STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/17/19 through 02/20/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# J13Q11.	E 000		
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 observation, staff interview and record review, the facility failed to provide a communication board to assist with the resident's ability to communicate for 1 of 1 resident observed with a communication deficit (Resident #100). The findings included: Resident # 100 was admitted to the facility on 11/13/18 with a diagnosis of aphasia, cerebrovascular accident (CVA), and hemiplegia. The admission Minimum Data Set (MDS) dated 11/20/18, noted Resident #100 to be cognitively impaired. The MDS further revealed Resident #100 was coded as having an absence of spoken words under speech clarity. Resident #100 was unable to express ideas or wants. Review of a care plan dated 11/03/18 read in part, Resident #100 had a communication deficit	F 558	Resident #100 was provided with a communication board on 3/1/2019. On 2/25/2019 Director of Nursing and/or designee performed a Quality Improvement Monitoring for all residents for effective communication. No other issues were identified. On 2/19/2019 through 2/26/2019 Director of Nursing and/or designee provided re-education to Licensed Nurses, Certified Nursing Assistants, and Therapy Staff on the use of interventions for effective communication of resident's needs. The Director of Nursing and/or Designee to perform Quality Improvement Monitoring of interventions in place for effective communication of residents	3/19/19

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

Electronically Signed | 03/11/2019

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F 558	Continued From page 1 related to impaired verbal communication as evidenced by expressive dysphasia. The goal for Resident #100 was to be able to make his needs known through the next review. Interventions included providing and utilizing a communication board, providing visuals, and having the resident do a return demonstration to ensure understanding. Review of Physician Orders revealed an order dated 11/15/18 for Resident #100 to be evaluated and receive speech therapy as indicated 5 times per week for a duration of 4 weeks related to aphasia and oral phase dysphagia. Review of speech therapy discharge summary dated 01/09/19 revealed Resident #100 had received speech therapy services on the dates of 11/15/19 through 1/9/19. A focus goal met on 01/09/19 included Resident #100 demonstrating basic needs and wants to caregivers by selecting an item using a communication board with 70% accuracy. Long term goals included Resident #100 utilizing a communication board to effectively comprehend and communicate basic medical and social needs during routine daily activities in functional living environment. Review of a physician progress note dated 01/28/19 revealed Resident #100 had a history of a CVA resulting in expressive aphasia and dysphagia. The note revealed Resident #100 was non-verbal during the physician's evaluation. Review of Resident #100's Kardex (used to communicate resident information to nurse aides) on 2/17/19 revealed Resident #100 was listed as having clear communication using signs, gestures and sounds.	F 558	needs two times a week for four weeks, then one time a week for eight weeks, then one time monthly for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by the QAPI committee monthly and Quality Monitoring (audits) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of, but not limited too, the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 558	Continued From page 2	F 558		

Review of the facility grievances dated July 2018 through February 2019 revealed two grievances for Resident #100. The first grievance dated 11/20/18 was regarding incontinence care. Resident #100 was observed with incontinence through his clothing for over an hour. Resolution included staff education on incontinence care and frequent rounding. The second grievance dated 1/29/19 was regarding food preference, stating Resident #100 needed his food seasoned and set up assistance provided with meals. Resolution to the issue included education given to nursing staff regarding meal tray set up.

On 02/17/19 at 3:45 PM, Resident #100 was observed sitting in his wheelchair in his room. Resident #100 was unable to communicate with the surveyor and was observed becoming increasingly agitated due to the inability to communicate. No communication board was observed in Resident #100's room.

On 02/19/19 at 9:51AM an interview was conducted with Nurse Aide (NA) #1 and revealed she was responsible for Resident #100 that day. NA #1 stated Resident #100 was not able to communicate with her although he tried. NA #1 stated she was unaware of any interventions used to aide in assisting Resident #100's communication and had never seen staff use a communication board with the resident. She stated communication was difficult with Resident #100.

On 02/19/19 at 10:02AM an interview was conducted with Nurse #1. Nurse #1 stated Resident #100 was able to point and make gestures to staff regarding his needs. She stated

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his communication was not clear and Resident #100 was non-verbal. Nurse #1 stated no interventions were in place to aide in communication for Resident #100. Nurse #1 was not aware of a communication board as listed on Resident #100's care plan.

