STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345312	A. BUILDING: _____ B. WING _____	2/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	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 family and staff interviews and record review, the facility failed to provide notice of a change in the resident's behaviors and of a room change for 1 of 2 sampled residents with a room change (Resident # 5).

The findings included:

Review of Resident # 5's record on 2/10/16 revealed he was admitted on 09/01/14 with diagnoses including Alzheimer's Dementia, Congestive Heart Failure and Anxiety Disorder. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 12/07/15 revealed he had short and long term memory deficits and had difficulty making himself understood and understanding others. The record listed a family member as his legally responsible party (RP) and Power of Attorney (POA).

Review of Resident # 5's progress notes revealed a nursing note dated 12/21/15 which read "Resident moved to room 302A this PM around 1600 (4:00 PM). Propelling self in hallway and in and out of other residents' rooms. Easily redirected, accepted redirection but very agitated. Resting in bed."

Further review of Resident # 5's record on 02/10/16 revealed no documentation in either nursing or social services notes of notification to Resident # 5's RP of the increased wandering behaviors and the room change.

Interview with Resident # 5's RP on 02/10/16 at 1:05 PM revealed Resident # 5 was initially admitted to the secure unit back in 2014, but his physical condition declined and he was moved out of the unit. The RP

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reported he became stronger and began propelling himself in a wheelchair for the past 2-3 months. The RP reported she was not notified of the room change to the secure unit on 12/21/15 or the increased wandering behaviors noting, "They did not call me or talk to me before they moved him. I was disturbed." The RP further reported she came to visit Resident # 5 the day after the room change and discovered the resident had been moved. The RP stated she spoke to the administrator about her concerns and was told her husband had been moved to the locked unit due to increased wandering behaviors.

Interview with the social worker on 02/10/16 at 3:00 PM revealed the facility typically gives a 24 hour notice prior to a room change and showed the resident or their RP the room prior to moving the client. She further reported Resident # 5 was moved late in the day on 12/21/15 due to increased wandering behaviors, and she was not in the facility when the move occurred. The Social Worker further reported "the family should have been notified that day, but I did not notify them as I was not here, but someone should have notified them of the behaviors and the move."

Interview with the Administrator and Director of Nursing on 02/10/16 at 4:30 PM confirmed Resident # 5's wife/POA was not notified of the increased wandering behaviors and the room change prior to or at the time of move, and should have been notified by either Social Services or Nursing staff. The Administrator further stated "Two families were upset and came to me about him wandering in female resident rooms, so we moved him back to the secure unit that day and we failed to notify his family."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff and family interviews, the facility failed to promote the dignity of 1 of 5 residents (Resident #4) by not changing soiled clothes. (Resident #4) Findings included: Resident #4 was admitted to the facility on 12/16/14 with diagnoses including non-Alzheimer's dementia, arthritis and gastric reflux. Review of the annual Minimum Data Set (MDS) on 12/07/15 indicated Resident #4 was limited assistance with eating, but extensive assistance with bathing, personal hygiene and dressing. Further review of the MDS revealed Resident #4 had moderately impaired decision making skills. An initial observation of Resident #4 on 02/10/16 at 9:55AM revealed he was wearing a blue sweatshirt with a dried, yellowish crusty substance across the chest on the left side. The soiled area was approximately 4 inches by 1.5 inches. An attempt to interview the resident was unsuccessful due to his impaired cognition. A second observation of Resident #4 on 02/10/16 at 12:46PM revealed he was wearing the same blue sweatshirt observed earlier with a dried, yellowish crusty area on the left side of the chest. A third observation of Resident #4 on 02/10/16 at 5:35PM revealed he was wearing the same blue sweatshirt observed throughout the day with the	F 241	Criteria #1- 1. Corrective action has been accomplished for resident #4 by ensuring the resident□s clothing remains unsoiled and if soiled it will be changed in a timely manner. 2. Criteria #2- All facility residents have the potential to be affected by the same alleged deficient practice. A 100% audit of current residents was completed to ensure all residents had clean clothing on. 3. Criteria #3- Measures put into place to ensure that the alleged deficient practice does not recur include: the DON will provide in-service/re-education to the CNA□s and CMA□s on changing resident□s clothing in a timely manner if soiled. Resident□s should also have clothing changed during morning and bedtime ADL care per resident preference. Additionally, the DON and Unit Managers will conduct audits 3 times weekly for four weeks and then 1 time weekly for 2 months visually making rounds to ensure residents have on unsoiled clothing.	3/5/16

