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	345237	A. BUILDING _____ B. WING _____	C 01/24/2017

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 166		2/17/17

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

Electronically Signed | 02/09/2017

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F 166	Continued From page 1	F 166		

receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as

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F 166	Continued From page 2 the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to resolve grievances for one (Resident # 7) out of four sampled residents whose families stated they had voiced grievances. The findings included: Record review revealed Resident # 7 was admitted to the facility on 8/30/14. Review of Resident # 7 ' s Minimum Data Set (MDS) assessment, dated 10/19/16, revealed the resident had a brief interview for mental status (BIMS) of 15, indicating the resident was cognitively intact. The resident was also assessed as needing total assistance from staff for hygiene and bathing needs. Resident # 7 ' s family member was interviewed via phone on 1/19/17 at 1:20 PM. The family member stated she had filed a grievance with the facility social worker the previous week and had received no follow up regarding the concern. The family member stated, " Every time I make a report it disappears. " The family member stated her most recent grievance was in regards to how a nurse aide (NA) had acted while caring for Resident # 7. The family member stated Resident # 7 had reported the NA ' s actions to her (the family member) and she (the family member) had in turn reported the NA ' s actions to the social worker the previous week. The family member	F 166	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding F166 □D Resident #7 concerns of inappropriate	

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F 166	Continued From page 3 stated Resident # 7 had her menstrual cycle recently. The family stated an evening shift NA cared for her during this time and the NA started singing over and over to the resident, " You ' re on your period. You ' re on your period, " while providing care. The family member felt it was inappropriate for the NA to be doing this while caring for Resident # 7. The family member stated she had provided the social worker with the date of the incident. Resident # 7 was interviewed on 1/19/17 at 3:50 PM. Resident # 7 stated she had difficulty remembering long term events and was not able to recall the incident during the interview. Interview with the facility social worker on 1/20/17 at 4:20 PM revealed she had received a formal grievance from Resident # 7 ' s family member related to the incident and had given it to the Director Of Nursing (DON) to address. Interview with the administrator on 1/20/17 at 8:15 PM revealed the DON had resigned and she already left employment with the facility. The administrator stated after the surveyor had talked to the social worker on 1/20/17 at 4:20 PM, he had gone through the DON ' s desk and found a " resident concern " form for Resident # 7 ' s grievance. The administrator stated the DON had never made him aware of the concern and he had not known about it until 1/20/16. Review of the " resident concern " form revealed the grievance was entered on 1/3/17. The form contained an area entitled, " narrative description of concern. " According to the social worker ' s narrative of the grievance, Resident # 7 had reported the concerns to the RP who had then reported them to the social worker. The social worker had then entered the following information into the grievance narrative. Resident # 7 had called the RP on 1/2/17 at approximately 10 PM	F 166	singing by the Nursing assistant and call bell response was written on a Resident Concern form on 1/3/2017 by the Social Worker. The Administrator and the Social Worker addressed the Resident concern on 1/20/2017 with resolution and follow up with the resident and Responsible Party (RP) on 1/20/2017. 100% audit of all resident concerns to include resident #7, for the past 30 days, were reviewed by the Administrator on 2/6/2017 to ensure all resident concerns were completed with appropriate timely resolution and followed up with the Resident/Family/Representative who filed the grievance. Any concerns identified, will be addressed with appropriate resolution and follow up during the audit by Admissions Coordinator. 100% in-service was initiated on 2/8/2017 by the Staff Facilitator with all licensed nurses, Nursing Assistants, Housekeeping, Dietary, and Therapy staff regarding the facility Grievance process to include ensuring all Resident Concerns are documented on the appropriate form immediately when received and notification to the appropriate Department Manager of the concern. Department managers to include the Activities director, Administrator, Director of Nursing (DON), Maintenance, Dietary manager, Social Worker (SW), A/R bookkeeper, Admissions coordinator, Housekeeping manager, and Therapy Manager were in-serviced on 2/7/2017 by Administrator reading the policy and procedure for the grievance process to include appropriate timely resolution and follow up with the	

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F 166	Continued From page 4 to report that she (Resident # 7) had rung her call light at 7 PM and not received an answer. According to the form the RP then called the supervisor and reported Resident #7 ' s lack of call bell response to the supervisor on 1/2/17 and it took 45 minutes for a NA to go into Resident # 7 ' s room after the RP had called the supervisor on 1/2/17. Once the NA arrived in Resident # 7 ' s room on 1/2/17, Resident # 7 had felt the NA was " weak " and had " struggled to provide incontinence care " to her. Resident # 7 had also reported that she was having her menstrual cycle and the NA repeatedly told " her over and over about it. " The form ' s narrative also contained documentation of the NA ' s name and description of her appearance. Review of the form also included an area entitled, " comments regarding follow-up with resident/family/ representative and response. " This area on the form was blank. The form also had an area where the administrator or designee was to sign and date the form. This area was also blank. During an interview with the administrator on 1/22/17 at 10 AM, the administrator stated the facility ' s practice was for the grievance forms to be routed to the appropriate departments to address. The administrator stated every morning there was an administrative staff meeting and department heads were asked by him if there were any resident or family concerns that needed to be addressed. The administrator stated the DON never mentioned Resident # 7 ' s grievance during the morning meetings or at any other time to him.	F 166	Resident/Family/Representative who filed the grievance. All newly hired licensed nurses, Nursing Assistants, Housekeeping, Dietary, and Therapy staff will be in-serviced by the Staff Facilitator during orientation regarding the facility Grievance process to include ensuring all Resident Concerns are documented on the appropriate forms immediately when received and notification to the appropriate department Manager of the concern. All resident concerns will be brought to the daily clinical meeting 5x per week by each department manager to include Activities director, Administrator, Director of Nursing (DON), Maintenance, Dietary manager, Social Worker (SW), A/R bookkeeper, Admissions coordinator, Housekeeping manager and Therapy manager and discussed for possible resolution and need for follow up with the Resident/Family/Representative who filed the grievance and documented on the clinical meeting form. All residents concerns forms, to include any concerns for resident #7, will be reviewed to ensure all concerns were completed timely, appropriate resolution and timely follow up with the Resident/Family/Representative who filed the grievance utilizing a Grievance Resolution QI tool to be completed by Admissions Coordinator 3X a week X 4 weeks, then weekly X 4 weeks and then monthly X 1 month. The Administrator will review and initial the Grievance Resolution QI tool weekly X 8 weeks and then monthly X 1 month for completion and will complete retraining	

