STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

(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/complaint survey was conducted on 6/10/19 through 6/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YQW711.	E 000		
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 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	F 585		6/27/19

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

Electronically Signed | 06/28/2019

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F 585	Continued From page 1	F 585		

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 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;

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F 585	Continued From page 2 (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: Based on record review and interviews the facility failed to provide written grievance decisions to the resident and family of the resident for 1 of 1 resident (Resident #31) reviewed for grievances. The findings included: Resident #31 was admitted to the facility on 1/10/2019 with diagnoses to include paraplegia, multiple pressure ulcers and hypertension. Resident #31's quarterly Minimum Data Set (MDS) assessment date 5/15/2019 revealed his cognition was intact, and he required extensive to	F 585	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F585 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. Resident # 31 was provided a written response to his grievance on 6/26/19. 2. The procedure for implementing the	

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F 585	Continued From page 3 total assistance from staff for activities of daily living. A "Concern Form" dated 4/4/2019 revealed a meeting was held with Resident #31, family member, and 5 facility staff members present. Grievances were noted on the form. The 2nd page of the form titled "Concern Form - Action" was dated as 4/4/2019, the day the concern came to the attention of the facility. The date the form was completed was 4/5/2019 or 4/6/2019, (the 5 and 6 were written on top of each other). Actions taken were documented on the form and noted the date of the follow up as 4/6/2019. The bottom of the form listed as a question - "Is the individual who raised the concern satisfied with the resolution: yes or no", which was left blank and not answered. The form was signed by the Administrator and dated on 4/6/2019. The 3rd page of the form titled "Concern Decision Form" was documented and signed by the Administrator on 4/6/2019. A hand-written note at the bottom of the form read: "gave to Activity to deliver with Amazon Package." On 6/12/2019 at 2:36 PM, an interview conducted with Resident #31 and his family representative regarding a meeting that was conducted on 4/4/2019 at the facility to voice grievances of Resident #31's care. Resident #31 stated he had not heard how the complaints were handled, did not know of the outcome of the grievance and had not received a written decision of the results of the grievance investigation from the facility. Resident #31's family representative stated she had not heard how the complaints were handled, did not know the outcome of the grievances filed, and had not received a written decision of the results of the grievance investigation from the	F 585	acceptable plan of correction for the specific deficiency cited. a) On 6/26/19 the Director of Nursing (DON) in-serviced the Administrator and the Social Services Manager were in-serviced on the grievance policy. On 6/26/19 the DON conducted an in-service with the Department Managers including the Administrator, Social Services Manager, Business Office Director, Admissions Coordinator, Activity Director, Maintenance Director, and Minimum Data Set Coordinator on the Grievance Policy to ensure that all grievances are reported to the Grievance Official (Nursing Home Administrator) promptly; and the Grievance Official thoroughly investigations and provides a written grievance decisions to residents and or families; according to the grievance policy. b) On 6/26/19 the DON conducted an in-service with the Department Managers including the Administrator, Social Services Manager, Business Office Director, Admissions Coordinator, Activity Director, Maintenance Director, and Minimum Data Set Coordinator on the Grievance Policy to ensure that within 72 hours of receiving the grievance, the Department Manager who is responding to the grievance will have verbal communication with the individual who voiced the grievance. Validation decisions of satisfaction will be determined via verbal communication with the individual who voiced the grievance at that time. c) On 6/26/19 the Director of Nursing and Social Services Manager reviewed the grievances for the last thirty days to	

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F 585	Continued From page 4 facility. On 6/13/2019 at 11:47 AM, an interview was conducted with the Administrator who stated she did not have the residents sign the results of the written decision of grievances. The Administrator stated she or the Social Worker (SW) would go over the results of the grievance with the person who filed the grievance after the grievance was investigated. The Administrator stated she would have had the Activity Director take a copy of the grievance to the resident's room with his Amazon package, as he frequently received packages from Amazon, but she could not verify if the resident had received a copy of the grievance.	F 585	determine if written grievance decisions were provided to residents and or families as indicated. There were no grievances found to not have a written response. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The Administrator will review the grievances twice weekly for three months to validate grievance decisions were provided to resident and or families. b) The findings will be reviewed weekly for three months by the DON for validation. c) The DON will report findings of the audits monthly, for three months, to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will analyze the data and provide any necessary recommendations to ensure sustained compliance ongoing. 4. The Administrator will be responsible for the implementation of the acceptable plan on correction. 5. Dates when corrective action will be completed 6/27/19. The corrective action dates must be acceptable to the State.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		7/1/19