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

Electronically Signed | 03/03/2016

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F 241	Continued From page 1 dried, yellow crusty area across the chest on the left side. During an interview with a family member of Resident #4 on 02/10/16 at 5:35PM, it was stated Resident #4 always had food all over him. It was also stated that the family member had not come into the facility when he didn't have food on his face, on his shirt or on his hands. A final observation of Resident #4 on 02/11/16 at 8:03AM revealed he was wearing the same blue sweatshirt from yesterday with the dried, yellowish crusty substance across the chest on the left side. During a staff interview on 02/11/16 at 9:30AM it was revealed Nurse Aide #1 had not noticed the sweatshirt was soiled 02/10/16 or 02/11/16 and had yet to change clothes for Resident #4 02/11/16. During a staff interview on 02/11/16 at 10:59AM, the DON stated her expectation was for each resident's clothes to be changed when they were found to be soiled. The DON stated her expectations was for residents to have day clothes to wear and be changed into night clothes for sleep on a daily basis.	F 241	4. Criteria #4- The Administrator and DON will conduct analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		3/5/16

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F 278	Continued From page 2 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and resident and staff interview, the facility failed to accurately assess the dental status of 2 residents on the Minimum Data Set (MDS) assessment for 2 of 2 residents (Resident's #9 and #12). Findings included: 1. Resident #9 was admitted to the facility on 07/19/2014. Review of the annual MDS dated 09/03/15, revealed Resident #9 was alert and oriented with no cognitive impairment. The MDS further indicated Resident #9 required extensive assistance with personal hygiene. There were no dental/oral concerns noted on this annual assessment with no development of a care plan. During an interview on 02/10/16 at 12:03PM, Nurse Aide #1 stated Resident #9 did not have dentures, but had her own teeth and could brush	F 278	Criteria #1- Corrective action has been accomplished for the alleged deficient practice with regard to resident #9 and resident #12. The assessments were modified to show correct coding for dentition. Criteria #2- Facility residents who have dentures have the potential to be affected by the same alleged deficient practice. The Resident Care Management Director and MDS coordinator completed 100% audit of currently admitted residents to ensure everyone with dentures were coded appropriately. 100% audit was completed on 2/19/16.	

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F 278	Continued From page 3 them independently. An interview was conducted with Resident #9 on 02/10/16 at 1:10PM. Resident #9 stated she had upper and lower dentures. Resident #9 took each plate out of her mouth and then reinserted them. During an interview with the MDS Coordinator on 02/11/16 at 10:16AM, it was revealed the coding of the dental section for Resident #9 was incorrect. She verified the MDS should have been coded correctly to indicate Resident #9 had no natural teeth. An interview was conducted with the Director of Nursing (DON) on 02/11/16 at 10:59AM. The DON stated her expectation was for information recorded in the MDS assessment would be accurate so a proper care plan could be developed. 2. Resident #12 was admitted to the facility on 11/23/15. Review of the 5 day admission MDS dated 11/30/15 indicated the resident had some mild memory impairment. The MDS further indicated Resident #12 required extensive assistance with personal hygiene. There were no dental/oral concerns noted on this assessment with no development of a care plan. During an interview with Nurse Aide #1 on 02/10/16 at 1:35PM, it was revealed that Resident #12 had no teeth and required assistance using a soft, spongy mouth cleaner for oral care. An interview with Resident #12 on 02/11/16 at 4:01PM revealed the resident had no natural	F 278	Criteria #3- Measures put into place to ensure that the alleged deficient practice does not reoccur include: The District Director of Clinical Services conducted in-service/re-education for the Resident Care Management Director and MDS Coordinator Director on 2/10/16, regarding MDS Accuracy and proper coding for all residents with dentures as described in the RAI manual. The Resident Care Management Director will audit 10 assessments per month for 3 months to ensure accurate coding of dentition. Criteria #4- The Resident Care Management Director will review data obtained during assessment audits, analyze the data and report patterns/ trend to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan. Committee will evaluate findings and make further adjustments and recommendations as indicated.	