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F 166	Continued From page 5	F 166	with the appropriate department manager for any identified areas of concern. The Executive QI Committee will meet monthly and review the Grievance Resolution Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure the removal of narcotics from storage and the administration of the narcotics were accurately documented for three (Residents # 10, # 11, and # 12) out of five sampled residents reviewed for medications. The findings included: 1) Record review revealed Resident # 10 was admitted to the facility on 4/4/12. The resident had multiple diagnoses. Two of the resident ' s diagnoses were listed as Alzheimer ' s disease and lower back pain. Review of the resident ' s MDS (Minimum Data Set) assessment, dated 1/6/17, revealed the resident was cognitively impaired. Record review revealed an order on 1/2/17 for	F 281	F281 □D Resident #10, #11, and #12 were assessed for pain on 2/7/2107 by ADON. Nurse #1, Nurse #2, Nurse #3, and Nurse #4 were in-serviced on 1/23/2017 by Staff Facilitator and Facility RN Clinical Consultant regarding documenting on the Narcotic controlled substance receipt/count sheet immediately after removing the narcotic medication from its original package and documenting on the Medication administration record immediately after the administration of medications to include narcotic medications.	2/17/17

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F 281	Continued From page 6 Percocet 5-325 mg (milligrams) to be given every night at bedtime. Resident # 10 ' s January 2017 MAR (medication administration record) was reviewed on 1/21/17 at 8:50 AM. This review revealed nurses had initialed every night they administered the Percocet since it had been ordered. There was no documentation the medication was held for any reason. On 1/21/17 at 8:50 AM Resident # 10 ' s " controlled substance receipt/count sheet " was reviewed. This review revealed no documentation the Percocet had been removed on 1/20/17 from the locked storage when Nurse # 3 initialed on the MAR she had given it. The resident ' s Percocet pills were observed with Nurse # 1 and Nurse # 2 at 8:50 AM on 1/21/17. Nurse # 1 was the unit nurse and Nurse # 2 was a quality improvement nurse. This observation revealed there were 15 Percocet pills present. This number matched the number of Percocet pills on the " controlled substance receipt/count sheet. " Nurse # 2 stated Resident # 10 was the unit ' s only resident on Percocet at that time, and if Nurse # 3 had given the Percocet on 1/20/17 there should only be 14 pills remaining. The administrator and corporate staff members were interviewed on 1/22/17 at 10 AM regarding the discrepancy between Resident # 10 ' s January MAR and Resident # 10 ' s " controlled substance receipt/count sheet. " These staff members acknowledged the documentation on the January MAR did not correlate with the " controlled substance receipt/ count sheet " and that there should be one less Percocet pill if the resident had received the Percocet as documented on the January MAR. This interview revealed it was their expectation that the MAR match the " controlled substance receipt/count	F 281	100% audit was completed on all resident□s receiving narcotics from 1/15/17 to 1/31/17 to include resident #10, #11, and #12 controlled substance receipt/count sheet and compared to the Medication Administration Record to ensure the administration of the narcotics were accurately documented on 2/9/2017 by the ADON, Quality Improvement nurse, Staff Facilitator and Resource Nurses. An investigation will be immediately initiated during the audit for any identified areas of concern to identify reason for the discrepancy by the DON/ADON 100% of all licensed nurses to include Nurse #1, Nurse #2, Nurse #3, and Nurse #4 were in-serviced on Medication Administration to include documenting on the Narcotic controlled substance receipt/count sheet immediately after removing the narcotic medication from its original package and documenting on the Medication administration record immediately after the administration of medications to include narcotic medications to be completed on 2/17/2017 by the Staff Facilitator and the Facility RN Clinical Consultant. All newly hired license nurses will be in-serviced by the staff facilitator during orientation regarding Medication Administration to include documenting on the Narcotic controlled substance receipt/count sheet immediately after removing the narcotic medication from its original package and documenting on the Medication administration record immediately after	

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F 281	Continued From page 7 sheet. " Nurse # 3 was interviewed on 1/22/17 at 3 PM. Nurse # 3 reviewed the " controlled substance receipt/count sheet " during the interview. Nurse # 3 stated she gave the Percocet on 1/20/17 but signed on the " controlled substance receipt/sheet " that she had removed it on 1/19/17. Nurse # 3 pointed to her name on the " controlled substance receipt/count sheet " which appeared by the date of 1/19/17. Nurse # 3 stated she had not worked on 1/19/17, and had inadvertently recorded she signed the Percocet out on 1/19/17. During the interview, Nurse # 3 explained no other staff member had previously signed out the Percocet for the date of 1/19/17. Nurse # 3 stated when she worked on 1/20/17, and the Percocet had not been signed out on 1/19/17, she recorded the date of 1/19/17 without realizing the date was actually 1/20/17. A review of the MAR with Nurse # 3 at this time revealed a nurse had initialed she administered the Percocet on 1/19/17 to Resident # 10. Nurse # 3 stated an agency nurse had worked on 1/19/17. 2. Record review revealed Resident # 11 was admitted to the facility on 6/28/13. The resident had diagnoses of dementia and chronic pain. Review of the resident ' s MDS (Minimum Data Set) assessment, dated 11/5/16, revealed the resident was cognitively impaired. Record review revealed Resident # 11 had a physician ' s order, dated 12/26/16, for Ultram 50 mg (milligrams) by mouth twice daily. On 1/21/17 at 8:55 AM a review of the resident ' s January 2017 MAR (medication administration record) revealed the nurses had initialed they gave Ultram twice per day every day from 1/1/17 through 1/20/17. The scheduled times were 8 AM and 8 PM.	F 281	the administration of medications to include narcotic medications. The Quality Improvement nurse will monitor 10% of residents receiving narcotic medication, to include resident #10, #11, and #12, Narcotic controlled substance receipt/count sheet and compare to the Medication administration records to ensure the administration of the narcotics were accurately documented 3x per week x 4 weeks then weekly x 4 weeks then monthly x 1 month utilizing a Controlled Substance Sheet documentation audit tool. The DON/ADON or Staff Facilitator will retrain the license nurse for all identified areas of concern during the audit. The DON or ADON will review and initial the controlled substance sheet documentation audit tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Executive QI Committee will meet monthly and review the Controlled Substance Sheet Documentation Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	

