STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 08/05/2016

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BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff and residents, the facility failed to provide visual privacy for 1 of 1 resident when providing incontinence care (Resident #142).	F 164	1. Resident #142 has had no adverse outcome related to the deficient practice. 2. All incontinent residents have the potential to be affected by the deficient practice therefore education was provided	8/29/16

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

Electronically Signed | 08/29/2016

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F 164	Continued From page 1 The findings included: 1. Resident #142 was admitted to the facility on 03/31/16 with diagnoses including: traumatic brain injury, hypertension, seizure disorder, anxiety disorder, depression and schizophrenia. The most recent nursing assessment was a quarterly Minimum Data Set (MDS) assessment dated 06/28/16 which indicated Resident #142 had no cognitive impairment, delirium, psychosis or behavioral symptoms. The MDS indicated Resident #142 required extensive assistance from staff with all activities of daily living (ADL) except eating for which he required supervision and locomotion off unit for which he required limited assistance. He was assessed as being frequently incontinent of bladder and occasionally incontinent of bowel. A care plan which was last updated on 07/01/16 addressed his need for assistance with ADL and incontinence care. Interventions included to use disposable briefs, change as needed and clean perineal area after each incontinence episode. On 08/03/16 at 12:15 PM Nurse Aide (NA) #4 and NA #6 were observed providing incontinence care to Resident #142. Staff entered the room to provide care and pulled the privacy curtain between the bed of Resident #142 and his roommate. Staff did not close the door to the room and did not closed the window blind. The window faced the lawn on the right front side of the main entrance to the facility. NA #6 cleaned and changed Resident #142 while NA #4 handed her supplies that she needed. NA #4 was standing between the bed of Resident #142 and his roommate. NA #6 was standing on the side of the bed between the bed and the window.	F 164	by the SDC to the nursing staff on providing privacy when rendering incontinence care to a resident by 8/29/2016. 3. Unit Managers and or designee will conduct random observations of incontinence care to ensure privacy is being maintained. Audits will be performed 5 x weekly x 4 weeks then 3 x weekly x 2 months. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI x 3 months and ongoing monitoring as the committee deems appropriate for any trends identified.	

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F 164	Continued From page 2 During an interview on 08/03/16 at 3:13 PM with NA #4 about not closing the door or window blinds to Resident #142's room prior to providing incontinence care, NA #4 stated she didn't feel it necessary to close the door to the room because the privacy curtain was closed. NA #4 stated she didn't think about closing the window blinds because she was standing on the opposite side of the bed from the window. During an interview of 08/03/16 at 3:53 PM with NA #6 about not closing the door or window blinds to Resident #142's room prior to providing incontinence care, NA #6 stated she should have closed the window blinds but didn't think Resident #142 cared if they were closed or not. An interview on 08/04/16 at 5:45 PM with the Director of Nursing about Resident #142 not being provided visual privacy during incontinence care revealed she expected staff to provide visual privacy when providing care and the window blinds should have been closed.	F 164		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 224		8/29/16

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F 224	Continued From page 3 Based on observations, record reviews, resident and staff interviews the facility neglected to provide showers to a resident who required extensive to total assistance with activities of daily living causing the resident to feel dirty, embarrassed, un-cared for, and unkempt for 1 of 7 residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/28/15 with diagnoses which included anxiety disorder and depression. A quarterly Minimum Data Set (MDS) dated 05/25/16 indicated Resident #1 was cognitively intact and capable of making her needs known. The MDS indicated Resident #1 required extensive assistance from staff with all activities of daily living (ADL), except for eating for which the resident was independent, and required total assistance from staff for bathing. Further review of the MDS indicated Resident #1's preferences for showers and hygiene was very important with no documented behaviors or refusal of care. A care plan with a revision date of 05/25/16 indicated Resident #1 required ADL assistance from staff related to the diagnosis of paralysis. The goals indicated Resident #1 would have ADL care needs met by staff. Interventions included for the resident to have extensive to total assistance of one staff person with bathing and/or showering and that Resident #1 was to receive at least 2 showers a week. A review of a document titled "Resident Care Specialist Assignment Sheet" dated 08/03/16 revealed Resident #1 was to have a shower on	F 224	1. Resident #1 has received a shower. 2. All residents have the potential to be affected by this deficient practice therefore the Unit Managers/DON have completed a 100% audit of current residents to verify showers were given as scheduled. 3. Education was provided by the SDC to the nursing staff on the expectation of showers to be completed as scheduled and documented. Unit Managers and or designee will conduct random audits of residents showers 5 x weekly x 4 weeks, then 3 x weekly x 2 months to ensure showers are completed as scheduled. Shower Sheet assignments have been implemented to ensure showers have been completed and documented daily. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identified.	

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Tuesday and Saturday by 1st shift staff.

On 08/03/16 at 11:15 AM, an interview was conducted with Resident #1. She stated she had not had a shower in approximately 2 weeks or more and she further stated, "I feel very dirty, grungy, I can smell my own-self, and I feel like they just don't care anything about me and I am embarrassed about my appearance." Resident #1 was unable to recall when the last time a staff member assisted or had given her a shower. She stated, "It has been at least 2 weeks if not longer since I have had a shower."

On 08/03/16 at 11:33 AM, Resident #1 was observed to have matted, greasy looking hair, with areas of the scalp visible, unpleasant smell of feces, a stout smell of body odor, unkempt, and a malodorous smell in her room.

On 08/03/16 at 11:35 AM, Nurse Aide (NA) #4 was observed to go into the resident's room. The NA asked the resident, "What can I help you with?" and turned off the call light. Resident #1 stated to NA #4, "I need to be cleaned up, I have laid in a mess long enough!" NA #4 advised the resident she would get someone to assist her and she would return.

On 08/03/16 at 11:53 AM, NA #4 and NA #6 were observed to provide incontinent care to the resident. The NAs were not observed to give Resident #1 a bed bath, they were observed to clean the perineal area and changed the brief. Resident #1 asked the NAs, "Am I going to get a shower today?" NA #4 asked Resident #1, "Is today your shower day?" and the resident indicated, "Yes."

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On 08/03/16 at 2:00 PM, Resident #1 was observed sitting outside in her wheelchair and stated, "Thank you, I finally got a shower today, I have not had one in weeks, and I feel so much better." Resident #1 was observed to have been cleansed, with shiny clean hair, no body odor, and well groomed.

An interview was conducted with NA #4 on 08/03/16 at 2:30 PM. NA #4 stated she had given Resident #1 a shower. NA #4 further stated Resident #1 was supposed to have a shower 2 times a week and that the residents were not getting their showers because the facility was short staffed. NA #4 was unable to verify or confirm the last time Resident #1 had received a shower. NA #4 indicated they were so short staffed the nurses, nurse supervisors, and the Director of Nursing were aware that resident showers were not being provided.

An interview was conducted with NA #6 on 08/03/16 at 2:45 PM. NA #6 stated the residents were supposed to have at least 2 showers a week and more often should they request it. NA #6 further stated the residents were not getting 2 showers a week and some residents would go several weeks with no shower or bath due to being so busy and short staffed. NA #6 was unable to verify or confirm the last time Resident #1 had received a shower. NA #6 indicated they were so short staffed the nurses, nurse supervisors, and the Director of Nursing were aware that resident showers were not being provided.

An interview was conducted with the Director of Nursing (DON) on 08/05/16 at 5:30 PM. The DON stated she was unaware Resident #1 smelled of

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F 224	Continued From page 6 body odor and had not received a shower. The DON further stated she would have expected the resident to have had a shower to ensure the resident did not feel dirty, un-cared for, or smelled of body odor. The DON indicated she had identified a problem with the residents not getting their showers and that was one of the things she was working on.	F 224		
F 241 SS=E	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, record review and interviews with staff and residents, the facility failed to provide showers to residents which resulted in 2 of 2 residents feeling embarassed (Resident #1 and Resident #45). The findings included: 1. Resident #45 was admitted to the facility on 10/22/15 and readmitted on 05/04/16 with diagnoses including: coronary artery disease, hypertension, diabetes mellitus type 2 and end stage renal disease. The most recent nursing assessment was a significant change Minimum Data Set (MDS) dated 05/13/16 which indicated Resident #45 had no cognitive impairment, delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated Resident #45 required extensive assistance from staff with	F 241	1. Resident #45 has received a shower and Resident #1 has received a shower. 2. All residents have the potential to be affected by this deficient practice therefore the Unit Mangers/DON have completed a 100% audit of current residents to verify showers were being given as scheduled. 3. Education was provided by the SDC to the nursing staff on the expectation of showers to be completed as scheduled and documented. Unit Mangagers and or designee will conduct random audits of residents showers 5 x weekly x 4 weeks, then 3 x weekly x 2 months to ensure showers are completed as scheduled. Shower sheets have been implemented to	8/29/16

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F 241	Continued From page 7 bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS indicated "did not occur" for bathing during the 7 day observation period. Review of the bathing documentation for Resident #45 revealed the last time he had a shower prior to 08/03/16 was 07/26/16. Review of the shower documentation for Resident #45 for June and July 2016 revealed several instances when he didn't have a shower for 12 or 13 days. During an interview on 08/02/16 at 2:50 PM Resident #45 stated he missed his bath the past 2 days because the Nurse Aide (NA) told him they didn't have enough staff to help him with his bath. During a follow up interview on 08/02/16 at 3:50 PM Resident #45 stated his regular shower day was 08/01/16 and he didn't get a shower. Resident #45 stated he had talked to several staff about not getting his showers and has been told repeatedly that they don't have enough help. Resident #45 stated he often goes more than a week without a shower. Resident #45 was unable to recall who he had talked to but stated he had not talked to the current Director of Nursing (DON). During a follow up interview on 08/03/16 at 4:49 PM Resident #45 stated he had routine appointments three times a week at a medical provider outside the facility and was asked by staff today at that provider's office when the last time was that he had a shower. Resident #45 stated he was very embarrassed because he knew he smelled bad. Resident #45 stated he got a shower today after he returned from his appointment. Resident #45 stated he was	F 241	ensure showers are completed and documented daily. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing as the committee deems appropriate for any trends identified.	

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scheduled for a shower every Sunday and Tuesday but he wasn't given a shower either time in the past week because they told him they didn't have enough staff.

An interview on 08/05/16 at 11:15 AM with NA #2 revealed all assistance provided to residents with their activities of daily living (ADL) was documented on the Care Tracker electronic record. NA #2 stated if a resident did not receive a shower it was documented as "activity did not occur" and if a shower was given she documented the level of assistance the resident was provided by staff.

An interview on 08/05/16 at 11:46 AM with the Director of Nursing (DON) revealed all residents should receive 2 showers per week unless they requested otherwise. The DON stated a resident's preferences for showers is obtained on admission and listed on the Resident Care Specialist Assignment sheet. The DON stated the facility had used agency staff for nurse aides and sometimes they didn't document the ADL assistance that was provided. The DON stated she expected residents to be given the number of showers per week they preferred.

An interview on 08/05/16 with the Administrator revealed he expected every resident to receive their showers according to their preference. The Administrator stated every staff member should make sure personal care was done.

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2) Resident #1 was admitted to the facility on 03/28/15 with diagnoses which included anxiety disorder and depression.

A quarterly Minimum Data Set (MDS) dated 05/25/16 indicated Resident #1 was cognitively intact with no behavioral symptoms or rejection of care. Further review of the MDS indicated Resident #1 required extensive assistance from staff with all activities of daily living (ADL), except for eating for which the resident was independent, and required total assistance from staff for bathing. The MDS further assessed Resident #1 as being always incontinent of bladder and bowel.

A care plan with a revision date of 05/25/16 indicated Resident #1 required ADL assistance from staff related to the diagnosis of paralysis. The goals indicated Resident #1 would have ADL care needs met by staff. Interventions included for the resident to have extensive to total assistance of one staff person with bathing and/or showering and that Resident #1 was to receive at least 2 showers a week.

