STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		10/16/15

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

Electronically Signed | 10/16/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to investigate an allegation of abuse for 1 of 2 resident (Resident #1). The findings included: Resident admitted to the facility on 10/16/14 with a diagnoses that included traumatic brain injury, joint contracture of multiple joints, and quadriplegia. The annual MDS dated 10/23/15 indicated the resident was severely cognitively impaired. Review of the facilities concern form dated 8/25/15 stated, " Agitate him, hitting him in his face, telling him to kick and bite us, taking pictures and videos, bounces on his bed, pulling his catheter off repeatedly (condom catheter). " The action taken revealed the facility social worker left a message with department of social services (DSS) so this referral could be made. The concern form continued with awaiting DSS to call back. The follow date was documented as 8/26/15. DSS was made aware of the concern on 8/28/15. The concern form did not indicate any measures to protect or investigate the allegation. Review of the facilities incident log from 8/1/15 through 9/21/15 revealed no incidents in regards to resident #1. Review of Resident #1 ' s nurse ' s notes from 8/1/15 through 9/21/15 revealed no notes in regards to alleged abuse from resident #1 ' s family member ' s interactions. Review of Resident #1 ' s skin/body assessment revealed no assessment for the date of alleged abuse on 8/25/15. In an interview on 9/21/15 at 2:57pm with Nurse #2 revealed she had not observed Resident #1 ' s family abuse him. Nurse #2 stated that she had overheard that an incident involving alleged	F 225	1. The Administrator and DON, were re-educated regarding the facilities Abuse & Neglect Prohibition policy to include what constitutes an allegation of abuse, investigation and the reporting of abuse by the DDCS on 10/16/15. 2. The Administrator and Director of Nursing reviewed the last 30 days of concerns/grievances to ensure that any further potential abuse was thoroughly investigated and the resident was protected. 3. Beginning 10/16/15 all facility employees will be re-educated by Director of Nursing, area Staff Development Coordinator, and Unit Managers on the Facility Abuse and Neglect Prohibition, this education will include, investigation process, and reporting and measures to prevent further potential abuse while the investigation is in process. Audits will be conducted 3x a week x 4 weeks and then weekly x 3 months of the facilities concern/grievance log binder to ensrue that any potential abuse is investigated thoroughly and the resident was protected. 4. The Administrator and Director of Nursing will review data obtained from concern/grievance logs and analyze the data and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the	

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F 225	Continued From page 2 abuse by Residents #1 ' s family was communicated to upper management by an unknown NA. Nurse #2 revealed she was unaware of which nursing assistant (NA) communicated the concern. Nurse #2 indicated that she was under the impression that Resident #1 ' s family was under supervised visits due to the family allegedly recording and hitting the resident. Nurse #1 indicated that she was in the room when the family member was observed to video tape the resident. Nurse #2 stated she informed the previous Director of Nursing (DON) of the family member videotaping the resident. Nurse #2 stated she had not observed any abuse from Resident #2 ' s family. NA#1 indicated she was not provided any guidance in regards to what she communicated to the previous DON. Resident #1 did not receive supervised visits until the beginning of September. In an interview on 9/21/15 at 3:14 pm with NA #2 revealed she had observed the family to be " a little over aggressive " with Resident #1. NA#2 stated the one of the family members was observed to bounce on the Resident #1 ' s bed and would tap this face with their hands saying " get mad " , " Kick " and " bite " . NA#2 stated that she had reported what she had observed to her nurse (no longer employed). The nurse told the former Director of Nursing (DON). The former DON came back to Resident #1 ' s room and stood outside the room so she could witness what was being communicated. NA#2 stated that she had not filled out an incident report, a witness statement or interviewed about her observation. NA#2 could not recall any interventions put into place until the beginning of September in which DSS entered the building to investigate. In an interview with the interim DON on 9/22/15 at 10:43am revealed she was made aware of	F 225	effectiveness of the above plan, and will add interventions based on identified outcomes to ensure continued compliance.	