On 02/19/19 at 10:12 AM an interview was conducted with Speech Therapist. The Speech Therapist revealed she had worked with Resident #100 on auditory comprehension, answering yes or no basic needs and the use of a communication board in which she provided. She stated Resident #100 did not have clear speech and she had considered picking the resident back up for speech services due to his inability to communicate with staff but had not done so. The interview revealed she did not know where the communication board went or if staff had been using it with Resident #100 stating she didn't know what current interventions were in place to aide in Resident #100's communication.

On 02/19/19 at 10:27 AM an interview was conducted with Nurse #2. Nurse #2 stated she had attempted the use of a communication board with Resident#100 however the resident had refused. She stated normally if a resident refused an intervention, it would be documented on the care plan along with updates. The interview revealed the information regarding resident refusal of an intervention had not been documented for Resident #100.

On 02/19/19 at 10:43 AM an interview was conducted with MDS Nurse #1. The interview revealed she had been the MDS nurse since October 2018. Nurse #3 stated she updated the care plans weekly based on discussions from

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clinical meetings and information from nursing staff. The interview revealed if a resident refused an intervention or the intervention was discontinued she would take the intervention out of the care plan. She stated she was familiar with Resident #100 and thought staff were using the communication board as an intervention in his care. Nurse #3 stated she had never heard of Resident #100 refusing the use of a communication board however if he did refuse to use the communication board the intervention should have been removed and his care plan revised accordingly

On 2/20/19 at 3:25PM an interview was conducted with the Director of Nursing (DON). The DON stated no interventions were in place to assist Resident #100 communicate with staff. The DON stated Resident #100 could clearly communicate by nodding yes or no and using gestures and a communication board was not being used. She stated she was not aware a communication board was listed on Resident #100's care plan and it should have been discontinued. The interview revealed Resident #100's Kardex had been changed to show he experienced aphasia and did not have clear speech on 02/18/19. The DON stated the change had been made by nursing staff and she believed Resident #100 could clearly communicate despite his diagnosis. She stated her expectation was for nursing staff to leave the Kardex showing Resident #100 could clearly communicate and did not have aphasia.

On 2/20/19 at 03:34PM an interview was conducted with the Administrator. The Administrator stated Resident #100 was able to answer yes or no questions by nodding his head.

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F 558	Continued From page 5 She stated no interventions were in place to aide in Resident #100's ability to communicate due to nursing staff failing to make her aware. She stated she had received two grievances for Resident #100 regarding incontinence care and food preferences however could not say they were due to the inability to communicate with staff. She stated she had spoken to Resident #100's significant other regarding the grievances due to difficulty in communication with Resident #100 himself. The Administrator stated her expectations of nursing staff were to notify her of residents needs and to accurately update the residents Kardex with correct information pertaining to the resident's diagnosis. The interview further revealed her expectation was for nursing staff to mark on Resident #100's Kardex aphasia instead of clear communication based on the resident's diagnosis. She stated her expectation was for the care plan to directly reflect interventions in use for Resident #100.	F 558		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F 585		3/19/19

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F 585	Continued From page 6	F 585		

resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(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, 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

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F 585	Continued From page 7 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 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:	F 585		

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F 585	Continued From page 8 Based on record review and resident and staff interviews the facility failed to communicate with the resident/family member who filed the grievance and also failed to document a summary of the investigation and resolution of the grievance for 2 of 3 residents reviewed for grievances (Resident #15 and Resident #42). Findings included: 1. Resident #15 was admitted to the facility 03/24/18 with diagnoses including anemia and diabetes. Review of the quarterly Minimum Data Set (MDS) dated 01/04/19 revealed Resident #15 was cognitively intact. Review of a grievance filed by Resident #15 dated 07/20/18 revealed she was concerned over meal portions and meal substitutions. Review of the grievance form revealed there was no documentation of an investigation or resolution. There was no evidence any corrective action was taken or that a written decision was issued. An interview with Resident #15 on 02/19/19 at 3:08 PM revealed no one followed up with her concerns regarding meal portions and meal substitutions. Resident #15 did not recall who she gave the grievance to. Resident #15 stated she still had concerns over meal portions. An interview with the Administrator on 02/19/19 at 5:21 PM revealed the grievance was filed with the previous Administrator and she was not able to provide any additional information. The Administrator stated she expected an investigation and response to all grievances. The Administrator stated grievances were forwarded	F 585	On 2/19/2019 the Executive Director spoke with Resident #15 and Resident #42 in reference to previous grievances. All concerned parties satisfied with no further concerns noted. On 2/19/2019 Dietary Manager and District Dietary Manager spoke with Resident #15, food preference sheet updated and tray card to reflect. no further concerns noted. On 2/27/2019 the Executive Director completed a Quality Improvement Monitor of all grievances between the dates of 11/1/2018-2/27/2019 to ensure that all were complete with resolutions and the concerned party was provided a copy of the grievance and was satisfied with the resolution. No further issues were identified. On 2/18/2019 the Executive Director was educated by the Regional Director of Clinical Services on the Grievance Policy and Procedure. On 2/18/2019 the Executive Director provided education to all Interdisciplinary Team Members, including the Director of Nursing, Work Force Manager, MDS Nurse, Social Services Manager, Unit Manager, Business Office Manager, Human Resources, Admissions, Maintenance Director, Dietary Manager, Housekeeping Supervisor, Activities, Central Supply, Medical Records Manager, and Therapy Manager on the grievance process and the responsibility of the Grievance Officer to ensure a complete and thorough investigation has been completed and a written copy of the resolution has been	

