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	345426	A. BUILDING _____ B. WING _____	C 10/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		11/16/17

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

Electronically Signed | 11/15/2017

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

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, family, and physician interviews the facility failed to notify the Responsible Party (RP) and the physician regarding the worsening condition of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #68); and the facility failed to notify the resident when a medical appointment had been rescheduled for 1 of 3 residents reviewed for medically-related social services (Resident #78). The findings included: 1. Resident #68 was admitted to the facility 05/08/17 with diagnoses which included multiple pelvis fractures, dementia, and chronic kidney disease. The latest MDS, a quarterly, dated 08/05/17 indicated the resident's cognition was severely impaired, required extensive staff assistance for all activities of daily living including eating, and was always incontinent of bowel and bladder. This MDS identified the resident as at risk for pressure ulcers but none were present on this assessment. A care plan updated 08/30/17 identified Resident #68 with a pressure ulcer identified on this date. The care plan goal specified the ulcer would be	F 157	1. After an internal root cause was completed, it was determined that an effective process was not in place for communicating wound status updates to residents responsible parties. After an internal root cause was completed, it was determined that an effective process was not in place for communicating changes in appointments to residents. Resident #68 no longer resides at the facility. 2. Residents with appointments in November of 2017 were notified in writing by the Nursing supervisor of their up coming appointment 11/7/17-11/14/17. If the resident has a responsible party they were notified via phone 11/7/17-11/14/17. Residents with wounds, physician was updated on their current status on 11/16/17 by the Nursing Supervisor. 3. Licensed Nurses were in serviced on the new process for appointments. The Unit Clerk to make the appointment, fill out a transportation form and give to the Nursing Supervisor for notification to resident and/or Responsible Party	

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F 157	Continued From page 2 healed by 11/30/17. Interventions included notify physician and notify RP. Review of Resident #68's medical record revealed an order signed by the facility's Medical Director (MD) and dated 08/30/17. The order provided instructions for treatment of the newly identified pressure ulcers on bilateral buttocks. Continued medical record review revealed purulent drainage (drainage that indicates infection) was noted when the wound was assessed 09/28/17. Also, by 09/28/17 the bilateral buttock wounds had opened into 1 wound measuring 5.5 centimeters (cm) in length, 4.2 cm in width, and 0.2 cm deep. The wound assessment on 10/05/17 indicated the wound was 2.5 centimeters (cm) larger in length, 2.8 cm larger in width and 0.8 cm deeper than the assessment on 09/28/17. A physician's order was obtained on 10/05/17 to change the treatment but no antibiotic was ordered. The wound assessment on 10/10/17 indicated the wound continued to have purulent drainage and had only enlarged 0.5 in width and 1 cm in depth. On 10/10/17 a note in the medical record specified the physician had visited the resident that day and left no new orders. Additional medical record review revealed no documentation was found to indicate the RP had been notified of the pressure ulcer worsening. On 10/15/17 a situation background, assessment and request form specified the resident was transported to an acute care facility for evaluation and treatment for labored breathing, low blood pressure, and fever of 101.3 Fahrenheit. An interview was conducted with the facility MD on 10/26/17 at 1:40 PM. The MD stated he did	F 157	11/8/17-11/9/17. Residents with appointments to be reviewed in Morning Clinical for proper notification. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents with appointments for notification of any changes 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents with wounds or new wounds for notification to responsible part and physician 3 times a week for 8 weeks, 2 times a week for 4 week for 4 weeks then monthly thereafter for one year. 4. The Director of Clinical Services to be responsible for implementing this plan. The Director of Nursing introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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see Resident #68 in the facility on 10/10/17 but was not aware of purulent drainage from a pressure ulcer.

An interview was conducted via phone with the Wound Nurse (WN) on 10/17/17 at 8:27 AM. The WN stated she began working for the facility as the wound nurse around September 20, 2017 and was no longer working at the facility since 10/23/17. The WN described purulent drainage as thick, yellow drainage. She stated she performed the dressing changes daily for Resident #68's wound except on weekends and did the weekly wound measurements and assessments. The WN added the wound did not have an odor until a few days before Resident #68 was transported to the hospital on 10/15/17. The WN stated the physician was made aware of the wound enlargement from 09/28/17 to 10/05/17. The WN further stated she kept the Director of Nursing (DON) notified of the wound's condition at all times and reported these findings in the daily morning meetings. The WN was unaware the RP had not been notified of the worsening of the wound.

An interview was conducted via phone with Resident #68's RP on 10/27/17 at 1:39 PM. The RP stated he had not been informed of Resident #68's pressure ulcer or the worsening of the ulcer until the resident was admitted to an acute care facility on 10/15/17. He stated he visited the resident in the facility mainly on weekends.

An interview was conducted with the DON on 10/27/17 at 1:16 PM. The DON stated she observed Resident #68's wound with the WN once. She was unable to recall when this observation occurred. The DON described the

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wound without signs of infection at the time of this observation. She stated if the WN observed purulent drainage she should have notified the MD. The DON added notification of the physician and RP was the WN's responsibility.