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On 1/21/17 at 8:55 AM Resident # 11 ' s " controlled substance receipt/count sheet " was reviewed. This review revealed no documentation the Ultram had been removed at 8 PM on 1/15/17 from the locked storage when Nurse # 4 initialed on the MAR she had given it. The resident ' s Ultram pills were observed with Nurse # 1 and Nurse # 2 at 8:55 AM on 1/21/17. Nurse # 1 was the hall nurse and Nurse # 2 was a quality improvement nurse. This observation revealed Resident # 11 had 18 Ultram pills in locked storage and this matched the " controlled substance receipt/count sheet. "

Nurse # 4 was interviewed on 1/21/17 at 3:33 PM. Nurse # 4 stated both Resident # 11 and Resident # 12 were on Ultram and they both had their individual supplies of Ultram locked in the medication cart. Nurse # 4 stated on 1/15/17 she signed she administered Resident # 12 a PRN (as needed) evening dose of Ultram which she documented and removed from Resident # 12 ' s supply of Ultram. Nurse # 4 stated she had not administered Resident # 12 this Ultram, but she had given the Ultram she removed from Resident # 12 ' s supply instead to Resident # 11 on 1/15/17. According to Nurse # 4, Resident # 12 had not needed and did not get the PRN dose of Ultram which she documented on the MAR she gave on 1/15/17.

Review of Resident # 12 ' s physician order ' s revealed an order, dated 10/3/16, for Ultram 50 mg every six hours as needed for pain.

Review of Resident # 12 ' s January MAR revealed Nurse # 4 had initialed she gave Resident # 12 a PRN dose of Ultram on 1/15/17. Nurse # 4 had not documented a time on the MAR for 1/15/17 she gave the Ultram. There was documentation on Resident # 12 ' s " controlled substance receipt/count sheet " that Nurse # 4

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F 281	Continued From page 9 removed a dose of Ultram from Resident # 12 ' s supply on 1/15/17 at 8:55 PM. The administrator and corporate staff members were interviewed on 1/22/17 at 10 AM regarding the discrepancy between Resident # 11 ' s January MAR and Resident # 11 ' s " controlled substance receipt/ count sheet. " These staff members acknowledged the documentation on Resident # 11 ' s January MAR did not correlate with the documentation found on Resident # 11 ' s " controlled substance receipt/ count sheet " and that it was their expectation that it should match and be accurate.	F 281		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (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 observation, record review, resident interview, and staff interview the facility failed to provide incontinence care as needed for 3 (Residents # 5, #9, and #13) out of six residents reviewed for activities of daily living assistance. The findings included: 1. Record review revealed Resident # 9 was admitted to the facility on 5/13/13. The resident ' s diagnoses included cerebrovascular accident, hemiplegia, and history of left hip fracture. Review of the resident ' s MDS (Minimum Data Set) assessment, dated 12/29/16, indicated the resident was cognitively intact. The resident was assessed to need extensive assistance with his toileting needs. The resident was also coded as	F 312	F312 □D NA #2, 3, 4 and 5 were in-serviced on 1/23/2017 by Staff Facilitator and Facility RN Consultant in regards to providing timely incontinent care for the resident and reporting to hall nurse if care cannot be provided timely. Resident # 5, 9 and 13 will continue to receive timely incontinent care per policy. 100% audit of all residents was initiated on 2/9/2017 by Treatment Nurses and Resource Nurses to include resident # 5, 9 and 13 to assure timely incontinent care to be completed on 2/10/2017. Incontinent	2/17/17

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F 312	Continued From page 10 always being incontinent of bowel. Review of the resident ' s care plan, last reviewed on 10/25/16, revealed the resident could not control his bowel movements. One of the listed interventions was perineal care will be given after each incontinent episode per incontinent program. The resident was observed on 1/20/17 at 9:10 AM in bed finishing his breakfast. The resident was interviewed at this time. The resident stated he was soiled with stool. The resident added he had been soiled with stool before he was served breakfast and had rung his call light to request to be changed. The resident stated NA (Nurse Aide) # 2 had told him she was busy passing breakfast trays and would return. On 1/20/17 at 9:22 AM NA # 2 was observed finishing with breakfast trays and preparing to go into Resident #9 ' s room. The NA was briefly interviewed regarding her assigned duties and Resident # 9 ' s needed assistance. NA # 2 stated Resident # 9 had called to be changed before he was served breakfast. Interview with the NA revealed at the time the resident called to be changed she also had other assigned duties and she was not able to change him at the time he called. NA # 2 stated she had 10 residents for whom to care and four of them needed to be fed. She stated one of the four residents, who needed to be fed, had her tray sent out routinely at 7 AM before the other trays. NA # 2 stated this resident (Resident # 4) ate very slowly. NA # 2 stated once she had assisted Resident # 4 she needed to pass the other residents their trays or their food would be cold. NA # 2 stated she was the only NA passing trays on the upper end of the hall that morning. NA # 2 stated there was another NA (NA # 3) that had been tied up with assisting a different resident (Resident # 7) on the lower part	F 312	care will immediately be provided for the resident and re-training to the nursing assistant for any areas of concern to be addressed by DON/ADON and Staff Facilitator during audit. 100% of licensed nurses and nursing assistants were re-educated on providing timely incontinent care for the resident and reporting to hall nurse if care cannot be provided timely by the Staff Facilitator to be completed on 2/17/2017. All newly hired nursing assistants will be in-serviced by the Staff Facilitator during orientation on providing timely incontinent care for the resident and reporting to hall nurse if care cannot be provided timely. Resident care audit tools will be completed by Treatment Nurses on 10% of residents to include resident # 5, 9 and 13 to ensure residents received timely incontinent care 3 X a week for 4 weeks, weekly X 4 weeks and monthly X 1 month. All nursing assistants will be immediately retrained for any identified areas of concern by the Treatment Nurses or Staff Facilitator during the observation. The DON/ADON will initial and review the results of the resident care audit tool weekly X 8 weeks and monthly X 1 month for completion and to ensure all areas of concerns have been addressed. The Executive QI Committee will meet monthly and review the Resident Care Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	

