STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the compliant investigation Event ID #MCDC11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		8/22/18

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

Electronically Signed | 08/17/2018

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by placing the resident in a brief at night instead of allowing the resident to use the bed pan for 1 of 3 residents sampled for bowel and bladder continence (Resident #42). The findings included: Resident #42 was admitted to the facility on 02/20/18 with diagnoses that included: pathological fracture, mechanical complications of internal hip prosthesis, heart failure, anxiety, and osteoporosis. Review of the quarterly minimum data set (MDS) dated 07/04/18 revealed that Resident #42 was cognitively intact. The MDS further revealed that she required extensive assistance of one staff member with toileting and was frequently incontinent of bladder. An interview with Resident #42 was conducted on 07/30/18 at 10:36 AM. Resident #42 stated that during the day she was able to go to and from the bathroom by herself and was fully aware of when she needed to use the bathroom. She indicated she wore a pull up for any accident that she may have due to the diuretics she took. Resident #42	F 550	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 RESIDENT RIGHTS/EXERCISE OF RIGHTS The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide care in a manner to maintain the resident's dignity by placing the resident in a brief at night instead of allowing the resident to use the bed pan for 1 of 3 residents sampled for bowel and bladder continence. The employee involved was not knowledgeable and no longer works for the facility. Resident #42. Resident was allowed to use the bed pan at night. Resident is alert	

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F 550	Continued From page 2 stated that at night the staff would put a brief on her and she did not like that and it made her feel like a child. She stated that she used to ring the call bell for the bed pan and the staff would come and put her on the bed pan. Resident #42 stated that one night the staff told her she was going to have to make up her mind if she wanted the brief or the bed pan, but she could not have both and from that conversation they have placed a brief on me each night. She stated that the staff instructed her to "pee 2 or 3 times in the diaper" and then ring the call bell and they would change it. Resident #42 stated that she had not seen that staff member in a long time and could not recall her name. An observation of Resident #42 was made on 08/01/18 at 8:55 AM. Resident #42 was sitting in bed with her head of bed elevated and was doing a word puzzle. She proceeded to raise her gown and stated, "I am still in this diaper from the night." Resident #42 added that the staff generally got her up around 9:30 Am and at that time they would remove the "diaper." An interview was conducted with Nursing Assistant (NA) #3 on 08/02/18 at 9:58 AM. NA #3 stated that she routinely cared for Resident #42 on 1st shift. She stated that during the day Resident #42 was continent of her bladder and was able to take herself to and from the bathroom as she needed. NA #3 added that Resident #42 wore a pull up for any accident that she may have but very rarely did that happen. She stated that when she arrived for her shift in the morning that Resident #42 would have a brief on and she would remove the brief and place a pull up on her.	F 550	and oriented x3 and was able to verify and confirm that her needs were met by being allowed to use the bed pan at night. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 8/2/2018, the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses, Licensed Practical Nurses and Nurse Aides: Full time, Part time and PRN) that a resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights. The resident has a right to use the bed pan at night and	

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F 550	Continued From page 3 An interview was conducted with NA #4 on 08/02/18 at 11:32 AM. NA #4 stated that she worked 3rd shift at the facility and routinely cared for Resident #42. NA #4 stated that when Resident #42 first came to the facility she would use her call bell and we would place her on the bed pan but now she used the brief but was not sure why. NA #4 stated she had never instructed Resident #42 to use the brief and never refused to place her on the bed pan. She added that when she arrived for her shift Resident #42 would already be in the bed with a brief on. NA #4 stated that Resident #42 was continent of her bowel and bladder and if she wanted the bed pan then she would assist her with using the bed pan. An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:14 PM. The DON stated that she had 2 NA that would tell the residents that they could not use the bed pan and had to use a brief at night and neither one of those employees still worked at the facility. She stated that she expected that the staff promote a dignified environment and if Resident #42 wanted to use the bed pan then they need to assist her with getting on and off the bedpan.	F 550	whenever requested and one cannot place the resident in a brief at night. As of 8/22/2018 no nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 8/22/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Unit Manager will interview 5 alert and oriented residents weekly to ensure that care was provided in a manner to maintain the resident's dignity and that resident was assisted with a bed pan at night and whenever requested and not placed in a brief at night. This will be done by using a quality assurance (QA) survey tool for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit	