An additional interview was conducted with the MD via phone on 10/27/17 at 3:56 PM. The MD stated he did not recall being notified of purulent drainage for Resident #68's wound. He added if he had been notified prior to or on his 10/10/17 facility visit, he would have ordered an antibiotic. The MD explained the resident was declining in general and was not eating well. He expected an antibiotic would have not improved the resident's condition.

2. Resident #78 was admitted on 02/15/17 with diagnoses that included right below knee amputation, blindness in both eyes, diabetes, and acute kidney failure.

Review of the quarterly Minimum Data Set (MDS) dated 07/06/17 indicated Resident #78 had no impairment in cognition. Review of Resident #78's medical record revealed he was listed as his own RP.

During an interview on 10/26/17 at 1:05 PM Resident #78 stated he had not been informed a medical appointment on 10/20/17 had been rescheduled until the morning of 10/20/17 when he had asked the nurse what time he would be leaving for his appointment.

During an interview on 10/26/17 at 2:25 PM Nurse #2 confirmed she had inquired about Resident #78's appointment at his request and

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F 157	Continued From page 5 discovered the appointment had been rescheduled. Nurse #2 added when she informed Resident #78, he stated no one had notified him the appointment had been changed. During an interview on 10/27/17 at 12:10 PM the Unit Clerk (UC) confirmed she scheduled all outside medical appointments for residents. The UC explained when an appointment was rescheduled, she noted the change in the appointment book and informed the resident's nurse of the rescheduled appointment date and time. She added nurses were informed in order to notify the resident and/or RP of the change. The UC confirmed she had rescheduled Resident #78's medical appointment but could not recall which nurse she had informed to notify Resident #78. During an interview on 10/27/17 at 6:13 PM the Director of Nursing stated it was her expectation for nursing staff to notify the resident and/or the RP when an appointment had been rescheduled.	F 157		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide assistance with bathing for 3 of 5 sampled residents who required extensive to total assistance with activities of daily living (Residents #56, #78 and #89).	F 312	1. After an internal root cause analysis was completed, it was determined that an effective process was not in place to change Certified Nurse Assistants assignments to cover showers when there was a decrease in the staffing level.	11/16/17

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F 312	Continued From page 6 Findings included: 1. Resident #56 was admitted on 07/08/16 and readmitted on 11/29/16 with diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), arthritis, muscle weakness, difficulty walking, and dementia. The annual MDS dated 07/16/17 indicated Resident #56 had no impairment in cognition and displayed no rejection of care. Further review of the MDS revealed Resident #56 required extensive assistance of 2 staff members for personal hygiene and total assistance of 2 staff members for bathing. A review of Resident #56's Activities of Daily Living (ADL) care plan, with a revised date of 07/31/17, addressed his need for staff assistance with bathing and personal hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and as needed (PRN). A review of the Bath Type Detail Report (BTDR) and Skin Observation Forms (SOF) for the period 09/21/17 through 10/26/17 revealed Resident #56 received bathing assistance with showers on 09/26/17, 10/04/17, 10/17/17 and 10/22/17. There was no documentation that indicated other bathing assistance, such as bed baths, had been provided or he had refused bathing assistance when offered by staff. On 10/26/17 at 5:10 PM Resident #56 was observed wearing a flannel jacket, clean t-shirt and pants. His hand and fingernails were dirty	F 312	Resident #56 had a shower on 10/28/17. Resident #89 had a shower on 10/28/17. Resident #78 refused a shower on 10/28/17. 2. The Interdisciplinary Team including but not limited Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor questioned residents and/or the patient□s responsible party on resident□s choice to frequency, type of bathing assistance 11/1/17-11/7/17. Care plan and Kardex updated. Future residents and/or their responsible party will be interviewed during Journey Home Meeting to determine their frequency and type of bathing assistance by the Admission Coordinator. The Director of Clinical Services and/or Nursing Supervisor re in serviced Certified Nurse Assistants on providing showers to residents per their choice 11/7/17-11/8/17. 3. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents receiving showers 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. Residents to be queried in Resident Council regarding honoring bathing choices. ED to review Resident Council Meeting Minutes for concerns. 4. The Director of Clinical Services to be responsible for implementing this plan.	

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F 312	Continued From page 7 and had noticeable beard growth. During an interview and observation on 10/27/17 at 10:30 AM Resident #56 was dressed in the same clothing from the previous day, his hands and fingernails were dirty and he had noticeable beard growth. Resident #56 stated he was supposed to receive assistance with bathing twice a week but was unable to recall when he had last received a shower or bath. During an interview on 10/27/17 at 11:06 AM Nurse Aide (NA) #1 revealed staffing had been an issue and "for months" they had frequently worked short-staffed. NA #1 explained the facility had a dedicated shower team to provide residents with bathing assistance but they were usually pulled to the floor to help with resident care. NA #1 added when the shower team was pulled to assist with care, residents were not given showers or baths. During an interview on 10/27/17 at 6:13 PM the Director of Nursing (DON) stated it was her expectation Resident #56 would receive bathing assistance twice weekly. 2. Resident #78 was admitted to the facility on 02/15/17 and readmitted on 09/11/17 with diagnoses that included right and left below knee amputations, blindness in both eyes and muscle weakness. The most recent quarterly MDS dated 07/06/17 indicated Resident #78 had no impairment in cognition, displayed no rejection of care and required extensive assistance of 2 or more staff members for personal hygiene and bathing. Further review of the MDS revealed the bathing	F 312	The Director of Nursing introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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activity did not occur during the assessment look back period.