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of the hall and had not been available to help pass any trays that morning.
On 1/20/17 at 10:12 AM, NA # 2 verified during an additional interview that when she had changed Resident # 9 at 9:22 AM the resident had been soiled with stool.
NA # 3, who shared responsibilities on NA # 2 ' s hall, was interviewed on 1/20/17 at 1:09 PM. NA # 3 stated she had been busy giving a shower to Resident # 7 on the lower end of the hall starting at approximately 7:30 AM that morning. NA # 3 added after she finished with Resident # 7 ' s shower, she then immediately fed Resident # 7 her breakfast. NA # 3 explained she was busy from approximately 7:30 AM to 9 AM helping Resident # 7 with her shower and breakfast. This was NA #3 ' s first day working with Resident #7 and her care took longer than expected.
Interview with the Administrator, a Nurse Consultant, and the Regional Vice President on 1/22/17 at 10 AM revealed it was their expectation that soiled residents receive incontinence care prior to being served meals.
2. Record review revealed Resident # 5 was admitted to the facility on 7/31/14. The resident had multiple diagnoses which included end stage dementia.
Review of the resident ' s MDS (Minimum Data Set) assessment, dated 11/8/16, revealed the resident ' s cognition was severely impaired. The resident was assessed as rarely being able to be understood, needed extensive assistance with her hygiene needs, and required total assistance with her bathing needs. The resident was also assessed as always being incontinent of bowel and bladder.
Review of the resident ' s care plan, last reviewed on 11/29/16, revealed the resident was to be cleaned after each incontinent episode. Nurse

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Aide (NA) #4 was observed on 1/21/17 at 11:10 AM preparing to go in and provide care to Resident #5. NA # 4 stated she had been assigned 13 residents for whom to care that morning and 11:10 AM was the first opportunity she had to check on the resident ' s incontinence needs since the beginning of her shift. NA # 4 stated the resident had not received any morning assistance with bathing or incontinence care since 7 AM, and the last time Resident #5 had been checked for incontinence needs would have been by night shift staff. As the NA gathered her supplies to enter, another NA (NA # 5) walked up to NA # 4 and informed her that she had been sent to help her. Continued interview with NA # 4 revealed this was the first time that morning she had been sent assistance. The two NAs were observed to enter and care for Resident # 5. The resident ' s brief was observed to be soiled with urine. There was discoloration on the draw sheet which the NAs stated had dried. After bathing Resident # 5, NA # 4 stated she still had another resident whom she had not been able to provide AM care for and needed to get to the other resident.

Interview with the Administrator, Nurse Consultant, and Regional Vice President on 1/22/17 at 10 AM revealed it was their expectation that incontinent residents be checked every two hours for incontinence needs and care provided.

3. Record review revealed Resident # 13 was admitted to the facility on 9/7/16. The resident had multiple diagnoses. One of the resident ' s diagnoses was listed as dementia.

Review of the resident ' s MDS (Minimum Data Set) assessment, dated 12/15/16, revealed the resident ' s cognition was severely impaired. The resident was also assessed to need total

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assistance from staff with her hygiene and bathing needs. The resident was assessed to always be incontinent of bowel and bladder. Review of the resident ' s care plan, last reviewed on 12/29/16, revealed the resident was incontinent and the staff were directed to provide an adult brief and incontinence care.
Resident #13 was observed as Nurse Aide (NA) # 4 and NA # 5 entered her room to provide care for the resident on 1/21/17 at 11:25 AM. As NA # 4 was gathering supplies she stated Resident # 13 was the last of her thirteen assigned residents for whom she needed to care. Interview with NA # 4 revealed she had not had the opportunity until 11:25 AM to check on Resident # 13 ' s incontinent needs or provide a bath to the resident since she had reported to work at 7 AM. During the care, Resident # 13 was observed to have a disposable brief with two thick pad inserts which had been placed inside the resident ' s disposable brief. The resident ' s brief and inserts were observed to be wet. There was a yellowish/brown stain on the draw pad beneath the resident which the NAs reported to be dried. Interview with the Administrator, Nurse Consultant, and Regional Vice President on 1/22/17 at 10 AM revealed it was their expectation that incontinent residents be checked every two hours for needs and care provided. The Nurse Consultant stated they were unaware why the resident would have had two inserts in her disposable brief. The nurse consultant stated the inserts were routinely used for residents who had slight stress incontinence so that the insert could be changed without having to change the entire brief if a resident voided a slight amount of urine. The nurse consultant stated Resident # 13 ' s care plan did not include using inserts.