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F 585	Continued From page 9 to the department involved in the grievance and staff from the involved department talk with the resident or family to help resolve the grievance. 2. Resident #42 was admitted to the facility 01/07/18 with diagnoses including anemia, diabetes, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #42 was cognitively intact. Resident #42's family filed a grievance on 05/29/18 with a concern that Resident #42's room was too cramped related to the roommate's belongings. The Action Taken section dated 04/30/18 stated the issue was resolved to the satisfaction of the patient and a copy of the resolution was given. It was noted on the grievance form the previous Administrator initialed the form. There was no further information regarding what steps were taken to resolve the grievance. Further review of the grievance form revealed there was no mention of contact with the family member who filed the grievance. An interview with Resident #42 on 02/18/19 at 3:23 PM revealed she did not recall the former Administrator talking with her or giving her any documentation regarding a grievance about her roommate's belongings. An interview with the Administrator on 02/18/19 at 4:43 PM revealed the grievance was filed with the previous Administrator and she was not able to provide any additional information about what action was taken or why Resident #42's family had not been contacted regarding the grievance.	F 585	provided to the concerned party. Any new employees will be educated upon hire. The Executive Director of Grievance Officer will track, monitor, and ensure investigation and written resolution provided to the concerned party utilizing Quality Monitoring Tool 1x/week for three months then 1x/month for three months. Grievance Officer will discuss grievances daily Monday-Friday during morning meeting for compliance. The results of the Quality Monitoring Tools will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly by the Executive Director. The Quality Assurance Performance Improvement Committee will evaluate effectiveness of the observation tools and make changes if necessary to maintain compliance with investigation and timely delivery of written resolution of grievances to concerned parties. The QAPI Committee consists of but not limited too the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 585	Continued From page 10 The Administrator stated she had no explanation as to why the Action Taken on the grievance stated it was completed before the grievance was filed. The Administrator also stated she expected the grievance to be resolved with the person who filed the grievance.	F 585		
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 staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge for 1 of 3 closed records reviewed for MDS accuracy (Resident #50). The findings included: Resident #50 was admitted to the facility on 01/25/2019 with multiple diagnoses including hypertension, hyperlipidemia and thyroid disorder. Review of the discharge Minimum Data Set (MDS) dated 02/04/19 revealed Resident #50 was discharged to acute hospital with return not anticipated. A review of the discharge summary dated 02/02/19 revealed Resident #50 was discharged to home with his family on 02/02/19. A review of a physician order dated 02/01/19 at 9:00AM revealed an order stating Resident #50 was stable for discharge with home health.	F 641	On 2/20/2019 Resident #50 Discharge MDS dated 2/4/2019 was updated to accurately reflect residents' place of discharge by the Minimum Data Set Nurse. On 3/1/2019 the MDS Nurse's and Regional Minimum Data Assessment Nurse performed Quality Improvement Monitoring of the last 30 days of MDS Discharge Assessments for accuracy of coding of place of discharge. Any issues identified were addressed. The Minimum Data Set Nurses' were re-educated by the Regional Minimum Data Assessment Nurse on Accurate Coding of the MDS Discharge Assessments on 3/1/2019. The Director of Nursing and/or Regional Minimum Data Assessment Nurse to perform Quality Improvement Monitoring of the Discharge MDS's for accurate coding of place of discharge three times a week for four	3/19/19