A review of Resident #78's ADL care plan, with a revised date of 08/31/17, addressed his need for staff assistance with bathing and personal hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and PRN.

A review of the BTDR for the period 09/21/17 through 10/26/17 revealed Resident #78 received bathing assistance with a shower on 10/24/17. There was no documentation that indicated other bathing assistance, such as bed baths, had been provided or that he had refused bathing assistance when offered by staff.

During an interview and observation on 10/27/17 at 1:05 PM Resident #78 was dressed in a slightly stained t-shirt and his hair was uncombed. Resident #78 stated he was supposed to receive bathing assistance twice a week but "had only gotten one shower in over a month" and could not recall when had had last received a bed bath. Resident #78 added he was unable to bathe himself and confirmed his preference was to receive at least 2 showers or bed baths per week.

During an interview on 10/27/17 at 11:06 AM Nurse Aide (NA) #1 revealed staffing had been an issue and "for months" they had frequently worked short-staffed. NA #1 explained the facility had a dedicated shower team to provide residents with bathing assistance but they were usually pulled to the floor to help with resident care. NA #1 added when the shower team was pulled to assist with care, residents were not

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given showers or baths.

During an interview on 10/27/17 at 6:13 PM the DON stated it was her expectation Resident #78 would receive bathing assistance twice weekly.

During an interview on 10/27/17 at 6:13 PM the Corporate Registered Nurse stated Resident #78 had a history of refusing showers but was unable to locate any additional documentation that indicated he had refused bathing assistance when offered by staff.

3. Resident #89 was readmitted to the facility on 05/05/17 with diagnoses that included diabetes, dementia and respiratory failure.

A review of Resident #89's ADL care plan, with a revised date of 08/31/17, addressed his need for staff assistance with bathing and personal hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and PRN.

The most recent quarterly MDS dated 09/06/17 indicated Resident #89 was moderately impaired in cognition, displayed no rejection of care and required extensive assistance of 1-2 staff members for personal hygiene and bathing. Further review of the MDS revealed the bathing activity did not occur during the assessment look back period.

A review of the BTDR and SOF for the period 10/01/17 through 10/26/17 revealed Resident #89 received bathing assistance with showers or bed bath on 10/03/17, 10/05/17, 10/09/17, 10/11/17, and 10/22/17. There was no documentation that

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F 312	Continued From page 10 indicated he had refused bathing assistance when offered by staff. During an interview and observation on 10/27/17 at 10:30 AM Resident #89 was noticed wearing the same clothing as the day before and had slight beard stubble. Resident #89 was unable to recall when or how often he was scheduled to receive a shower or bath. During an interview on 10/27/17 at 12:00 PM NA #2 revealed they often worked short with only 3 NA's for the entire building to provide resident care. NA #2 stated when working short-staffed they were unable to provide bathing assistance. During an interview on 10/27/17 at 3:17 PM NA #5 revealed they had been short-staffed for the past few months and were unable to assist with bathing when there were only 3 NA's for the entire building to provide resident care. During an interview on 10/27/17 at 6:13 PM the DON stated it was her expectation that Resident #89 would receive bathing assistance twice weekly.	F 312		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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	F 353		11/16/17

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F 353	Continued From page 11 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and	F 353	1. After an internal root cause analysis	

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F 353	Continued From page 12 resident and staff interviews, the facility failed to provide sufficient nursing staff which resulted in bathing assistance not being provided for 3 of 5 sampled residents who required extensive to total assistance with activities of daily living (Residents #56, #78 and #89). Findings included: This tag is cross-referenced to: F 312: "Based on observations, record reviews, resident and staff interviews, the facility failed to provide assistance with bathing for 3 of 5 sampled residents who required extensive to total assistance with activities of daily living (Residents #56, #78 and #89)." Review of the facility's Daily Census Report for 10/25/17 revealed a resident census of 65. An interview conducted with the Corporate Registered Nurse on 10/26/17 at 10:00 AM confirmed the current facility census was 65 with an admission expected later in the day which would increase the census to 66. An interview conducted with Nurse Aide (NA) #4 on 10/26/17 at 5:15 PM revealed they had been short-staffed on second shift for "months" with only 2-3 NA's to provide resident care. NA #4 stated showers were supposed to be given during first shift and residents had complained they had not been receiving a shower. NA #4 added they would try to give the residents a bed bath but were not always able to accommodate the residents request when working short-staffed. An interview conducted with NA #2 on 10/27/17 at	F 353	was completed, it was determined that an effective process was not in place to change Certified Nurse Assistants assignments to cover showers when there was a decrease in the staffing level. 2. The facility is actively recruiting staff. Ads are placed to try and recruit CNA's. The facility has in place a sign on bonus and referral bonus for current staff to refer a friend,. The facility has contacted the closest school that provides CNA classes. The facility currently has participated in a round table discussion with other facilities on recruitment which was hosted by the local Ombudsman. Certified Nurse Assistants who are in other roles in the facility are currently providing showers during the week. 3. During the morning meeting the Executive Director to perform Quality Improvement Monitoring of current day staffing and the next day staffing to determine any open floor positions 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. Residents to be queried in Resident Council Meetings regarding bathing choices being honored. ED to review Resident Council minutes for concerns. 4. The Director of Clinical Services will be responsible for implementing this plan. The Director of Nursing introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to	

