised during smoke breaks.	F 242	and individualized results of the Safe Smoking Evaluation. Quality Improvement Monitoring will be conducted 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 weeks, and then 1 time per month for 3 months using a sample size of 5 residents. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Social Services Director for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		10/23/15

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F 253	Continued From page 7 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary environment in one resident room on 1 of 5 halls. The findings included: 1. a. Observations in room 207 on 09/22/15 at 3:15 PM revealed Resident #61's overbed table had raised, dried, white crusty matter scattered across the entire surface of the table top and 2 nickel sized, dried orange colored spills at one corner of the table top. The white crusty matter could be scraped off using a fingernail and the dried orange spill was sticky. Observations of Resident #61's overbed table on 09/23/15 at 12:25 PM revealed a raised, dried, white crusty matter scattered across the entire surface of the table top and 2 nickel sized, dried orange colored spills at one corner of the table top. The white crusty matter could be scraped off using a fingernail and the dried orange spill was sticky. Resident #61 was observed eating from her lunch tray a short time later which had been placed on the overbed table. Subsequent observations on 09/24/15 at 8:37 AM and 11:25 PM revealed a raised, dried, white crusty matter scattered across the entire surface of the table top and 2 nickel sized, dried orange colored spills at one corner of the table top. The white crusty matter could be scraped off using a fingernail and the dried orange spill was sticky.	F 253	Resident #61's room was inspected and thoroughly cleaned by housekeeping on 9/24/15 and will continue to be cleaned routinely per the facility cleaning schedule. Residents residing at the facility are at risk of the alleged deficient practice. The housekeeping supervisor completed an inspection of resident living areas and completed an Environmental Safety Survey on 9/25/15 to ensure facility cleanliness. Any areas identified as needing cleaning were immediately addressed by housekeeping services to provide for a clean, sanitary, orderly, and comfortable interior, at that time. The Housekeeping Supervisor reeducated current housekeeping staff regarding the policy to maintain a clean living environment for residents, and compliance with the cleaning schedule by 9/25/15. Newly hired housekeeping staff will be educated upon hire. Housekeeping staff will complete cleaning duties per the cleaning schedule to ensure compliance with facility cleanliness. The Executive Director and/or Interdisciplinary team inclusive of facility departmental directors and administrative personnel will conduct Quality Improvement Monitoring of residential	

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F 253	Continued From page 8 b. Observations in the shared bathroom for room 207 on 09/22/15 at 3:15 PM revealed a dried brown stain approximately 1/2 inch wide on the front of the base of the toilet. The dried, brown stain started at the top of the toilet base just below the toilet seat and extended down to the caulking at the floor. Subsequent observations on 09/23/15 at 12:25 PM and 09/24/15 at 11:25 AM revealed the shared bathroom for room 207 had a dried brown stain approximately 1/2 inch wide on the front of the base of the toilet. The dried, brown stain started at the top of the toilet base just below the toilet seat and extended down to the caulking at the floor. c. Observations of the heating/air conditioner unit in room 207 on 09/22/15 at 3:15 PM revealed 2 dime sized, dried orange colored spills on the right side of the unit close to the wall and 2 large crumbs the size of a pencil eraser on top of the vent. Subsequent observations on 09/23/15 at 12:25 PM and 09/24/15 at 11:25 AM revealed the heating/air conditioner unit had 2 dime sized, dried orange colored spills on the right side of the unit close to the wall and 2 large crumbs the size of a pencil eraser on top of the vent. An interview was conducted with the Housekeeping Account Manager (HM) on 09/24/15 at 11:29 AM. The HM stated there were three housekeepers scheduled to work daily from 7:00 AM to 2:30 PM. The HM explained the housekeepers clean the common areas first and then work together to clean all the resident rooms on the 200 and 500 hall. After that each	F 253	living areas to ensure a clean and sanitary environment. Quality Improvement Monitoring will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 12 weeks, and/or until substantial compliance is obtained using a sample size of 10 resident areas. The results of these Quality Improvement Monitors will be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Compliance: October 23, 2015	

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F 253	Continued From page 9	F 253		

housekeeper cleaned the resident rooms on their assigned hall. The HM stated the housekeepers were expected to clean all vertical and horizontal surfaces in the room and bathroom including the overbed table, heating/air conditioner unit, and the base of the toilet every day.

An interview with Housekeeper #1 on 09/24/15 at 1:39 PM revealed the housekeepers had completed cleaning in all of the resident rooms for the day. Housekeeper #1 stated there were always 3 housekeepers scheduled and they cleaned three rooms apiece on the 200 and 500 halls at the beginning of the shift. Housekeeping #1 further stated her daily routine included high dusting, emptying the trash, spraying surfaces with a cleaning product including table tops, the toilet seat, and the base of the toilet then wiping them down with a cloth. Housekeeper #1 stated she had not cleaned room 207 today and could not recall if she had cleaned it any other day this week.

On 09/24/15 at 1:41 PM the HM was accompanied to room 207 and observed Resident #61's overbed table, the heating/air conditioner unit, and the base of the toilet in the shared bathroom and stated it was not acceptable and would all be cleaned immediately. The HM could not explain how these areas in room 207 had not been cleaned on 09/22/15, 09/23/15, or 09/24/15. The HM stated he thought Housekeeper #2 had cleaned room 207 that day and she had already left for the day.