On 08/03/16 at 11:15 AM, an interview was conducted with Resident #1. She stated she had not had a shower in approximately 2 weeks or more and she further stated, "I feel very dirty, grungy, I can smell my own-self, and I feel like they just don't care anything about me and I am

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embarrassed about my appearance."

On 08/03/16 at 11:33 AM, Resident #1 was observed to have matted, greasy looking hair, with areas of the scalp showing, unpleasant smell of feces, a stout smell of body odor, unkempt, and a malodorous smell in her room. Resident #1 was also observed to push the call light for staff assistance.

On 08/03/16 at 11:35 AM, Nurse Aide (NA) #4 was observed to go into the resident's room, asked the resident, "What can I help you with?" and turn off the call light. Resident #1 stated to NA #4, "I need to be cleaned up, I have laid in a mess long enough!" NA #4 advised the resident she would get someone to assist her and she would return.

On 08/03/16 at 11:53 AM, NA #4 and NA #6 were observed to provide incontinent care to the resident. The NAs were not observed to give Resident #1 a bed bath, they were observed to clean the perineal area and changed the brief. Resident #1 asked the NAs, "Am I going to get a shower today?" NA #4 asked Resident #1, "Is today your shower day?" and the resident indicated, "Yes."

On 08/03/16 at 2:00 PM, Resident #1 was observed setting outside in her wheelchair and stated, "Thank you, I finally got a shower today, I have not had one in weeks, and I feel so much better." Resident #1 was observed to have been cleansed, with shiny clean hair, no body odor, and well groomed.

An interview was conducted with NA #4 on 08/03/16 at 2:30 PM. NA #4 stated she had given

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F 241	Continued From page 11 Resident #1 a shower. NA #4 further stated Resident #1 was supposed to have a shower 2 times a week and that the residents were not getting their showers because the facility was short staffed. NA #4 was unable to verify or confirm the last time Resident #1 had received a shower. An interview was conducted with NA #6 on 08/03/16 at 2:45 PM. NA #6 stated the residents were supposed to have at least 2 showers a week and more often should they request it. NA #6 further stated the residents were not getting 2 showers a week and some residents would go several weeks with no shower or bath due to being so busy and short staffed. NA #6 was unable to verify or confirm the last time Resident #1 had received a shower. An interview was conducted with the Director of Nursing (DON) on 08/05/16 at 5:30 PM. The DON stated she was unaware Resident #1 smelled of body odor and had not received a shower. The DON further stated she would have expected the resident to have had a shower to ensure the resident did not feel dirty, un-cared for, or smelled of body odor. The DON indicated she had identified a problem with the resident's not getting their showers and that was one of the things she was working on.	F 241		
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	F 242		8/29/16

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F 242	Continued From page 12 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to honor residents' choices by not providing the number of showers or baths per week the resident requested for 1 of 4 residents reviewed for choices (Resident #45). The findings included: 1. Resident # 45's most recent nursing assessment was a significant change Minimum Data Set (MDS) dated 05/13/16 which indicated Resident #45 had no cognitive impairment, delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated Resident #45 required extensive assistance from staff with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS indicated "did not occur" for bathing during the 7 day observation period. Review of the bathing documentation for Resident #45 revealed the last time he had a shower prior to 08/03/16 was 07/26/16. Review of the shower documentation for Resident #45 for June and July 2016 revealed several instances when he didn't have a shower for 12 or 13 days. Review of the Resident Care Specialist Assignment Sheet revealed Resident # 45 was scheduled for a shower on Monday and Fridays on the 7:00 AM - 3:00 PM shift. Observation of Resident #45 on 08/02/16 at 2:50	F 242	1. Resident #45 has had a shower. 2. All residents have the potential to be affected by this deficient practice therefore the Unit Managers/DON have completed a 100% audit of current residents to verify showers were being given as scheduled. 3. Education was provided by the SDC to the nursing staff on the expectation of showers to be completed as scheduled and documented. Unit Manages and or designee will conduct random audits of residents showers 5x weekly x 4 weeks, then 3 x weekly x 2 months to ensure showers are completed as scheduled. Current residents shower preferences of shower frequency, type and day/evening have been honored. Shower preferences will be addressed with the resident or Responsible Party on admission going forth. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identifed.	

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PM revealed he had a heavy stubble of beard and had a slight body odor.

Observation of Resident #45 on 08/03/16 at 4:49 PM revealed he was clean shaven and his hair was damp.

During an interview on 08/02/16 at 2:50 PM Resident #45 stated he missed his shower the past 2 days because the Nurse Aide (NA) told him they didn't have enough staff to help him with his shower.

During a follow up interview on 08/02/16 at 3:50 PM Resident #45 stated his regular shower day was 08/01/16 and he didn't get a shower. Resident # 45 stated he had talked to several staff about not getting his showers and has been told repeatedly that they don't have enough help. Resident #45 stated he often goes more than a week without a shower. Resident #45 stated he would like to have at least 2 showers a week. Resident #45 was unable to recall who he had talked to but stated he had not talked to the current Director of Nursing (DON).

During a follow up interview on 08/03/16 at 4:49 PM Resident #45 stated he got a shower today after he returned from an appointment outside the facility. Resident #45 stated he was told by staff he would get a shower this past Sunday and Tuesday but he wasn't given a shower either time because they told him they didn't have enough staff.

An interview on 08/05/16 at 11:15 AM with NA #2 revealed all assistance provided to residents with their activities of daily living (ADL) was documented on the Care Tracker electronic

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F 242	Continued From page 14 record. NA #2 stated if a resident did not receive a shower it was documented as "activity did not occur" and if a shower was given she documented the level of assistance the resident was provided by staff. An interview on 08/05/16 at 11:46 AM with the Director of Nursing (DON) revealed all residents should receive 2 showers per week unless they requested otherwise. The DON stated a resident's preferences for showers is obtained on admission and listed on the Resident Care Specialist Assignment sheet. The DON stated the facility had used agency staff for nurse aides and sometimes they didn't document the ADL assistance that was provided. The DON stated she expected residents to be given the number of showers per week they preferred. An interview on 08/05/16 at 5:33 PM with the Administrator revealed he expected every resident to receive their showers according to their preference. The Administrator stated every staff member should make sure personal care was done.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and properly store personal hygiene products and resident care equipment in	F 253	Resident care equipment was labeled and properly stored in resident bathrooms for rooms #500, 504, 506,508,510, and	8/29/16

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F 253	Continued From page 15 5 resident bathrooms on 1 of 5 resident hallways (Room #500, #504, #506, #508, and #510), failed to properly store and label resident care equipment in 1 resident room on 1 of 5 hallways (Room #212), and failed to provide clean privacy curtains in 1 resident room on 1 of 5 hallways (Room #509). The facility also failed to repair holes in the walls of 2 resident rooms on 1 of 5 hallways (Room # 302 and #312) and failed to maintain air conditioning units in 6 resident rooms on 1 of 5 hallways (Room #300, #302, #304, #305, #311, and #312). Findings included: 1. a. Observations in the bathroom for rooms 500 and 501, shared by 4 residents, on 8/1/16 at 4:07 PM revealed 2 unlabeled wash basins on the floor nesting inside each other, a specimen hat on the floor and an unlabeled bottle of body wash stored on the back of the commode. Observations in the bathroom for rooms 500 and 501 on 8/2/16 at 11:20 AM revealed 2 unlabeled wash basins on the floor nesting inside each other, a specimen hat on the floor and an unlabeled bottle of body wash stored on the back of the commode. Observations in the bathroom for rooms 500 and 501 on 8/4/16 at 8:00 AM revealed 2 unlabeled washbasins on the floor nesting inside each other, specimen hat on the floor and the bottle of body wash stored on the back of the commode had been labeled. b. Observations in the bathroom for rooms 504 and 505, shared by 4 residents, on 8/1/2016 at 3:14 PM revealed a plunger laying in the bathroom floor, 5 unlabeled washbasins stacked nesting inside each other on bathroom floor, an unlabeled denture cup containing 1 denture stored on the shelf above the sink, an unlabeled tube of toothpaste on the shelf above the sink,	F 253	212. Privacy curtain has been cleaned for resident room #509. Holes were repaired in the walls of resident rooms #302 and 312. Air conditioner units were repaired in residents rooms #300, 302,304,305,311, and 312. All residents have the potential to be affected by the same alleged deficient practice. Therefore, measures put in place to ensure that the alleged deficient practice does not reoccur include: The Administrator provided education to the Maintenance and Housekeeping Director on the cleanliness of residents rooms, storage of personal equipment and what to do when needed repairs are identified. The area SDC provided education to the nursing staff on the labeling and storage of residents personal items. 100% audit of resident personal care items, including equipment will be conducted by 8/29/2016 to ensure needed repairs are identified and personal care items and equipment are stored properly. Personal items labeled and stored in bed side table in resident rooms. Urinals, bedpans, and basins will be stored in patient belonging bags in resident bathrooms. The Housekeeping Manger will audit resident rooms for proper storage of resident care items and personal care item storage, including equipment 5x weekly x 4 weeks then 3x weekly x 2 months for needed resident room repairs. The Administrator/Ambassdors will make weekly random rounds to ensure items are labeled and stored appropriate. The	

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F 253	Continued From page 16 and a bar of soap on the shelf above the sink that was not in a container. Observations in the bathroom for rooms 504 and 505 on 8/2/16 at 10:42 AM revealed a plunger laying in the bathroom floor, 5 unlabeled washbasins stacked nesting inside each other on bathroom floor, an unlabeled denture cup containing 1 denture stored on the shelf above the sink, an unlabeled tube of toothpaste on the shelf above the sink, and a bar of soap on the shelf above the sink that was not in a container. Observations in the bathroom for rooms 504 and 505 on 8/4/2016 at 8:02 AM revealed a plunger laying in the bathroom floor, 5 unlabeled washbasins stacked nesting inside each other on bathroom floor, an unlabeled denture cup containing 1 denture stored on the shelf above the sink, an unlabeled tube of toothpaste on the shelf above the sink, and a bar of soap on the shelf above the sink that was not in a container. c. Observations in the bathroom for rooms 506 and 507, shared by 4 residents, on 8/1/2016 at 3:06 PM an unlabeled urinal hanging from the grab bar on the left side of the commode, an unlabeled electric razor plugged in and resting on the right side of the sink, and 3 unlabeled toothbrushes in the toothbrush holder sitting on the shelf above the sink. Observations in the bathroom for rooms 506 and 507 on 8/2/2016 at 11:20 AM revealed an unlabeled urinal hanging from the grab bar on the left side of the commode, an unlabeled electric razor plugged in and resting on the right side of the sink, and 3 unlabeled toothbrushes in the toothbrush holder sitting on the shelf above the sink. Observations in the bathroom for rooms 506 and 507 on 8/4/2016 at 8:04 AM an unlabeled urinal hanging from the grab bar on the left side of the	F 253	Administrator/ Ambassadors will make weekly random rounds to ensure the environment of the resident room ie cleanliness, items in need of repair are addressed in a timely manner. Results will be reported to the QAPI committee for review. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any tends identified.	

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commode, an unlabeled electric razor plugged in and resting on the right side of the sink, 2 tubes of unlabeled Butt paste on the back of the commode, 2 unlabeled toilet seat covers on the floor stacked on top of each other, and 3 unlabeled toothbrushes in the toothbrush holder sitting on the shelf above the sink.

d. Observations in the bathroom for rooms 508 and 509, shared by 4 residents, on 8/1/2016 at 2:30 PM revealed an unlabeled wash basin on the floor, an uncovered and unlabeled bar of soap in a denture cup sitting on the shelf above the sink, 4 unlabeled bottles of personal hygiene products sitting on the back of the commode, and an unlabeled urinal, containing about ½ inch of urine, hanging on the grab bar by the right side of the commode.