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F 353	Continued From page 13 12:00 PM revealed there were only 3 NA's to provide resident care on 10/26/17 and due to insufficient staff, residents did not receive showers. An interview conducted with NA #5 on 10/27/17 at 3:17 PM revealed normal staffing for NA's were 4 on both first and second shifts. NA #5 stated for the past few months there had only been 3 NAs for each shift and some days there had only been 2. NA #5 added the facility had continued to accept new admissions. During a joint interview conducted on 10/27/17 at 6:13 PM, the Director of Nursing (DON) acknowledged staffing had been a challenge but showers should be given even with staffing limitations. The DON stated it was her expectation residents would receive bathing assistance twice weekly. During a joint interview conducted on 10/27/17 at 6:13 PM, the Administrator was unaware that residents had not received bathing assistance twice weekly due to insufficient staffing. She acknowledged staffing had been a challenge and stated the hiring process has been a "constant work in progress." The Administrator explained they worked with 2 staffing agencies but the agencies had been unable to find anyone that would come to the area. She added they have also utilized staff from sister facilities when short-staffed. The Administrator confirmed that the facility continued accepting new admissions even with the staffing limitations they had identified.	F 353	the QAPI Committee by the Director of Clinical Services. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		11/16/17

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F 514	Continued From page 14 LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain 1 of 9 clinical records with complete and accurate information.	F 514	1. After an internal root cause analysis was completed, it was determined that an effective process of filing and storage of	

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F 514	Continued From page 15 Resident #68's clinical record was not complete and did not accurately reflect decline in medical status, vital sign assessments, and nursing progress notes from 09/21/17 until discharge from the facility on 10/15/17. The findings included: Resident #68 was admitted to the facility 05/08/17 with diagnoses which included multiple pelvic fractures, dementia, and chronic kidney disease. A quarterly Minimum Data Set (MDS) dated 08/05/17 indicated the resident's cognition was severely impaired. The MDS coded the resident required extensive staff assistance for all activities of daily living including eating, demonstrated continuous inattention, and was at risk for pressure ulcers but had none at the time of this assessment. A review of Resident #68's closed medical record revealed a flow sheet for vital sign documentation and nurses' progress notes from 09/21/17 through 10/14/17 were not located in the record. A SBAR (situation, background, assessment and request form) dated 10/15/17 describing the resident was found with labored breathing and vital signs which included a blood pressure of 60/35, pulse of 104, and temperature of 101.3 Fahrenheit (F). No nurses' notes were found to describe the resident's condition from 09/21/17 leading up to this episode. No documentation was found regarding notification of the resident's condition to the physician nor the family prior to 10/15/17. An interview with Nurse Aide (NA) #3 on 10/26/17 at 2:40 PM revealed she had cared for Resident #68 frequently. NA #3 stated for the last 3 weeks	F 514	medical records was not in place. Resident #68 no longer resides at the facility. 2. Current resident Medical records were thinned and documents filed to bring medical records current. 3. Director of Clinical Services and or Nursing Supervisor re-educated Licensed Nurses were re in serviced on documenting in the medical record to reflect resident current status and file any and all notes on 11/8/17-11/9/17. A dedicated person has been hired to work as the Medical Records Coordinator. This person will be responsible for filing medical records and keeping them in an organized manner. The Executive Director to perform Quality Improvement Monitoring of organization of the Medical Records and for documentation being placed in the medical records in a timely manner 3 times a week for 8 weeks, 2 times a week for 4 weeks then weekly thereafter for one year. 4. The Executive Director to be responsible for implementing this plan. The Executive Director introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Maintenance Director. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of	

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F 514	Continued From page 16 the resident was in the facility, she was coughing. The nurse aide added she reported this to any nurse that worked. NA #3 stated she recalled taking the resident's temperature approximately a week before the resident left the facility. The temperature registered 102 F on the thermometer. NA #3 stated she reported this finding to the nurse. She was unable to recall which nurse. An interview was conducted with the Administrator, Director of Nursing, and a Corporate Nurse (CN) on 10/27/17 at 8:27 AM. The CN reported the staff member for medical records turned in her keys at the end of the day 10/26/17 and was not coming back to the facility. She stated numerous records were left unfilled. The CN stated additional medical records for Resident #68 were not found. An interview was conducted with the facility Therapy Manager (TM) on 10/27/17 at 9:15 AM. The TM reported Resident #68 was seen by physical therapy starting 09/13/17 for strengthening. TM stated the resident began a rapid decline. September 22, 2017 was the last day she walked and her knees were buckling then. The TM stated the resident began to draw up into a fetal position. The therapy goal was changed to position and contracture management. At 9:30 AM on 10/27/17, the CN provided lists of vital signs which included Resident #68's vital signs none of which revealed elevated temperatures. The lists provided were dated 10/01/17, 10/03/17, 10/08/17, and 10/09/17. The CN stated these lists contained the names of residents that needed vital signs done on the	F 514	Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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F 514	Continued From page 17	F 514		

days mentioned and were provided to the nurse aides to obtain the findings. The CN stated these were not part of the medical record and were the only lists of vital signs that could be found that were dated. The CN reported no nursing progress notes could be found.