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F 278	Continued From page 4 teeth. Resident #12 stated he had thrown away his dentures several months before coming to live in the facility. During an interview with the Resident Care Management Director on 02/11/16 at 5:03PM, it was acknowledged that the MDS coding of the dental section was incorrect and would be corrected and resubmitted for accuracy. An interview was conducted with the DON on 02/11/16 at 5:33PM. The DON stated her expectation was for information recorded in the MDS to be accurately coded.	F 278		
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 medical record review and staff interview the facility failed to administer medication consistent with physician orders for 2 of 2 sampled residents with medications reviewed. (Resident #3 and Resident #10) The findings included: 1. Resident #3 was admitted to the facility 01/09/16 with diagnoses which included spinal stenosis, chronic post procedural pain, polyneuropathy and laminectomy. The current care plan for Resident #3 dated 02/01/16 included the following problem area:	F 281	Criteria #1- 1. Resident #3 has Norco 5/325 order discontinued immediately, MD and resident notified, medication variance report was completed. Resident evaluated by FNP at this time and no issues were noted. Practice was corrected for Resident #10 by obtaining Biotin 1mg , notifying MD and resident of missed doses, and completion of a medication variance report.	3/5/16

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F 281	Continued From page 5 Receives pain medication therapy related to status post laminectomy. Approaches to this problem area included, administer analgesic medications as ordered by physician. Observe/document side effects and effectiveness. Review of admission physician orders for Resident #3 included the following medications: 1. Acetaminophen 500 milligrams (mg). Give 2 tablets by mouth three times a day not to exceed 4000 mg/day total acetaminophen from all sources. 2. Norco 7.5/325 (hydrocodone/acetaminophen). Give 2 tablets by mouth every 4 hours as needed for pain. 3. Hydrocodone-acetaminiphen tablet 5-325. Give 2 tablets by mouth every 4 hours as needed for pain until Norco 7.5/325 available then discontinue. Review of the January 2016 Medication Administration Record (MAR) for Resident #3 noted the 2 tablets of 500 mg of acetaminophen were scheduled three times a day; providing 3000 mg of acetaminophen every day. In addition to the 3000 mg of acetaminophen/day Resident #3 received the following additional sources of acetaminophen as documented on the January 2016 MAR: 01/10/16-Resident #3 received 2 separate doses of 2 tablets of 7.5-325 Norco (hydrocodone-acetaminophen) for an additional 1300 mg of acetaminophen. With the 3000 mg of scheduled acetaminophen this totalled 4300 mg of acetaminophen on 01/10/16. 01/17/16-Resident #3 received 2 separate doses of 2 tablets of 7.5-325 Norco (hydrocodone-acetaminophen) for an additional	F 281	Criteria #2- 2. All residents have the potential to be affected by the Alleged deficient practice; therefore the DON and Unit Managers completed a 100% audit of physician□s Orders of one time doses for the last 30 days to ensure all orders are accurate. Also, a 100% audit of all OTC medications was performed to ensure we have on-hand the correct medications and dosages needed. Criteria #3- 3. Measures put into place to ensure this deficient practice does not reoccur include: Current licensed nurses and CMA□s were educated on notifying DON or Unit Mangers if a needed medication is not available and proper way to put in a one-time order in PCC. DON and Unit Managers will audit new one time dose orders to ensure they were entered into PCC correctly and new OTC medication orders to ensure correct dosage is available weekly for 4 weeks, bi-weekly for 2 weeks, and monthly for 3 months. Criteria #4- 4. The Administrator and Director of Nursing will review data obtained from audits and , analyze the data and report patterns/trends to the QAPI committee every month.	

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1300 mg of acetaminophen. In addition, Resident #3 received 2 tablets of Hydrocodone-acetaminophen 5-325 for an additional 650 mg of acetaminophen. With the 3000 mg of scheduled acetaminophen this totalled 4950 mg of acetaminophen on 01/17/16.
01/20/16-Resident #3 received 2 separate doses of 2 tablets of 7.5-325 Norco (hydrocodone-acetaminophen) for an additional 1300 mg of acetaminophen. With the 3000 mg of scheduled acetaminophen this totalled 4300 mg of acetaminophen on 01/20/16.
01/29/16-Resident #3 received 2 separate doses of 2 tablets of 7.5-325 Norco (hydrcodone-acetaminophen) for an additional 1300 mg of acetaminophen. With the 3000 mg of scheduled acetaminophen this totalled 4300 mg of acetaminophen on 01/29/16.

On 02/11/16 at 2:21 PM the Director of Nursing (DON) reviewed the January 2016 MAR for Resident #3 and verified Resident #3 exceeded the 4000 mg of acetaminophen on 01/10/16, 01/17/16, 01/20/16 and 01/29/16. The DON stated the Hydrocodone-acetaminiphen should have been entered as a one time order until the Norco arrived to prevent it from remaining on the MAR. The DON stated the Hydrocodone-acetaminiphen should have been discontinued 01/09/15 when the Norco was delivered for Resident #3.