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F 641	Continued From page 11 On 02/20/19 at 10:40AM an interview was conducted with MDS Nurse #1. During the interview she stated Resident #50 was not discharged to the hospital on 02/02/19 but was discharged to home on that date. The interview revealed the MDS dated 02/04/19 should have reflected Resident #50 was discharged to the community instead of acute hospital. MDS Nurse #1 stated the information was coded in error. On 02/20/19 at 3:21PM an interview was conducted with the Director of Nursing (DON). The interview revealed Resident #50 was never discharged to the hospital. The interview revealed the MDS should have shown Resident #50 had been discharged to community and was coded as being discharged to the hospital by mistake. The DON stated her expectation was for Resident #50's MDS to be coded correctly reflecting his discharge status.	F 641	weeks, then one time a week for three months, and then one time monthly for three months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and the quality monitoring (audits) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited too Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		3/19/19

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F 656	Continued From page 12 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to implement a care plan interventions for 1 of 1 resident reviewed for accommodation of needs (Resident #100).	F 656	Resident #100 was provided a communication board on 3/1/2019. On 2/25/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring of care plans for	

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F 656	Continued From page 13 The findings included: Resident # 100 was admitted to the facility on 11/13/18 with a diagnosis of aphasia, cerebrovascular accident (CVA), and hemiplegia. The admission Minimum Data Set (MDS) dated 11/20/18, noted Resident #100 to be moderately cognitively impaired. The MDS further revealed Resident #100 required extensive, two-person assistance with all activities of daily living (ADL). Resident #100 was coded as having an absence of spoken words and was unable to express ideas or wants. Review of a care plan dated 11/03/18 had a focus area of communication deficit related to impaired verbal communication as evidenced by expressive dysphasia. The goal for Resident #100 was to be able to make his needs known through the next review. Interventions included providing and utilizing a communication board, providing visuals, and having the resident do a return demonstration to ensure understanding. Review of Physician Orders revealed an order dated 11/15/18 for Resident #100 to be evaluated and receive speech therapy as indicated 5 times per week for a duration of 4 weeks related to aphasia and oral phase dysphagia. Review of speech therapy discharge summary dated 01/09/19 revealed Resident #100 had received speech therapy services on the dates of 11/15/18 through 1/9/19. A focus goal met on 01/09/19 included Resident #100 demonstrating basic needs and wants to caregivers by selecting an item using a communication board with 70%	F 656	all residents with ineffective communication. No other issues were identified. On 2/19/2019 through 2/26/2019 Director of Nursing and/or designee provided re-education to Licensed Nurses, Certified Nursing Assistants, and Therapy Staff on the use of interventions care planned for effective communication of resident's needs. The Director of Nursing and/or designee to perform Quality Improvement Monitoring of the use of interventions care planned for effective communication of resident's needs two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The findings will be reviewed by the QAPI committee monthly and the Quality Monitoring (audits) will be updated to reflect changes if needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited too the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor,	

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F 656	Continued From page 14 accuracy. Long term goals included Resident #100 utilizing a communication board to effectively comprehend and communicate basic medical and social needs during routine daily activities in functional living environment. On 02/17/19 at 3:45 PM, Resident #100 was observed sitting in his wheelchair in his room. Resident #100 was unable to communicate with the surveyor and was observed becoming increasingly agitated due to the inability to communicate. No communication board was observed in Resident #100's room. On 02/19/19 at 9:51AM an interview was conducted with Nurse Aide (NA) #1 and revealed she was responsible for Resident #100 that day. NA #1 stated Resident #100 was not able to communicate with her although he tried. NA #1 indicated she was unaware of any interventions used to aide in assisting Resident #100's communication and had never seen staff use a communication board with the resident. NA #1 further stated communication was difficult with Resident #100. On 02/19/19 at 10:02AM an interview was conducted with Nurse #1. Nurse #1 stated Resident #100 was able to point and make gestures to staff regarding his needs. She stated his communication was not clear and Resident #100 was non-verbal. Nurse #1 stated no interventions were in place to aide in communication for Resident #100. Nurse #1 was not aware of a communication board as listed on Resident #100's care plan. On 02/19/19 at 10:12 AM an interview was conducted with Speech Therapist. The Speech	F 656	Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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Therapist revealed she had worked with Resident #100 on auditory comprehension, answering yes or no basic needs and the use of a communication board which she provided. The interview revealed she did not know where the communication board went or if staff had been using it with Resident #100.