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F 353 SS=D	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 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 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.	F 353		2/17/17

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F 353	Continued From page 15 (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 observation, record review, resident interview, and staff interviews the facility failed to ensure there was sufficient nursing staff available to meet the needs of three (Residents # 5, #9, and #13) of six residents reviewed for activities of daily living assistance. The findings included: 1. Record review revealed Resident # 9 was admitted to the facility on 5/13/13. The resident had diagnoses of cerebrovascular accident and hemiplegia. Review of the resident ' s MDS (Minimum Data Set) assessment, dated 12/29/16, revealed the resident was assessed to have a BIMS (Brief Interview for Mental Status) score of 15, which indicated he was cognitively intact. The resident was assessed to need extensive assistance with his toileting needs. The resident was also coded as always being incontinent of bowel. Review of the resident ' s care plan, last reviewed on 10/25/16, revealed the resident could not control his bowel movements. One of the listed interventions was to provide incontinence care. The resident was observed on 1/20/17 at 9:10 AM in bed finishing his breakfast. The resident stated he was soiled with stool. The resident stated he had been soiled with stool before he	F 353	F 353 □D The facility will provide sufficient nursing staff to meet the needs of the residents, to include resident #5, 9, and 13 and to assure the timely answering of call bells, provide for toileting assistance, honoring of resident□s choices, and receiving showers on designated shower days based upon the acuity and specialty. The Regional Vice Presidents, Administrator, RN Corporate Clinical Director, RN Clinical Consultant, Facility Scheduler and DON reviewed the staffing patterns on 2/6/2017 to determine and assign the appropriate staffing patterns that meet the resident□s needs based upon acuity and to review the recruitment, hiring, orientation and retention process. The Administrator, Scheduling Coordinator and DON will review the daily staffing Hours per Patient Day (HPPD). The Administrator, Director of Nursing, and Scheduling Coordinator will calculate the acuity levels and ensure the	

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F 353	Continued From page 16 was served breakfast and activated his call light to request to be changed. The resident stated NA (Nurse Aide) # 2 had told him she was busy passing breakfast trays and would return. On 1/20/17 at 9:22 AM, NA # 2 was observed finishing with breakfast trays and preparing to go into Resident #9 ' s room. The NA was briefly interviewed regarding her assigned duties and Resident # 9 ' s needed assistance. NA # 2 stated Resident # 9 called to be changed before he was served breakfast. Interview with the NA revealed at the time the resident called to be changed she also had other assigned duties and she was not able to change him at the time he called. Therefore she served his breakfast and planned to change him after breakfast. NA # 2 stated she had 10 residents for whom she was assigned to provide care and four of them needed to be fed. She stated one of the four residents, who needed to be fed, had her tray sent out routinely at 7 AM before the other trays because NA # 2 stated this resident ate very slowly. NA # 2 stated once she had assisted this resident then she needed to pass the other residents their meal trays or their food would be cold. NA # 2 stated there was only one other NA (NA # 3), who was assigned to care for residents on the upper hall, but NA # 3 had been tied up with assisting another resident and was not available to help her pass any trays or provide needed assistance to other residents on the hall that morning. During the interview with NA # 2 on 1/20/17 at 9:22 AM it was observed that the hall nurse was busy passing medications on the unit. On 1/20/17 at 10:12 AM, NA # 2 verified in an additional interview that when she had changed Resident # 9 at 9:22 AM the resident had been soiled with stool. The other NA (NA # 3), who shared	F 353	appropriate Licensed Nurses and Certified Nursing assistants are assigned to meet the needs of the residents by reviewing the Case Mix Index Report generated from the Point Click Care System, tube feeding, total care, pressure ulcer and other specialty services daily to identify and account for the acuity of the residents and placement of the appropriate nursing staff. The new staffing alignment patterns will be initiated by 2/17/2017 by the Director of Nursing and Administrator. All callouts will be addressed immediately utilizing certified department heads and agency by the scheduling coordinator or the on-call nurse The facility will utilize the following formula to account for the HPPD. Census X HPPD Budget=Actual Hours Per day/Hours per shift=Total number of RN, LPN or C.N.A.□s The facility is budgeted for 7 for Registered Nurses, 14 for Licensed Practical Nurses and 45 for Certified Nursing Assistants. The staffing coordinator was in-serviced by the Administrator and Regional Vice President on 2/9/2017 regarding the appropriate number of staff required daily on each shift to assure resident needs are met. The number of residents assigned to each C.N.A each shift will be followed according to the facility's budgeted HPPD. Staffing assignment will be adjusted accordingly with acuity level changes by the Director of Nursing and Administrator. The Nursing Supervisor/Resource Nurse, QI Nurse, or Staff Facilitator will perform resident care audits 3x per week to	

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F 353	Continued From page 17 responsibilities on NA # 2 ' s hall, was interviewed on 1/20/17 at 1:09 PM. NA # 3 stated she had been busy on 01/20/17 from approximately 7:30 AM to 9:00 AM helping a resident with her shower and breakfast. This interview revealed NA # 3 was not available to assist NA # 2 with distributing and serving resident meal trays or with Resident # 9 ' s call for assistance during the morning of 1/20/17. NA # 3 reported 1/20/17 was her first day working on her assignment and she was new to the hall. Interview with the administrator on 1/20/17 at 8:15 PM revealed the DON had a planned resignation date of 1/20/17 and had permanently left the facility earlier that day. Thus the DON was not available for interview at that time. Interview with the administrator, corporate nurse consultant, and regional vice president on 1/22/17 at 10:00 AM revealed it was their expectation that soiled residents receive incontinence care prior to being served meals. Resident # 9 ' s unmet care need was shared with these staff members. The administrator was interviewed again on 1/24/17 at 11:20 AM regarding the facility ' s system to allocate staff in order to assure there were sufficient staff available to meet resident ' s needs. The administrator stated two staff members (employee # 1 and employee # 2) were responsible for scheduling and allocating staff. The administrator stated if the NAs were not able to meet their resident ' s needs due to their other assigned duties then they should let him or the schedulers know so that staff could be allocated in the needed areas. The administrator stated no one had been made aware of Resident # 9 ' s unmet incontinent need on 1/20/17 or that there was a need for further staff on that morning. 2. Record review revealed Resident # 5 was admitted to the facility on 7/31/14. The resident	F 353	monitor actual provision of care, to include care for Resident #5, 9 and 13, utilizing a Resident Care Audit Tool. The DON or Administrator will review assignment sheets and Resident Care Audits Tools to include for resident #5, #9 and #13 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month to ensure appropriate number of staff scheduled for each shift daily ensuring resident needs are met to include showers and toileting and for completion and monitoring of Resident Care Audit Tools. The DON will immediately address all identified areas of concern with reeducation of staff or adjusting staffing needs as indicated. The Regional Vice President will review staffing weekly and follow up to ensure adequate staffing and follow up with the Administrator or Director of Nursing for any identified concerns. The Executive QI Committee will review daily schedules and resident care audit tools monthly x 3 months to ensure appropriate number of staff is scheduled per requirement to meet the needs of our residents to include showers and toileting.	