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supervised visits with Resident #1 during a morning meeting. She stated it was communicated that the supervised visits were due to allegations of abuse. It was alleged that one of the family members would bounce on Resident #1 ' s bed and had slapped the resident. The interim DON stated she was not involved in the investigation and the supervised visitation was in place prior to her arrival. The Interim DON stated she was unable to locate an incident report or investigation in regards to the allegation. The DON revealed it was her expectation that allegations of abuse be investigated immediately to ensure the protection of the resident. Staff are to repot allegations of abuse when they occur. No paperwork could be obtained by the facility in regards to an internal facility investigation. She was unaware of any Intervention put into place prior to DSS entering the building.
In an interview on 9/22/15 at 11:14 am the Administrator revealed he was notified of the concern form dated 8/26/15 via a phone call. The administrator indicated the social worker had received a concern form in her mailbox and she wanted to inform him that she was going to notify DSS of allegations regarding Resident #1 and abuse from his family. The concern form was submitted anonymously. The administrator stated an investigation was not conducted by the facility. The Administrator indicated that he felt as though the thought process of the former DON was due to the allegation of abuse being from a family member it was to be reported to APS/DSS. The Administrator stated that DSS entered the building on 8/31/15 and they wanted the facility to put a plan together that would protect the resident and send it them. A finalized plan was sent to DSS on 9/17/15. Supervised visits began on 8/31/15 in which we the Administrator indicated

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F 225	Continued From page 4 he stood outside of Resident #1 ' s door to monitor the family interactions. Interview with the previous DON on 9/22/15 at 1:31 pm revealed the concern of Resident #1 ' s family had been brought to her as a concern a couple of times during her employment. The DON indicated the facility watched the family periodically and addressed the family about removing the bedside mat. The DON indicated a concern form was located in the social workers mailbox that stated Resident #1 ' s family had hit him, bounced on the bed and removed his catheter. The interdisciplinary team had reviewed the concern form and felt that Adult Protective Services needed to get involved. When it came to family abuse the best agency to investigate the incident was Adult protective services. No interventions were put into place until DSS recommended the supervision to protect the resident on 8/31/15. In an interview with Resident #1 ' s family members on 9/22/15 at 5:05pm revealed that they had not been approached by the facility or interviewed about allegations. The family was questioned about the situation from DSS and the police department. Following 9/1/15 the family stated they were told by the facility that they would be on supervised visits indefinitely. The family member revealed the allegations to be bouncing on the resident ' s bed, holding his legs to restrict his movement, and smacking him on the face to get Resident #1 to talk to her. The family members denied the allegations. The family indicated they were able to visit with Resident #1 unsupervised in his room until 9/1/15. In an interview with NA#3 on 9/23/15 at 9:17am revealed she had observed one of Resident #1 ' s family members agitate him as evidenced by	F 225		

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F 225	Continued From page 5 jumping up and down on his bed and smacking him on the face. Resident #1 would become agitated as evidenced by kicking his legs and attempting to bite. Nurse #3 indicated the smacking could be heard in the hallway but she did not believe the family member was doing it to harm the resident. The slaps were described by NA#3 as not hard. NA#3 states she told her nurse what she had observed (no longer employed). NA#3 revealed she had not filled out the concern form dated 8/25/15 but she had communicated it to her nurse verbally in July. NA#3 stated that she had not been interviewed by anyone in regards to the allegation until DSS entered the building on 9/1/15. NA#3 stated no interventions were communicated to her in regards to protecting the resident or supervision. Supervision was initiated following the DSS investigation.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, detective interview and staff interview the facility failed to investigate and protect an alleged abuse of 1 of 2 sampled resident (Resident #1). The findings included: Abuse and Neglect Prohibition/policy (revision date: June 2013) - each resident has the right to	F 226	1. An incident report will be completed for resident #1 by the Unit Managers on 10/17/15 A skin and body assessment will be completed for resident # 1 by the Unit Managers on 10/17/15. An investigation summary will completed for resident #1 on 10/17/15 by the Administrator .The	10/20/15