An interview was conducted with Nurse #3 on 10/27/17 at 10:51 AM. Nurse #3 stated she worked at the facility 3 days a week, 12 hour shifts 7 AM to 7 PM, and cared for Resident #68 when she worked. She stated she was unaware of the resident having a fever. Nurse #3 added she knew the resident was in the final stages of dementia.

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{F 253} SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to maintain a clean feeding tube pump for 1 of 1 feeding tube pumps, replace grout between new tiles and clean a black substance off the tile baseboard and in the seams where tile from perpendicular walls meet in 1 of 2 resident showers (D hall), and keep a soap dispenser operational in a 1 of 3 resident bathrooms (bathroom between room 120 and room 122) on D hall affecting Residents #6 and Resident #49. The findings included: 1. a. An observation on 10/26/17 at 11:30 AM revealed a feeding pump by the A bed in room 104 contained what appeared to be spilled feeding solution in the inset that held the tubing from the feeding solution container so the tubing could be threaded through the regulator wheel that controlled the amount of feeding solution going to the resident. The bottom of the pump contained 2 hardened drops of apparent spilled feeding. Underneath the pump 2 approximately half inch splatters of apparent feeding solution were observed. The splatters were dark beige in color. The underneath splatters were visible to the resident when lying in bed. No feeding was in progress at the time of this observation. An additional observation of the feeding pump was conducted 10/26/17 at 2:21 PM. The areas of apparent spilled feeding solution were	{F 253}	1. After an internal root cause analysis was completed, it was determined that an effective system was not in place to identify housekeeping and maintenance issues. The feeding pump in room #104 was cleaned by the Nursing Supervisor on 10/27/17. The D hall shower room baseboard seams and tiles were cleaned by the Housekeeping Supervisor on 10/27/17. The D hall shower room tile was replaced and grouted on 11/13/17. The soap dispenser in the bathroom for room #120 had its soap replenished on 10/27/17. 2. Observations of resident shower rooms for missing grout, black substance on tiles, and soap dispensers for soap and feeding pumps was completed on 10/27/17 by Housekeeping Supervisor and Nursing Supervisor. The Director of Clinical Services re-educated staff on reporting issues with resident shower room tiles by filling out a work order and reporting black substance on tiles in shower rooms, empty soap dispensers and to clean up spills on tube feeding machine/pole as they occur 11/8/2017-11/9/2017. 3. The Interdisciplinary Team including but	11/16/17

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

Electronically Signed | 11/15/2017

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

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{F 253}	Continued From page 1 unchanged. No feeding was in progress at the time of this observation. Another observation of the feeding pump was conducted 10/27/17 at 7:30 AM. A feeding was in progress. The feeding solution was observed to be dark beige in color. The splatters of apparent feeding solution at the bottom and underneath the pump were unchanged. Due to the feeding tubing in the insert the dark beige colored spill was not visible. On 10/27/17 at 11:27 AM the Administrator confirmed the feeding pump contained what appeared to be spilled feeding. She stated the way the fluid was hardened at the base of the feeding pump, it appeared the spill had been on the pump for some time. b. An observation was conducted of the D hall resident shower room on 10/26/17 at 11:20 AM. Floor tiles were observed in place on the shower floor without grout between the tiles leaving an open groove approximately 1/8 of an inch or less. A dark colored substance was noted on the tile baseboard in the back of the shower and in the seams where the tile from perpendicular walls met extending approximately 2 to 3 inches above the shower floor. The black substance was noted in the tile wall seams on both sides of the shower. On 10/27/17 at 11:10 AM an additional observation of the D hall shower was conducted with the Housekeeping Supervisor (HS). The HS confirmed there was no grout between tiles on the shower floor. He added with open grooves, mold could accumulate. The HS also confirmed the presence of black colored substance on the tile baseboard and in the seams of the tile walls.	{F 253}	not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping to perform Quality Improvement Monitoring of resident bathroom soap dispensers for soap and feeding tube pump needing cleaning 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Housekeeping Supervisor and/or Maintenance Director to perform Quality Improvement Monitoring of shower room tiles requiring grout, black substance on tiles 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year. The Housekeeping Supervisor and Maintenance Director and Housekeeping Director to be responsible for correction of reported concerns. 4. The Executive Director to be responsible for implementing this plan. The Executive Director introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Maintenance Director. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a	