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F 550	Continued From page 4	F 550	Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and resident interviews the facility failed to place a resident's call light within reach to allow the residents to request staff assistance if needed for 2 of 2 residents sampled for accommodations of needs (Resident #27 and #12). The findings included: 1. Resident #27 was readmitted to the facility on 04/30/16 with diagnoses that included: cerebral palsy, hemiplegia, chronic kidney disease, and others. Review of the comprehensive minimum data set (MDS) dated 06/16/18 revealed that Resident #27 was cognitively intact and required extensive assistance with activities of daily living.	F 558	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F558 REASONABLE ACCOMMODATIONS NEEDS/PREFERENCES The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	8/22/18

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F 558	Continued From page 5 An observation of Resident #27 was made on 07/30/18 at 10:11 AM. Resident #1 was resting in bed with her eyes open. Resident #27's call bell was laying in the top drawer of her night stand and the drawer was closed. The night stand was located slightly behind the head of the bed and was out of the reach of Resident #27. Resident #27 confirmed that she could not reach her call bell and stated if she needed assistance she would just have to wait for the staff to come to her room. An observation of Resident #27 was made on 07/31/18 at 2:39 PM. Resident #27 was up in a high back wheelchair in her room. Resident #27's call bell was laying in the top drawer of her night stand and the drawer was closed. The night stand was located directly behind the high back wheelchair and was out of the reach of Resident #27. Resident #27 confirmed that she could not reach her call bell. An observation of Resident #27 was made on 08/01/18 at 8:51 AM. Resident #27 was in bed with the head of her bed elevated and she was eating her breakfast. Resident #27's call bell was laying in the top drawer of her night stand and the drawer was closed. The night stand was located slightly behind the head of the bed and was out of the reach of Resident #27. Resident #27 confirmed that she could not reach her call bell. An observation of Resident #27 was made on 08/02/18 at 9:46 AM. Resident #27 was resting in bed with her eyes open. Resident #27's call bell was laying in the top drawer of her night stand and the drawer was closed. The night stand was located slightly behind the head of the bed and was out of the reach of Resident #27. Resident	F 558	cited; The facility failed to place a resident's call light within reach to allow the residents to request staff assistance if needed for 2 of 2 residents sampled for accommodations of needs (Resident #27 and #12). Call bell was not placed at reach because staff were not aware that residents could not reach it. Resident #27: Call bell was immediately placed within reach. Resident #12. Call bell was immediately placed within reach. Call light was bifurcated and resident is able to reach it when in bed or when in his recliner. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 8/2/2018, the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses , Licensed Practical Nurses and Nurse Aides: Full time, Part time and PRN) that a resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Resident's call light should be placed within reach at all times to allow the residents to request staff assistance when needed. As of 8/22/2018 no nursing staff (Registered nurses, Licensed Practical Nurses and Nurse Aides: Full time, Part time and PRN) will be allowed to work	

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F 558	Continued From page 6 #27 confirmed that she could not reach her call bell. An observation and interview was conducted with Resident #27 on 08/02/18 at 9:52 AM with Medication Aide (MA) #1. MA #1 confirmed that Resident #27 was able to use her call bell and that it should always be within reach. Resident #27's call bell was laying in the top drawer of her night stand and the drawer was closed. The night stand was located slightly behind the head of the bed and was out of the reach of Resident #27. Resident #27 stated to MA #1, "I can't reach it back there." MA #1 apologized to Resident #27 for the call bell being out of her reach and immediately clipped the call bell to her blanket where she could reach it. An interview was conducted with Nurse #2 on 08/02/18 at 10:21 AM. Nurse #2 stated that Resident #27 was able to use her call bell and it should always be within reach. Nurse #2 indicated that Resident #27 ' s roommate kept a close on eye on her and would often ring the call bell on her behalf. An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:36 PM. The DON stated that her expectation was that call bells were within reach at all times 2. Resident #12 was readmitted to the facility on 09/02/16 with diagnoses which included Parkinson's disease, dementia, major depressive disorder, anxiety disorder and others. Review of the annual comprehensive minimum data set (MDS) dated 05/25/18 revealed Resident #12 was moderately cognitively impaired but alert and oriented to person, place and time. Resident	F 558	until the training has been completed. Effective 8/22/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Unit Manager will observe and interview 5 residents weekly to ensure that resident's call light has been placed within reach to allow the residents to request staff assistance when needed. This will be done by using a quality assurance (QA) survey tool for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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F 558	Continued From page 7	F 558		

#12 required limited to total assistance with most activities of daily living (ADL) and used a wheelchair as his means of ambulation.