An interview with Housekeeper #2 on 09/25/15 at 10:15 AM revealed her typical daily cleaning routine included dusting surfaces, spraying and wiping down overbed tables, and spraying and

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F 253	Continued From page 10 wiping down the toilet including the base. Housekeeper #2 stated she had memory problems and could not recall if she had cleaned room 207 this week. During an interview on 09/24/15 at 2:04 PM the Administrator expected all surfaces in the residents' room to be sprayed and wiped down everyday including overbed tables, toilets, and heating/ air conditioner units.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document the consumed percentage of a nutritional supplement as ordered by the physician for 1 of 5 residents (Resident #95). The findings included: Resident #95 was admitted to the facility 05/13/13 with diagnoses which included progressive debility, diabetes mellitus, and dementia. A care plan updated 02/05/15 identified Resident #95 with weight fluctuation. The care plan goal specified the resident would maintain an adequate nutritional status by maintaining weight within 215 to 225 pounds. Intervention included Registered Dietician (RD) to evaluate and make diet change recommendations as needed.	F 281	Resident #95 received a clarification order on 9/23/15 from the physician to discontinue recording of percentage consumed and to change the type of supplementation. Residents with physician orders for dietary supplementation with documented consumptions are at risk for the alleged deficient practice. The Director of Clinical Services completed a review of residents with dietary supplement orders by 10/7/2015 to ensure accurate order transcription onto the Medication Administration Record. Any discrepancy identified was reported to the physician with order clarification obtained and Medication Discrepancy Report completed by the licensed nurse, at that	10/23/15

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F 281	Continued From page 11 A quarterly Minimum Data Set (MDS) dated 08/04/15 indicated the resident's cognition was moderately impaired. The MDS specified Resident #95 was on a therapeutic diet and weighed 199 pounds. A review of Resident #95's medical record revealed a note written 08/07/15 by the RD. The note specified the RD recommended 60 cubic centimeters (cc) of a liquid nutritional supplement be offered twice a day related to recent weight loss. The note also specified to document the percentage of the supplement consumed. Continued medical record review revealed a physician's order written 08/11/15. The order specified to administer 60 cc of a liquid nutritional supplement twice a day and document the percentage consumed. A review of Resident #95's Medication Administration Record (MAR) dated 08/01/15 through 8/31/15 revealed the supplement was initialed as administered twice a day for 15 days. The percentage of supplement consumed was documented 6 times. There was no documentation of consumed supplement the other 26 times the supplement was offered. Nurse #1's and Nurse #2's initials indicated they had administered the nutritional supplement during the month of August 2015 and did not document the percentage consumed. An interview was conducted with Nurse #1 on 09/24/15 at 2:21 PM. Nurse #1 confirmed the physician's order for the nutritional supplement written on the MAR instructed to document the percentage of supplement consumed. She	F 281	time. The Director of Clinical Services reeducated licensed nurses regarding accurate transcription of supplement orders onto the Medication Administration Record and documentation of administration per physician orders including recording percent consumed, if indicated by 10/5/15. Newly hired nurses will be educated upon hire. The Director of Clinical Services and/or Nurse Supervisor will review residents to validate that nurses are administering, transcribing, and documenting dietary supplements per physician orders. Director of Clinical Services and/or Nurse Supervisor will conduct Quality Improvement Monitoring 3 times per week for four weeks, 2 times per week for 4 weeks, then 1 time per week for 4 weeks, and then 1 time monthly for three months. The results of Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members	

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F 281	Continued From page 12 stated she did administer the supplement to Resident #95 but forgot to document the percentage consumed each time she offered the supplement. An interview was conducted with the Director of Nursing on 09/24/15 at 2:22 PM. She explained documenting the percentage of supplement consumed by the resident allowed other care givers to be able to evaluate the effectiveness of the supplement. The DON stated the percentage of intake of the nutritional supplement should have been documented. An interview was conducted with Nurse #2 on 09/24/15 at 2:57 PM. Nurse #2 confirmed she had administered the nutritional supplement to Resident #95. She also confirmed she had failed to document the percentage of supplement consumed each time it was administered. She stated the resident liked the supplement and always drank 100%. Nurse #2 added she overlooked documenting the percentage of intake.	F 281	consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	
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. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide physician ordered restorative nursing services to 1 of 1 resident referred by therapy for a maintenance	F 311	Resident #73 was recently discharged from skilled therapy on 10/12/15 with a referral to Restorative Nursing for continued utilization of the NuStep.	10/23/15

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F 311	Continued From page 13 program (Resident #73). The findings included: Resident # 73 was admitted to the facility on 11/29/13 with diagnoses including flaccid hemiplegia affecting dominant side, spasm of muscle, and difficulty walking. Review of the quarterly Minimum Data Set (MDS) dated 07/28/15 revealed Resident #73's cognition was intact and she was able to make her needs known. The quarterly MDS noted Resident #73 required extensive assistance for bed mobility and transfer and walking with extensive assistance occurred once or twice. The quarterly MDS further revealed Resident #73 received 5 days of physical therapy with a total of 195 minutes during the 7 day look back period. Review of Physical Therapy (PT) documentation revealed Resident #73 was on the PT caseload 5 days a week from 07/01/15 through 08/12/15 for therapeutic exercises, therapeutic activities, and gait training. Review of a PT discharge summary dated 08/12/15 revealed the physical therapist recommended a restorative nursing maintenance program and spoke with staff regarding the restorative nursing program (RNP) and the possibility for using the NuStep (recumbent cross trainer) during the week. The physical therapist further documented Resident #73 had a guarded prognosis considering the lack of RNP in the facility and the chronic nature of her condition. Review of the medical record revealed a physician's order for Resident #73 to be discontinued from PT skilled services and referred to the RNP for NuStep.	F 311	Residents requiring assistance with Activities of Daily Living are at risk for the alleged deficient practice. The Director of Clinical Services, Rehab Program Manager, and Minimum Data Set Nurse completed a restorative nursing evaluation of current residents to identify residents that could benefit from a restorative program on 10/2/15. Identified residents were referred to the Restorative Nurse and restorative programs were initiated as recommended by Rehab Program Manager on 10/7/15. The Regional Director of Clinical Services provided education to the Director of Clinical Services, Restorative Nurse, and Rehab Program Manager on 10/15/15 regarding implementation of a restorative program to promote residents independence with activities of daily living. The Director of Clinical Services and Restorative Nurse educated restorative aides by 10/16/15 and competencies were completed to assure understanding of skills. Any newly hired Restorative Nurse Aides will be educated upon hire. Residents will be screened by the Restorative Nurse upon admission, readmission, quarterly, and with a significant change in condition. Those identified residents will be referred to a restorative program as appropriate to promote independence with activities of daily living. The Director of Clinical Services and/or Nurse Supervisor conduct Quality	