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had multiple diagnoses. One of the diagnoses included end stage dementia.
Review of the resident ' s MDS (Minimum Data Set) assessment, dated 11/8/16, revealed the resident was cognitively impaired. The resident was assessed as rarely being able to be understood. The resident was assessed to need extensive assistance with her hygiene needs and total assistance with her bathing needs. The resident was also assessed to always be incontinent of bowel and bladder.
Review of the resident ' s care plan, last reviewed on 11/29/16, revealed the resident was to have pericare after each incontinent episode.
On 1/21/17 at 9:30 AM Resident # 5 was observed in bed on her right side at this time. Resident # 5 was observed in her room on 1/21/17 at 11:10 AM as NA # 4 prepared to go in the room and provide care. Resident # 5 was on her right side prior to NA # 4 beginning care. NA # 4 stated she was assigned 13 residents to care for that morning and 11:10 AM was the first opportunity she had to check on Resident # 5 ' s incontinence needs since her shift began at 7:00 AM. NA # 4 stated she had been busy feeding residents and had five residents she had fed during the breakfast meal. Interview with NA # 4 revealed Resident # 5 had not received any morning assistance with bathing or incontinent care and the last time she had been checked for incontinence needs would have been by night shift staff. As the NA gathered her supplies to enter the resident ' s room, another NA (NA # 5) walked up to NA # 4 and informed her that she had been sent to help her. Interview with NA # 5 revealed she was an agency NA. Interview with NA # 4 revealed this was the first time (11:10 AM) that morning she had been sent assistance. NA # 4 stated to NA # 5 that she was concerned

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because of the number of residents she had and that she did not feel she could give all them the proper care. The two NAs were observed to enter and care for Resident # 5. The resident ' s brief was observed to be soiled with urine. There was discoloration on the draw sheet which the NAs stated had dried. After bathing Resident # 5 NA # 4 stated she still had another resident whom she had not been able to provide care for during this morning and she needed to get to this resident.
Staffing sheets for Resident # 5 ' s hall were reviewed for the 7-3 shift on 1/21/17. These staffing sheets had two NAs ' names written on the assignment sheet for Resident # 5 ' s hall. One was NA # 4 and the staffing sheet showed she had been assigned 12 residents. The other NA (NA # 6) was an agency NA, and the staffing sheet showed NA # 6 had been assigned 13 residents.
Interview with the administrator, corporate nurse consultant, and regional vice president on 1/22/17 at 10 AM revealed it was their expectation that incontinent residents be checked every two hours for needs and care provided.
The administrator was interviewed again on 1/24/17 at 11:20 AM regarding the facility ' s system to allocate staff in order to assure there were sufficient staff available to meet resident ' s needs. The administrator stated two staff members (employee # 1 and employee # 2) were responsible for scheduling and allocating staff. The administrator stated if the NAs were not able to meet their resident ' s needs due to their other assigned duties then they should let him or the schedulers know so that staff could be allocated in the needed areas.
3. Record review revealed Resident # 13 was admitted to the facility on 9/7/16. The resident had multiple diagnoses. One of the resident ' s

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diagnoses was listed as dementia.
Review of the resident ' s MDS (Minimum Data Set) assessment, dated 12/15/16, revealed the resident was cognitively impaired. The resident was also assessed to need total assistance from staff with her hygiene and bathing needs. The resident was assessed to always be incontinent of bowel and bladder.
Review of the resident ' s care plan, last reviewed on 12/29/16, revealed the resident was incontinent and the staff were directed to provide an adult brief and incontinence care.
The Resident was observed as NA # 4 and NA # 5 entered to provide care for the resident on 1/21/17 at 11:25 AM. As NA # 4 was gathering supplies she stated Resident # 13 was the last of her thirteen assigned residents for whom she needed to provide care. Interview with NA # 4 revealed she had not had the opportunity until 11:25 AM to provide Resident # 13 with incontinence care or bathing since her shift to work began at 7 AM due to her other assigned responsibilities. During the care, Resident # 13 was observed to have a disposable brief with two inserts. The resident ' s brief and inserts were observed to be wet. There was a yellowish/brown stain on the draw pad beneath the resident which the NAs reported to be dried.
Interview with the administrator, corporate nurse consultant, and regional vice president on 1/22/17 at 10 AM revealed it was their expectation that incontinent residents be checked every two hours for needs and care provided.
The administrator was interviewed again on 1/24/17 at 11:20 AM regarding the facility ' s system to allocate staff in order to assure there were sufficient staff available to meet resident ' s needs. The administrator stated two staff members (employee # 1 and employee # 2) were

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F 353	Continued From page 21 responsible for scheduling and allocating staff. The administrator stated if the NAs were not able to meet their resident ' s needs due to their other assigned duties then they should let him or the schedulers know so that staff could be allocated in the needed areas.	F 353		
F 411 SS=E	ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS CFR(s): 483.55(a)(1)(2)(4) (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview, and staff interviews the facility failed to follow up on needed dental services for two (Resident # 1 and # 2) out of three sampled residents who were reviewed for dental needs. The findings included.	F 411	F411 □E Resident #1 no longer resides at the facility. Resident #2 was seen by Oral Surgeon on 2/7/17 all recommendations were followed as ordered.	2/17/17

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	345237	A. BUILDING _____ B. WING _____	C 01/24/2017