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F 226	Continued From page 6 be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property. Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the administrator and/or director of nursing. Procedure: 3) the facility will screen for potentially abusive individuals involved with the resident who are not providing a professional services. Prevention: 2) facility supervisor will immediately correct and intervening in reported or identified situations in which abuse, neglect, injures of unknown origin, or misappropriation of resident ' s property is at risk for occurring. 3) staff will be instructed to report any signs of stress from employees , family or other individuals involved with the resident that may lead to abuse, neglect, injured o unknown origin, or misappropriate of resident property, and to intervene as appropriate. Identification: 1) the facility QAPI committee will investigate occurrences, patterns and trends that may indicate the presence of abuse, neglect, injuries of unknown origin, or misappropriating of resident property to determine the direction of the investigation/intervention, though analysis of systems, audits and reports. Investigation: 1) the facility will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state lay. 2) The facility will report such allegations to the state, in accordance with state regulation 3) the facility will report all investigation findings to the state in accordance with state regulations. Protection: 1) the facility will protect residents from harm during the investigation Documentation: 1) incident/accident report for residents 2) in-service reports 3) concern report	F 226	Administrator and the DON, were re-educated regarding the Facilities Abuse & Neglect Prohibition policy to include what constitutes allegation of abuse, investigation and the reporting of abuse by the DDCS on 10/16/15. 2. Interviews to be conducted by the Director of Nursing, Social Services, and Unit managers with current staff to verify the reporting of allegations of abuse to be completed by 10/20/15 .Residents with BIMS > 10 to be interviewed by the Social Service Director, Director of Nursing, and Unit Managers to ensure allegations of abuse have been reported timely and accurately . These interviews to be completed by 10/20/15. 3. Beginning 10/16/15 all facility employees will be re-educated by Director of Nursing, SDC, and Unit Managers on the Facility Abuse and Neglect Prohibition, this education will include, investigation process, and reporting to be completed by 10/20/15.Staff interviews will be conducted 3 x a week x 4 weeks and then monthly x 3 months on reporting abuse and investigation process. 4. The Administrator and Director of Nursing will review data obtained from staff interviews and analyze the data and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified	

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F 226	Continued From page 7 4) concern report log. Resident #1 was admitted to the facility on 10/16/14 with a diagnoses that included traumatic brain injury, joint contracture of multiple joints, and quadriplegia. The annual MDS dated 10/23/15 indicated the resident was severely cognitively impaired. Review of the facilities concern form dated 8/25/15 stated, " Agitate him, hitting him in his face, telling him to kick and bite us, taking pictures and videos, bounces on his bed, pulling his catheter off repeatedly " (condom catheter). The action taken revealed the facility social worker left a message with department of social services (DSS) so this referral could be made. The concern form continued with awaiting department of social services to call back. The follow date was documented as 8/26/15. DSS was made aware of the concern on 8/28/15. The concern form did not indicate any measures to protect or investigate the allegation. Review of the facilities incident log from 8/1/15 through 9/21/15 revealed no incidents in regards to resident #1. Review of Resident #1 ' s nurse ' s notes from 8/1/15 through 9/21/15 revealed no notes in regards to alleged abuse from resident #1 ' s family member ' s interactions. Review of Resident #1 ' s skin/body assessment revealed no assessment for the date of alleged abuse on 8/25/15. In an interview on 9/21/15 at 2:21pm with Nurse #1 (unit manager) revealed she had recently begun employment in July. She stated that Resident #1 ' s family visited with the resident daily. Currently the visitations with Resident #1 ' s family was supervised and took place in the front lobby of the facility. Nurse #1 stated she was unaware of the specifics as to why the family	F 226	outcomes to ensure continued compliance.	

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was under supervised visits but it was her understanding that an allegation was communicated by staff that the family had hit the resident. Nurse #1 stated that she had witnessed Resident #1 ' s family member agitate Resident #1. One of the family members was observed to bounce on the residents bed and tell Resident #1 if he does what she wants the family member would buy Resident #1 a milk shake although the family member was aware Resident #1 was nothing thing by mouth status (NPO). Nurse #1 stated she had not observed the family members to be aggressive with Resident #1 although the resident became visibly agitated.