An observation of Resident #12 on 07/30/18 at 11:03 AM revealed he was resting in his recliner in his room and was reading. Resident #12's call light was observed to be wrapped around the side rail at the head of his bed approximately ten feet away from where he was sitting in his recliner. Resident #12 confirmed he had to get in his wheelchair and roll over to the head of the bed to use his call light if he needed assistance. He stated he would like to have a call light that was bifurcated so he had a call light when he was in bed and one when he was in his recliner.

An observation of Resident #12 on 07/31/18 at 1:55 PM revealed he was again up in his recliner in his room with the door closed. Resident #12's call light was wrapped around the side rail at the head of his bed approximately ten feet away and not within his reach.

An observation of Resident #12 on 08/01/18 at 1:29 PM revealed he was again up in his recliner in his room with his call light wrapped around the side rail at the head of his bed. The call light was not within his reach.

An observation of Resident #12 on 08/02/18 at 10:01 AM revealed he was up in his recliner with his call light wrapped around the side rail at the head of his bed. The call light was again not within his reach.

An observation and interview was conducted with Resident #12 on 08/02/18 at 10:09 AM with Nurse Aide (NA) #1 and Nurse #1 who were assigned to

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F 558	Continued From page 8 the resident. NA #1 and Nurse #1 both confirmed that Resident #12 was able to use his call light and it should always be within reach. Resident #12's call light was again wrapped around the side rail at the head of his bed approximately ten feet from the resident. Resident #12 stated to NA #1 and Nurse #1 that he would like to have a call light on his bed and on the recliner at all times. Nurse #1 stated she would have the maintenance director install a bifurcated call light so he could have one at his bed and one at his recliner within his reach at all times. Nurse #1 stated his call light should be within his reach at all times. An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:36 PM. The DON stated her expectation was call lights were within reach at all times.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code a resident ' s eating ability on the quarterly minimum data set for 1 of 3 residents sampled for nutritional status (Resident #42). The finding included: Resident #42 was admitted to the facility on 02/20/18 with diagnoses that included: pathological fracture, mechanical complications of internal hip prosthesis, heart failure, anxiety,	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	8/22/18