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F 411	Continued From page 22 1) Record review revealed Resident # 2 was admitted to the facility on 7/30/15. The resident had diagnoses of cerebrovascular accident, dementia, and atherosclerotic heart disease. Review of the resident ' s MDS (Minimum Data Set) assessment, dated 10/18/16, revealed the resident was cognitively impaired. Record review revealed the resident was seen on 6/24/16 by a dentist who evaluated residents in the facility. The dentist documented the resident needed to have all her teeth removed. The dentist also documented " severe infection concern. " The dentist ' s recommendations were to refer Resident # 2 to an oral surgeon. Review of the record revealed no follow up regarding the 6/24/16 dental recommendations. Review of the resident ' s care plan revealed on 7/25/16 the staff added as a focus area that the resident had carious teeth. The facility ' s goal for the resident was that she remain free of an infection within her oral cavity. One of the listed interventions was to refer the resident to the dentist for evaluation and recommendations for her carious teeth. Review of the record revealed the resident was seen again by the visiting dentist on 12/16/16. The dentist documented again the resident needed to be referred to an oral surgeon. The dentist noted, " Please extract all remaining teeth as decay noted. Also pus in certain areas. " The administrator was interviewed on 1/22/17 at 10 AM regarding any dental follow up that had been done for the resident. The administrator stated routinely there was a resource nurse who handled the dentist ' s recommendations, but there had been no follow up with Resident # 2 ' s family regarding the dental recommendations and the resident had never been referred to the oral surgeon.	F 411	100% audit was initiated on 1/20/17 by Quality Improvement nurse, MDS Nurse, Treatment Nurse and Staff Facilitator of all resident□s dental consult recommendations to include resident #2 from 6/24/16 to 1/20/17 to ensure appropriate follow up to all recommendations. Follow through of the recommendations will be completed for any identified areas of concerns during the audit by DON/ADON. Social Worker #1 and #2, the director of nursing and assistant director of nursing will be in serviced regarding the process of following dental consults recommendations on 2/7/2017 by Administrator. The Social worker will forward all dental consult recommendations to the Assistant Director of Nursing. The Assistant Director of Nursing will ensure the dental consults recommendations are reviewed and approved by the primary physician and a physician telephone order is written for the recommendation and followed through. The Quality Improvement nurse will review 10% of all residents Dental Consult recommendations to include resident #2 weekly x 8 weeks then monthly X 1 month to ensure all dental consult recommendations are followed utilizing a Dental Consult Recommendation QI Tool. The Assistant Director of Nursing will be retrained by the DON for all identified areas of concern during the audit. The DON will review and initial the Dental Consult Recommendation QI Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of	

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F 411	Continued From page 23 Social Worker #1 and Social Worker # 2 were interviewed on 1/22/17 at 4:20 PM. The social workers stated they ran the facility dental clinic, and a visiting dentist came into the facility to see residents. The social workers stated they routinely took the dentist ' s recommendations and gave them to the resource nurse. The social workers stated the resource nurse, who had been given Resident # 2 ' s dental recommendations, was no longer a facility employee and they had not been aware of any follow up she had done. Resident # 2 was observed on 1/22/17 at 2 PM. The resident was observed to have many missing teeth. Several of her remaining teeth were observed to be broken or black. 2. Record review revealed Resident # 1 resided in the facility from 6/23/15 until 1/3/17. The resident had multiple diagnoses. Two of the resident ' s diagnoses were listed as dementia and dysphagia. Review of the resident ' s MDS (minimum data set) assessment, dated 12/1/16, revealed the resident was cognitively impaired. Review of the resident ' s care plan, last reviewed on 10/11/16, revealed the staff had identified the resident had no dentures. Interview with the resident ' s responsible party on 1/19/17 at 11:46 AM revealed the resident had lost her dentures and Medicaid had not agreed to pay for a second pair. The responsible party stated the facility social worker was planning on resubmitting a second request to Medicaid asking they consider paying for the dentures. The family member could not recall the exact date the social worker planned to submit the second request, but she had never heard any follow up regarding whether Medicaid would approve the denture replacement. Interview with NA (Nurse Aide) # 1 on 1/21/17 at	F 411	concern are addressed. The Executive QI Committee will meet monthly and review the Dental Consult Recommendation QI tool and address any issues, concerns and/or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	

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F 411	Continued From page 24	F 411		

3:20 PM revealed she had helped care for the resident since June, 2016. The NA stated the resident had lost her dentures at some time and as she recalled the dentures were missing when she started working with her in June.
Review of the record revealed a 9/16/16 dental consult. The dentist noted within the consult that the resident was edentulous and it was the recommendation that she need a complete set of upper and lower dentures. The dentist documented, " Narrative for Complete dentures: Resident has lost a lot of weight. Nursing home has seen failure to thrive and they are requesting help. "
Social Worker #1 and Social Worker # 2 were interviewed on 1/22/17 at 4:20 PM. The social workers stated they ran the facility dental clinic and that a visiting dentist came into the facility to see residents. Social worker # 1 stated in July 2016 the dentist had submitted to Medicaid a request for replacement dentures for Resident # 1, and the request had been denied. The social worker stated the dentist directly received the denial letter and in turn had informed the facility. Following the initial Medicaid denial for denture replacement, the social worker stated he had spoken to the resident ' s family and informed them that the facility could try to resubmit the request along with an explanation from the dentist why the dentures were needed. The social worker stated therefore the resident was seen again on 9/16/16 by the dentist and the narrative note was completed. The social worker stated the dentist then routinely submitted the second request to Medicaid. Following 9/16/16, the social worker stated the facility never heard anything back from the dentist regarding whether the second request was denied or accepted. The social worker stated the dentist had heard from Medicaid within