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F 311	Continued From page 14 During an interview on 09/23/15 at 10:15 AM Resident #73 stated there was not sufficient nursing staff to meet her needs because she had not received restorative nursing services for 6 weeks and this was very important to her. An interview with the Therapy Program Manager on 09/24/15 at 2:27 PM revealed NA #2 had been trained to assist Resident #73 on the NuStep at the time of her discharge from therapy services. The interview further revealed the Therapy Program Manager did not know how functional the facility's RNP was at the time of Resident #73's discharge from therapy services on 08/12/15. An interview was conducted with the Administrator on 09/24/15 at 3:16 PM. During the interview the Administrator stated the facility did not currently have a formalized restorative nursing program. The Administrator explained the facility had 2 full time restorative aides until the middle of June 2015 when one of the restorative aides went out on medical leave. The Administrator further stated some days NA #2 was able to work with group of residents with orders for the RNP and other days he had a resident assignment on the hall. Restorative tracking grids were reviewed during the interview and the Administrator confirmed Resident #73 had no documentation of services provided to Resident #73. During an interview on 09/25/15 at 11:49 AM NA #2 stated it had been difficult since May of 2015 to do the RNP because he had been pulled to the floor frequently and given a resident assignment. NA #2 further stated he had not been able to	F 311	Improvement Monitoring of 10 residents to validate that each resident is receiving restorative services if indicated. Quality Improvement Monitoring will be completed 3 times per week for 8 weeks, 2 times per week 4 weeks, 1 time per week for 4 weeks, and then 1 time monthly for 2 months. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Restorative Nurse for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	

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F 311	Continued From page 15 assist Resident #73 on the NuStep in August 2015 or September 2015 due to staffing.	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 reviews, and staff interviews the facility failed to provide nail care for 2 of 3 dependent residents reviewed for activities of daily living (Resident #61 and #95). The findings included: 1. Resident #61 was admitted on 07/29/15 with diagnoses including diabetes mellitus and wound infection. Review of the admission Minimum Data Set (MDS) dated 08/05/15 revealed Resident #61 had moderately impaired cognition and required extensive assistance with personal hygiene. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) Functional/Rehabilitation Potential dated 08/05/15 revealed Resident #61 required total assistance with ADL. Review of a care plan dated 08/09/15 revealed Resident #61 had a self care deficit due to the	F 312	Resident #61's nails were cleaned 9/25/15 by the Director of Clinical Services and will continue to receive assistance with nail care from facility nursing personnel as needed. Resident #95's nails were trimmed on 9/25/15 by a certified nurse aide and will continue to receive assistance with nail care from facility nursing personnel as needed. Residents who are dependent with Activities of Daily Living are at risk for the alleged deficient practice. Dependent resident nails were assessed by nursing staff on 10/5/15 for cleanliness, length, and smooth edges. Nail care was provided where appropriate at that time by facility nursing personnel. The Director of Clinical Services reeducated nursing staff regarding care of residents nails by 10/16/15. Newly hired nurses and nurse aides will be educated upon hire. Dependent residents will	10/23/15

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F 312	Continued From page 16 inability to complete self care tasks independently. The care plan noted Resident #61 required extensive assistance for ADL with interventions including nail care routine. Review of the care kardex at the nurses's station revealed Resident #61's required the assistance of one staff member for nail care, combing her hair, and perineum care. Review of the facility's shower schedule revealed Resident #61 was scheduled for showers on Wednesday and Saturday during the second shift (3:00 PM To 11:00 PM). Observations of Resident #61's fingernails were as follows: - On 09/22/15 at 3:15 PM black debris was noted under the middle and ring fingernail on her right hand. - On 09/23/15 at 12:25 PM black debris was noted under the middle and ring fingernail on her right hand and under all five fingernails on her left hand. - On 09/24/15 at 8:37 AM black debris was noted under all ten fingernails. - On 09/25/15 at 8:47 AM black debris was noted under all ten fingernails. An interview with Nurse Aide (NA) #3 on 09/25/15 at 9:09 AM revealed he cleaned and trimmed residents fingernails if he had time and there were also NAs assigned to light duty that cleaned and trimmed resident's fingernails. NA #3 noted the facility had started a shower team a few weeks ago and residents typically had fingernails cleaned during their showers. NA #3 confirmed he was assigned to Resident #61 on 09/23/15, 09/24/15, and 09/25/15 and could not recall if	F 312	receive nail care twice weekly during showers, and randomly as needed for any identified debris, soiling, or roughness during routine activities of daily living care. The Director of Clinical Services and/or Nurse Supervisor will conduct Quality Improvement Monitoring of dependent residents' nails 3 times per week for 8 weeks, then 2 times per week for 8 weeks, then 1 time per week for 4 weeks, and then monthly for 1 month for cleanliness and appropriateness of shape. The results of the Quality Improvement Monitoting will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Supervisor for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	

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Resident #61's fingernails needed to be cleaned.

An interview was conducted with the Assistance Director of Nursing (ADON) on 09/25/15 at 9:30 AM. The shower sheets were reviewed during the interview and the ADON confirmed NA #4 had showered Resident #61 on 09/23/15.