In an interview on 9/21/15 at 2:57pm with Nurse #2 revealed she had not observed the Resident #1 ' s family abuse him. Nurse #2 stated that she had overheard that an incident involving alleged abuse by Residents #1 ' s family was communicated to upper management by an unknown NA. Nurse #2 revealed she was unaware of which NA communicated the concern. Nurse #2 indicated that she was under the impression that Resident #1 ' s family was under supervised visits due to the family allegedly recording and hitting the resident. Nurse #1 indicated that she was in the room when the family member was observed to video tape the resident. Nurse #2 stated she informed the previous Director of Nursing (DON) of the family member videotaping the resident. Nurse #2 stated she had not observed any abuse from Resident #2 ' s family.

In an interview on 9/21/15 at 3:14 pm with NA #2 revealed she had observed the family to be " a little over aggressive " with Resident #1. NA#2 stated the one of the family members was observed to bounce on the Resident #1 ' s bed and would tap this face with their hands saying "

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get mad " , " Kick " and " bite " . NA#2 stated that she had reported what she had observed to her nurse (no longer employed). " The nurse told the former Director of Nursing. The former DON came back to Resident #1 ' s room and stood outside the room so she could witness what was being communicated. NA#2 stated that she had not filled out an incident report, a witness statement or interviewed about her observation.
In an interview with the interim DON on 9/22/15 at 10:43am revealed she was made aware of supervised visits with Resident #1 during a morning meeting. She stated it was communicated that the supervised visits were due to allegations of abuse. It was alleged that one of the family members would bounce on Resident #1 ' s bed and had slapped the resident. The interim DON stated she was not involved in the investigation and the supervised visitation was in place prior to her arrival. The Interim DON stated she was unable to locate an incident report or investigation in regards to the allegation. The DON revealed it was her expectation that allegations of abuse be investigated immediately to ensure the protection of the resident. Staff are to repot allegations of abuse when they occur.
No paperwork could be obtained by the facility in regards to an internal facility investigation.
In an interview on 9/22/15 at 11:14 am the Administrator revealed he was notified of the concern form dated 8/26/15 via a phone call. The Administrator indicated the social worker had received a concern form in her mailbox and she wanted to inform him that she was going to notify DSS of allegations regarding Resident #1 and abuse from his family. The concern form was submitted anonymously. The administrator stated an investigation was not conducted by the facility. The Administrator indicated that he felt as

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though the thought process of the former DON was due to the allegation of abuse being from a family member it was to be reported to APS/DSS. The Administrator stated that DSS entered the building on 8/31/15 and they wanted the facility to put a plan together that would protect the resident and send it them. A finalized plan was sent to DSS on 9/17/15. The administrator stated the family had not been approached in an attempt to conduct an in-house investigation until DSS entered the building on 8/231/15 in which DSS interviewed the family.

Interview with the previous DON on 9/22/15 at 1:31 pm revealed the concern of Resident #1 ' s family had been brought to her as a concern a couple of times during her employment. The DON indicated the facility watched the family periodically and addressed the family about removing the bedside mat. The DON indicated a concern form was located in the social workers mailbox that stated Resident #1 ' s family had hit him, bounced on the bed and removed his catheter. The interdisciplinary team had reviewed the concern form and felt that Adult Protective Services needed to get involved. When it came to family abuse the best agency to investigate the incident was Adult protective services. No interventions were put into place until DSS recommended the supervision to protect the resident on 8/31/15.