On 02/19/19 at 10:27 AM an interview was conducted with Nurse #2. Nurse #2 stated she had attempted the use of a communication board with Resident#100 however the resident had refused. She stated normally if a resident refused an intervention, it would be documented on the care plan along with updates. The interview further revealed the information had not been documented for Resident #100.

On 02/19/19 at 10:43 AM an interview was conducted with MDS Nurse #1. The interview revealed she had been the MDS nurse since October 2018. Nurse #3 stated she updated the care plans weekly based on discussions from clinical meetings and information from nursing staff. The interview revealed if a resident refused an intervention or the intervention was discontinued she would take the intervention out of the care plan. She stated she was familiar with Resident #100 and thought staff were using the communication board as an intervention in his care. Nurse #3 stated she had never heard of Resident #100 refusing the use of a communication board.

On 2/20/19 at 3:25PM an interview was conducted with the Director of Nursing (DON). The DON stated no interventions were in place to assist Resident #100 communicate with staff. The DON stated Resident #100 could clearly

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F 656	Continued From page 16 communicate by nodding yes or no and using gestures and a communication board was not being used. On 2/20/19 at 03:34PM an interview was conducted with the Administrator. The Administrator stated Resident #100 was able to answer yes or no questions by nodding his head. She stated no interventions were in place to aide in Resident #100's ability to communicate due to nursing staff failing to make her aware. She stated her expectation was for the care plan to directly reflect interventions in use for Resident #100.	F 656		
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 reviews, and resident, and staff interviews, the facility failed to provide scheduled showers to maintain personal hygiene (Resident #205) and toe nail care (Resident #206) for 2 of 5 dependent residents reviewed for activities of daily living (ADL). The findings included: 1. Resident #205 was admitted to the facility on 02/12/19 with diagnoses which included back pain related to compression fracture, dementia and generalized muscle weakness. A review of Resident #205's medical record	F 677	Resident #205 was provided a shower on 2/19/2019. Resident #206 was provided toenail care on 2/19/2019 by Licensed Nurse. Director of Nursing and/or designee assessed current residents nails on 2/19/2019 through 2/20/2019, nail care provided as needed. On 2/22/2019 the Director of Nursing reviewed bathing preferences for all residents and ensured that bathing was provided as preferred for each resident. Any issues identified were addressed.	3/19/19

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F 677	Continued From page 17 revealed a Minimum Data Set (MDS) was not completed because the resident was admitted only 8 days prior. Review of the resident's 2/12/19 nursing admission assessment revealed the resident was alert and oriented to person, and place and was able to make his needs known. A review of Resident #205's baseline care plan dated 02/12/19 revealed he had a care plan for ADL self-care deficit. The goal was for the resident to achieve maximum functional abilities. The interventions included providing resident with assistance of 1-2 persons with transfers, toileting, ambulation, grooming, hygiene, bathing and dressing. The resident was independent with bed mobility and eating. A review of Resident #205's bathing preference sheet dated 02/12/19 revealed he preferred showers twice weekly on Tuesday and Thursday. A review of the Shower Schedule for all residents revealed Resident #205 was scheduled for showers on Tuesday and Thursday during the day shift (7:00 AM to 3:00 PM). An observation and interview on 02/17/19 at 2:06 PM with the resident and family members, revealed he had not had a shower since he was admitted to the facility on 02/12/19. The resident was lying in bed with clothes on and hair appeared to be greasy. The resident and family member stated he had not had a shower since he got to the facility. An observation and interview on 02/18/19 at 8:34 AM revealed Resident #205 still had not had a shower and his hair appeared greasy. The resident was dressed and sitting in his wheelchair	F 677	On 2/20/2019 through 2/26/2019 the Director of Nursing and/or designee provided re-education to Licensed Nurses and Certified Nursing Assistants regarding care of residents nails and bathing preferences. The Director of Nursing and/or designee will conduct Quality Improvement Monitoring of Residents nails and that bathing preferences are followed and completed three times a week for four weeks, then two times a week for eight weeks, and then one time monthly for three months. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement (QAPI) Committee. Findings will be reviewed by the QAPI Committee monthly and the Quality Monitoring Tool will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of, but not limited too, the Executive Director, Director of Nursing, Pharmacist, Medical Director, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Dietary Manager, Human Resources, Admissions, Housekeeping Supervisor, Medical Records, Maintenance Director, and MDS Nurse. The QAPI committee meets monthly and quarterly at a minimum.	