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{F 253}	Continued From page 2 He stated it was the responsibility of the housekeepers to keep the shower clean. He stated he would take care of the black substance. On 10/27/17 at 11:20 AM an observation of the D hall shower room was made with the Administrator. The Administrator confirmed there was no grout between the shower floor tiles. The black colored substance was not visible on this observation. c. An observation on 10/26/17 at 4:35 PM of the bathroom between rooms 120 and 122 revealed the soap dispenser would not deliver soap when the lever to release soap was pushed. This soap dispenser was the only source of soap for hand washing observed in the bathroom or either resident room. An interview was conducted with Resident #49 on 10/26/17 at 4:47 PM. An annual Minimum Data Set (MDS) dated 07/15/17 assessed Resident #49 with an intact cognition. Resident #49 stated she used the bathroom between Room 122 and 120 frequently and had attempted to use the soap in the dispenser when washing her hands. She added the soap dispenser had not worked in a while. She was unable to recall how long. The resident stated she had reported this but was unable to recall to whom. Attempted interview with Resident #6 on 10/27/17 at 7:40 AM. The resident was unable to complete the interview. An additional observation on 10/27/17 at 12:10 PM revealed the soap dispenser in the bathroom between Rooms 120 and 122 remained dysfunctional.	{F 253}	minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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{F 253}	Continued From page 3 An interview with Nurse Aide (NA) #1 on 10/27/17 at 12:15 PM revealed both Resident #6 and Resident #49 used the bathroom between their rooms without assistance. NA #1 stated the nurse aides used the soap dispensers in resident bathroom when washing their hands after providing care to residents. The NA confirmed the soap dispenser had appeared empty for some time. NA #1 stated housekeeping was supposed to keep the soap dispensers filled. NA #1 added she had been using hand sanitizer instead of washing her hands with soap when providing care in this area of the building. An interview was conducted with Housekeeper #1 on 10/27/17 at 2:40 PM. Housekeeper #1 stated it was the responsibility of the housekeepers to keep soap dispensers full and working. An additional interview with the Administrator 10/27/17 at 6:16 PM revealed she expected nurses to keep the feeding pump clean. The Administrator stated the facility was going to rent a pressure washer to get the shower room floor clean. The Administrator added it was the responsibility of housekeepers to be checking soap dispensers and keeping them functional.	{F 253}		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	F 282		11/16/17

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to follow resident care plans to provide skin assessments every 7 days for 1 of 1 resident reviewed for skin assessments (Resident #6) and failed to provide assistance with bathing twice weekly for 3 of 5 residents reviewed for activities of daily living (Residents #56, #78, and #89). The findings included: 1. Resident #6 was admitted to the facility 08/24/17 with diagnoses which included diabetes mellitus and congestive heart failure. A quarterly Minimum Data Set (MDS) dated 08/03/17 indicated Resident #6's cognition was intact. The MDS coded the resident required limited staff assist for hygiene, toileting, dressing, and bed mobility. The MDS specified Resident #6 was occasionally incontinent of bladder and bowel and was at risk for pressure ulcers but had no ulcer at the time of this assessment. The MDS skin assessment specified the resident had moisture associated skin damage. A care plan updated 10/13/17 identified Resident #6 at risk for skin breakdown related to need for occasional episodes of bladder incontinence and a new wound on the left great toe. Interventions included assess skin weekly by licensed nurse. A review of Resident #6's medical record revealed a physician's order dated 10/13/17 for medi honey and wound barrier to left great toe 3 times a week. Multiple physician's orders dated 10/18/17 provided instructions for treating a wound on the resident's right ankle, increasing	F 282	1. After an internal root cause analysis was completed, it was determined that an effective process was not in place to monitor the completion of skin assessments. After an internal root cause analysis was completed, it was determined that an effective process was not in place to change Certified Nurse Assistants assignments to cover showers when there was a decrease in the staffing level. Resident #6 had a skin assessment completed on 11/1/17. No new concerns noted. Resident #56 had a shower on 10/28/17. Resident #89 had a shower on 10/28/17. Resident #78 refused a shower on 10/28/17. 2. Skin assessments was completed 10/31/17-11/2/17 on current residents. Completion of Skin Assessments to be reviewed in Morning Clinical Meeting and or Weekly Wound meeting. The Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor questioned residents and/or the patient□s responsible party on resident□s choice to frequency, type of bathing assistance 11/1/17-11/7/17. Care plan and Kardex updated. Future residents and/or their responsible party to be interviewed at Journey Home Meeting to determine their frequency and type of bathing assistance by the Admission Coordinator. The	

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F 282	Continued From page 5 the medi honey treatments to daily, and instructions for wound prevention for right and left buttocks. A review of skin assessment documentation revealed the last skin assessment documented was done on 10/17/17 which noted ongoing treatments in progress for the left great toe, right ankle, and left and right buttocks. This assessment was signed by the Wound Nurse. No further documentation for wound assessments was found in the medical record. An interview was conducted with Nurse #1 on 10/27/17 at 3:30 PM. Nurse #1 stated the Wound Nurse was responsible for skin assessments. The nurse stated the Wound Nurse was no longer employed by the facility since 10/23/17. Nurse #1 added no instructions had been provided to the hall nurses to obtain skin assessments until the new Wound Nurse started 10/30/17. An interview with the Director of Nursing on 10/27/17 at 6:16 PM revealed she expected skin assessment to be completed on all residents every 7 days. 2. Resident #56 was admitted to the facility on 07/08/16 and readmitted on 11/29/16 with diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), arthritis, muscle weakness, and dementia. The annual MDS dated 07/16/17 indicated Resident #56 had no impairment in cognition and displayed no rejection of care. Further review of the MDS revealed Resident #56 required	F 282	Director of Clinical Services and/or Nursing Supervisor re in serviced Licensed Nurses on completion of and documentation of the weekly skin assessment 11/8/17-11/9/17. The Director of Clinical Services and/or Nursing Supervisor re in serviced Certified Nurse Assistants on providing showers to residents per their choice 11/7/17-11/8/17. 3. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents receiving showers 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents skin assessments for completion 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. 4. The Director of Clinical Services to be responsible for implementing this plan. The Director of Nursing introduced the plan of correction to the QAPI committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director,	