In an interview with Resident #1 ' s family members on 9/22/15 at 5:05pm revealed that they had not been approached by the facility or interviewed about allegations. The family was questioned about the situation from DSS and the police department. Following 9/1/15 the family stated they were told by the facility that they would be on supervised visits indefinitely. The family member revealed the allegations to be

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bouncing on the resident ' s bed, holding his legs to restrict his movement, and smacking him on the face to get him to talk to me. The family members denied the allegations.
In an interview with NA#3 on 9/23/15 at 9:17am revealed she had observed one of Resident #1 ' s family members agitate him as evidenced by jumping up and down on his bed and smacking him on the face. Resident #1 would become agitated as evidenced by kicking his legs and attempting to bite. Nurse #3 indicated the smacking could be heard in the hallway but she did not believe the family member was doing it to harm the resident. The slaps were described by NA#3 as not hard. NA#3 states she told her nurse what she had observed (no longer employed). NA#3 revealed she had not filled out the concern form dated 8/25/15 but she had communicated it to her nurse verbally in July. NA#3 stated that she had not been interviewed by anyone in regards to the allegation until DSS entered the building on 9/1/15.
During an interview with the detective/police on 9/23/15 at 10:02am revealed he did come to the facility due to allegations of abuse. The facility had submitted an informal incident report (concern log). I spoke with NA#3 due to the facility indicating that NA#3 had written filed the concern form dated 8/25/15. NA#3 indicated she did not fill out the form and she had communicated a concern regarding the family ' s treatment of Resident #1 in July. NA#3 communicated she one of the family members hit Resident #1 in the face in July and bouncing on his bed. The detective indicated he asked the facility administrator why the facility waited so long to report the incident. The admin stated it occurred a month prior than the concern form dated 8/25/15. The admin stated it was not

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F 226	Continued From page 12 handled the way it should have been handled. The detective revealed he had spoken with the family members and the family members disputed the allegations. No charges were filed due to so much time between the time is was claimed to be reported in July and the time I arrived in August. The facility did now why the concern form was dated in August.	F 226		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview the facility failed to resolve grievances for 5 of 6 sampled Residents (Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) who communicated grievances in regards to missing clothing in resident council meetings. The findings included: Review of the facilities grievance log from 6/1/15 to 9/21/15 revealed 9 Grievances in regards to missing clothing. 7 grievances were observed as not having follow up or resolve. Resident Council Meeting minutes were reviewed from July 2015 through September 2015. Resident council meeting notes dated 7/8/15 revealed section H: housekeeping. The minute ' s identified resident had missing items. No follow	F 244	1. Concern forms will be completed by the Administrator, DON, Social Services on 10/19/2015 to ensure resident satisfaction with the resolution of the missing clothing items for residents #2, #3, #4, #5, and #6, The Administrator, Activity Director was re-educated regarding the facilities grievance/concern form process by the area Staff Development by 10/20/2015. 2. Clothing items of residents in-house to be inventoried by the IDT to ensure clothing items are labeled with the residents name by 10/20/15. Concerns forms will be reviewed for the last 30 days by the Administrator by	10/20/15

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F 244	Continued From page 13 up was documented in July ' s resident council minutes. Resident Council meeting notes dated 8/3/15 revealed section H: housekeeping. The minutes identified residents had concern and completed concern forms. Resident council notes dated 9/9/15 indicated section H: housekeeping. Complete concern form for specific concerns: completed concerns. Resident #2 was admitted to the facility on 9/2/12. The most recent Minimum Data Set (MDS) assessment dated 9/9/15 indicated Resident #2 was cognitively intact. Interview with Resident #2 on 9/21/15 at 4:00pm revealed he was the resident council president for the facility. Clothing had been an ongoing issue discussed at resident council meetings. Resident clothing was going missing and not being returned after it was sent to the facility laundry. Resident #2 stated he had clothing was to be laundered and returned in 2 days but that never occurs. Resident #2 stated it may take 2 weeks for clothing to return to the resident. Housekeeping did attended resident council meetings and have listened to the grievance regarding clothing. The response provided by housekeeping was they were working on it. Laundry blames it on the nursing assistants, and the nursing assistance says its laundry fault. Resident #3 was admitted to the facility on 9/15/15. The most recent MDS assessment dated 8/28/15 indicated Resident 33 was cognitively intact. Interview with Resident #3 on 9/21/15 at 4:02pm revealed she had clothing go missing and communicated it to the facility 2 weeks prior. The resident indicated she had dresses to go missing. Resident #3 stated, " the new administer told me he would get back with me. " She indicated no one ever got back with her in regards to her	F 244	10/20/15 to ensure compliance with completion and resolution per the resident /family member. Concern forms will be brought to the facilities stand-up morning meeting by the Administrator/IDT and logged into the concern/grievance log binder by the Administrator. Investigation and interventions will be completed by the member of the IDT, completed concern forms will be returned to the Administrator and resolution will be validated by the Administrator. 3. The IDT will be re-educated on the facility concern/grievance process to include the completion/resolution of the concern/grievance by the area Staff Development Coordinator by 10/20/2015. Audits will be conducted 3 x week x 4 weeks and then weekly x 3 months of the facilities concern/grievance log binder to ensure completion/resolution of the grievance/concern forms by DNS, Social Services. Unit Managers. Nursing and Housekeeping to be educated by the area Staff Development Coordinator/IDT team on where to place soiled personal clothing items to prevent personal clothing being sent to outside laundry company to be completed by 10/20/15 4. The Administrator will report the results of these audits and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified outcomes to ensure continued compliance.	