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waiting on therapy.

An interview on 02/20/19 at 10:51 AM with Nurse Aid #1 revealed she had not given Resident #205 his shower on 02/14/19 as scheduled. NA #1 stated she had reported off to the NA on second shift that she had not given the resident his shower on 1st shift.

An interview on 02/20/19 at 3:36 PM with NA #4 revealed she had not given Resident #205 a shower on 2nd shift and stated she was not aware that he had not been given his shower on 1st shift. NA #4 stated NA #1 had not reported to her that the resident needed a shower.

An interview on 02/20/19 at 4:13 PM with the Director of Nursing and Administrator revealed they both expected residents to receive their showers as designated by the shower schedule and if residents refused, they expected it to be reported to the nurse.

2. Resident #206 was admitted to the facility on 02/13/19 with diagnoses which included bradycardia and deep vein thrombosis.

A review of Resident #206's medical record revealed a Minimum Data Set (MDS) was not completed because the resident was admitted only 5 days prior. Review of the resident's 2/13/19 admission nursing assessment revealed the resident was alert and oriented to person, and place and was able to make his needs known.

A review of Resident #206's baseline care plan dated 02/12/19 revealed he had a care plan for ADL self-care deficit. The goal was for the resident to achieve maximum functional abilities.

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The interventions included providing resident with assistance of 1 person with transfers, toileting, and bathing, and set up with grooming, hygiene, and dressing. The resident was independent with bed mobility and eating.

A review of the Shower Schedule for all residents revealed Resident #206 was scheduled for showers on Tuesday and Friday during the day shift (7:00 AM to 3:00 PM).

An observation and interview on 02/18/19 at 8:49 AM revealed Resident #206 lying in bed. His toenails on both feet were noted to be ¼ to ½ inch beyond the end of his toes and some of his toenails were bending downward onto the back of his toes.

A review of Resident #206's shower sheet for 02/19/19 revealed Nurse Aid #2 had documented on his shower sheet for Toenails cut "didn't need."

An observation and interview on 02/19/19 at 2:29 PM revealed Resident #206 had his shower earlier in the day and stated he felt much better. An observation of his toenails revealed he had not had them trimmed after his shower. The resident stated he did not like for his toenails to be long and would like for them to be trimmed. Resident #206 indicated he could not cut his own toe nails because he could not reach them.

An interview on 02/19/19 at 2:45 PM with Nurse #1 and observation of Resident #206's toenails revealed the resident's toenails did need to be cut. Nurse #1 reviewed the shower sheet completed by NA #2 and stated his assessment was not correct and Resident #206's toenails needed to be cut.

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F 677	Continued From page 20 An interview on 02/20/19 at 9:06 AM with NA #2 revealed he had given Resident #206 his shower on 02/19/19 and stated he "did not pay attention to his toenails" although he documented on his shower sheet they did not need to be cut. An interview on 02/20/19 at 4:13 PM with the Director of Nursing (DON) and Administrator revealed they both expected residents to have nail care after their showers and as needed. The DON stated if the resident's nails could not be cut by the staff she expected them to refer the resident for podiatry services.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		3/19/19

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F 690	Continued From page 21 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to maintain a bladder catheter below the level of the bladder and failed to keep the catheter bag and tubing off the floor during transport for 1 of 1 resident (Resident #206) reviewed for catheter care. The findings included: Resident #206 was admitted to the facility on 02/13/19 with diagnoses which included bradycardia, deep vein thrombosis and benign prostatic hypertrophy. A review of Resident #206's medical record revealed a Minimum Data Set (MDS) was not completed because the resident was admitted only 4 days prior. Review of the resident's 2/13/19 admission nursing assessment revealed the resident was alert and oriented to person, and place and was able to make his needs known. A review of Resident #206's baseline care plan dated 02/13/19 revealed he had a care plan for	F 690	Resident #206 catheter tubing and bag was placed appropriately while sitting in the wheelchair by the Certified Occupational Therapy Assistant immediately on 2/19/2019. Resident #206 catheter bag was placed appropriately immediately during catheter care on 2/19/2019. On 2/19/2019 Director of Nursing and/or designee performed a Quality Improvement Monitoring for all residents with catheters for proper placement. No other issues were identified. On 2/19/2019 through 2/26/2019 Director of Nursing and/or designee provided re-education to Licensed Nurses and Certified Nursing Assistants on appropriate catheter bag placement. The Director of Nursing and/or designee to perform Quality Improvement Monitoring of proper catheter bag and	