During an interview on 09/25/15 at 9:52 AM the Director of Nursing (DON) stated resident's fingernails should be cleaned during showers and checked during daily care and cleaned as needed. At 9:55 AM the DON was accompanied to Resident #61's room to observe Resident #61's fingernails. The DON confirmed Resident #61 needed the debris cleaned from under all ten fingernails.

NA #4 was not available for interview on 09/25/15.

2. Resident #95 was admitted to the facility 05/13/15 with diagnoses which included progressive debility, dementia, and diabetes mellitus. A quarterly Minimum Data Set (MDS) dated 08/04/15 indicated the resident's cognition was moderately impaired. The MDS specified Resident #95 understood others, was verbally understood, and required extensive staff assistance with dressing and personal hygiene.

A care plan updated 08/09/15 described Resident #95 with inability to complete self care tasks independently. The care plan specified the resident would be neat and clean through the

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next 90 review period. Interventions included routine nail care.

An interview was conducted with Resident #95 on 09/22/15 at 3:23 PM. At that time, his fingernails were observed to be uneven in length. One nail was observed jagged across the top of the nail, and all nails had pointed corners that protruded from the sides of his fingertips. Resident #95 stated he could not remember the last time they were cut. He stated he would like them trimmed like they should be.

An observation on 09/23/15 at 8:23 AM revealed Resident #95's fingernails remained untrimmed. At 1:00 PM, Nurse Aide (NA) #1 was observed returning Resident #95 to his room in a wheelchair following a shower. An observation at this time revealed his fingernails were unchanged.

An observation on 09/24/15 at 9:42 AM revealed Resident #95's fingernails remained uneven in length with pointed corners protruding from the sides of his fingertips.

An interview was conducted via phone with NA #1 on 09/24/15 at 10:17 AM. NA #1 stated care provided during showers included shaving if needed, washing hair if the resident wanted their hair washed, and cutting fingernails if needed.

An additional observation on 09/25/15 at 9:54 AM revealed Resident #95's fingernails remained unchanged.

An additional interview was conducted with NA #1 on 09/25/15 at 10:03 AM. NA #1 stated she provided a shower for Resident #95 on Tuesday

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F 312	Continued From page 19 09/22/15. She added she was part of a shower team that the facility just started 2 weeks ago. NA #1 stated she did not know Resident #95 and was worried he might be diabetic. NA #1 added she did not think nurse aides could cut fingernails of diabetic residents. An interview was conducted with the Director of Nursing (DON) on 09/25/15 at 10:15 AM. During this interview, Resident #95's fingernails were observed. The DON stated Resident #95's nails needed to be rounded and smoothed on the corners.	F 312		
F 314 SS=D	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 initiate treatment for an unstageable pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident #153). The findings included: Resident #153 was admitted to the facility	F 314	Resident #153 had a skin assessment completed on 9/23/15 by the Director of Clinical Services and physician orders were obtained, transcribed to the Treatment Administration Record, and initiated for continued treatment of a pressure ulcer. The wound was measured and staged by the Registered Nurse and a Pressure Ulcer Record was	10/23/15

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F 314	Continued From page 20 09/21/15 with diagnoses which included severe depression, diabetes mellitus, catatonia, and anxiety. A review was conducted of a nursing admission assessment dated 09/21/15 at 5:30 PM. Nurse #2 signed the assessment with a notation she had conducted all sections of the assessment. Resident #153 was described as stuporous, without speech and sometimes understood others. Skin assessment documentation included a 3 centimeter (cm) by 2 cm opening in the coccyx area described as a pressure ulcer. Nurse #1 documented in an admission nurse's note the "decub" on the buttocks measured 3 cm by 2 cm. Further documentation specified the area was cleaned with normal saline and a dressing applied. No other information was provided regarding the pressure ulcer. A review of Resident #153's medical record on 09/23/15 revealed no physician's order for treatment of the pressure ulcer was provided. Nurse #1 was the nurse on Resident #153's hall on 09/23/15. This nurse was interviewed at 1:19 pm on 09/23/15. Nurse #1 was unaware of any skin condition regarding Resident #153. Nurse #1 confirmed there were no treatment orders for wound care in the resident's medical record or on the resident's treatment administration record. An observation on 09/23/15 at 1:35 PM with Nurse #1 revealed Resident #153 did have an opening on the coccyx area. The opening was observed undressed. A yellow slough was observed covering the base of the wound. Nurse #1 stated she did not know this wound existed. In an interview on 09/23/15 at 3:28 PM, the	F 314	completed on 9/23/15 by the Director of Clinical Services. Current residents have the potential to be affected by the alleged deficient practice. A skin assessment was completed on facility residents by the Minimum Data Assessment Nurse and Wound Nurse by 9/25/15 and documented on the Weekly Skin Integrity Review form. Any identified skin impairments, pressure and non-pressure, were assessed and documented on the Pressure Ulcer Record or Non-Pressure Skin Condition Record by a licensed nurse and reported to the resident's physician and new treatment orders were obtained, implemented, and documented as appropriate. The Director of Clinical Services reeducated licensed nurses by 10/1/15 on the accurate completion of the Weekly Skin Integrity Reviews and the initiation of a Pressure Ulcer Record and/or Non-Pressure Skin Condition Record for any wounds identified. The education also included timely physician notification, obtained and starting new treatment orders, and transcription onto the residents Treatment Administration Record. Newly hired nurses will receive education during new hire orientation. Residents will have a weekly skin assessment completed by a licensed nurse to identify skin concerns. Any skin issue identified will be reported to the physician by the licensed nurse and new treatment orders obtained, implemented,	

