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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

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F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews the facility failed to honor the choice of Resident #105 who preferred a shower every day and honor the choice of Resident #3 who preferred a shower twice a week. This was for 2 of 3 residents reviewed for choices, (Resident # 105, and Resident #3). Findings included: Resident #105 was admitted to the facility on 12/6/2016 with cumulative diagnoses which included acute kidney failure, chronic pain and hypertension. The Minimum Data Set (MDS) dated 12/13/2016 indicated Resident #105 was cognitively intact. Resident #105 required supervision/limited assistance with one person physical assistance for bathing.	F 242	Preparation and/ or execution of this plan of correction doesn't constitute admission or agreement by the provider of the truth of facts alleged of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Resident #105 shower schedule reviewed with resident and Shower Book updated to reflect resident's choice of daily shower on second shift. Completed 2/2/2017 Resident #3 shower schedule reviewed with resident and Shower Book updated to reflect her preference of Tuesdays & Fridays showers on second	3/1/17

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

Electronically Signed | 02/24/2017

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F 242	Continued From page 1 Review of his Care Plan dated 12/15/2016 revealed Resident #105 requires supervision to limited assistance with one person physical with bathing. Intervention: Bathing/Showering: Resident #105 was able to: bathe self independently after set-up of supplies. During an interview with Resident #105 during stage 1 on 1/30/17 at 1:30 PM he revealed that he had requested a shower every day during his admission back in December and had not been getting them. During a second interview on 1/31/2017 at 1:15 PM with Resident #105 revealed that he had told Nurses on the hall and several Nursing Assistants that he would like a shower daily. Resident #105 revealed that on the weekend he does not get his shower at all because staff are not available, so he just washed up in his bathroom. Resident #105 revealed that this was also discussed in Resident council meeting on the 1/11/2017 and this is still a problem. Interview with Nurse LPN #51 on the Hall on 1/31/2017 at 1:45PM revealed that she was aware Resident #105 wanted a shower daily. Nurse #52 stated, if a resident requested a shower daily we would honor that resident ' s choice. Interview with Nursing Assistant (NA) # 52 on 1/31/2017 at 3:00PM stated she was also aware of Resident #105 wanting showers daily. NA #52 revealed that she only does showers on Wednesday for Resident #105. Stated that the resident has complained to her that he does not get a shower on Saturday. NA# 52 revealed she	F 242	shift. Resident made aware that she could receive more showers by request. Completed 2/2/2017 The interview able residents will be interviewed for shower preferences with the Shower Book updated to reflect their preferences. Nursing staff will be in-serviced on following resident choices and shower schedules. Resident showers will be audited weekly x4, then monthly for 2 months by the DON and/or designee until a pattern of compliance is established. Audit results will be reviewed by the Director of Nursing and Administrator and presented to the Quality Assurance and Performance Improvement Committee, for monitoring and on-going compliance.	

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F 242	Continued From page 2	F 242		

would do better with this resident.

Interview with Nurse LPN #53 on 1/31/2017 at 4:15 PM revealed someone told him that this Resident #105 wanted a shower every day. Nurse #53 indicated that his shower days are on Wednesday and Saturday during second shift. Nurse #53 revealed that if a resident wants a shower every day, this choice needs to be honored.

Interview with Director of Nursing (DON) on 2/1/2017 at 11:30 AM, indicated that she was aware of Resident #105 wanting a shower every day and her expectations is that the staff needs to honor resident ' s choice.

Interview with the Administrator on 2/1/2017 at 11:45 AM indicated that her expectations of staff will honor residents choices.

2. Resident # 3 was admitted on 4/30/2013 with cumulative diagnoses which included chronic venous hypertension, acute and chronic respiration failure and major depressive disorder.

The Minimum Data Set (MDS) dated 1/8/2017 indicated that Resident #3 was cognitively intact, hearing and vision was adequate. Resident # 3 required total dependence one staff for bathing with one to two persons' physical assistance. Resident Brief Interview for Mental Status was 15 she is able to make her needs known to staff.

During stage 1 resident #3 on 1/30/17 at 2:45 PM

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revealed that she does not get her shower during the week, "showers are slow around here."

During an interview on 2/1/2017 at 8:30 AM, Resident #3 revealed she finally got a shower on 1/31/2017 and hope that this will continue. "Resident # 3 revealed that the facility indicated that we can get showers twice a week would love more but can I at least get them twice a week."