Observations in the bathroom for rooms 508 and 509 on 8/2/16 11:10 AM revealed an unlabeled wash basin on the floor, an uncovered and unlabeled bar of soap in a denture cup sitting on the shelf above the sink, brown ring around waterline on the inside of the commode, 4 unlabeled bottles of personal hygiene products sitting on the back of the commode, and an unlabeled urinal hanging on the grab bar by the right side of the commode.

Observations in the bathroom for rooms 508 and 509 on 8/4/16 at 8:15 AM revealed an unlabeled wash basin on the floor, an uncovered and unlabeled bar of soap in a denture cup sitting on the shelf above the sink, rust build-up around the faucet, brown ring around waterline on the inside of the commode, 4 unlabeled bottles of personal hygiene products sitting on the back of the commode, and an unlabeled urinal hanging from the grab bar by the right side of the commode.

e. Observations in the bathroom for rooms 510 and 511, shared by 4 residents, on 8/1/2016 at

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2:40 PM revealed 2 unlabeled wash basins, with water visible in the top basin, on the floor stored nesting inside of each other resting on top of the bedside commode insert, an unlabeled urinal hanging from the grab bar on the right of the commode, and a partially used, unlabeled 2 oz. bottle of mouthwash stored on the shelf above the sink.
Observations in the bathroom for rooms 510 and 511 on 8/2/2016 at 10:08 AM revealed 2 unlabeled wash basins, with water visible in the top basin, on the floor stored nesting inside of each other resting on top of the bedside commode insert, an unlabeled urinal hanging from the grab bar on the right of the commode, and a partially used, unlabeled 2 oz. bottle of mouthwash stored on the shelf above the sink.
Observations in the bathroom for rooms 510 and 511 on 8/4/2016 at 8:20 AM revealed 2 unlabeled wash basins, with water visible in the top basin, on the floor stored nesting inside of each other resting on top of the bedside commode insert, an unlabeled urinal hanging from the grab bar on the right of the commode, and an unlabeled 2 oz. bottle of mouthwash, that was almost empty, stored on the shelf above the sink.
f. Observations in room #212 on 8/1/16 at 12:56 PM revealed an unlabeled and uncovered bedpan on the floor near the head of the resident ' s bed.
Observations in room #212 on 8/2/16 at 8:19 AM revealed an unlabeled and uncovered bedpan on the floor near the head of the resident ' s bed.
Observation in room #212 on 8/3/16 at 11:08 AM revealed an unlabeled and uncovered bedpan on the floor near the head of the resident ' s bed.
g. Observation in room #509 on 8/3/16 at approximately 3:00 PM revealed the privacy curtain hanging in the middle of the room between the two resident's beds had several

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brown stains on the bottom and middle of the curtain.
Observations in room #509 on 8/4/2016 at approximately 8:20 AM revealed the privacy curtain hanging in the middle of the room between the two resident's beds had several brown stains on the bottom and middle of the curtain.
An interview with Nurse Aide (NA) #7 on 8/4/16 at 10:09 AM revealed that bed pans were supposed to be stored in the bathroom on the back of the toilet, labeled with the resident's name and placed in a plastic bag when not in use. NA #7 confirmed the resident's bedpan was on the floor, unlabeled and uncovered.
During a tour and interview with the Director of Nursing (DON) on 8/4/16 at 9:20 AM she confirmed that the items stored in the shared bathrooms (rooms 500, 501, 504, 505, 506, 507, 508, 509, 510, and 511) and the personal care equipment on the floor of the resident ' s room (room #212) were not labeled with the resident's names and had been stored inappropriately.
DON stated that all personal hygiene products were to be labeled and stored in the drawer of the resident's nightstand when not being used. DON stated that plungers and toilet seat inserts should be removed and sanitized by housekeeping once used and never stored in the resident's bathrooms. DON stated that all wash basins and bedpans should be labeled with the resident's name, stored in the resident's room on their nightstand when not being used and should not be stored on the bathroom floor. DON stated that it was her expectation that all resident personal items would be labeled with the resident's name and stored appropriately. DON also confirmed that the privacy curtain located in the middle of room #509 was stained and needed to be

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laundered. DON stated that it was her expectation that staff would notify housekeeping when stains were noticed on privacy curtains so that they could be removed and laundered.
2. a. Observations in resident room #302 on the locked unit on 8/1/16 at 2:32 PM revealed a hole in the wall behind the door that was approximately 4" x 4" in size. The hole had plaster flaking but no sharp edges.
Observations in resident room #302 on the locked unit on 8/2/16 at 8:45 and 10:11 AM revealed a hole in the wall behind the door that was approximately 4" x 4" in size. The hole had plaster flaking but no sharp edges.
Observations in resident room #302 on the locked unit on 8/3/16 at 9:03 AM and 2:48 PM revealed a hole in the wall behind the door that was approximately 4" x 4" in size. The hole had plaster flaking but no sharp edges.
b. Observations in the resident's bathroom in room #312 on the locked unit on 8/1/2016 at 2:13 PM revealed an unpainted, previously patched area approximately 2 inches above the baseboard that was soft to the touch and cracked with flaked plaster particles on the floor.
Observations in the resident's bathroom in room #312 on the locked unit on 8/2/16 at 8:45 and 10:11 AM revealed an unpainted, previously patched area approximately 2 inches above the baseboard that was soft to the touch and cracked with flaked plaster particles on the floor.
Observations in the resident's bathroom in room #312 on the locked unit on 8/3/16 at 9:03 AM and 2:48 PM an unpainted, previously patched area approximately 2 inches above the baseboard that was soft to the touch and cracked with flaked plaster particles on the floor.
c. Observations of the air conditioning units located in the resident's rooms on the locked unit

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(rooms 300, 302, 304, 305, 311, and 312) on 8/1/16 at 2:36 PM revealed the front covers of the units were loose and moveable with 1/2 inch gaps on the top where the edge of the cover connected to the base of the unit.

Observations of the air conditioning units located in the resident's rooms on the locked unit (rooms 300, 302, 304, 305, 311, and 312) on 8/2/16 at 8:50 and 10:15 AM revealed the front covers of the units were loose and moveable with 1/2 inch gaps on the top where the edge of the cover connected to the base of the unit.

Observations of the air conditioning units located in the resident's rooms on the locked unit (rooms 300, 302, 304, 305, 311, and 312) on 8/3/16 at 8:47 AM and 2:51 PM revealed the front covers of the units were loose and easily moved with 1/2 inch gaps on the top where the edge of the cover connected to the base of the unit.

An interview with NA #7 on 8/3/16 at 10:47 AM revealed a process for reporting repairs to maintenance. NA #7 stated she had not noticed the hole in the wall of room # 302 but had noticed the loose covers on the air conditioning units and reported it to the Nurse but could not remember when that had been. NA #7 also stated that she had not filled out a work order or notified maintenance.

An interview with Nurse #10 on 8/3/16 at 11:49 AM revealed a process for reporting repairs to maintenance. Nurse #10 stated he had not been informed by any NA of needed repairs or had he noticed any holes in the walls or the loose covers on the air conditioning units in the resident's rooms.

An interview with NA #5 on 8/3/16 at 2:55 PM revealed a process for reporting repairs to maintenance. NA #5 stated that she had not noticed the holes in the wall or loose air

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F 253	Continued From page 22 conditioning units and had not notified maintenance of any repairs that needed to be done within the last week. On 8/4/16 at 9:35 AM the DON stated that the Maintenance Director was not available for an interview and tour of the locked unit; therefore, the tour would be conducted with the Corporate Director of Operations for the North Carolina West District (CDO). During an interview and tour with the DON and CDO on 8/4/16 at 9:40 AM they both confirmed that the previously repaired area on the wall in the bathroom of room #312 should have been redone and the hole in the wall behind the door of room #312 should have been repaired. During an observation of the air conditioning units (rooms 300, 302, 304, 305, 311, and 312) with the DON and CDO, the cover of the unit located in room #312 fell to the floor. The DON and CDO both stated that although the covers to the units were loose, there had been no accidents as a result but agreed that the unit covers should be more secure and confirmed they would be fixed. The DON stated that there was a procedure for reporting repairs and she would have expected staff to notify maintenance. On 8/4/16 at 12:29 PM a follow-up tour of rooms 300, 302, 304, 305, 311, and 312 was conducted with the CDO that revealed each cover had been secured to the base of the air conditioning units with two screws placed on top. The CDO stated that maintenance had been unaware of the issues and had received no work orders indicating repairs needed to be done. The CDO also confirmed that maintenance would be repairing the hole in the wall in room #302 and the patched wall in the bathroom of room #312 later in the day.	F 253		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		8/29/16

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F 279 SS=D	Continued From page 23 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a care plan for a foot wound for 1 of 4 residents reviewed for wounds (Resident #158). The findings included: Resident #158 was admitted to the facility on 02/02/16 with diagnoses of heart failure, hemiplegia and chronic respiratory failure. Review of the significant change Minimum Data Set (MDS) dated 06/22/16 revealed #158 was cognitively intact and required extensive assistance for bed mobility, transfers, dressing, personal hygiene, toileting and bathing. She was	F 279	1. Resident #158 Care Plan has been updated to reflect her foot wound. 2. All residents have the potential to be affected by this deficient practice therefore the RCMD has completed a 100% audit of current residents with wounds to verify care plans reflecting the residents wounds. 3. Education was provided to the RCMD by the DON on the expectation of developing a care plan to reflect the	

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F 279	Continued From page 24 coded as receiving Hospice services. Review of the care plans developed for Resident #158 revealed there was no care plan specific to the wound on her left foot. The care plan dated 07/05/16 revealed Resident #158 had a stage 4 pressure ulcer to her sacrum with a goal that it would show signs of healing by the next review date but did not mention the wound on the left foot or goals and interventions for that wound. Review of the July 2016 Treatment Record (TAR) revealed the following: Left foot wound, clean with normal saline, pat dry, apply xeroform, a non-adhesive medicated dressing, cover with absorbent pads and wrap with gauze dressing once a day and as needed for soiling. The TAR revealed the dressing changes were completed as ordered. An interview conducted on 08/05/16 at 3:25 PM with the MDS Nurse #1 revealed she reviewed nurse's notes, treatment record and observations when making care plans for wounds. She stated if a new wound occurred it was discussed in the morning stand up meeting from the 24 nurse's report. She stated she would then speak to the treatment nurse and review the record to develop a care plan for the new wound. The MDS Nurse #1 stated she was not aware of the wound on Resident #158's left foot that was diagnosed on 07/05/16 and a care plan should have been developed for the wound. An interview conducted on 08/05/16 at 3:50 PM with the Director of Nursing revealed nurse's should document all new wounds or any change in condition on the 24 hour report so they could discuss them at the morning stand up meeting. She stated the wound to Resident #158's left foot was not documented on the 07/04/16 24 hour report. She stated it was her expectation for all wounds to be care planned and the care plan	F 279	residents wounds. DON/Unit Managers and or designee will conduct random audits on residents with wounds 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure care plans were developed on residents with wounds. Results will be reported to QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any tends identified.	