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F 690	Continued From page 22 bladder elimination with goals to establish individual bowel/bladder routine and be odor free without skin breakdown. The interventions included catheter care per policy (dated 02/17/19), incontinent care as needed, monitor skin, monitor for hematuria (dated 02/18/19), catheter related to urinary retention and hematuria (dated 02/18/19), and change catheter as needed for occlusion, clot, etc. An observation and interview on 02/18/19 at 8:49 AM revealed Resident #206 lying in bed with a bladder catheter attached to the side of the bed draining amber colored urine. The resident stated he had gone to the Emergency department at the local hospital. He stated he had returned to the facility last evening with a catheter and had been told he had a urinary tract infection (UTI). The catheter bag was clipped to the side of the bed at a level below the bladder. An observation was made on 02/19/19 at 9:35 AM of catheter care performed on Resident #206. Nurse Aid #1 performed catheter care using aseptic technique. As she completed the catheter care, the tubing was under his right leg and she brought the bag up and over his leg causing the urine in the tubing to reflux back into the bladder and when she untangled the tubing she brought the bag back over his leg to clip to the side of the bed, again resulting in the urine in the tubing refluxing back into the bladder. Nurse #1 who was also in the room to put a leg strap on Resident #206's leg to anchor his catheter was instructing NA #1 to keep the catheter bag below the level of the bladder. An interview on 02/19/19 at 10:45 AM with NA #1 revealed she was aware she was supposed to	F 690	tubing placement two times a week for four weeks, then one time a week for eight weeks, and then one time a month for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by the Quality Assurance Performance Improvement Committee monthly and Quality Monitoring (audits) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of, but not limited too, Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 02/20/2019

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F 690	Continued From page 23	F 690		

keep the catheter bag below the level of the bladder, but stated she had not kept it below the level of the bladder during Resident #206's catheter care. NA #1 stated she was trying to get the tubing from under his leg and didn't think when she raised the bag above his bladder. NA #1 stated she was aware Resident #206 had a urinary tract infection.

An interview on 02/19/19 at 10:46 AM with Nurse #1 revealed she was aware NA #1 had placed the catheter bag above the level of Resident #206's bladder during catheter care and stated it should have remained below the level of the bladder. Nurse #1 stated it was her expectation that Resident #206's catheter bag remain below the level of his bladder at all times.

An interview on 02/20/19 at 4:13 PM with the Director of Nursing and Administrator revealed they expected the resident's catheter bag to remain below the level of his bladder at all times.

An observation on 02/19/19 at 10:55 AM revealed the resident in his wheelchair being transported out of the shower room by the occupational therapy assistant (OTA) to therapy. A swishing sound was noted while the resident was being pushed out of the shower room by the OTA. Resident #206's catheter bag and tubing were observed dragging the floor under his wheelchair as the OTA was pushing him down the hall approximately 180 feet to the therapy department.

An interview on 02/19/19 at 10:58 AM with the OTA revealed she was not aware the catheter bag and tubing were dragging the floor while the resident was transported from the shower room

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F 690	Continued From page 24 to the therapy department. The OTA stated Resident #206's catheter and tubing should not be in contact with the floor and should have been attached below his bladder but off the floor. An interview on 02/19/19 at 2:50 PM with Nurse #1 revealed she was not aware Resident #206's catheter bag and tubing had been dragging on the floor from the shower room to the therapy department earlier in the day. Nurse #1 stated if she had seen it she would have stopped the OTA and adjusted the bag and tubing. An interview on 02/20/19 at 4:13 PM with the Director of Nursing and Administrator revealed they expected the resident's catheter bag to remain below the level of his bladder and his bag and tubing to remain off the floor during transport in his wheelchair to prevent contamination and urinary tract infection.	F 690		