During this same interview Resident #3 revealed that she had discussed this in Resident Council Meeting on 1/11/2017, and the situation still had not improved.

Both residents #105 and #3 were present during that Resident council meeting.

A review of south hall shower schedule for Resident #3 on 2//1/2017 at 10 AM, revealed that Resident #3 received her showers on Tuesday and Friday on 2nd shift.

During an interview with NA #131 on 2/1/2017 at 9 AM, revealed that Resident #3 can bathed herself we just provide her with the linen. NA #131 revealed that she gets her shower on second shift.

Interview with DON on 2/1/2017 at 11:30 AM, indicated that she was aware of Resident #3 shower concerns. DON revealed she was a part of the Resident council meeting on 1/11/2017.

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F 242	Continued From page 4 DON indicated her expectations that residents choice needs be honored. Interview with the Administrator on 2/1/2017 at 11:45 AM indicated that her expectations of staff will honor residents choices.	F 242		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		3/1/17

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F 278	Continued From page 5 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessment to reflect Hearing, speech and Vision Section B for 1 of 3 residents in the sample reviewed for Dignity. (Resident #19) The faility failed to accurately code on the comprehensive MDS assessment a level two PASRR (Preadmission Screening and Resident Review) for 1 0f 1 Resident (Resident #122) for PASRR. Finding include: Resident #19 was admitted on 7/9/2011 with cumulative diagnoses which included mixed conductive and sensorineural hearing loss and acute angle-closure glaucoma. Review of the MDS assessment dated 1/31/2017 revealed Section B of the MDS was not coded to reflect resident had an impaired hearing. Review of the Care Plan dated 10/31/2016 revealed Resident at risk for Impaired Communication due to Impaired Cognition and Impaired hearing. During an interview with MDS Coordinator on 1/31/2017 at 11:30 AM revealed she had coded inaccurately on Section B and she was going to complete a modification.	F 278	Resident #112 Comprehensive MDS modified on 2/1/17 to accurately reflect accurate coding of level II PASRR 100% Audit of most recent comprehensive MDSs for current residents with level II PASRR completed on 2/1/17 with modifications occurring as needed. The District Director of Care Management will provide education on the accurate coding of PASRR Level II. All comprehensive MDSs will be audited by the MDS Coordinator weekly x 4 weeks for accurate coding of Level II PASRR, then a minimum of seven comprehensive MDSs will be audited monthly x 3 months by the MDS Coordinator for accurate coding of Level II PASRR. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.	

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F 278	Continued From page 6 During an interview with Director of Nursing (DON) on 1/31/2017 at 11:30 AM revealed upon the identification of an erroneous data entry it is her expectation that MDS assessment are coded to accurately reflect the resident's status. Based on staff interviews and record review, the facility failed to accurately code on the comprehensive Minimum Data Set (MDS) assessment a level two PASRR (Preadmission Screening and Resident Review) for 1 of 1 resident (Resident #122) reviewed for PASRR. Findings include: 1. Resident #122 was admitted to the facility on 8/4/16 with diagnoses including schizophrenia and opioid dependence. A review of the PASRR Level II Determination Notification dated 11/29/16 revealed that Resident #122 was determined to be a PASRR level 2 (The purpose of the Level II screening is to determine if the individual has any special needs due to his/her identified condition that need to be addressed in a nursing facility). A review of the comprehensive MDS assessment dated 12/16/16 indicated resident was not coded as a level 2 PASRR. An interview was completed with the MDS Coordinator on 2/1/17 at 9:41am. She reported that the incorrect coding was a data entry error. An interview with the Administrator on 2/1/17 at 4:45pm revealed her expectation that the MDS assessments were to be accurately coded.	F 278		
F 314	483.25(b)(1) TREATMENT/SVCS TO	F 314		3/1/17

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F 314 SS=D	Continued From page 7 PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to complete dressing changes to a left foot pressure ulcer as ordered by the physician for 1 of 3 residents that were reviewed for wound care (Resident #32). Findings Included: Resident #32 was admitted to the facility on 9/21/16 and her diagnoses included: stage 2 pressure ulcer of the sacral region, stage 2 pressure ulcer of the right heel, diabetes and dementia. A review of the minimum data set (MDS) dated 12/20/16 for resident #32 revealed she was cognitively impaired, required extensive assistance with the majority of her activities of	F 314	Resident #32 left heel pressure ulcer treatment order reviewed for accuracy and a current TAR was provided to the CNA II for use in completing the treatment per MD order. Completed 2/3/2017 Audit of current resident's with pressure ulcer TARs was completed to ensure the current treatment was as prescribed by the MD. Audit of the Current residents' TARs was completed to ensure no other omissions were noted. Licensed nurses and CNA II were in-serviced on completing the Resident Treatment Record and printing the updated Resident Treatment Record for the CNA II whenever new orders are received.	