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F 411	Continued From page 25 approximately a month ' s time period regarding the first request. The social worker was asked if there had been any follow up by the facility between 9/16/16 and 1/3/17 regarding the second submission for denture approval, and the social worker was not aware of any follow up on the facility ' s part.	F 411		
F 463 SS=D	RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH CFR(s): 483.90(g)(2) (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all portions of the call light system were functioning properly for 4 out of 16 random resident bathrooms located on 2 out of 4 hall. Beginning at 11 AM on 1/20/17 the maintenance director was accompanied as call lights were checked in 16 random rooms on the 100, 200, 300, and 400 halls. The following was observed during these checks. It was observed the bathroom call lights in Rooms 200-202, 201-203, 301-303 and 329-331 were not fully functioning. The call light was observed to ring at the desk but the light above the door did not light in the hallway at the entrance to the resident ' s rooms. During the observations, the	F 463	F 463 □D The call lights for room 200-202, 201-203, 301-303, and 329-331 were fixed by the Maintenance Director on 1/20/2017 and rechecked by the Administrator to ensure they were fully functioning on 1/20/2017. 100% audit was completed by the Maintenance Director and the Maintenance Assistant on 1/20/2017 of all call bells to include room 200-202, 201-203, 301-303, and 329-331 to ensure proper functioning of the call bell systems to include call bell control panel at the nurses□ station and lights above the door. The Maintenance Director and the Maintenance Assistant immediately	2/17/17

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F 463	Continued From page 26 maintenance director stated the call lights should both alarm at the desk and light above the door. Interview with the maintenance staff on 01/20/2017 at 11:20 a.m. also revealed that he gets work orders at each station in the morning if there is a malfunctioning call light. The maintenance staff stated that the department heads completed morning rounds daily to assure functioning of the call lights. The maintenance staff could not show evidence of documentation that this had been occurring daily. The maintenance staff did not know the lights that were checked needed to be repaired. Interview with nurse aide on 01/20/2017 at 3:00 p.m. revealed that 2 out of the 6 residents were independent with toileting. Interview with the nursing home administrator on 01/20/2017 at 4:45 p.m. revealed that there was no consistent documentation or system in place for assuring that the call light system was fully functioning.	F 463	repaired any identified areas of concern during the audit. 100% of all License nurses, nursing assistants, Dietary, housekeeping, therapy staff, and department managers were in-service by the Maintenance Director and Staff Facilitator regarding reporting and filling out work orders for defective equipment to include call bells not properly working to be completed on 2/17/2017. All newly hired License nurses, NAs, Dietary, housekeeping, therapy staff, and department managers will be in serviced regarding reporting and filling out work orders for defective equipment to include call bells not properly working during orientation by the Staff Facilitator. The Administrator in-serviced the Maintenance Director and Maintenance Assistant regarding schedule for checking for proper functioning of call bell system on 1/20/2017. A preventative maintenance schedule was initiated by the Administrator on 1/20/2017 for the Maintenance Director and/or Maintenance Assistant to check the functioning of 100% of call bell weekly. The Medical Records Director will audit 10% of all call bells to include lights above doors and call bell control system at the nurses station weekly x 8 weeks, then monthly x 1 month to ensure proper functioning utilizing a call bell monitoring QI Tool. A work order will be completed by Medical Records Director and the Maintenance Director and/or the Maintenance Assistant will immediately repair any identified areas of concern	

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F 463	Continued From page 27	F 463	during the audit. The Administrator will review and initial the call bell monitoring QI Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI Committee will meet monthly and review the Call Bell Monitoring QI Tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 490 SS=D	EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING CFR(s): 483.70 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility administration staff failed to assure two of their four emergency crash carts were stocked with back boards. The findings included: Beginning at 2:30 PM on 1/22/17 corporate nurse consultant # 1 was accompanied to check the crash carts on all units. (Crash carts are portable carts used to store emergency items in the event a resident required resuscitation.) According to corporate nurse consultant #1 there were four facility crash carts. One was located on the 800 hall; one on the 100/200 hall; one on the 400 hall and one on the 500 hall. Two of the crash carts	F 490	F 490 –D Back board were ordered and replaced on the emergency crash cart on 2/6/2017 by The Central Supply Clerk. 100% audit was completed of all four emergency crash carts on 1/20/2017 by Central Supply Clerk to ensure carts were supplied with all necessary supplies to include back boards. Items of depletion were reordered on 1/20/2017 and restocked on the emergency crash carts on 2/6/2017 by Central Supply Clerk. 100% of all license nurses were in-serviced regarding the crash cart	2/17/17

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F 490	Continued From page 28 (the 100/200 and the 800 unit carts) did not have a back board on them. (A backboard is used during cardiopulmonary resuscitation to provide a hard surface behind the resident ' s back so that chest compressions are effective.) There was a daily crash cart checklist located on each of the carts. The January checklist for the 100/200 cart revealed the nurses had been placing " N/A " (not available) on the item list for backboard daily since 1/1/2017. The January checklist for the 800 cart revealed the nurses had been placing " N/A " on the item list for backboard daily since 1/16/17. A statement was at the top of the checklist directing staff, " If items are missing, it is your responsibility to ensure that the crash cart is restocked. " The corporate nurse consultant # 1 stated she did not know why the nurses were putting " N/A " and immediately went to ask the supply clerk. Corporate nurse consultant # 1 was accompanied as she immediately went to talk to the supply clerk following these observations. The supply clerk stated she had just recently been told the facility needed more backboards. The supply clerk was asked when they were ordered and she provided a purchase order showing they were ordered on 1/20/17. Interview with the administrator on 1/22/17 at 3:15 PM revealed no one in the nursing department had told him they were missing backboards on two of their crash carts. Corporate nurse consultant #2 was interviewed at approximately 3:30 PM on 1/22/17. Nurse consultant #2 stated, until the ordered backboards arrived, the facility would plan to put a sign on the carts alerting staff to go to one of their fully stocked crash carts.	F 490	checklist and replenishing items on the crash carts to be completed on 2/17/2017 by Staff Facilitator. All newly hired license nurses will be in-serviced regarding the crash cart checklist and replenishing items on the crash carts during orientation by the Staff Facilitator. The 11-7 supervisor\ resource nurse will audit the crash carts nightly, replenish items as necessary, and document on the crash cart check list nightly. The supply clerk will audit the crash cart and the crash cart check list 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month to ensure no items are depleted on the crash cart or depleted items reordered utilizing the Crash Cart QI monitoring tool. The Director of Nursing will review and initial the Crash Cart QI monitoring tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern have been addressed. The Executive QI Committee will meet monthly and review the Crash Cart QI monitoring tool and address any issues, concerns and/or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	