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F 314	Continued From page 21 Director of Nursing (DON) confirmed Resident #153 was admitted with an unstageable pressure ulcer. The DON also confirmed she had assessed the wound on this day. She stated the wound measured 3 cm by 2 cm and the base of the wound was covered in yellow slough. The DON stated the admission nurse should have notified the physician of this wound when it was found during the nurse's admission assessment. The DON added a treatment order should have been obtained from the physician when the wound was found. An interview was conducted with Nurse #2 on 09/23/15 at 3:46 PM. Nurse #2 stated she did Resident #153's nurse's admission assessment on 09/21/15. Nurse #2 stated she did assess the wound and document in her notes that the resident had a pressure ulcer. Nurse #2 added she did cleanse and redress the wound with the same kind of dressing that she removed in order to do the assessment. Nurse #2 explained she intended to obtain a wound treatment order from the physician that was scheduled to be at the facility the following day, but forgot to notify him. Nurse #2 described the wound she assessed upon admission with yellow slough that covered the wound base and measured 3 cm by 2 cm in length and width.	F 314	and transcribed onto the Treatment Administration Record and Pressure Ulcer Record or Non-Pressure Skin Condition Record as appropriate. A nurse manager will round weekly with the wound physician to assess, measure, and document the condition of the wound on the Pressure Ulcer Record. The Director of Clinical Services, the Minimum Data Set Nurse, Dietary Manager, and Nurse Manager will discuss identified residents during a weekly wound meeting to ensure necessary treatment and services are being provided to promote healing, prevent infection, and prevent the development of new sores. The Director of Clinical Services/Nurse Manager will complete Quality Improvement Monitoring of the weekly skin assessments, Pressure Ulcer Record and/or Non-Pressure Skin Condition Records and Treatment Administration Records if indicated on 5 residents 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 timer per for 3 months to validate compliance with the alleged deficient practice. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for	

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F 314	Continued From page 22	F 314	maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	
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 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 staff interviews the facility failed to provide physician ordered continuous oxygen therapy to a resident while in her wheelchair to maintain an oxygen saturation greater than 90% for 1 of 1 resident reviewed for respiratory care (Resident #26).	F 328	Resident #26 was assessed by the licensed nurse on 9/22/15 and no harm was noted. Resident continues to receive oxygen as ordered by the physician via oxygen concentrator and/or portable oxygen tank.	10/23/15

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F 328	Continued From page 23 The findings included: Resident #26 was admitted on 01/14/15 with diagnoses including chronic respiratory failure. Review of a care plan dated 04/12/15 revealed Resident #26 required oxygen (O2) therapy and the goal stated Resident #26 would have her O2 saturation checked per the schedule and to titrate the O2 to keep her O2 saturation greater then 90%. Interventions included: monitor for changes in resident symptoms and report to the physician, administer oxygen as ordered, change tubing per protocol, and if O2 saturation drops below 90% notify the physician for orders. Review of Resident #26's September 2015 Physician's Orders revealed she was to be given O2 at 3 liters/min (l/min) via a nasal cannula (NC) and for her O2 saturation to be monitored every shift. Review of the quarterly Minimum Data Set (MDS) 09/02/15 revealed Resident #26 had moderately impaired cognition and had received oxygen therapy during the 14 day assessment period. Observations of Resident #26 were as follows: - On 09/22/15 at 12:32 PM she was sitting in her wheelchair in her room facing the wall behind her bed with a NC in her nostrils. The oxygen tubing was attached to a portable O2 tank located in a holder on the back of her wheelchair. The needle on O2 tank's oxygen gauge was at the bottom of the red zone indicating the tank was empty. Resident #26 was in no visible distress. - On 09/22/15 at 12:58 PM she was sitting in her wheelchair in her room facing the wall behind her	F 328	Residents with orders for continuous oxygen have the potential to be affected by the alleged deficient practice. The Director of Clinical Services completed a review of residents with oxygen orders by 9/24/15 to ensure compliance with oxygen treatments. Nursing staff was in-serviced by the Director of Clinical Services by 10/15/15 regarding administering oxygen therapy as ordered via oxygen concentrator and/or portable tank, and the operation of oxygen equipment and supplies. Newly hired nursing staff will be educated upon hire. The licensed nurse will observe residents with oxygen each shift to validate compliance with oxygen administration per physician's orders and document accordingly on the Medication Administration Record. The Director of Clinical Services/Nurse Manager will perform Quality Improvement Monitoring of residents with oxygen therapy to validate compliance three times per week for 4 weeks, 2 times per week for 8 weeks, then monthly for 3 months using a sample size of 5 residents The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement	

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F 328	Continued From page 24 bed with a NC in her nostrils. The oxygen tubing was attached to a portable O2 tank located in a holder on the back of her wheelchair. The needle on O2 tank's oxygen gauge was at the bottom of the red zone indicating the tank was empty. Resident #26 was in no visible distress. - On 09/22/15 at 1:22 PM she was sitting in her wheelchair in her room facing the wall behind her bed with a NC in her nostrils. The oxygen tubing was attached to a portable O2 tank located in a holder on the back of her wheelchair. The needle on O2 tank's oxygen gauge was at the bottom of the red zone indicating the tank was empty. Resident #26 was in no visible distress. - On 09/22/15 at 1:26 PM Nurse Aide (NA) #5 walked behind and past Resident #26 to check on her roommate. NA #5 did not check the portable O2 tank to see if Resident #26 had O2 available. Resident #26 was in no visible distress. - On 09/22/15 at 1:28 PM NA #5 returned to the room and picked up Resident #26's meal tray. NA #5 did not check the portable O2 tank to see if Resident #26 had O2 available. Resident #26 was in no visible distress. An interview with Nurse #3 on 09/22/15 at 1:37 PM revealed NAs could change out portable oxygen tanks and would let the nurses know if they needed assistance. At 1:39 PM Nurse #3 was accompanied to Resident #26's room and checked her oxygen saturation which was 88% and confirmed the oxygen tank was empty. Nurse #3 stated Resident #26 should have been switched over to the oxygen concentrator when she returned to her room. Nurse #3 further stated she had not seen Resident #26 since earlier this morning. Nurse #3 switched Resident #26 to the oxygen concentrator in her room at 3 l/min at that time.	F 328	Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	