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F 314	Continued From page 8 daily living (ADL ' s) and had one stage 2 pressure ulcer. A review of the care plan for resident #32 revealed she had a stage 2 left heel pressure ulcer and a stage 2 sacrum pressure ulcer. Interventions included: administer treatments as ordered and observe for effectiveness, assess/record/observe wound healing every week measuring length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician. A review of the skin assessment for resident #32 dated 12/26/16 revealed she developed a stage 2 pressure ulcer to her left heel that measured 4.0 centimeters (cm) by 3.0cm. The onset date of the ulcer was 12/26/16. A review of the physician ' s orders for resident #32 revealed a new order dated 12/26/16 for foam base foam, apply to the left heel topically every day shift every 3 days, clean with wound cleanser. This order was discontinued on 1/8/17 and a new order was written for santyl ointment, apply to the left heel topically every day shift for the left heel wound, clean with wound cleanser, apply santyl and dry dressing, change every day. The January 2017 treatment administration records (TAR ' s) for resident #32 were provided by the director of nursing (DON) and revealed that there were 2 treatment records being maintained. One was being completed in the electronic medical record system (EMR) and the second one was being completed in a handwritten form. A review of the TAR being	F 314	All resident TARs will be reviewed for completeness and order changes weekly x4 then monthly by the DON and/or designee until a pattern of compliance is established. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.	

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F 314	Continued From page 9	F 314		

maintained in the EMR reflected the treatment order change for the santyl ointment, apply to the left heel topically every day shift for the left heel wound, clean with wound cleanser, apply santyl and dry dressing, change every day that was ordered on 1/8/17. This treatment order was not signed off as being completed on 1/9, 1/10, 1/11, 1/12, 1/13, 1/16, 1/18, 1/22 and 1/27. A review of the TAR that was being completed in the handwritten form did not reflect the treatment order change for the santyl ointment to the left heel on 1/8/17. It continued to reflect the 12/26/16 order for foam base foam, apply to the left heel topically every day shift every 3 days, clean with wound cleanser. This treatment order, that was discontinued on 1/8/17, was signed off as being completed on 1/10, 1/12, 1/13, 1/16, 1/19, 1/25, 1/27 and 1/30.

Wound care was observed for resident #32 on 2/1/17 at 9:10 am. The dressing change was performed by the wound nurse and nursing assistant #1. The dressing was removed from the left heel and there was a small amount of yellow drainage present. The wound was circular to the right inside of the heel and approximately the size of a quarter. Granulation tissue was present, no slough was present and the edges were pink and flaky. The area was cleaned with normal saline and gauze. Santyl was applied to gauze and placed over the wound. Vitamin A and D cream was applied to the foot for dryness. The foot was wrapped with kerlex, taped and ulna boots were applied to both heels. The resident did not display any signs or symptoms of pain during the dressing change.

An interview on 1/31/17 at 3:23 pm with nurse #2 revealed that she was the nurse for Resident #32.

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She stated that she did have a pressure ulcer on her left heel and she was receiving santyl on the wound. She stated that the wound nurse completed the wound treatments and that a new wound nurse had just started.

An interview on 1/31/17 at 3/37 pm with the wound nurse revealed that today was her first day and that she was working with nursing assistant #1 today.

An interview was conducted on 2/1/17 at 8:19 am with the nursing assistant #1. She stated that she had started helping with the wound treatments in December, when the previous treatment nurse left. She stated that she typically worked Friday through Monday and that she would do the wound treatments on the weekends or when the nurse didn ' t. She stated that she wasn ' t able to document in the EMR and that the nurses would provide her with a paper copy of the TAR ' s that had the wound treatment orders on them. She stated that if a treatment order changed the nurses were supposed to provide her with a new TAR and she would staple it to the old one. She stated that she had performed the wound treatment on resident #32 ' s left heel and she used the TAR (the handwritten TAR that reflected the foam on foam treatment to the left heel every 3rd day) to complete the wound treatment.