On 02/11/16 at 3:10 PM the Family Nurse Practitioner (FNP) for Resident #3 stated the medications containing acetaminophen should have been administered as ordered with no more than 4000 mg of acetaminophen provided daily from all sources. The FNP stated she just ordered liver function tests for Resident #3 after

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staff informed her of the 4 days in January 2016 more than 4000 mg of acetaminophen had been administered to Resident #3.

In a follow-up interview on 02/11/16 at 3:30 PM the DON stated she expected staff to stay within the parameters of orders when administering medications. The DON stated with the electronic MAR the medications due are displayed on the computer screen. The DON stated PRN (as needed) medications like the Norco and Hydrocodone-acetaminophen would display on another screen. The DON stated if a resident complained of pain she expected staff to look at scheduled pain medications containing acetaminophen prior to administering PRN medications containing acetaminophen to ensure staying within parameters. The DON verified the Hydrocodone-acetaminophen should have been discontinued on 01/09/16 and not left on the MAR for administration and could offer no explanation why this had not been done.

2. Resident #10 was admitted to the facility 10/09/13. Review of physician orders in the medical record included an order for Biotin (a vitamin supplement) 3 milligrams (mg) every day.

Review of the Medication Administration Record (MAR) for Resident #10 for January and February 2016 noted 17 doses of Biotin were not given on 01/06/16, 01/07/16, 01/08/16, 01/13/16, 01/14/16, 01/15/16, 01/20/16, 01/21/16, 01/22/16, 01/24/16, 01/28/16, 01/29/16, 01/30/16, 02/03/16, 02/05/16, 02/07/16 and 02/11/16. Notation in the medical record of Resident #10 noted the reason for the Biotin not being administered was "waiting upon arrival."

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F 281	Continued From page 8 On 02/11/16 at 3:10 PM the Family Nurse Practitioner of Resident #10 stated the expectation was for all medication to be administered as ordered by the physician. On 02/11/15 at 5:25 PM the Director of Nursing (DON) stated the Biotin was ordered for Resident #10 and should have been administered as ordered. The DON stated she spoke with the staff member that did not administer the 17 doses of Biotin in January and February 2016. The DON stated the staff member that did not administer the Biotin stated the 3 mg dose was not available which was why it was not administered. The DON stated there was Biotin on the medication cart that could have been split to provide the 3 mg dosage. The DON stated the staff member should have informed either herself or a supervisor about the Biotin so education could be provided.	F 281		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews with residents, families and staff the facility failed to provide showers as scheduled for 5 of 5 sampled dependent residents. (Residents #3, #4, #8, #10 and #13)	F 312	Criteria #1- 1. Resident #3 will receive showers as scheduled. Resident #10 will receive showers as scheduled. Resident #13 will receive showers	3/5/16

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F 312	Continued From page 9 The findings included: 1. Resident #3 was admitted to the facility 01/09/16 after an L3-L4 laminectomy. The admission Minimum Data Set (MDS) dated 01/16/16 for Resident #3 assessed no cognitive impairment or short or long term memory problems. This MDS also assessed Resident #3 required extensive assistance of one person with bathing. The current care plan for Resident #3 dated 02/01/16 included the problem area: Has an activity of daily living self care performance deficit related to status post L3-L4 laminectomy, history of lumbar stenosis, lumbosacral pseudoarthrosis, hypertension and peripheral neuropathy. Approaches to this problem area included: -bathing/showering-the resident requires assistance by staff with bathing/showering 2 times a week and as needed. On 02/11/16 at 7:45 AM Resident #3 stated that, since admission, she had only received 4 showers; with two of the showers provided by therapy staff. Resident #3 stated whenever it was time for her shower the nursing assistants would say they were so short staffed they couldn't provide the shower but the next shift would assist with the shower. Resident #3 stated she never refused a shower and the showers would consistently not be provided and it made her feel dirty. Review of nursing assistant documentation in the electronic medical record noted in conjunction with the Medication Administration Record (MAR) revealed 3 showers were documented as given to Resident #3 since admission. With showers	F 312	as scheduled. Resident #4 will receive showers as scheduled. Criteria #2- 2.All residents have the potential to be affected by the same alleged deficient practice; therefore, the DON will complete a 100% audit of current residents to verify showers are be giving as scheduled. Criteria #3- 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: the DON In-serviced/ re-educated all Nursing staff on expectation of showers to be completed as scheduled and documented. Unit Managers and supervisors were educated on ensuring showers are completed by CNA□s. The DON will audit at least 10 residents showers weekly x 4weeks, Then 10 residents monthly x 3 months to ensure showers are completed as scheduled. Criteria #4- 4.The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/ trends to the QAPI committee every month.	