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effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and staff

Preparation and/or execution of this Plan

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F 655	Continued From page 6 interview the facility failed to develop an accurate base line care plan for 1 of 1 sampled residents (Residents # 97) observed for tracheostomy care. The findings included: Resident # 97 was admitted to the facility on 6/5/19 with diagnoses including acute respiratory failure. Review of the Physician order dated 6/6/19 revealed Resident #97 was to receive oxygen at 6 Liters per minumte (LPM) via tracheostomy (trach) collar continuously. Staff were to change the trach inner cannula with # 6 Shiley cuffless. Review of the baseline care plan completed on 6/6/19 did not address Resident #97's tracheostomy status. During an interview on 6/12/19 at 1:40 PM the Minimum Data Set nurse stated she had completed the 48 hour baseline care plan and not care planned the resident's tracheostomy. She stated it would be two days before she had the time to care plan the tracheostomy. During an interview on 6/12/19 at 2:25 PM the Administrator stated that she would have expected the tracheostomy to have been care planned.	F 655	of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F655 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. Resident # 97 care plan was updated by the Minimum Data Set Coordinator to reflect the tracheostomy on 6/19/19. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) On 6/27/19 the Director of Nursing (DON) and a District Director of Care Management provided in-service education to the Minimum Data Set Coordinators (MDSC) on development of accurate baseline care plans. b) The DON audited the baseline care plans for the residents who were admitted in the last twenty one days to validate accurate baseline care plans were developed. Any care plan needing to be updated to accurately reflect the resident's status was updated at that time by the DON or MDSC. Three patients were admitted during that timeframe. The audits revealed each of the three resident medical records audited had accurate baseline care plans in place. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the	

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F 655	Continued From page 7	F 655	regulatory requirements. a) The Director of Nursing or Unit Coordinator will audit newly admitted residents' baseline care plans weekly times four weeks, then monthly for two months to validate development of accurate base line care plans. If during the auditing process, a baseline care plan has not been developed, or is noted to be inaccurate, the DON will provide one to one re-education and validate the baseline care plan is updated as needed. b) The audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly for a minimum of three months. The QAPI Committee will make recommendations, based on the audit results, for additional education or auditing to assure the system is sustained ongoing. 4. Date when corrective action will be completed is 6/27/19. The corrective action dates must be acceptable to the State.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		7/1/19

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F 679	Continued From page 8 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to provide community outings/activities for 8 of 8 residents reviewed in resident council group meeting and failed to provide ongoing activities for 3 of 19 sampled residents reviewed for activities. (Resident #19, Resident #26 and Resident #31). The findings included: During a Resident Council Group Meeting held on 6/4/19 at 11:00 AM, the eight residents in the meeting revealed they had not gone on community outings in over one year. Most revealed they had not been on an outing in about three years. During an interview on 6/11/19 at 11:00 AM, in Resident Council Meeting, Resident #13 said they do not go on outside trips. She stated she had been in the facility for 2 1/2 years and she had not been on an outing for over a year. She revealed during that time she went to a ball game and went to see Christmas lights over a year ago. Resident #13 said she did not know why they did not go on community outings. The other residents in the Resident Council Meeting agreed that they had not been on community outings. During an interview on 6/12/19 at 9:22 AM, the facility Activity Director stated the last time she took residents on community outings was 2 1/2 years ago. She stated they had been having transportation problems with their own van and had been sharing a van with another facility. She revealed the shared van was used for	F 679	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F679 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. On 6/4/19 during Resident Council Meeting, residents expressed a concern during annual survey have not been on community outings. The facility will utilize the facility van, as well as the Nursing Home Administrator has sought alternative methods of transportation services to accommodate residents who wish to participate in community outings. A Resident Council Meeting was held on 6/26/19 to discuss what type of outings the residents would like to attend. Residents #31, #26, #19 had their activities of interest likes and dislikes reviewed by the Activity Director on 6/26/19. Residents #31, #26, #19's respective Care Plans were updated by the Activity Director or Minimum Data Set Coordinator on 6/26/19 to reflect their specific activities of interest. The Monthly Activity Calendar was updated for the month of July to reflect community outings chosen by Resident	