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F 279	Continued From page 25 followed by staff.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow the physician's orders as written for treatments, the care plans, and failed to complete wound care treatments for 1 of 3 sampled residents reviewed for dressing changes and wound care (Resident #56). The findings included: Resident #56 was admitted to the facility on 3/13/14 with diagnoses of dementia, psychosis, anxiety disorder, and major depressive disorder, lack of coordination, muscle wasting and atrophy. An annual minimum data set (MDS) dated 7/5/16 indicated the resident was cognitively impaired, usually understood and sometimes able to understand others. The MDS further indicated the resident had no rejection of care, required extensive assist with activities of daily living (ADL) with no skin problems. A care plan updated on 7/18/16 revealed the resident had a skin tear on her right forearm and was at risk for skin issues related to impaired mobility, impaired cognitive function and uncontrolled movement at times. The goal was the wound would show signs of healing. The interventions included to cleanse skin tear with	F 282	1. Resident #56 has received wound care as written per the physician's orders. 2. All residents have the potential to be affected by this deficient practice therefore the DON completed a 100% audit of current residents with wounds to verify treatments were completed per the physician's orders. 3. Education was provided by the SDC to the licensed nurses on the expectation of completing treatments as per the physician's orders/care plan and documented. Unit Managers and or designee will conduct random audits of residents with wounds 5x weekly x 4 weeks, then 3 x weekly x 2 months to ensure treatments were completed as per the physician orders. Results will be reported to the QAPI committee for review. 4. The Administrator /Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3	8/29/16

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F 282	Continued From page 26 normal saline (NS), pat dry, apply triple antibiotic ointment (TAO), and cover with border gauze every other day until healed. A physician order dated 7/18/16 indicated for skin tear to right forearm to cleanse area with NS, pat dry, apply TAO and cover with bordered gauze every other day until resolved. A treatment sheet for July 2016 indicated to cleanse skin tear to right forearm with NS, pat dry, apply TAO and cover with bordered gauze every other day until resolved. Treatments were dated as completed on 7/19, 7/21, 7/23, 7/25, 7/27, and 7/31. No treatment for skin tear to right forearm was completed on 7/29/2016 for resident #56. A treatment sheet for August 2016 indicated to cleanse skin tear to right forearm with NS, pat dry, apply TAO and cover with bordered gauze every other day until resolved. There were no treatments for skin tear to right forearm dated as completed for August 2016 for resident #56. A nursing note dated 8/5/16 revealed that a dressing to resident #56 right forearm was changed, wound was improved with no drainage or signs and symptoms of infection. There was no adverse effects of the dressing not being changed timely for resident #56 noted during the time of the survey. Observations of resident #56 revealed: · 08/04/2016 9:27:39 AM a dressing dated 7/31/16 noted on resident's right forearm. · 08/04/2016 3:34:58 PM a dressing to resident #56 right forearm intact with date 7/31/16. · 08/04/2016 5:54:56 PM a dressings to resident's right forearm dated 7/31/16. · 08/05/2016 8:43:43 AM a dressing to resident's right forearm intact dated 7/31/16. 08/05/2016 8:59 AM an interview with nurse #1 responsible for the care of the resident stated the	F 282	months and ongoing monitoring as the committee deems appropriate for any trends identified.	

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treatment nurses would perform wound treatments for the units. She stated if there was not a treatment nurse or if the bandage came off or was soiled the floor nurses would change the dressing. Nurse #1 stated she had not noticed that the resident had any skin tears or dressing changes ordered.
08/05/2016 9:33 AM an interview with a wound & treatment nurse responsible for resident #56 stated the resident had a treatment order for skin tear to right forearm, cleanse area with NS, pat dry, apply TAO and cover with bordered gauze every other day until resolved. She stated the order was written on 7/18/16, the treatment started on 7/19/16 and was still current. The wound nurse indicated that resident #56 dressing was supposed to be changed on 8/4/16 and it was not completed. She further indicated the last treatment to the resident's forearm was performed on 7/31/16. The wound nurse went on to say that resident #56 treatment was missed on Thurs 8/4/16 and Tues 8/2/16. The wound nurse in resident #56 room with surveyor present indicated the dressing on resident's arm was the dressing she had changed on 7/31/16.
08/05/2016 11:21 AM an interview with the Director of Nursing (DON) indicated her expectations were for the facility staff to follow the doctor's orders, the care plans, and complete the treatments as ordered. The DON stated that one of the treatment nurses performed the treatments on Monday to Thursday and the other treatment nurse completed the treatments Friday to Sunday. She also indicated that one of the treatment nurses called out of work on 8/4/16. The DON stated that her expectations were when the treatment nurses were not in the facility, the nurses on the floor were to complete the treatments. She further indicated that she would

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F 282	Continued From page 28 fill out a variance form and notify the physician that the dressing change for resident #56 was missed. 08/05/2016 11:32 AM an interview with the Administrator indicated that his expectations were for the facility to follow the doctor's orders as written for treatments. He further stated there should be documentation as to why the treatment for resident #56 was not completed.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and family interviews, and staff and physician interviews the facility failed to administer pain medication to a resident who had a below the knee amputation causing the resident to have unrelenting pain for 1 of 3 sampled residents reviewed for pain management. The facility also failed to follow a physician's order for wound care and dressing changes for 1 of 4 sampled residents reviewed for wound care (Resident #197 and #158). The findings included: 1) Resident #197 was admitted to the facility on	F 309	1. Resident #158 has received wound care as written per the physician's orders. Resident #197 has her pain medication as prescribed by the physician orders. 2. All residents have the potential to be affected by this deficient practice therefore the DON completed a 100% audit of current residents with wounds to verify treatments were completed per the physician's orders. The DON/Unit Managers completed a 100% audit to ensure current resident has their pain medications as prescribed.	8/29/16

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F 309	Continued From page 29 07/18/16 with diagnoses of bacterial infection, acute pain related to trauma, and after-care for below the knee amputation (BKA). A review of a physician's order dated 07/19/16 read in part Oxycodone (an opioid, used for moderate to severe pain) tablet 5 milligrams (mg) administer 10 mg by mouth every 4 hours as needed for pain. A review of a document titled "Controlled Medication Utilization Record" dated 07/29/16 through 08/03/16 with an affixed pharmacy label which read in part Oxycodone 5 mg take 1 tablet every 4 hours as needed for mild pain and take 2 tablets by mouth every 4 hours as needed for moderate to severe pain. The document indicated Resident #197 was administered her last dose of Oxycodone 10 mg (2 tablets) on 08/03/16 at 9:31 AM with the remaining amount of medication available as "0" zero. A review of the electronic Medication Administration Record (MAR) dated 08/01/16 through 08/05/16 revealed Resident #197 was administered Oxycodone 5 mg (2 tablets to equal 10 mg) by mouth three times a day on 08/01/16 and 08/02/16. Further review of the MAR revealed Resident #197 was administered oxycodone 10 mg on 08/03/16 at 9:28 AM with the next dose of oxycodone 10 mg being administered on 08/04/16 at 6:20 AM. There was no indication on the MAR that Resident #197 was administered oxycodone of any dose amount on 08/04/16 at 1:30 AM. Review of the admission Minimum Data Set (MDS) dated 08/03/16 revealed Resident #197 was cognitively intact and required limited	F 309	3. Education was provided by the SDC to the licensed nurse's on the expectation of completing treatments as per the physician's orders and documented and ensuring that resident's pain medications are available as prescribed. Unit Managers and or designee will conduct random audits of residents with wounds 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure treatments were completed as per the physician's orders. Unit Managers or designee will conduct random audits of residents with pain medications 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure pain medication is available as prescribed. The facility has granted additional POA to management staff to ensure the facility's omnicell has controlled pain medication available. The facility has revised the treatment nurse duties to enable her to complete all resident's treatments as per the physician's orders. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identifed.	

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assistance for toileting and was independent with all other activities of daily living (ADL). Further review of the MDS under Section J titled Pain Assessment coded Resident #197's pain as "almost constantly" with a pain rating of "8" out of 10 on a scale of 1 to 10, with 1 being little to no pain and 10 being the worst pain.

A review of a nurse's note dated 08/03/16 at 9:28 AM indicated Resident #197 had been administered oxycodone 10 mg. Further review of the nurse's notes indicated on 08/03/16 at 2:14 PM the pain medication administered at 9:28 AM was effective.

Resident #197 had no Oxycodone noted as being administered for pain from 08/03/16 at 9:28 AM until 08/04/16 at 1:30 AM (approximately 16 hours between doses) or until 08/04/16 at 6:20 AM (approximately 21 hours between doses).

Further review revealed another document titled "Controlled Medication Utilization Record" dated 08/04/16 through 08/05/16 with an affixed pharmacy label which read in part Oxycodone 5 mg-take 1 tablet every 4 hours as needed for mild pain and take 2 tablets by mouth every 4 hours as needed for moderate to severe pain. The document indicated a quantity of 30 tablets was received from the pharmacy on 08/04/16 and that Resident #197 was administered Oxycodone 10 mg (2 tablets) on 08/04/16 at 1:30 AM and on 08/04/16 at 6:20 AM.

A nurse's note dated 08/04/16 at 6:20 AM indicated Resident #197 had been administered oxycodone 10 mg. The nurse' note further indicated Resident #197 was again administered oxycodone 10 mg on 08/04/16 at 10:03 AM. The

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nurse's note dated 08/04/16 at 3:07 PM indicated the pain medication administered at 10:03 AM was effective.

Resident #197 was observed on 08/04/16 at 11:07 PM to be in a wheelchair on the side walk at the front of the facility. Resident #197 stated "the facility was out of my pain medication and I went all day yesterday (08/03/16) without any." Resident #197 was observed to have a below the knee amputation (BKA) with staples noted and no dressing over the stump. The resident further stated "they let me suffer all day with pain and did not give me anything."

On 08/04/16 at 11:25 PM, an interview was conducted with Nurse #7. She stated she was unaware of Resident #197 not having pain medication on 08/03/16. Nurse #7 further stated medications were delivered to the facility each night between 12:00 AM and 5:00 AM Monday through Saturday by an out of town night-time pharmacy. Nurse #7 also stated they used a local pharmacy for back-up should a medication be needed before the night delivery of medications was made. She revealed the facility also had a "Pyxis" machine which was used primarily for newly admitted residents or when medications had not yet been delivered from the night-time pharmacy. Nurse #7 went on to say the "Pyxis" was not stocked with oxycodone and was stocked with a limited amount of medications which consisted of antibiotics, Tylenol, and insulins.

On 08/04/16 at 11:35 PM, an interview was conducted with Nurse #8. She stated she was unaware of Resident #197 not having pain medication on 08/03/16. Nurse #8 further stated she signed for the medications which were

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delivered by the night-time pharmacy on 08/04/16 at around 2:00 AM and the oxycodone medication for Resident #197 was included in the delivery.

On 08/05/16 at 10:45 AM, an interview was conducted with Medication Aide (MA) #1. MA #1 confirmed she was the MA on 08/03/16 from 3:00 PM until 11:00 PM on the hall were Resident #197 resided. MA #1 stated she was not aware that Resident #197 was out of her pain medication, oxycodone until the resident came to her around 4:00 PM and requested the pain medication. MA #1 stated Resident #197 had reported her pain at an "8" on a scale of 1 to 10. MA #1 further stated she immediately advised her nurse supervisor, Nurse #9, that Resident #197 needed her oxycodone and would there be any way of getting the medication for her from the back-up pharmacy or from the "Pyxis." MA #1 revealed as a medication aide she was not allowed to take medication from the Pyxis or to call the pharmacy to order a medication and that she was to advise her nurse supervisor, which was what she had done. MA #1 further stated she had apologized to Resident #197 on the evening of 08/03/16 around 6:00 PM for being out of the pain medication and that she had advised the nurse supervisor. MA #1 further stated at that time Resident #197 appeared to be in great pain and was upset in regards the pain medication not being available.

On 08/05/16 at 10:55 AM, Resident #197's pharmacy bubble pack card for oxycodone was observed and MA #1 verified the date of 08/03/16 for which the pharmacy filled and dispensed the medication. MA #1 stated the medication was delivered to the facility by the night-time pharmacy on 08/04/16 at around 2:00 AM.