An interview on 2/1/17 at 4:00 pm with the wound doctor for resident #32 revealed that it was his expectation that wound treatments would be provided by the staff as ordered by the physician.

An interview on 2/1/17 at 4:11 pm with the DON revealed that she expected wound treatments to be done according to the physicians orders. She

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F 314	Continued From page 11 also stated that if a wound order was changed the nurse should have printed out an updated TAR for nursing assistant #1 to use when she was completing wound care.	F 314		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to obtain lab work as ordered by the physician for 1 of 3 residents that were reviewed for unnecessary drug use. (Resident #28). The findings included: Resident #28 was admitted to the facility on 1/3/17 and her diagnoses included anxiety	F 329	Resident # 28 lab orders were reviewed for accuracy. Completed 2/3/17 Resident #28 Depakote level was drawn on 2/3/2017. Results were also received 2/3/2017 with the level being therapeutic. Current residents' lab orders were reviewed for the last 30days for accuracy and to ensure there	3/1/17

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F 329	Continued From page 12 disorder, depression and dementia. A review of the minimum data set (MDS) dated 1/15/17 for Resident #28 revealed she had received antianxiety and antidepressant medications and her cognition was impaired. Review of the January 2017, monthly Physician's Orders for Resident #28, revealed directions to administer Depakote 125mg three times daily related to generalized anxiety and mood disorder. On 1/13/17 the Nurse Practitioner wrote an order to increase the Depakote to 375mg three times daily and ordered a valproic acid (VPA) level to be drawn on 1/17/17. A review of the medical record for Resident #28 revealed no lab results for a VPA level. A review of the lab book, provided by nurse #1, revealed a Bisphenol-A (BPA) level (a urine test to check for Bisphenol A levels, a product used to manufacture plastics) was collected for Resident #28 on 1/17/17. The facility was unable to provide evidence that a valproic acid level was drawn for Resident #28. An interview on 2/1/17 at 1:16pm with nurse #1 revealed that he had received the orders from the psychiatric evaluation on 1/13/17 and had entered the lab order in the lab book. He stated that he had collected a urine sample from Resident #28 on 1/17/17 for a BPA (Bisphenol A) level. He stated that the urine sample had to be frozen and was sent to lab on 1/23/17. A review of the lab orders written on 1/13/17 was conducted with nurse #1 and the Assistant Director of Nursing (ADON) on 2/1/17 at 2:11 pm.	F 329	were no other omissions. The licensed nurses were educated on the lab process and tracking tool. The Lab Log was put into place per policy for tracking. All residents' lab orders will be reviewed weekly x4 then monthly x2 months by the DON and/or designee until a pattern of compliance is established. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.	

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	345014	A. BUILDING _____ B. WING _____	C 02/01/2017

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F 329	Continued From page 13 The ADON confirmed a VPA level, not a BPA level, was ordered to be completed on 1/17/16. Nurse #1 stated during this review that he thought he had confirmed with the Nurse Practitioner that the order was for a BPA level. An interview on 2/1/17 at 3:28 pm with the nurse for the Nurse Practitioner that conducted the psychiatric evaluation for Resident #28 on 1/13/17, confirmed that the Nurse Practitioner had ordered a VPA level. She stated that the VPA level was requested related to the dosage change of the Depakote. She stated that the Nurse Practitioner had not requested a BPA level. During an interview on 2/1/17 at 4:19pm, the Director of Nursing stated her expectation was that lab orders would be completed as ordered by the physician	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on interviews, record review and observations, the facility failed to maintain a medication error rate less than 5% as evidence by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4% for 2 of 5 resident observed for medication pass (Resident #100, Resident #74). Findings included:	F 332	Nurse #1 in-serviced on the 5 rights of medication administration. Completed 2/3/17. No other nurses noted with medication errors during the survey process. All nursing staff will be in-serviced on the 5 rights of medication administration, completion of the medication error report,	3/1/17