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scheduled twice a week, Resident #3 should have received 9 showers since admission.

On 02/11/16 at 4:30 PM the occupational therapist that worked with Resident #3 stated one shower was done with Resident #3 as part of therapy. The occupational therapist stated she couldn't remember if assistance with the second shower for Resident #3 was given for any specific reason but, if a resident reported they were having trouble getting showers, they would provide an additional shower as part of therapy.

On 02/11/16 at 5:35 PM the Director of Nursing (DON) stated she was aware showers were not being provided as scheduled for residents. The DON acknowledged there had been staffing challenges and that showers had been missed for some residents in the past 2 months. The DON stated residents should receive showers as scheduled and noted measures that were being put into place to address the staffing concerns.

2. Resident #10 was admitted to the facility 10/09/13. A quarterly Minimum Data Set (MDS) dated 02/02/16 for Resident #10 assessed no cognitive impairment or short or long term memory problems. This MDS also assessed Resident #10 required total dependence of one person with bathing.

On 02/10/16 at 3:30 PM Resident #10 reported that for approximately two months he had missed showers. Resident #10 stated he was supposed to receive 2 showers a week and had missed several showers in January. Resident #10 stated he always enjoyed showers and had never refused a shower when offered.

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Review of nursing assistant documentation in the electronic medical record in conjunction with the Medication Administration Record (MAR) noted 5 of 11 showers had been missed since January 2016.

On 02/11/16 at 5:35 PM the Director of Nursing (DON) stated she was aware showers were not being provided as scheduled for residents. The DON acknowledged there had been staffing challenges and that showers had been missed for some residents in the past 2 months. The DON stated residents should receive showers as scheduled and noted measures that were being put into place to address the staffing concerns.

3. Resident #13 was admitted to the facility 01/30/16 with diagnoses which included cerebrovascular accident. The admission Minimum Data Set (MDS) dated 02/06/16 for Resident #13 assessed no cognitive impairment or short or long term memory problems. This MDS also assessed Resident #13 required extensive assistance of one person with bathing.

The current care plan for Resident #3 dated 02/01/16 included the problem area: Has an activity of daily living self care performance deficit with approaches which included:
-bathing/showering-the resident requires assistance by staff with bathing/showering 2 times a week and as needed.

During an interview on 02/11/16 at 3:15 PM with Resident #13 and 2 family members they reported only one shower had been provided since admission to the facility though they had been told during the admission process there would be 2 showers provided every week. The

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family stated they spoke to administrative staff about Resident #13 not being provided a shower and that is when the first shower was provided on 02/06/16. Resident #13 stated he refused the shower on 02/10/16 because staff had just assisted him to bed when he was offered to get back out of bed for a shower.

Review of nursing assistant documentation in the electronic medical record in conjunction with the Medication Administration Record (MAR) noted 1 shower was documented as given to Resident #13 since admission. With showers scheduled twice a week, Resident #13 should have received 3 showers since admission.

On 02/11/16 at 5:35 PM the Director of Nursing (DON) stated she was aware showers were not being provided as scheduled for residents. The DON acknowledged there had been staffing challenges and that showers had been missed for some residents in the past 2 months. The DON stated residents should receive showers as scheduled and noted measures that were being put into place to address the staffing concerns.

4. Resident #4 was admitted to the facility on 12/16/14 with diagnoses of non-Alzheimer's dementia, gastric reflux disease and arthritis. The annual Minimum Data Set (MDS) dated 12/07/15 indicated the resident had short and long term memory problems with moderate cognitive impairment. The MDS also revealed the resident required extensive assistance with bed mobility, transfers, dressing, bathing and personal hygiene. The MDS further revealed the resident was frequently incontinent of urine and occasionally incontinent of bowel. A review of the care plans for Resident #4 revealed the resident required assistance with ADL's.

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An observation of Resident #4 on 02/10/16 at 09:55AM revealed the resident was lying in bed and was dressed. His hair was very oily and he was unshaven and had a dried, yellowish, crusty substance across his sweatshirt. An attempt to interview the resident was unsuccessful due to his impaired cognition.

During an interview with a family member of Resident #4 on 02/10/16 at 5:35PM, it was stated Resident #4 always had food all over him. The family member also stated there had not been a time he had come into the facility when Resident #4 didn't have food on his face, on his shirt or on his hands. The family member further stated Resident #4 had gone up to 3 weeks without a shower.