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F 282	Continued From page 6 extensive assistance of 2 staff members for personal hygiene and total assistance of 2 staff members for bathing. A review of Resident #56's Activities of Daily Living (ADL) care plan, with a revised date of 07/31/17, addressed his need for staff assistance with bathing and personal hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and as needed (PRN). A review of the Bath Type Detail Report (BTDR) and Skin Observation Forms (SOF) for the period 09/21/17 through 10/26/17 revealed Resident #56 received bathing assistance with showers on 09/26/17, 10/04/17, 10/17/17 and 10/22/17. There was no documentation that indicated other bathing assistance, such as bed baths, had been provided or that he had refused bathing assistance when offered by staff. During an interview and observation on 10/27/17 at 10:30 AM Resident #56 hands and fingernails were dirty and he had noticeable beard growth. Resident #56 stated he was supposed to receive assistance with bathing twice a week but was unable to recall when he had last received a shower or bath. During an interview on 10/27/17 at 11:06 AM Nurse Aide (NA) #1 revealed staffing had been an issue and "for months" they had frequently worked short-staffed. NA #1 explained the facility had a dedicated shower team to provide residents with bathing assistance but they were usually pulled to the floor to help with resident care. NA #1 added when the shower team was	F 282	Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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pulled to assist with care, residents were not given showers or baths.

During an interview on 10/27/17 at 6:13 PM the Director of Nursing (DON) was unaware that Resident #56 had not received bathing assistance as care planned. The DON stated it was her expectation for all residents to receive bathing assistance twice weekly.

3. Resident #78 was admitted to the facility on 02/15/17 and readmitted on 09/11/17 with diagnoses that included right and left below knee amputations, blindness in both eyes and muscle weakness.

The quarterly MDS dated 07/06/17 indicated Resident #78 had no impairment in cognition, displayed no rejection of care and required extensive assistance of 2 or more staff members for personal hygiene and bathing. Further review of the MDS revealed the bathing activity did not occur during the assessment look back period.

A review of Resident #78's ADL care plan, with a revised date of 08/31/17, addressed his need for staff assistance with bathing and personal hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and PRN.

A review of the BTDR for the period 09/21/17 through 10/26/17 revealed Resident #78 received bathing assistance with a shower on 10/24/17. There was no documentation that indicated other bathing assistance, such as bed baths, had been provided or that he had refused bathing

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assistance when offered by staff.

During an interview and observation on 10/27/17 at 1:05 PM Resident #78 was dressed in a slightly stained t-shirt and his hair was uncombed. Resident #78 stated he was supposed to receive bathing assistance twice a week but "had only gotten one shower in over a month" and could not recall when had had last received a bed bath. Resident #78 added he was unable to bathe himself and confirmed his preference was to receive at least 2 showers or bed baths per week.

During an interview on 10/27/17 at 11:06 AM Nurse Aide (NA) #1 revealed staffing had been an issue and "for months" they had frequently worked short-staffed. NA #1 explained the facility had a dedicated shower team to provide residents with bathing assistance but they were usually pulled to the floor to help with resident care. NA #1 added when the shower team was pulled to assist with care, residents were not given showers or baths.

During an interview on 10/27/17 at 6:13 PM the DON was unaware that Resident #78 had not received bathing assistance as care planned. The DON stated it was her expectation for all residents to receive bathing assistance twice weekly.

4. Resident #89 was readmitted to the facility on 05/05/17 with diagnoses that included diabetes, dementia and respiratory failure.

A review of Resident #89's ADL care plan, with a revised date of 08/31/17, addressed his need for staff assistance with bathing and personal

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hygiene due to an ADL self-care performance deficit. Interventions included for staff to provide him with full assistance to bathe 2 times a week and PRN.

The most recent quarterly MDS dated 09/06/17 indicated Resident #89 was moderately impaired in cognition, displayed no rejection of care and required extensive assistance of 1-2 staff members for personal hygiene and bathing. Further review of the MDS revealed the bathing activity did not occur during the assessment look back period.

A review of the BTDR and SOF for the period 10/01/17 through 10/26/17 revealed Resident #89 received bathing assistance with showers or bed bath on 10/03/17, 10/05/17, 10/09/17, 10/11/17, and 10/22/17. There was no documentation that indicated he had refused bathing assistance when offered by staff.

During an interview and observation on 10/27/17 at 10:30 AM Resident #89 was noticed wearing the same clothing as the day before and had slight beard stubble. Resident #89 was unable to recall when or how often he was scheduled to receive a shower or bath.