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F 328	Continued From page 25 An interview with NA #5 09/22/15 at 1:42 PM revealed NAs were allowed to change resident's portable oxygen tanks if they noticed they were empty. NA #5 stated she did not usually check the gauge on the portable oxygen tanks and did not notice Resident #26's portable oxygen tank was empty or that Resident #26 was not connected the the oxygen concentrator when she was in the room earlier. During an interview on 09/22/15 at 2:50 PM the Director of Nursing (DON) stated NAs should check the portable oxygen tanks when they assisted them to their wheelchairs and change the tank when it was empty. The DON further stated she expected the NAs to monitor resident's portable oxygen tanks throughout their shift and change as needed. The interview further revealed residents with orders for continuous oxygen should be placed on the oxygen concentrator when they were in their rooms.	F 328		
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 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		10/23/15

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F 353	Continued From page 26 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 record reviews and staff and resident interviews, the facility failed to provide sufficient nursing staff to offer physician ordered restorative nursing services to 1 of 1 resident reviewed for maintaining activities of daily living (Resident #73). The findings included: This tag is cross-referred to: F311: Maintaining Activities of Daily Living: Based on record review and resident and staff interviews the facility failed to provide physician ordered restorative nursing services to 1 of 1 resident referred by therapy for a maintenance program (Resident #73). An interview was conducted with the Director of Nursing (DON) on 09/25/15 at 11:41 AM. The DON stated the facility phased out 12 hour shifts for staff. She added some staff left because of this. In a continued interview on 09/25/15 at 2:36 PM, the DON stated nurse aides were supposed to incorporate restorative nursing services into daily	F 353	Resident #73 was recently discharged from skilled therapy on 10/12/15 with a referral to Restorative Nursing for continued utilization of the NuStep. Resident #73 will continue to receive restorative care as appropriate. Residents requiring assistance with Activities of Daily Living are at risk for the alleged deficient practice. The Director of Clinical Services, Rehab Program Manager, and Minimum Data Set Nurse completed a restorative nursing evaluation of current residents to identify residents that could benefit from a restorative program. Identified residents were referred to the Restorative Nurse and restorative programs were initiated as recommended. The Regional Director of Clinical Services provided education to the Director of Clinical Services, Restorative Nurse, and Rehab Program Manager on 10/15/15 regarding implementation of a restorative program to promote residents independence with activities of daily living.	

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F 353	Continued From page 27 routines such as walk to dine at meal times and working in range of motion while dressing. The DON explained the facility had no formal restorative nursing. In a continued interview on 09/25/15 at 4:36 PM the Administrator confirmed the day shift was almost back to full staff so restorative nursing services could be reinstalled.	F 353	The Director of Clinical Services and Restorative Nurse educated restorative aides by 10/16/15 and competencies were completed to assure understanding of skills. Newly hired restorative aides will be educated upon hire. Residents will be screened by the Restorative Nurse upon admission, readmission, quarterly, and with a significant change in condition. Those identified residents will be referred to a restorative program as appropriate to promote independence with activities of daily living. The Restorative Aides will be responsible for providing restorative care as appropriate per the resident's care plan. In the absence of the Restorative Aide the Restorative Nurse and/or other member of Nurse Management will be designated to ensure the delivery of resident specific restorative care in accordance with the care plan to maintain or improve each residents' abilities. The Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement Monitoring of 10 residents to validate that each resident is receiving restorative services if indicated. Quality Improvement Monitors will be completed 3 times per week for 8 weeks, 2 times per week 4 weeks, 1 time per week for 4 weeks, and then 1 monthly for 2 months. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Restorative Nurse for six months and/or until substantial	

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F 353	Continued From page 28	F 353	compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date 1 opened container of orange juice, 1 opened container of cranberry juice, 1 covered bowl of applesauce, 1 and ½ trays of	F 371	On 9/22/15 the Dietary Manager disposed of improperly sealed/stored items and unlabeled items not specifying the preparation, thawing, or expiration	10/23/15

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F 371	Continued From page 29 sandwiches stored ready for use and 4 healthy shakes in 1 of 1 nourishment refrigerator. The findings included: An initial tour of the kitchen was made on 09/22/15 at 10:45 AM with the Dietary Manager (DM). The tour included observations of the facility's nourishment room that revealed the following items not labeled or dated stored ready for use: · 1 uncovered, undated opened container of orange juice in a clear multi-use serving pitcher, confirmed by the DM as orange juice · 1 uncovered, undated opened container of cranberry juice in a clear multi-use serving pitcher, confirmed by the DM as cranberry juice · 1 covered, undated bowl of applesauce not in the original container, confirmed by the DM as applesauce · 1 and ½ trays of hard pimento cheese and peanut butter sandwiches undated and stored ready for use, confirmed by the DM as snack used for residents · 4 healthy shakes (a fortified nutritional supplement), confirmed by the DM as not having a thaw date and use by date indicated on the carton that specified the supplement be used within 14 days of thawing An interview was conducted on 09/25/15 at 8:36 AM with the Unit Manager. She stated it was her responsibility to check the nourishment refrigerator juices, applesauce and healthy shakes dates Monday through Friday. She stated the orange juice and cranberry juice should be dated with the date it was prepared and disposed of at the end of that day the applesauce should have been dated with the date it was placed in the bowl and discarded at the end of the day as well. She stated the nurse supervisor should check dates on the weekends. She further stated	F 371	date found in the nourishment room. Residents residing at the facility are at risk as related to the alleged deficient practice. The Dietary Manager/ Department member will inspect the kitchen and nourishment rooms to validate that no items are expired, improperly sealed/stored, or mislabeled. Food items identified will be disposed of per company policy. The Dietary Manager educated current staff by 10/16/15 on proper disposal of expired, improperly sealed/stored, and unlabeled food items. The Executive Director educated current members of the Interdisciplinary Team inclusive of facility departmental directors and administrative personnel on proper disposal of expired, improperly sealed/stored, and unlabeled food items. Newly hired staff will be educated upon hire. The Executive Director and/or Interdisciplinary Team inclusive of facility departmental directors and administrative personnel will complete Quality Improvement Monitoring of the kitchen and nourishment room 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 weeks, 1 time per month for 2 months to ensure compliance with food storage. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive	