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F 309	Continued From page 33 On 08/05/16 at 3:50 PM, an interview was conducted with Nurse #6. She stated she was responsible for ordering of the narcotic medications for the facility. Nurse #6 indicated she had to obtain a hard copy prescription from the physician, faxed the prescription to the pharmacy, and the hard copy prescription would be placed in a bin for the night-time pharmacy to pick up when the medications were delivered to the facility. Nurse #6 stated she had obtained a hard copy prescription for the narcotic oxycodone for Resident #197 on 08/03/16 around 4:30 PM after she had finished her shift from 7:00 AM until 3:00 PM on another hall. Nurse #6 further stated she had not had an opportunity or the time to have obtained a hard copy prescription from the nurse practitioner (NP) until the 2nd shift nurse had relieved her. Nurse #6 confirmed she faxed the hard copy prescription for Resident #197's pain medication, oxycodone, to the pharmacy around 5:30 PM and had not marked the prescription as a "stat" order. Nurse #6 stated she could have called the local pharmacy to have obtained a one-time stat dose of the oxycodone but did not do so because she was unaware that Resident #197 was completely out of the pain medication. On 08/05/16 at 4:10 PM, an interview was conducted with the NP. The NP stated she was at the facility all day on 08/03/16 and was advised sometime around 5:00 PM by Nurse #6 that she needed a hard copy prescription written for oxycodone for Resident #197. The NP further stated she was not made aware at any time on 08/03/16 that Resident #197 was completely without her pain medication. The NP stated she would have expected the nursing staff to have	F 309		

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informed her sooner in order for the resident to have not been without her pain medication.

On 08/05/16 at 5:00 PM, a telephone interview was conducted with the pharmacist. She confirmed that the pharmacy had received a faxed copy of the hard copy prescription for oxycodone for Resident #197 on 08/03/16 at around 6:00 PM and that it was not a "stat" order. The pharmacist also confirmed 60 tablets of the oxycodone for Resident #197 was delivered to the facility on 08/04/16 around 2:00 AM. The pharmacist stated should the prescription have indicated "stat" the pharmacy would have delivered the medication in approximately 1 hour from obtaining the faxed copy of the prescription.

On 08/05/16 at 5:30 PM, an interview was conducted with the Director of Nursing (DON). She stated she would have expected the nursing staff to have better communicated to ensure that Resident #197's pain medication was in the facility and ready to be administered at her request. The DON further stated she was aware of some problems with ordering of residents medications and that was one of the many things she would be fixing.

On 08/05/16 at 7:15 PM, a telephone interview was conducted with the 2nd shift nurse, Nurse #9. Nurse #9 confirmed he was responsible for the residents on halls 200 and 500 on 08/03/16 from 3:00 PM until 11:00 PM. Nurse #9 stated he was made aware by MA #1 of Resident #197's pain medication, oxycodone was not available. Nurse #9 further stated he was told by Nurse #6 that the order was called into the pharmacy as a "stat" order and it was after Resident #197 came to him cursing, upset, and appeared to be in great

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F 309	Continued From page 35 pain that he started looking into why the medication was not available. Nurse #9 indicated he called the pharmacy around 9:00 PM, which was the first time he had an opportunity to call, and was advised by the pharmacy that the medication was not ordered "stat" and that it would be delivered to the facility later that night. Nurse #9 stated the medication was not available in the "Pyxis" and he apologized to Resident #197 and made her aware of the situation in regards to her pain medication. 2. Resident #158 was admitted to the facility on 02/02/16 with diagnoses of heart failure, hemiplegia, chronic respiratory failure and a stage 4 pressure ulcer to the sacrum. Review of the significant change Minimum Data Set (MDS) dated 06/22/16 revealed Resident #158 was cognitively intact and required extensive assistance for bed mobility, transfers, dressing, personal hygiene, toileting and bathing. She was coded as receiving Hospice services. There was no care plan for the left foot vascular wound.	F 309		

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Review of the Nurse Practitioner's (NP) note dated 07/05/16 revealed Resident #158 had left foot edema/discoloration. Will treat with conservative measures and elevation and pain management. The NP note dated 07/12/16 revealed Resident #158's left foot with edema and discoloration - hematoma? Stable.
Review of the physician order's revealed the following;
· 07/07/16 left foot wound - cleanse with normal saline, pat dry, apply xeroform, a non-adherent medicated wound dressing, to wound bed, cover with an absorbent pad and wrap with a gauze bandage roll.
An observation made on 08/04/16 at 2:45 PM revealed Resident #158's left foot elevated on a pillow with a piece of xeroform dressing hanging loosely from her toes. Resident #158's foot was black from the top of the foot to her toes, there was a dried reddish, brownish substance on her pillow case her foot was elevated on and on the sheets.
An observation made on 08/05/16 at 4:12 PM revealed Resident #158's left foot to be lying on the bed, not elevated on pillows, the pillows were in the floor by the bedside, a piece of xeroform dressing continued to hang loosely over her toes. There was a dried reddish, brownish substance on her fitted sheet and top sheet from the waist level down and she had the same dried substance on her right foot and toes.
An interview conducted on 08/04/16 at 2:45 PM with Resident #158's family member revealed he visited her every day and most days when he came in the dressing was not on her left foot. He stated he had asked the nurse aides (NAs) and nurses over and over to make sure the dressing stayed on Resident #158's foot.
An interview conducted on 08/04/16 at 4:00 PM

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with the Certified Medication Aide (CMA) revealed she was aware Resident #158's dressing on her left was off but it was the nurse's job to do the dressing changes. She stated she told the NA to let the nurse know the dressing needed to be changed. The CMA further stated Resident #158's dressing came off often and wouldn't be redressed until the nurse got time to do it.
An interview and observation of Resident #158's left foot and dressing change of the left foot wound was conducted on 08/04/16 at 4:30 PM with the Corporate Nurse, the Director of Nursing (DON) and Nurse #2. They agreed there was no dressing on Resident #158's left foot except a piece of xeroform hanging loosely over her toes and there was a dried reddish, brownish substance on the sheets and her other foot. Nurse #5 performed the dressing change on the left foot. The Corporate Nurse stated it was unacceptable the left foot was not treated as ordered and the nurse should have been notified and changed the dressings. She further stated the bed linens should have been changed and Resident #158's right foot should have been washed.
An interview conducted on 08/04/16 at 4:20 PM with Nurse #4 revealed it was her job to do dressing changes for the entire building on 08/04/16 but she also worked the medication cart on the 100 hall and stated she had not had time to change Resident #158's dressings. She stated no one had informed her the dressings were off.
An interview conducted on 08/05/16 at 8:34 AM with the NP revealed she was asked to see Resident #158 on 07/05/16 for left foot edema and discoloration. She stated when she assessed the left foot it was red, edematous and had what appeared to be a blister on the top of her foot. The NP stated Resident #158 had a fall on

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F 309	Continued From page 38 07/03/16 and hit her foot when she fell and due to being chronically anticoagulated was the cause of the redness and edema. She stated she ordered treatment for the left foot to be cleaned with normal saline, wrapped with xeroform, absorbent pads and a gauze dressing once a day. The NP stated the wound had progressed to a vascular ulcer and the treatment was the same. The NP stated it was her expectation all treatments be done as ordered. An interview conducted on 08/05/16 at 3:15 PM with NA #3 revealed she provided care for Resident #158 on 08/04/16 day shift. NA #3 stated Resident #158 would kick her dressing off of her left foot because she moved around in the bed. She stated she would let the nurse know but she had been very busy on 08/04/16 and may not have told the nurse the dressing was off. She further stated the dressing to the left foot would be off for most of the shift on days the nurse was too busy to put it back on. An interview conducted on 08/05/16 at 3:50 PM with the DON revealed it was her expectation for treatments to be done as ordered. She stated if the dressing came off the nurse should be notified immediately and the dressing be redone. An interview conducted on 08/05/16 at 4:15 PM with the facility Physician revealed it was his expectation for treatments to be done as ordered and dressings to stay in place. He stated it was important to the healing process for the medicated dressings to be done and worn as ordered.	F 309		
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	F 312		8/29/16

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F 312	Continued From page 39 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with residents, family and staff the facility failed to provide oral care and showers for 4 of 7 dependent sampled residents (Resident #1, #8, #45, and #109). The findings included: 1. Resident # 45's most recent Minimum Data Set (MDS) assessment was a significant change dated 05/13/16 which indicated Resident # 45 had no cognitive impairment, delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated Resident # 45 required extensive assistance from staff with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS indicated "did not occur" for bathing during the 7 day observation period. Resident # 45's care plan which was last updated on 05/26/16 addressed his need for staff assistance with showers. Interventions included: The resident requires extensive to total assist of 1 staff with bath/shower. Shower 2 times a week and as necessary. Review of the bathing documentation for Resident #45 revealed the last time he had a shower prior to 08/03/16 was 07/26/16. Review of the shower documentation for Resident #45 for June and July 2016 revealed he didn't have a shower from 06/01/16 - 06/09/16, from 06/11/16 -	F 312	1. Resident #8 is no longer at this facility. Resident #45 has received a shower. Resident #109 has received a shower and Resident #1 received a shower. 2. All residents have the potential to be affected by this deficient practice therefore the Unit Managers/DON have completed a 100% audit of current residents to verify showers/oral care is being completed. 3. Education was provided by the SDC to the nursing staff on the expectation of showers/oral care to be completed as scheduled and documented. Unit Managers and or designee will conduct random audits of residents showers 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure showers are completed as scheduled. Unit Managers and or designee will conduct random audits of residents oral care 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure oral care is completed as scheduled. Shower sheets have been implemented to ensure showers have been completed and documented daily. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing	

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F 312	Continued From page 40 06/23/16, from 06/25/16 - 07/07/16 and from 07/09/16 - 07/20/16. Review of the Resident Care Specialist Assignment Sheet revealed Resident #45 was scheduled for a shower on Monday and Fridays on the 7:00 AM - 3:00 PM shift. Observation of Resident #45 on 08/02/16 at 2:50 PM revealed he had a heavy stubble of beard and had a slight body odor. Observation of Resident #45 on 08/03/16 at 4:49 PM revealed he was clean shaven and his hair was damp. During an interview on 08/02/16 at 2:50 PM Resident # 45 stated he missed his shower the past 2 days because the Nurse Aide (NA) told him they didn't have enough staff to help him with his shower. During a follow up interview on 08/02/16 at 3:50 PM Resident #45 stated his regular shower day was 08/01/16 and he didn't get a shower. Resident #45 stated he had talked to several staff about not getting his two showers per week as scheduled and was told repeatedly that they don't have enough help. Resident # 45 stated he often goes more than a week without a shower. Resident #45 stated he would like to have at least 2 showers a week. Resident #45 was unable to recall who he had talked to but stated he had not talked to the current Director of Nursing (DON). Resident #45 stated he felt very embarrassed when he went to an appointment on 08/01/16 at an outside medical provider because he knew he smelled bad when the staff there asked him when he last had a shower.	F 312	will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identified.	

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In an interview on 08/03/16 at 10:47 AM Nursing Assistant (NA) #1 stated she often worked a hall by herself for 20 residents and was unable to provide the care residents needed such as turning and repositioning. NA #1 stated it was not possible to answer call bells in a timely manner or get all the showers done with just 1 NA for 20 residents.

In an interview on 08/03/16 at 2:55 PM NA #5 stated some halls needed more than 2 NAs because the residents had heavy care needs and proper resident care couldn't be done such as showers and personal hygiene when they worked short.

2. Resident #109 was admitted on 7/1/15 with diagnoses that included dementia, diabetes, muscle weakness, and hypertension.

The quarterly Minimum Data Set (MDS) dated 7/25/16 coded Resident #109 as severely, cognitively impaired and displayed no rejection of care. The MDS indicated that Resident #109 required extensive assistance with transfers, dressing, toileting and personal hygiene and total dependence with bathing.

On 8/1/16 at 4:30 PM an interview was conducted with Resident #109's daughter. Resident #109's daughter indicated that during her last visit, Resident #109 had a strong body odor and did not appear to have had a shower. Resident #109's daughter indicated that she was unaware of when Resident #109 had last been bathed but preferred Resident #109 receive at least 2-3 showers per week.

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Review of Resident #109's care plan, with a review date of 7/25/16, revealed an active plan in place for Activities of Daily Living (ADL). The ADL care plan included goals that addressed her need for staff assistance with a bath or shower. Interventions included for the resident to have extensive to total assistance of 1 staff with bathing and/or showering and that Resident #109 was to receive 2 showers per week and as needed.