During an interview on 10/27/17 at 12:00 PM NA #2 revealed they often worked short with only 3 NA's for the entire building to provide resident care. NA #2 stated when working short-staffed they were unable to provide bathing assistance.

During an interview on 10/27/17 at 3:17 PM NA #5 revealed they had been short-staffed for the past few months and were unable to assist with bathing when there were only 3 NA's for the entire

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F 282	Continued From page 10 building to provide resident care. During an interview on 10/27/17 at 6:13 PM the DON was unaware that Resident #89 had not received bathing assistance as care planned. The DON stated it was her expectation for all residents to receive bathing assistance twice weekly.	F 282		
F 520 SS=E	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 (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;	F 520		11/16/17

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F 520	Continued From page 11 (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 observations, record reviews, and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2017. This was for two recited deficiencies which were originally cited in September of 2017 on a recertification/complaint survey and again on the current follow up/complaint survey. The deficiencies were in the areas of maintenance and housekeeping and services provided by qualified professional per care plan. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1. F 253: Maintenance and Housekeeping: Based on observation, record review, and staff and resident interviews the facility failed to maintain a clean feeding tube pump for 1 of 1	F 520	1. Facility has QAPI committee in place and implements plans for improvement and monitors and revises as needed through the QAPI process. 2. Observations of resident shower rooms for missing grout, black substance on tiles, and soap dispensers for soap and feeding pumps was completed on 10/27/17 by Housekeeping Supervisor and Nursing Supervisor. The Director of Clinical Services re-educated staff on reporting issues with resident shower room tiles by filling out a work order and reporting black substance on tiles in shower rooms, empty soap dispensers and to clean up spills on tube feeding machine/pole as they occur 11/8/2017-11/9/2017. Skin assessments was completed 10/31/17-11/2/17 on current residents. The Interdisciplinary Team including but not limited Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor questioned residents and/or	

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F 520	Continued From page 12 feeding tube pumps, replace grout between new tiles and clean a black substance off the tile baseboard and in the seams where tile from perpendicular walls meet in 1 of 2 resident showers (D hall), and keep a soap dispenser operational in a 1 of 3 resident bathrooms (bathroom between room 120 and room 122) on D hall affecting Residents #6 and Resident #49. F 253 was originally cited during the 09/21/17 recertification/complaint survey for failing to maintain a safe clean environment as evidenced by loose floor tiles in a resident shower, a loose commode seat in a resident bathroom, a clean feeding pump, and a missing chair rail in a resident room. 2. F 282: Services Provided by Qualified Professional per Care Plan: Based on observations, record review and staff and resident interviews, the facility failed to follow resident care plans to provide skin assessments every 7 days for 1 of 1 resident reviewed for skin assessments (Resident #6) and failed to provide assistance with bathing twice weekly for 3 of 5 residents reviewed for activities of daily living (Residents #56, #78, and #89). During the recertification/complaint survey of 09/21/17 the facility was cited for failing to assess and resident on a weekly basis consistent with the care plan. On the current follow up survey, the facility continued to fail to follow care plans for completing weekly skin assessments and providing assistance with bathing twice weekly. During an interview on 10/27/17 at 6:43 PM the Administrator stated the Maintenance Director had been out due to an illness and with so many	F 520	the patient□s responsible party on resident□s choice to frequency, type of bathing assistance 11/1/17-11/7/17. Care plan and Kardex updated. Future residents and/or their responsible party will be interviewed on admission to determine their frequency and type of bathing assistance by the Admission Coordinator. 3. The QAPI committee review the ongoing Quality Improvement Monitoring of showers, housekeeping and maintenance for compliance and modify monitoring schedule based on findings. The Director of Clinical Services and/or Nursing Supervisor re in serviced Licensed Nurses on completion of and documentation of the weekly skin assessment 11/8/17-11/9/17. The Director of Clinical Services and/or Nursing Supervisor re in serviced Certified Nurse Assistants on providing showers to residents per their choice 11/7/17-11/8/17.The Interdisciplinary Team including but not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping to perform Quality Improvement Monitoring resident bathroom soap dispensers for soap and feeding tube pump needing cleaning 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Housekeeping Supervisor and/or Maintenance Director to perform Quality	

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F 520	Continued From page 13 things that had needed to be repaired, they were doing the best they could with a short follow up period from the recertification/complaint survey of 09/21/17. She added they had completed a house wide audit to identify other issues and would continue daily audits throughout the year to help identify and address issues more frequently. The Administrator stated they have hired a wound nurse and unit manager to assist with addressing issues identified. She stated they were committed to "continuing whatever efforts were needed to improve the overall system."	F 520	Improvement Monitoring of shower room tiles requiring grout, black substance on tiles 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. The Housekeeping Supervisor and Maintenance Director and Housekeeping Director will be responsible for correction of reported concerns. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents receiving showers 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of residents skin assessments for completion 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. 4. The Executive Director and the Director of Clinical Services are responsible for implementing this plan. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/16/17. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services or designee in DCS absence. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical	

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F 520	Continued From page 14	F 520	Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	