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F 332	Continued From page 14 1.) Resident #100 was admitted on 4/11/16 with the current diagnosis of depression, hypertension, and chronic kidney disease. The resident had a gastrostomy tube (G- tube). The resident's orders for January, 2017 revealed the resident had an order for Hydralazine HCL tablet to give 2.5 tablets via G-tube three times a day for hypertension to equal 25 milligrams (mg) (order date 1/20/17). Nurse #1 was observed on 1/31/17 at 9:04 AM to pull out two 10 mg tablets of Hydralazine, which was in the resident's bubble pack and one 25mg tablet of hydralazine, which was in an individual prepackaged plastic package for resident #100. Nurse #1 threw out one of the 10 mg Hydralazine tablets, which was in the bubble pack. Nurse #1 crushed then gave resident #100 one 25mg tablet of Hydralazine and one 10mg tablet of Hydralazine via G-tube, which together equaled 35mg of Hydralazine. Nurse #1 was interviewed on 1/31/17 at 11:33 AM. He stated that he tossed out the other (both 10mg) hydralazine pills too after he punched it out because he realized the pharmacy had packaged one 25mg pill. 2.) Resident #74 was admitted on 12/8/16 with the current diagnosis of hypertension, diabetes and acute kidney failure. Resident #74 orders for January, 2017 revealed the resident had orders for 5mg of Ramipril by mouth one time a day for hypertension (order date 1/12/17). Nurse #1 was observed to pull out one 10 mg	F 332	and family/physician notification in the event of a medication error. Random medication administration audits (all Shifts) will be conducted weekly x4 then monthly x2 for accuracy by the DON and/or designee. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.	

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F 332	Continued From page 15 capsule of Ramipril from resident #74 bubble pack and administered it to the resident by mouth. The bubble pack stated Ramipril 10mg capsule, take 1 tab by mouth daily. Nurse #1 was interviewed on 1/31/17 at 11:33 AM. He checked the order for resident #74 Ramipril and verified that the dose was for 5mg then he pulled out the bubble pack of Ramipril, which stated the capsules were 10mg. He stated 5mg of Ramipril were not usually ordered. The Director of Nursing was interviewed on 2/1/17 at 3:02 PM. She stated her expectation was for medication to be given as prescribed and if an error occurs then they are to call the physician, the resident's family and to ask the physician for direction and to complete a medication error report.	F 332		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		3/1/17

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F 520	Continued From page 16 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 10/19/16 complaint investigation survey. This was for a recited deficiency in the area of choices (F242). This deficiency was cited again on the current recertification survey on 2/1/17. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. Findings include:	F 520	1. The 2 residents who were not receiving showers according to their choices have been corrected as indicated per the plan of Correction for F242. 2. Audit of resident□s showers completed per Plan of Correction for F 242. Interviewable residents were audited to assess if their right of self determination □ right to make choices is being met. 3. The Administrator, department managers and facility staff received training on the Quality Assurance and Performance Improvement Process as it	

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F 520	Continued From page 17 This tag is cross referenced to: 1. F242-Choices: Based on record reviews, staff and resident interviews the facility failed to honor the choice of Resident #105 who preferred a shower every day and honor the choice of Resident #3 who preferred a shower twice a week. This was for 2 of 3 residents reviewed for choices, (Resident #105 and Resident #3). During the complaint investigation survey of 10/19/16 the facility was cited at F242 for failing to honor the choices of a resident's preferred time to get out of bed and another resident's preferred time to be transferred back to bed. On the current recertification survey of 2/1/17, the facility failed to honor the rights of two residents who chose when to take a shower. An interview was conducted with the Administrator on 2/1/17 at 4:38pm. She stated that she was the head of the QAA Committee. Other committee members included the Medical Director, Director of Nursing and department managers. The committee meets quarterly. The Administrator reported that management is meeting with Resident Council regarding any issues. She revealed that the facility has been "staffing challenged" which is why residents have not been consistently receiving showers. She stated that half of her staff on days is agency staffing but that evening and night staffing is okay. Additionally, the Administrator has re-implemented a shower book system where the nurse aides are completing a form that the shower has been completed and the nurse checks the book in the morning to verify completion. The Administrator stated she was	F 520	relates to their position. 4. Administrator will hold Quality Assurance and Performance Improvement Committee Meetings monthly for 3 months and then quarterly and as needed. These will include reviews of any outstanding Plans of Correction, Performance Improvement Plans as well as discussion and review of any high risk areas for potential system failures which require a plan to address. District Director of Clinical Services to review Quality Assurance and Performance Improvement Minutes for next three months and randomly thereafter.	

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F 520	Continued From page 18 going to get more involved in the "shower business."	F 520		