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F 371	Continued From page 30 it was the dietary staff's responsibility to check and date any snacks or sandwiches in the nourishment refrigerator used for resident snacks. An interview was conducted on 09/25/15 at 9:39 AM with the Director of Nursing (DON). She stated it was her expectation for dietary to date and check sandwiches in the nourishment refrigerator used for resident snack and the Unit Manger's responsibility to check dates on everything else stored in the refrigerator. She stated juice and applesauce that was not in its original container that was stored in the nourishment refrigerator should have been dated with the date it was placed in the refrigerator and discarded at the end of that day. During an interview conducted on 09/25/15 at 1:35 PM with the Dietary Manager she stated the sandwiches in the refrigerator should have been labeled with the date they were made; adding that the sandwiches were good for 3 days. The DM was unaware of the date the 1 and ½ trays of sandwiches stored for use had been made or how long they had been in the refrigerator. She further stated the healthy shakes should have been labeled with the date they had been taken out of the freezer to be thawed because they were only good for use 14 days after the thaw date. She stated she had no way of knowing how long the healthy shakes had been thawed due to them having no thaw date on them.	F 371	Director for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		10/23/15

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F 520	Continued From page 31 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to monitor the plans of action to correct identified quality deficiencies and maintain compliance in the areas of respiratory care, activities of daily living, notification of changes, and sufficient staffing . This was for one deficiency in the area of respiratory care which was originally cited on a recertification survey in October of 2014 and recited on the current recertification survey. One deficiency in the area of activities of daily living was originally cited on a complaint investigation in December of 2014, recited again during a complaint investigation in April of 2015 and	F 520	The Regional Director of Clinical Services provided education on 10/9/15 to members of the Quality Assurance Improvement Committee inclusive of the Executive Director, Director of Clinical Services, Minimum Data Assessment Nurse, Dietary Director, Maintenance Director, Activities Director, and Social Services Director on the Federal Regulation F520 QAA Committee and the facility's Policy and Procedure for Quality Assurance. Newly hired Interdisciplinary Team Members will be educated upon hire.	

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F 520	Continued From page 32 recited again on the current recertification survey. One deficiency in the area of notification of changes was originally cited on a complaint investigation in December of 2014 and recited on the current recertification survey. One deficiency in the area of sufficient staffing was originally cited on a complaint investigation in April of 2015, and recited again on the current recertification survey. The continued non-compliance of the facility during four federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 157: Notification of Changes: Based on record review and staff interviews, the facility failed to notify the physician to obtain treatment orders for an unstageable pressure ulcer noted on a newly admitted resident for 1 of 4 residents reviewed for notification of changes (Resident #153). During a complaint investigation on December 17, 2014 the facility was cited for failure to notify immediate family members of a change in psychotropic medications for a resident. The facility was recited on the current recertification survey for failing to notify the physician of a pressure ulcer noted on the nursing admission assessment of a resident. b. F 312: Activities of Daily Living: Based on observations, record reviews, and staff interviews the facility failed to provide nail care for 2 of 3 dependent residents reviewed for activities of	F 520	The Quality Assessment and Assurance Committee will meet at a minimum of monthly. A member of the Regional support team inclusive of, but not limited to, the Regional Clinical Director, Regional Director of Operations, Regional Director of Resident Assessment, Regional Director of Human Resources, and/or Regional Director of Nutritional Services, will attend the monthly Quality Assessment and Assurance Meeting. The Regional Support staff will evaluate the on-going Quality Improvement Monitors to validate substantial compliance is maintained and recommend changes to the corrective actions to obtain compliance if necessary. Quality Improvement Monitors will be monitored initially for a minimum time period of six months, or longer if necessary to successfully evaluate ongoing compliance with regulatory requirements. Upon successful, sustained compliance the identified area will be reviewed quarterly there after by the facility members of the Quality Assessment and Assurance Committee and Regional Support for the ongoing effectiveness of the program. Quality Improvement Monitors may be reinitiated at any time if compliance is not maintained. Resident #153 did have physician orders obtained for treatment of the unstageable pressure ulcer on 9/23/15 by Director of Clinical Services. Resident #153 has been receiving treatments as ordered by the physician since 9/23/15.	