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F 641	Continued From page 9 and osteoporosis. Review of the quarterly minimum data set (MDS) dated 07/04/18 revealed that Resident #42 was cognitively intact and required extensive assistance of one staff member with eating. An observation of Resident #42 was made on 07/30/18 at 12:35 PM. Resident #42 was sitting in her wheelchair at bedside and was feeding herself lunch. She was observed to eat 100% of the lunch meal with no assistance from staff. An observation of Resident #42 was made on 08/01/18 at 8:25 AM. Resident #42 was sitting up in bed and was feeding herself breakfast that included eggs, bacon, and a biscuit. The tray also included oatmeal, juice, and coffee. Resident #42 was observed to eat 100% of the meal with no assistance from staff. An observation of Resident #42 was made on 08/02/18 at 8:10 AM. Resident #42 was sitting up in bed and was feeding herself breakfast that included eggs, sausage, and toast. Resident #42 was observed to spread jelly over her toast before she ate the toast. She was observed to eat 100% of the meal with no assistance from staff. An interview was conducted with the MDS Coordinator on 08/02/18 at 11:56 AM. She confirmed that she had completed the quarterly MDS dated 07/04/18. She indicated that she ran the report from the point of care documentation that the Nursing Assistants (NAs) enter and that was how she knew what to code for activities of daily living including eating on the MDS. The MDS Coordinator stated she was not very familiar with Resident #42 and when she ran the report and	F 641	F641 ACCURACY OF ASSESSMENTS The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to accurately code a resident's eating ability on the quarterly minimum data set for 1 of 3 residents sampled for nutritional status (Resident #42) Employee who coded Section G0110H2 (Eating Support) was not knowledgeable on coding support provided for late loss ADL Eating. Employee was educated on 8/2/2018 on accurately coding late loss ADL Eating in point of care (POC). Resident #42. Resident Minimum Data Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) 7/4/2018) was modified with a Corrective Attestation Date of 8/2/2018. The assessment was submitted to the state QIES system on 8/3/2018 and was accepted on 8/3/2018. Submission ID: 15203265 The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 8/2/2018 the Quality Assurance Nurse Consultant and Minimum Date Set (MDS) Coordinator reviewed the most recent Minimum Data Set (MDS) for current residents in the last 6 months to ensure that Section G0110H2 was coded accurately. On 8/2/2018, Quality Assurance and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 saw that NA #5 had coded extensive assistance with eating on 3 separate occasions (06/28/18, 07/03/18, and 07/04/18) during the lookback period that was what she coded. She indicated she had no reason to question the information that NA #5 had entered. An interview was conducted with NA #5 on 08/02/18 at 1:45 PM. NA #5 stated that on 06/28/18, 07/03/18, and 07/04/18 Resident #42 only required set up assistance with her meals. He confirmed that she did not require extensive assistance with eating and that he was still new at the facility and was learning how to code the care he provided but stated he coded her eating incorrectly at the time. An interview was conducted with the MDS Consultant on 08/02/18 at 3:37 PM. The MDS consultant stated that they would immediately correct the MDS to reflect the set-up assistance and not the extensive assistance that was coded inaccurately. An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:45 PM. The DON stated that she expected that the MDS was coded as accurately as possible to reflect the status of the resident.	F 641	Minimum Data Set Consultant in serviced the Minimum Data Set Coordinator that the Minimum Data Set assessment much accurately reflect the resident's status. On 8/2/2018 the Minimum Data Set Coordinator and or Director of nursing and or Unit Manager in serviced Nurse Aides and Nurses (full time, part time or PRN) on accurately documenting late loss ADL Eating (How resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means for example tube feeding, total parenteral nutrition, IV fluids, administered for nutrition or hydration). When coding Section G0110H2 (support provided) code the most support provided by staff. For ADL support Setup help with late loss ADL Eating this includes cutting meat and opening containers at meals; giving one food item at a time. For ADL support Supervision with late loss ADL Eating this includes for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating. General supervision of a dining room is not the same as individual supervision of a resident and is not captured in the coding for Eating. For ADL support Activity did not occur with late loss ADL this would be coded: if the resident received no Nourishment by any route (oral, IV, TPN, enteral), if the resident was not fed by facility staff, or if family and/or non-facility staff fed the resident 100% of the time.	

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	345543	A. BUILDING _____ B. WING _____	C 08/02/2018

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F 641	Continued From page 11	F 641	As of 8/22/2018 no nursing staff (Registered nurses Licensed Practical and Nurse Aides: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 8/22/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Minimum Data Set (MDS) Coordinators will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section G0110H2 (Support provided for Late loss ADL Eating) was coded appropriately. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit	

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F 641	Continued From page 12	F 641	Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 review, and staff interviews the facility failed to trim a dependent residents toe nails for 1 of 5 residents sampled for activities of daily living (Resident #35). The findings included: Resident #35 was admitted to the facility on 01/10/17 with diagnoses that included dementia, major depressive disorder, anxiety, and history of traumatic fracture. Review of Resident #35's medical record revealed that she had been seen by the podiatrist on 02/07/18 and again on 04/13/18. Review of the most recent quarterly minimum data set (MDS) dated 07/01/18 revealed that Resident #35 was severely cognitively impaired for daily decision making and no behaviors or rejection of care was noted. The MDS further	F 677	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to trim a dependent residents toe nails for 1 of 5 residents	8/22/18