Review of the facility's Resident Care Specialist Assignment Sheet (RCSAS) dated 8/3/16 revealed that Resident #109 was scheduled for 2 showers per week on Wednesdays and Saturdays on second shift.

On 8/02/2016 at 10:01 AM Resident #109 was observed in her wheelchair sitting in the hallway dressed in a pair of slacks and a stained shirt. There was no odor noticed.

Review of the facility's ADL Documentation Survey Report for bathing revealed that Resident #109 had only received one shower per week on 6 of 13 weeks during the period May through July 2016.

A review of the nurses' notes for the period June through August 2016 revealed there was no documentation that Resident #109 had refused showers.

On 8/3/16 at 10:47 AM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated that residents were given showers on the days indicated on the RCSAS. NA #1 stated that the number of showers a resident received was based on the resident's preference. NA #1

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indicated that "when working short-staffed it makes it difficult to provide the care resident's need and showers may not get done." NA #1 was not sure when Resident #109 had last received a shower but stated that Resident #109 was on the day's schedule to receive a shower.

On 8/3/16 at 2:55 PM an interview was conducted with NA #5. NA #5 stated that most residents received two showers as indicated on the RCSAS. NA #5 stated that resident's rarely received a bed bath unless they had had an incontinent episode. NA #5 indicated that when working short-staffed, sometime showers would not be given to the residents scheduled that day in order to meet their other needs such as incontinent care and assistance with meals.

On 8/03/2016 at 3:19 AM Resident #109 was observed sitting in her wheelchair in the lounge area dressed in a clean outfit with slightly damp but combed hair. NA #1 indicated that Resident #109 had just received a shower.

On 8/5/16 at 11:15 AM an interview was conducted with NA #2. NA #2 stated residents were given the number of showers as indicated on the RCSAS. NA #2 stated that when a shower was not given it was recorded in the facility's computer system as "activity did not occur."

On 8/5/16 at 11:46 AM an interview was conducted with the Director of Nursing (DON). DON stated that a resident's shower preference was obtained upon admission and documented on the RCSAS. DON stated that RCSAS were updated frequently as the resident's preference or needs change. DON reviewed the RCSAS and confirmed that Resident #109 should have

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received 2 showers per week. DON stated that it was her expectation that residents received the number of showers per week based on their preferences as indicated on the RCSAS.

On 8/5/16 at 4:38 PM an interview was conducted with the Administrator. The Administrator stated that it was his expectation that every resident would receive the number of showers they preferred on a weekly basis.

3) Resident #1 was admitted to the facility on 03/28/15 with diagnoses which included anxiety disorder and depression.

A quarterly Minimum Data Set (MDS) dated 05/25/16 indicated Resident #1 was cognitively intact with no behavioral symptoms or rejection of care. Further review of the MDS indicated Resident #1 required extensive assistance from staff with all activities of daily living (ADL), except for eating for which the resident was independent, and required total assistance from staff for bathing. Further review of the MDS indicated Resident #1's preferences for showers and hygiene was very important to her with no documented behaviors or refusal of care.

A care plan with a revision date of 05/25/16 indicated Resident #1 required ADL assistance from staff related to the diagnosis of paralysis. The goals indicated Resident #1 would have ADL care needs met by staff. Interventions included for the resident to have extensive to total assistance of one staff person with bathing and/or showering and that Resident #1 was to receive at least 2 showers a week.

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A review of a document titled "Resident Care Specialist Assignment Sheet" dated 08/03/16 revealed Resident #1 was to have a shower on Tuesday and Saturday by 1st shift staff.

On 08/03/16 at 11:15 AM, an interview was conducted with Resident #1. She stated she had not had a shower in approximately 2 weeks or more and she further stated, "I feel very dirty, grungy, I can smell my own-self, and I feel like they just don't care anything about me and I am embarrassed about my appearance." Resident #1 was unable to recall the last time a staff member assisted or had given her a shower. She stated, "It has been at least 2 weeks, if not longer, since I have had a shower."

On 08/03/16 at 11:33 AM, Resident #1 was observed to have matted, greasy looking hair, with areas of the scalp showing, unpleasant smell of feces, a stout smell of body odor, unkempt, and a malodorous smell in her room. Resident #1 was also observed to push the call light for staff assistance.

On 08/03/16 at 11:35 AM, Nurse Aide (NA) #4 was observed to go into the resident's room. The NA asked the resident, "What can I help you with?" and turned off the call light. Resident #1 stated to NA #4, "I need to be cleaned up, I have laid in a mess long enough!" NA #4 advised the resident she would get someone to assist her and she would return.

On 08/03/16 at 11:53 AM, NA #4 and NA #6 were observed to provide incontinent care to the resident. The NAs were not observed to give Resident #1 a bed bath, they were observed to clean the perineal area and changed the brief.

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Resident #1 did not receive or want a bed bath and she specifically specified a shower. Resident #1 asked the NAs, "Am I going to get a shower today?" NA #4 asked Resident #1, "Is today your shower day?" and the resident indicated, "Yes."

On 08/03/16 at 2:00 PM, Resident #1 was observed sitting outside in her wheelchair and stated, "Thank you, I finally got a shower today, I have not had one in weeks, and I feel so much better." Resident #1 was observed to have been cleansed, with shiny clean hair, no body odor, and well groomed.

An interview was conducted with NA #4 on 08/03/16 at 2:30 PM. NA #4 stated she had given Resident #1 a shower. NA #4 further stated Resident #1 was supposed to have a shower 2 times a week and that the residents were not getting their showers because the facility was short staffed. NA #4 was unable to verify or confirm the last time Resident #1 had received a shower.

An interview was conducted with NA #6 on 08/03/16 at 2:45 PM. NA #6 stated the residents were supposed to have at least 2 showers a week and more often should they request it. NA #6 further stated the residents were not getting 2 showers a week and some residents would go several weeks with no shower or bath due to being so busy and short staffed. NA #6 was unable to verify or confirm the last time Resident #1 had received a shower.

An interview was conducted with the Director of Nursing (DON) on 08/05/16 at 5:30 PM. The DON stated she was unaware Resident #1 smelled of body odor and had not received a shower. The

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DON further stated she would have expected the resident to have had a shower to ensure the resident did not feel dirty, un-cared for, or smelled of body odor. The DON indicated she had identified a problem with the residents not getting their showers and that was one of the things she was working on.

4) Resident #8 was admitted to the facility on 09/10/15 with diagnoses which included paralysis, intellectual disabilities, and disorders of the respiratory system.

A quarterly Minimum Data Set (MDS) dated 06/06/16 indicated Resident #8 was severely cognitively impaired and was unable to be understood or understand. The MDS indicated Resident #8 required extensive assistance with 2 persons physical assist with her activities of daily living (ADL) which included bed mobility, transfers, dressing, toileting, and personal hygiene and was totally dependent on staff for eating and bathing. Further review of the MDS indicated Resident #8 had no behavioral symptoms or rejection of care.

A care plan with a revision date of 06/15/16 indicated Resident #8 required ADL assistance from staff related to the diagnosis of paralysis. The goals indicated Resident #8 would have all her ADL care needs met by staff. Interventions included for the resident was to have oral care twice daily and as needed.

On 08/01/16 at 3:20 PM, Resident #8 was observed lying in bed. Her shirt raised slightly with her abdominal area exposed and a feeding tube was observed to be in place. Resident #8's upper

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teeth were observed to be coated with a white substance around the teeth and into the gum line.

On 08/02/16 at 10:20 AM, Resident #8 was observed lying in bed with the upper teeth coated in a white substance around the teeth, into the gum line, and the lower lip was observed to have a white crusted substance.

On 08/02/16 at 3:45 PM, Resident #8 was observed to be in her room in a wheelchair with a white substance coated on the upper teeth and into the gum line, and the lower lip was observed to have a white crusted substance.

On 08/03/16 at 9:45 AM, Resident #8 was observed lying in bed with her upper teeth being coated with a thick white substance around the teeth, up into the gum line, and the lower lip was observed to have a white crusted substance.

On 08/03/16 at 11:15 AM, Resident #8 was observed in her room and her upper teeth remained coated with a thick white substance around the teeth and up into the gum line, the white crusted substance on the lower lip appeared to be the same.

On 08/03/16 at 11:35 AM, Nurse Aide (NA) #4 was observed to go into the resident's room and checked on Resident #8's roommate.

On 08/03/16 at 11:37 AM an interview was conducted with NA #4. NA #4 confirmed Resident #8 was in need of oral care. NA #4 reported Resident #8 was supposed to have oral hygiene care at least 2 times a day and as needed. NA #4 indicated that resident's oral care was not always provided because the facility was short-staffed.

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NA #4 was unable to verify or confirm the last time Resident #8 had received oral care. NA #4 further indicated she was unable to recall the last time she had provided Resident #8 with oral care. NA #4 indicated she would complete the resident's oral care immediately.

On 08/03/16 at 2:45 PM, an interview was conducted with NA #6. NA #6 stated the residents in the facility was supposed to have oral hygiene completed at least 1 to 2 times a day. NA #6 confirmed Resident #8 was in severe need of oral care. NA #6 was unable to recall the last time Resident #8 had received oral care. NA #6 stated that the resident's oral hygiene care was not provided or completed because the facility was so short staffed and not having enough time to get all of the residents care needs met.

On 08/03/16 at 2:50 PM, a follow-up interview was conducted with NA #4. NA #4 stated she had forgotten to perform Resident #8's oral care due to being so short staff and not having the time to get all of the residents' care needs met.

On 08/03/16 at 2:55 PM, an interview was conducted with Nurse #4. She stated she would have expected Resident #8 to have had oral care provided. Nurse #4 confirmed Resident #8 needed immediate assistance with her oral care. Nurse #4 stated she was unaware Resident #8 was not being assisted with oral care. Nurse #4 further stated it was her expectation for the residents to be assisted with oral care twice daily. Nurse #4 was observed to provide oral care for Resident #8.

On 08/05/16 at 5:30 PM, an interview was conducted with the Director of Nursing (DON).

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F 312	Continued From page 50 The DON stated it was her expectation that ADL care was to be provided to a resident as required or needed. The DON further stated she would have expected the nursing staff to have provided Resident #8 with oral care twice daily and as needed.	F 312		
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: 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 observations, record review and interviews with residents, family and staff, the facility failed to provide sufficient nursing staff to meet the needs for residents in the areas of staff	F 353	1. Resident #1, Resident #45, and Resident # 109 has no adverse outcome related to this deficient practice.	8/29/16

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F 353	Continued From page 51 not meeting the needs of the residents' showers and incontinence care (Residents #1, #45, #109). The findings included: This tag is cross referred to: 1. F241 Based on observations, record review and interviews with staff and residents, the facility failed to provide showers to residents which resulted in 2 of 2 residents feeling embarassed (Resident #1 and Resident #45). 2. F242 Based on observations, record review and staff interview the facility failed to honor residents' choices by not providing the number of showers or baths per week the resident requested for 1 of 4 residents reviewed for choices (Resident #45). 3. F312 Based on observations, record review and interviews with residents, family and staff the facility failed to provide oral care and showers for 3 of 7 dependent residents (Resident # 8, #45 and #109). An interview with the Director of Nursing (DON) on 08/03/16 at 3:33 PM revealed the usual staffing pattern was as follows: 100 Hall 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM: 1 nurse and 1.5 Nurse Aides(NAs) 100 Hall 11:00 PM - 7:00 AM: 1 nurse and 1 NA 200, 300, 500 and 600 halls for 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM: 1 nurse and 2 NAs 200 and 300 halls for 11:00 PM - 7:00 AM: shared 1 nurse and 1 NA 500 and 600 halls for 11:00 PM - 7:00 AM: shared 1 nurse and 1 NA	F 353	2. All residents have the potential to be affected by this deficient practice therefore the Unit Managers/DON have completed a 100% audit of current residents to verify showers/incontinence care were being given as scheduled. 3. The facility has initiated advertising and recruiting with outside agency's for staffing support. The facility will utilize internal support for staffing as needed. Education was provided by the DDCS to the DON/Scheduler on the expectation of facility staffing 08/29/2016. Unit Managers and or designee will conduct a random audit of residents showers 5x weekly x 4 weeks, them 3x weekly x 2 months to ensure showers are completed as scheduled. Unit Managers and or designee will conduct random audits of residents incontinence care 5x weekly x 4 weeks, then 3x weekly x 2 months to ensure incontinence care is completed as scheduled. The DON will conduct random audits 5 x weekly x 4 weeks, then 3x weekly x 2 months to ensure appropriate staffing is sufficient. The DON will review the staffing with the scheduler to ensure the facility has sufficient staffing to meet the resident's needs. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identifed.	