During a staff interview on 02/11/16 at 9:24AM, Nurse Aide #1 stated Resident #4 and other residents did go without showers because a lot of times there was not enough staff. Nurse Aide #1 also stated the Registered Nurses were too busy and could not help give showers.

Review of the shower schedule on 02/11/16 at 11:04AM revealed Resident #4 had showers twice a week on Monday and Thursday. Review of the Nurse Aide (NA) documentation for showers from 01/01/16 through 02/11/16 indicated the resident was only showered on 01/04, 02/02 and 02/04.

During an interview with the Director of Nursing (DON) on 02/11/16 at 5:33PM, the DON acknowledged there was an issue between staffing and showers. DON stated the NAs tried to focus on the safety of the residents, making sure their skin wasn't breaking down and feeding them. The DON noted both she and the Unit Managers had been trying to fill in and help as much as they could, including coming in on weekends to give showers. The DON

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acknowledged showers were not being given as frequently as they needed to be.
5. Resident #8 was admitted to the facility on 02/26/15 with diagnoses of schizophrenia, depression, anxiety, and muscle wasting. The admitting Minimum Data Set (MDS) dated 03/05/15 indicated the resident had short and long term memory problems with moderate cognitive impairment. The MDS also revealed the resident required total dependence for bathing and extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS further revealed the resident was frequently incontinent of both urine and bowel. A review of the care plans for Resident #8 revealed the resident required assistance with activities of daily living (ADL's).
An observation of Resident #8 on 02/10/16 at 1:03PM revealed that Resident #8 was lying in bed, dressed and her hair appeared to be oily. An interview was attempted, however Resident #8 was unable to understand what she was being asked.
During a staff interview on 02/11/16 at 9:24AM, Nurse Aide #1 stated Resident #8 and other residents went without showers because a lot of times there was not enough staff. Nurse Aide #1 also stated the Registered Nurses were too busy and could not help give showers.
Review of the shower schedule on 02/11/16 at 11:04AM revealed Resident #8 had showers twice a week on Monday and Thursday. Review of the Nurse Aide (NA) documentation for showers from 01/01/16 through 02/11/16 indicated the resident was only showered on 01/07, 01/12 and 1/26.
During an interview with the Director of Nursing (DON) on 02/11/16 at 5:33PM, the DON acknowledged there was an issue between

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F 312	Continued From page 15 staffing and showers. The DON stated the NAs tried to focus on the safety of the residents, making sure their skin wasn't breaking down and feeding them. The DON noted both she and the Unit Managers had been trying to fill in and help as much as they could, including coming in on weekends to give showers. The DON acknowledged showers were not being given as frequently as they needed to be.	F 312		
F 520 SS=D	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 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.	F 520		3/5/16

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F 520	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2015. This was for one recited deficiency which was originally cited in July of 2015 on a recertification/complaint survey. The deficiency was in the area of accuracy of an assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 278 Accuracy of Assessment: Based on observations, medical record review and resident and staff interview, the facility failed to accurately assess the dental status of 2 residents on the Minimum Data Set (MDS) assessment for 2 of 2 residents (Resident's #9 and #12). The facility was cited for F 278 on the recertification/complaint survey July 2015 for failure to accurately code an admission Minimum Data Set (MDS) to reflect a resident had been evaluated by Level II PASSR (Preadmission Screening and Review). On 2/11/16 at 6:20 PM the Director of Nursing stated the focus of the Quality Assurance Program from the recertification/complaint survey in July 2015 was on the specific issue of correct coding of PASSR on the MDS. The Director of Nursing stated the Quality Assurance Program	F 520	Criteria #1- 1. The District Director of Clinical Services conducted re-education for the Administrator on the facility□s Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identify areas of opportunity. 2. Criteria #2- All facility residents have the potential to be affected by this alleged deficient practice. 3. Criteria #3- The Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program by The District Clinical Director. The Quality Assurance committee consists of: " Administrator " Director of Nursing " Dietary Manager " Rehabilitation Manager " Maintenance or Environmental Representative " Activities Director " Social Services Director " Human Resource Designee " Business Office Director " Resident Care Management Director " Medical Director 4. Criteria #4- The District Team will review the minutes of the facility□s QAPI meetings for three	

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F 520	Continued From page 17 had not considered other potential problems related to the area of accurate coding of the MDS.	F 520	months to monitor for trending of outcomes and implementation of plans for opportunities identified.	