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F 677	Continued From page 13 revealed that Resident #35 required extensive assistance of one staff member with activities of daily living. An observation of Resident #35 was made on 07/30/18 at 3:08 PM. Resident #35 was up in a geri chair in the hallway and had pulled her socks off. Resident #35's toe nails were noted to be approximately a half inch long and jagged on both feet. An observation of Resident #35 was made on 07/31/18 at 8:31 AM. Resident #35 was up in a geri chair and her toe nails were observed to be approximately a half inch long and jagged on both feet. An observation of Resident #35 was made on 08/01/18 at 8:57 AM. Resident #35 was up in a geri chair in front of the nurse's station. Resident #35's toe nails were observed to be approximately a half inch long and jagged on both feet. An observation of Resident #35 was made on 08/01/18 at 3:55 PM. Resident #35 was up in a geri chair in the hallway with no socks on. Her toe nails were observed to be approximately a half inch long and jagged on both feet. An interview was conducted with Nurse #2 on 08/02/18 at 11:06 AM. Nurse #2 stated that she routinely took care of Resident #35 and was familiar with her needs. Nurse #2 stated that she had never trimmed Resident #35's toe nails and she was routinely seen by the podiatrist. She stated that the last time the podiatrist was at the facility Resident #35 was accidentally left off the list and if the resident was not on the list they	F 677	sampled for activities of daily living (Resident #35). The resident did not have her toe nails trimmed by the podiatrist in July 2018 because she was accidently left off the podiatrist list. Resident #35: Outpatient Appointment was scheduled with podiatrist on 8/2/2018. On 8/9/2018 resident went for the appointment and was assessed by the podiatrist. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 8/6/2018 all current residents toe nails were assessed by Director of Nursing or/and Unit Manager and/or Staff nurse. 7 other residents were noted to have been accidentally left off the podiatrist list for July 2018. Podiatrist was scheduled for these residents immediately. On 8/2/2018 the Director of nursing and or Unit Manager in serviced Nurse Aides and Nurses (full time, part time or PRN) that 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. Each resident□s toe nails should be assessed. Toe nails need to be trimmed by nursing staff, if unable to be trimmed, resident needs to be seen by a podiatrist in facility or as an outpatient out of facility. All residents scheduled for the podiatrist have to be seen at facility or out patient appointment per schedule. As of 8/22/2018 no nursing staff	

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F 677	Continued From page 14 could not be seen until the next visit. Nurse #2 stated that she had noticed Resident #35's toe nails were long but did not really think anything about it because she was aware that she would be seen by the podiatrist. An observation of Resident #35 was made on 08/02/18 at 11:22 Am with Nurse #3. Resident #35 was up in a geri chair and her toe nails were observed to be approximately a half inch long and jagged on both feet. Nurse #3 agreed that Resident #35's toe nails were long and she needed to be seen by the podiatrist. An interview was conducted with Nursing Assistant (NA) #2 on 08/02/18 at 11:27 AM. NA #2 stated that she routinely cared for and was familiar with Resident #35. NA #2 stated that she had noticed her long toe nails but assumed that she was being seen by the podiatrist. An interview was conducted with the Social Worker (SW) on 08/02/18 at 2:08 PM. The SW stated that everyone on the unit where Resident #35 resided was seen by the podiatrist. She stated that the podiatrist came to the facility every 3 months and only saw a certain number of resident on each visit. The SW indicated that the podiatrist was at the facility in February 2018 and was scheduled to be at the facility in May of 2018, but they cancelled. She added the podiatrist was at the facility in early July 2018, but Resident #35 was not seen on that visit, she would be seen on the scheduled visit in August 2018. The SW indicated that if Resident #35's toe nails were long she could be seen as an outpatient and someone just needed to let her know that and she would schedule the appointment.	F 677	(Registered nurses , Licensed Practical Nurses and Nurse Aides: Full time, Part time and PRN) will be allowed to work until the training has been completed. Effective 8/22/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Unit Manager will observe 5 dependent residents weekly to ensure that toe nails have been trimmed and that they have been seen by a podiatrist as ordered. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of	

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F 677	Continued From page 15 An interview was conducted with the Director of Nursing (DON) on 08/02/18 at 3:14 PM. The DON stated that each resident had scheduled bath days and nail care was a part of the bathing process. The DON stated she expected that Resident #35's toe nails be trimmed or if they were unable to be trimmed then an appointment scheduled for her to be seen as an outpatient with the podiatrist.	F 677	correction; Administrator and /or Director of Nursing.	