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F 353	Continued From page 52 In an interview on 08/03/16 at 4:32 PM Resident #81, who had no cognitive impairment according to a quarterly Minimum Data Set (MDS) assessment dated 05/27/16, stated there were a lot of night shifts when there was just 1 NA for the whole building and 2 nurses. Resident #81 stated the staffing was worse on the weekends and she observed residents left in bed all weekend and smelling as if they hadn't been changed. In an interview on 08/03/16 at 9:36 PM NA #8 stated she often had to work without enough staff. NA #8 stated most of the time there were only 2 NAs for the whole building including the locked memory care unit. NA #8 stated they didn't have time to do a full round in the whole building to check residents for incontinence needs because all they had time to do was answer call bells. In an interview on 08/04/16 at 10:36 AM NA #10 stated she works on the memory care unit by herself when staff call in sick. NA # 10 stated she was unable to give showers or answer alarms promptly. NA #10 stated she lets the next shift know when showers are missed. NA #10 stated there were many times when there was only 1 NA from 11:00 PM to 3:00 AM and it was impossible to do incontinence care rounds for every resident.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		8/29/16

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F 356	Continued From page 53 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to post the daily staffing sheet for 2 of 5 days of the recertification survey conducted on 08/01/16 to 08/05/16. The findings included: On 08/01/16 at 10:03 AM during an initial tour of the facility the daily staffing sheet was observed posted by the entrance to the 100 hallway nursing unit with the date of 07/20/16. The daily staffing sheet indicated a census of 104 and contained staffing data for all shifts (7:00AM to 3:30 PM,	F 356	1. The daily staffing sheets were immediately posted. 2. No resident has had an adverse outcome related to the posting of the daily staffing sheets. 3. Education was provided by the Administrator/DON to the staff assigned to the posting of the daily staffing to ensure completed and posted daily. The DON/designee will conduct random audits 5 x weekly x 4 weeks, then 3 s weekly x 2	

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F 356	Continued From page 54 8:00 AM to 4:30 PM, 3:00 PM to 11:30 PM, and 11:00 PM to 7:30 AM). On 08/02/16 at 8:10AM the daily staffing sheet was observed posted by the entrance to the 100 hallway nursing unit with the date of 07/20/16 and contained the same staffing data and census of 08/01/16. On 08/03/16 at 3:46 PM the daily staffing sheet was observed posted by the entrance to the 100 hallway nursing unit with the date of 08/03/16 and indicated a census of 107 and contained staffing data for all shifts (7:00AM to 3:30 PM, 8:00 AM to 4:30 PM, 3:00 PM to 11:30 PM, and 11:00 PM to 7:30 AM). On 08/03/16 at 4:04 PM an interview was conducted with the Director of Nursing (DON) who stated the daily staffing sheet should have been posted by 12:00 AM for the following day. The DON stated the daily staffing sheet should have been posted by midnight on 7/20/16 to 08/03/16 at midnight. The DON stated the daily staffing sheet was not posted until around 9:30 AM on 08/03/16. The DON stated the posting of the daily staffing sheet was missed for posting from 7/21/16 until 8/03/16 at around 9:30 AM. The DON stated due to the facility not having a staffing coordinator, it was ultimately the DON's responsibility to post the daily staffing sheet. On 08/03/16 at 6:06 PM an interview was conducted with the Administrator who stated his expectation was the daily staffing sheet would have been posted daily in the facility. The Administrator stated the daily staffing sheet was posted in the facility on 07/20/16 and had not been posted again until 08/03/16.	F 356	months to ensure the posting of the daily staffing sheet is completed. Results will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any trends identified.	

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 431	1. The 2 Levemir Flex Pens, 2 NovoLog	8/29/16

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F 431	Continued From page 56 interviews the facility failed to discard 2 opened Levemir insulin FlexPens that were not dated when opened for 2 of 2 residents (Resident #54 and Resident #112) and 2 opened NovoLog insulin FlexPens for 2 of 2 residents (Resident #209 and Resident #112) and were available for use in 2 of 5 medication carts and failed to discard 1 outdated Resperdal Consta dose pack, 1of 3 multi-dose tuberculin vaccine vial that was opened and undated, and 8 of 8 multi-dose influenza vaccine vials that were outdated and were available for use in the medication refrigerator. Findings included: 1. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated once any medication or biological package was opened, the facility should follow manufacturer or supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date when opened. A further review of the facility protocol for insulin storage recommendations indicated Levemir pen was good for 42 days when opened and refrigerated or unrefrigerated. Resident #54 was admitted to the facility on 07/01 09 with diagnoses of diabetes mellitus. A physician's order dated 08/04/16 with start date of 08/05/16 indicated Resident #54 was to receive Levemir Flexpen 10 units in the morning and increase Levemir to 10 units in the morning for a total of 20 units of Levemir insulin.	F 431	Flex Pens, the Risperdal Consta dose pack, the 3 multi dose tuberculin vials and influenza vials were immediately disposed of. Resident #54, Resident #112 and Resident #209 had no adverse outcome due to the deficient practice. 2. All residents have the potential to be affected by the deficient practice therefore the Unit Managers/DON have completed a 100% audit of current med carts/med room to verify vials or Risperdal Consta dose packs that were opened and not labeled and expired medication were disposed of. 3. Education was provided by the SDC to the licensed nurse's/Certified Medication Aide on the expectation of dating, labeling and storage of biological and the checking for expired medication. Unit Mangers and or designee will conduct random audits of the med carts and med rooms 5x weekly x 4 weeks, the 3x weekly x 2 months to ensure the appropriate dating, labeling storage of biological are completed and the expired medication is removed from the medication cart/room and returned to pharmacy. Unit Managers and or designee will conduct weekly inspections of the medication rooms and medication carts to ensure items are labeled appropriately when open and the expired medication is removed from the medication cart/room and returned to the pharmacy. If items are identified to be open with no dated label and or expired medication is identified pharmacy is to be notified and medication delivered. Results	

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F 431	Continued From page 57 On 08/05/16 at 11:22 AM Resident #54s Levemir Flexpen was observed on the 200 hall nurse's medication cart ready for use and was opened and undated. A place was indicated for date opened on the Levemir FlexPen and the space was blank. A review of the Medication Administration Record (MAR) revealed Resident #54 received Levemir insulin 20 units on 08/05/16 at 8:00 AM per Physician's orders and as indicated by Nurse #1's documentation on the MAR. On 08/05/16 at 11:30 AM an interview was conducted with Nurse #1 who stated she used the undated Levemir FlexPen to administer 20 units of Levemir insulin to Resident #54 on 08/05/16 at 8:00 AM. Nurse #1 stated she was in a hurry and had not checked that Resident #54's Levemir Flex pen had been dated when opened. Nurse #1 stated the facility protocol was that insulin was to be dated when opened. Nurse #1 stated she was unsure how long Resident #54's NovoLog insulin FlexPen had been opened and would expire. On 08/05/16 at 12:11 an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that all insulin was to be dated when opened and placed on the medication cart for resident use as per facility protocol. The DON stated it was her expectation that nursing staff would have verified that Resident #54's Levemir insulin had a date when opened prior to administering Levemir insulin to Resident #54. The DON stated because the Levemir insulin for Resident #54 was not dated when opened there was no way to determine	F 431	will be reported to the QAPI committee for review. 4. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months and ongoing monitoring as the committee deems appropriate for any tends identified.	

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F 431	Continued From page 58	F 431		

when the Levemir insulin had expired.

On 08/05/16 at 12:40 PM an interview was conducted with the Administrator who stated it was his expectation that insulin would be dated by the nurse when opened and placed on the medication cart for resident use. The Administrator stated it was his expectation that the nurse would have verified that the insulin was dated when opened as per facility protocol prior to administering insulin to Resident #54. The Administrator stated if the Levemir insulin was undated then the facility staff would be unable to determine when the Levemir insulin Flexpen had expired for Resident #54.

2. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated once any medication or biological package was opened, the facility should follow manufacturer or supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date when opened. A further review of the facility protocol for insulin storage recommendations indicated NovoLog pen was good for 28 days when opened and refrigerated or unrefrigerated.

Resident #209 was admitted to the facility on 04/17/14 with diagnoses of diabetes mellitus.

A physician's order dated 11/12/15 indicated Resident #209 was to receive 5 units of NovoLog insulin using a NovoLog insulin FlexPen before meals.

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F 431	Continued From page 59 On 08/05/16 at 11:23 AM Resident #209's NovoLog Flexpen was observed on the 200 hall nurse's medication cart ready for use and was opened and undated. A place was indicated for date opened on the NovoLog FlexPen and the space was blank. A review of the Medication Administration Record (MAR) revealed Resident #209 received NovoLog insulin 5 units on 08/05/16 at 7:30 AM per Physician's orders and as indicated by Nurse #1's documentation on the MAR. On 08/05/16 at 11:30 AM an interview was conducted with Nurse #1 who stated she used the undated NovoLog FlexPen to administer 5 units of NovoLog insulin to Resident #209 on 08/05/16 at 7:30 AM. Nurse #1 stated she was in a hurry and had not checked that Resident #209's NovoLog Flex pen had been dated when opened. Nurse #1 stated the facility protocol was that insulin was to be dated when opened. Nurse #1 stated she was unsure how long Resident #209's NovoLog insulin FlexPen had been opened and would expire. On 08/05/16 at 12:11 an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that all insulin was to be dated when opened and placed on the medication cart for resident use as per facility protocol. The DON stated it was her expectation that nursing staff would have verified that Resident #209's NovoLog insulin had a date when opened prior to administering Novolog insulin to Resident #209. The DON stated because the NovoLog insulin for Resident #209 was not dated when opened there was no way to determine when the NovoLog insulin had expired.	F 431		

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F 431	Continued From page 60 On 08/05/16 at 12:40 PM an interview was conducted with the Administrator who stated it was his expectation that insulin would be dated by the nurse when opened and placed on the medication cart for resident use. The Administrator stated it was his expectation that the nurse would have verified that the insulin was dated when opened as per facility protocol prior to administering insulin to Resident #209. The Administrator stated if the NovoLog insulin was undated then the facility staff would be unable to determine when the NovoLog insulin Flexpen had expired for Resident #209. 3. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated once any medication or biological package was opened, the facility should follow manufacturer or supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date when opened. A further review of the facility protocol for insulin storage recommendations indicated Levemir pen was good for 42 days when opened and NovoLog pen was good for 28 days when opened and refrigerated or unrefrigerated. Resident #112 was admitted to the facility on 11/7/15 with a diagnoses of diabetes mellitus. A physician's order dated 12/21/15 indicated Resident #112 was to receive 50 units of Levemir insulin using a Levemir FlexPen at 8:00 AM. A physician's order dated 05/05/16 indicated Resident #112 was to receive NovoLog insulin 18	F 431		

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F 431	Continued From page 61 units with meals using NovoLog FlexPen. On 08/05/16 at 11:25 AM Resident #112's Novolog insulin FlexPen was observed on the 500 hall nurse's medication cart ready for use and was opened and undated. A place was indicated for date opened on the NovoLog FlexPen and the space was blank. A Levemir Flexpen was observed on the 500 hall nurse's medication cart which was not labeled with resident name and was opened and undated. A place was indicated for date opened on the Levemir FlexPen and the space was blank. A review of the medication Administration record (MAR) revealed Resident #112 received Levemir insulin 50 units and NovoLog insulin 18 units on 08/05/16 at 8:00 AM per physician's order and as indicated by Nurse #1's documentation on the MAR. On 08/05/16 at 11:30 AM an interview was conducted with Nurse #1 who stated she administered to Resident #112 50 units of Levemir insulin at 8:00 AM on 08/05/16 using the Levemir insulin FlexPen that was unlabeled with Resident #112's name and was undated when opened. Nurse #1 stated she was busy and had not verified that the Levemir FlexPen was labeled with Resident #112's name and had not verified that the Levemir insulin Flexpen had a date to indicate when it had been opened. Nurse #1 stated she had used the unlabeled Levemir FlexPen to administer insulin to Resident #112 because the only other Levemir insulin Flexpen on the medication cart had another resident's name on it. Nurse #1 stated she did not know how long the Levemir insulin FlexPen had been on the medication cart because the Levemir	F 431		

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insulin Flexpen was not dated when opened and was unsure if the Levemir insulin was expired prior to administering the Levemir insulin to Resident #112 on 08/05/16 at 8:00 AM. Nurse #1 stated the facility protocol was to date insulin when opened and to label the insulin FlexPen with resident's name. Nurse #1 stated she administered to Resident #112 18 units of NovoLog insulin using the undated Novolog insulin Flexpen at 8:00 AM on 08/05/16. Nurse #1 stated she was in a hurry and had not verified that Resident #112's NovoLog insulin Flexpen had a date to indicate when the insulin had been opened and would expire. Nurse #1 stated she was unsure if the NovoLog insulin was expired prior to administering the NovoLog insulin to Resident #112 because it was undated when opened.