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F 520	Continued From page 33 daily living (Resident #61 and #95). During a complaint investigation on December 17, 2014 and an additional complaint investigation on April 8, 2015, the facility was cited for not providing assistance with toileting and incontinence care. The facility was recited on the current recertification survey for failing to keep residents' fingernails clean and trimmed. c. F 328: Respiratory Care: Based on observations, record review, and staff interviews the facility failed to provide physician ordered continuous oxygen therapy to a resident while in her wheelchair to maintain an oxygen saturation greater than 90% for 1 of 1 resident reviewed for respiratory care (Resident #26). During a recertification survey of November 26, 2014 the facility was cited for failing to provide oxygen therapy while a resident was in a wheelchair. The facility was cited again on the current recertification survey for failing to provide oxygen therapy to a resident in a wheelchair. d. F 353: Sufficient Nurse Staffing: Based on record reviews and staff and resident interviews, the facility failed to provide sufficient nursing staff to offer physician ordered restorative nursing services to 1 of 1 resident reviewed for maintaining activities of daily living (Resident #73). During a complaint investigation of April 8, 2015 the facility was cited for failing to provide sufficient nursing staff to provide timely incontinence care to incontinent residents. The facility was cited on the current recertification survey for failing to provide restorative nursing to a resident as	F 520	Current residents, inclusive of newly admitted residents, had a skin assessment completed 9/24/15 - 9/25/15 by the Minimum Data Assessment Nurse and Wound Nurse to ensure that any prior, or currently identified skin impairments, had appropriate existing treatment orders and/or new orders were obtained for treatment and services. The Director of Clinical Services provided education to licensed nurses on 10/1/15 regarding the notification of the physician to obtain treatment orders for any newly admitted resident with identified skin impairment, or for any existing residents who develops skin impairment requiring treatment. Newly hired licensed nurses will receive education upon hire. Licensed nurses will notify the resident's physician and responsible party upon identification of skin impairment, and obtain treatment orders as indicated and document notification in the medical record. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring of residents to ensure that any necessary treatment orders were obtained timely for any identified skin impairments. Quality Improvement Monitoring will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 12 weeks, and/or until substantial compliance is obtained using a sample size of 5 residents.	

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F 520	Continued From page 34 ordered by the physician. Staff and resident interviews confirmed the lack of restorative nursing services was due to not enough nursing staff. An interview was conducted with the Administrator and Director of Nursing (DON) on 09/25/15 at 4:24 PM. The DON stated recently in the past 2 weeks the facility had designated staff for shower teams. The DON stated the facility planned to designate 2 days during the week to concentrate on toenail and fingernail care. The Administrator stated the empty portable oxygen tank was related to a new activity person that did not understand how to deal with portable oxygen. The Administrator stated the facility had been working on staffing. The Administrator added nurse staffing on the day shift was almost back to having enough staff to provide restorative nursing again.	F 520	Resident #61's nails were cleaned 9/25/15 by the Director of Clinical Services and will continue to receive assistance with nail care by facility nursing personnel as needed. Resident #95's nails were trimmed on 9/25/15by a certified nurse aide and will continue to receive assistance with nail care by facility nursing personnel as needed. Residents who are dependent with Activities of Daily Living are at risk for the alleged deficient practice. Dependent resident nails were assessed by nursing staff on 10/5/15 for cleanliness, length, and smooth edges. Nail care was provided where appropriate. The Director of Clinical Services reeducated nursing staff regarding care of residents nails by 10/16/15. Newly hired nurses and nurse aides will be educated upon hire. Dependent residents will receive nail care twice weekly during showers, and randomly as needed for any identified debris, soiling, or roughness during routine activities of daily living care. The Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement Monitoring of dependent residents' nails 3 times per week for 8 weeks, then 2 times per week for 8 weeks, then 1 time per week for 4 weeks, and then monthly for 1 month for cleanliness and appropriateness of shape. Resident #26 was assessed by the	

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F 520	Continued From page 35	F 520	licensed nurse on 9/22/15 and no harm was noted. Resident continues to receive oxygen as ordered by the physician via oxygen concentrator and/or portable oxygen tank. Residents with orders for continuous oxygen have the potential to be affected by the alleged deficient practice. The Director of Clinical Services completed a review of residents with oxygen orders by 9/24/15 to ensure compliance with oxygen treatments. Nursing staff were in-serviced by the Director of Clinical Services by 10/15/15 regarding administering oxygen therapy as ordered via oxygen concentrator and/or portable tank, and the operation of oxygen equipment and supplies. Newly hired nursing staff will be educated upon hire. The licensed nurse will observe residents with oxygen each shift to validate compliance with oxygen administration per physician's orders and document accordingly on the Medication Administration Record. The Director of Clinical Services/Nurse Manager will perform Quality Improvement Monitoring of residents with oxygen therapy to validate compliance three times per week for 4 weeks, 2 times per week for 8 weeks, then monthly for 3 months using a sample size of 5 residents Resident #73 was recently discharged from skilled therapy on 10/12/15 with a referral to Restorative Nursing for	

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F 520	Continued From page 36	F 520	continued utilization of the NuStep. Resident #73 will continue to receive restorative care as appropriate. Residents requiring assistance with Activities of Daily Living are at risk for the alleged deficient practice. The Director of Clinical Services, Rehab Program Manager, and Minimum Data Set Nurse completed a restorative nursing evaluation of current residents to identify residents that could benefit from a restorative program. Identified residents were referred to the Restorative Nurse and restorative programs were initiated as recommended. The Regional Director of Clinical Services provided education to the Director of Clinical Services, Restorative Nurse, and Rehab Program Manager on 10/15/15 regarding implementation of a restorative program to promote residents independence with activities of daily living. The Director of Clinical Services and Restorative Nurse educated restorative aides by 10/16/15 and competencies were completed to assure understanding of skills. Newly hired restorative aides will be educated upon hire. Residents will be screened by the Restorative Nurse upon admission, readmission, quarterly, and with a significant change in condition. Those identified residents will be referred to a restorative program as appropriate to promote independence with activities of daily living. The Restorative Aides will be responsible for provided restorative care as appropriate per the resident's care	

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plan. In the absence of the Restorative Aide the Restorative Nurse and/or other member of Nurse Management will be designated to ensure the delivery of resident specific restorative care in accordance with the care plan to maintain or improve each residents' abilities.

The Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement Monitoring of 10 residents to validate that each resident is receiving restorative services if indicated. Quality Improvement Monitoring will be completed 3 times per week for 8 weeks, 2 times per week 4 weeks, 1 time per week for 4 weeks, and then 1 time monthly for 2 months.

The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary

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F 520	Continued From page 38	F 520	Director, and Minimum Data Assessment Nurse. Date of Completion: October 23, 2015	