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messing dresses.
Resident #4 was admitted to the facility on 1/14/13. The Most recent MDS assessment dated 8/18/15 indicated Resident #4 was cognitively intact.
Interview with Resident #4 on 9/22/15 at 9:05am revealed he only had one pair of pants left and he entered the facility with 6 pair of pants. Resident #4 indicated he told the housekeeping director and the Administrator about his missing as recently as 2 weeks ago. He had communicated the concern to the housekeeping several times over the last couple of months. Missing clothing had been an ongoing issue off and on for about a year and were discussed in resident council meetings. Resident #4 stated he had 2 missing golf shirts, a couple of sweaters and a jacket go missing. Resident #4 indicated he had put his name in his clothing and would still get other residents clothing and not his own.
Resident #5 was admitted to the facility on 10/2/14. The most recent MDS assessment dated 8/7/15 indicated Resident #5 was cognitively intact.
Interview with Resident #5 on 9/22/15 at 9:09am revealed he had keep a list of items that were lost in the facility laundry. Resident #5 stated he had begun his list in July. The list contained 8 gray socks, 1 pair of white socks, 1 pair of blue, and 1 pair of navy. The list continued with green shirt with snaps, black paints, and tan shorts. The resident indicate he had communicated the missing items in resident council. Housekeeping continue to state they are looking for the times and working on the issue. Items continued to go missing.
Resident #6 was admitted to the facility on 10/10/14. The most recent MDS assessment dated 7/29/15 revealed Resident #8 was

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cognitively intact.
Interview with Resident #6 on 9/22/15 at 9:23am revealed her clothing didn ' t always return from the facility laundry. The facility had not located her times. Resident #6 indicated she had a blanket go missing about 3 months ago but she got tired of asking about it. She stated she had pants go missing although she has put her name in her items. Resident #6 revealed she attended resident council meeting regularly and missing clothing had remained a topic. The facility communicate they are looking for lost items but fail to follow up. It is common that we get other residents clothing but not our own.
Interview with the Housekeeping manager on 9/22/15 at 1:54pm revealed he was aware of concerns in regards to resident complaints about coting not being returned. The housekeeping manger indicated he tried to take care of the grievances immediately. He stated in the instance he received a grievance he would go to laundry to attempt to locate the clothing or do a room sweep. In some instance he did have issues finding some resident clothing. The housekeeping director stated that the facility used an outside agency for soiled linen and occasionally resident clothing may get mixed in. Revealed resident inventory logs were not located or not updated. Interview with the Housekeeping/Laundry Director revealed he did not always document on the concern form.
Interview on 9/23/15 at 2:30 PM with the Administrator and Interim DON revealed the audits for F166 had not been completed by the QA committee. The audits of the concern forms were completed on 7/10, 7/13 and 7/28/15. There were no further audits of the concern forms after this date that would have been due per the previous plan of correction. The concerns were

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F 244	Continued From page 16 not monitored for the presence of who took the concern, who made the concern, when it happened, and the follow up the facility implemented for addressing the concern.	F 244		