On 08/05/16 at 12:11 an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that all insulin was to be dated when opened and placed on the medication cart for resident use as per facility protocol. The DON stated it was her expectation that nursing staff would have checked that the Levemir insulin was dated when opened and was labeled with resident's name prior to administering the Levemir insulin to Resident #112 and would have verified that Resident #112's NovoLog insulin had a date when opened prior to administering Novolog insulin to Resident #112. The DON stated because the Levemir insulin and NovoLog insulin for Resident #112 were not dated when opened there was no way to determine when the insulins had expired.

On 08/05/16 at 12:40 PM an interview was conducted with the Administrator who stated it

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was his expectation that insulin would be labeled with the resident's name and would be dated by the nurse when opened and placed on the medication cart for resident use. The Administrator stated it was his expectation that the nurse would have verified that the insulin was dated when opened as per facility protocol prior to administering insulin to Resident #112. The Administrator stated if the insulin was undated then the facility staff would be unable to determine when the Levemir and NovoLog Flexpen ' s had expired.

4. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated the facility should ensure that medications and biologicals would have an expiration date on the label and would not have been retained longer than recommended by manufacturer or supplier guidelines.

On 08/05/16 at 3:49 PM 1 dose pack of Risperdal Consta 12.5 mg (milligram) was observed in the medication refrigerator with an expiration date of 02/16. Nurse #2 verified that the Risperdal Consta had expired on 02/16 and remained in the medication refrigerator ready for resident use. Nurse #2 immediately removed the Risperdal Consta from the medication refrigerator.

On 08/05/16 at 4:34 PM and interview was conducted with the Director of Nursing (DON) who stated it was the responsibility of the nurse manager to check the medication refrigerator for outdates. The DON stated the nurse manager checked the medication refrigerator 2 days ago and the expired medication just got missed.

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On 08/05/16 at 5:14 PM an interview was conducted with the Administrator who stated his expectation was that the medication refrigerator would have been checked for outdated medications by the nurse manager or by the Assistant Director of Nursing and any expired medications would have been removed.

5. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated the facility should ensure that medications and biologicals would have an expiration date on the label and would not have been retained longer than recommended by manufacturer or supplier guidelines. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date when opened. A further review of the manufacturer's guideline storage for tuberculin vaccine vial indicated a tuberculin vial that was in use for more than 30 days should have been discarded due to possible oxidation and degeneration which could affect potency.

On 08/05/16 at 3:49 PM 1of 3 multi-dose vials of tuberculin purified protein derivative with lot #799052 and a manufacturer's expiration date of 12/17 was observed opened and undated in the medication refrigerator. Nurse #2 verified that the tuberculin vaccine was opened and undated and remained in the medication refrigerator ready for resident use. Nurse #2 stated the tuberculin vaccine was good for 30 days once it was opened. Nurse #2 stated because the tuberculin vaccine had not been dated when it was opened it could not be determined when the tuberculin vaccine had expired. Nurse #2 immediately removed the undated tuberculin vaccine vial from

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the medication refrigerator.

On 08/05/16 at 4:34 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that any multi-dose vial when opened should have been dated by the staff as per facility protocol. The DON stated it was the responsibility of the nurse manager to check the medication refrigerator for outdates. The DON stated the nurse manager checked the medication refrigerator 2 days ago and the expired medication just got missed.

On 08/05/16 at 5:14 PM an interview was conducted with the Administrator who stated his expectation was that the medication refrigerator would have been checked for outdated medications by the nurse manager or by the Assistant Director of Nursing and any expired medications would have been removed. The Administrator stated it was his expectation that the facility staff would have dated the tuberculin vaccine vial when it was opened.

6. A review of the facility policy entitled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles and revised on 01/01/13 indicated the facility should ensure that medications and biologicals would have an expiration date on the label and would not have been retained longer than recommended by manufacturer or supplier guidelines. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date when opened.

On 08/05/16 at 3:49 PM 8 of 8 multi-dose 5 ml (milliliter) vials of influenza vaccine with manufacturer's expiration date of 06/30/16 were

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F 431	Continued From page 66 observed in the medication refrigerator. Nurse #2 verified that the 8 multi-dose influenza vials had a manufacture's expiration date of 06/30/16 and should have been removed from the medication refrigerator and discarded. Nurse #2 stated the 8 vials of expired influenza vaccine remained in the medication refrigerator ready for resident use. Nurse #2 immediately removed the 8 vials of influenza vaccine with an expiration date of 06/30/16 from the medication refrigerator. On 08/05/16 at 4:34 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that nurses were responsible to check for manufacturer ' s expiration date prior to administering medication and remove any expired medication from the medication refrigerator. The DON stated it was the responsibility of the nurse manager to check the medication refrigerator for outdates. The DON stated the nurse manager checked the medication refrigerator 2 days ago and the expired medication just got missed. On 08/05/16 at 5:14 PM an interview was conducted with the Administrator who stated his expectation was that the medication refrigerator would have been checked for outdated medications by the nurse manager or by the Assistant Director of Nursing and any expired medications would have been removed. The Administrator stated it was his expectation that the facility staff would have removed the expired influenza vaccine from the medication refrigerator.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		8/29/16

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F 520	Continued From page 67 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place July 2015 and February 2016. This was for four recited deficiencies which were originally cited July 2015 on the recertification survey, two recited deficiencies which were originally cited February 2016 on a complaint survey, and on the current recertification survey. The deficiencies	F 520	1. Education has been provided for the Administrator by DDCS on 8/10/2016. 2. QAPI committee has reviewed the meeting minutes for the past 3 months to identify trends and ensure actions have been completed as it relates to the previous cited tags F241, F242, F279, F309, F312,and F253. Quality Assurance monitoring of this area will be completed as specific in the POC	

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F 520	Continued From page 68 were in the areas of choices, environment, development of comprehensive care plans, well-being, dignity/respect, and activities of daily living. The continued failure of the facility during two federal surveys of record and a complaint investigation show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F241: Dignity/Respect: Based on observations, record review and interviews with staff and residents, the facility failed to provide showers to residents which resulted in 2 of 2 residents feeling embarrassed (Resident #1 and #45). During the complaint survey of February 11, 2016, the facility was cited for F241 for failure to promote dignity by not changing the soiled clothes of a resident. On the recertification survey, the facility failed to provide showers to residents causing the residents to feel embarrassed. b. F242: Choices: Based on observations, record review and staff interview, the facility failed to honor residents' choices by not providing the number of showers or baths per week the resident requested for 1 of 4 residents reviewed for choices (Resident # 45). During the recertification survey of July 17, 2015, the facility was cited for F242 for failure to honor preferences for showers. On the current recertification survey, the facility failed to honor	F 520	related to the reciting of F241, F242, F279, F309, F312, F253. 3. Education was provided on 8/10/2016 for the QAPI committee members regarding the purpose of the QAPI committee meeting and their responsibilities as QAPI members. 4. QAPI will be held weekly x 4 weeks then monthly to discuss the deficiencies cited and the plan of care. The Administrator will send the QAPI meeting minutes weekly x 4 to the DDO and DDCS for review and recommendations. The Administrator/Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly x 3 months with ongoing monitoring as the committee deems appropriate for any tends identified.	

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residents' choices by not providing the number of showers or baths per week the resident requested.

c. F253: Environment: Based on observations and staff interviews, the facility failed to label and properly store personal hygiene products and resident care equipment in 5 resident bathrooms on 1 of 5 resident hallways (Room #500, #504, #506, #508, and #510), failed to properly store and label resident care equipment in 1 resident room on 1 of 5 hallways (Room #212), and failed to provide clean privacy curtains in 1 resident room on 1 of 5 hallways (Room #509). The facility also failed to repair holes in the walls of 2 resident rooms on 1 of 5 hallways (Room #302 and #312) and failed to maintain air conditioning units in 6 resident rooms on 1 of 5 hallways (Room #300, #302, #304, #305, #311, and #312).

During the recertification survey of July 17, 2015, the facility was cited for failure to replace stained and cracked caulking at the base of toilets and maintain the veneer of resident bedroom doors and a fire door and failed to maintain an environment free of odors. On the current recertification survey, the facility failed to label and properly store personal hygiene products and resident care equipment in resident bathrooms, failed to provide clean privacy curtains in a resident's room, failed to repair holes in the walls of resident rooms, and failed to maintain air conditioning units in resident rooms.

d. F279: Development of Comprehensive Care Plans: Based on observations, record review, and staff interviews, the facility failed to develop a care plan for a foot wound for 1 of 4 residents reviewed for wounds (Resident #158).

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During the recertification survey of July 17, 2015, the facility was cited for failure to develop a comprehensive care plan for range of motion. On the current recertification survey, the facility failed to develop a comprehensive care plan for a foot wound.

e. F309: Well-Being: Based on observations, record reviews, resident and family interviews, and staff and physician interviews, the facility failed to administer pain medication to a resident who had a below the knee amputation causing the resident to have unrelenting pain for 1 of 3 sampled residents reviewed for pain management. The facility also failed to follow a physician's order for wound care and dressing changes for 1 of 4 sampled residents reviewed for wound care (Resident #197 and #158).

During the recertification survey of July 17, 2015, the facility was cited for failure to assess a resident that requested an as needed pain medication before administering the medication. On the current recertification survey, the facility failed to administer pain medication to a resident who had a below the knee amputation causing the resident to have unrelenting pain and failed to follow a physician's order for wound care and dressing changes.

f. F312: Activities of Daily Living: Based on observations, record reviews and interviews with residents, family and staff, the facility failed to provide oral care and showers for 4 of 7 dependent sampled residents (Resident #1, #8, #45, and #109).

During the complaint survey of February 11,

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BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 520	Continued From page 71 2016, the facility was cited for failure to provided showers as scheduled for dependent residents. On the current recertification survey, the facility failed to provide oral care and showers for dependent residents. On 08/05/16 at 7:20 PM, an interview was conducted with the acting Administrator and the Interim Director of Nursing (DON). They stated they were not aware of the previous citations and was unable to speak to what was done in regards to the previous tags (citations). The interim DON stated she would be looking at the recites aggressively and would be reviewing all the current citations which would be driven by the QAA process and would maintain the progress and the documentation to support the process. The acting Administrator stated that a follow up process of checks and balances would be ongoing.	F 520		