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F 679	Continued From page 9 appointments. The Activity Director stated the facility van had been broken for a month or two and now it was fixed. During an interview on 6/13/19 at 9:28 AM, the Administrator stated a bus company would volunteer once a year to take residents in the facility to see festival of lights. She stated she was working on a PIP (Performance Improvement Plan) to see how to take residents on community outings. She stated two months ago residents in a Resident Council Meeting voiced their concerns about not going on community outings. The Administrator said the facility van could accommodate two residents when there were no appointments and could take residents to where they wanted to go. She stated in order to take residents on group outings they would have to do multiple trips because of the size of the van. She stated the van could accommodate two non-ambulatory residents and one ambulatory resident. The Administrator stated that was the only option except for paying for additional transportation or using personal automobiles. She stated staff go shopping and purchase items and go to the bank for residents when needed. She revealed one resident used the city transit bus once a month to go shopping. 1. Resident #19 was admitted to the facility on 9/28/15, with diagnoses including Quadriplegia, Calculus of kidney, Neuromuscular Dysfunction of bladder, Muscle Weakness, Muscle Wasting and Atrophy and Acute Osteomyelitis. According to Resident #19's Quarterly Minimum Data Set dated 4/19/19, Resident #19's cognition was intact and he required extensive assistance in most areas of activities of daily living.	F 679	Council. The Monthly Activity Calendar was updated for the month of July to reflect the additional activities being provided to meet the interest of Residents #31, #26, #19. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) On 6/26/19 the Nursing Home Administrator provided one on one education to the Activity Director on meeting activity programming needs of the residents, beginning activities on time as scheduled, and documenting resident participation in activities. b) On 6/26/19 the Nursing Home Administrator provided education to the staff members assisting in activities on meeting activity programming needs of the residents, beginning activities on time as scheduled, and documenting resident participation in activities. c) During Resident Council Meeting monthly, the residents will be asked about community outings of interest and be provided an update by the Activity Director or Social Services Director as to how the facility will work to accommodate their requests by using the facility van and contracted transportation services to assist residents to attend community outings. d) During Resident Council Meeting monthly, the residents will be asked if the activities being provided are meeting their interests by the Activity Director or Social Services Director. If the activities are not meeting the interests, the Activity Director	

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F 679	Continued From page 10 Review of Resident #19's Care Plan which was revised on 6/2/19 revealed Resident #19 enjoyed being outdoors, music and rap music. He was safe to go out without supervision. Interventions included listening to music on his play station, visiting his friends outside and going to college off grounds. Review of the Individual Activity Participation Record for Resident #19 from January through June, 2019 are noted as follows: January, 2019- Blank Activity Participation Record No month or year listed-Cards/other games-Refused-1st, 4th, 6th, 11 th, 15 th, 18 th, 20 th, 22 th, 25 th, and 27 th Music-Active-23rd and 27 th TV/Radio/Movies-Active-4th, 18 th and 25 th Parties/Socials/Special events-Active-14 th Nails- Active-5th, 12 th, 19 th and 26 th No month or year listed-Blank Activity Participation Record No month or year listed-Blank Activity Participation Record May, 2019- Exercise/Sports-Active-1st, 3rd, 7th, 9th, 13 th and 15 th TV/Radio/Movies-Active-6th and 13 th Nails-Active-7th and 14 th Bingo-Observed-1st, 3rd, 6th, 8th and 10 th June, 2019-Blank Activity Participation Record During an interview on 6/10/19 at 2:03 PM, Resident #19 revealed he does his own activities in his room. He said the activity room was not open after 5:00 PM and he stated he liked to record music in the activity room. Resident #19 said there were no outings. He stated 1 1/2 years ago outings used to be scheduled on Tuesdays and Thursdays. He revealed he and other facility	F 679	will review activities of interest with Resident Council monthly, to ensure activities are meeting the interests of the residents. The Activity Director will subsequently update the Activity Calendar, as needed, to reflect activities of interest per the Resident Council. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. e) On 6/26/19, the Activity Director or Social Services Director will interview alert and oriented residents to review activities of interest likes and dislikes for residents residing in the facility. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents' activities of interest as well as community outings. f) On 6/26/19, the Activity Director or Social Services Director will conduct a new baseline interview with resident representatives, for residents who are not alert and oriented, to review activities of interest likes and dislikes and if the resident representative would like the resident to participate in community outings. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents' activities of interest as well as community outings. g) Quarterly, the Activity Director or Social Services Director will interview alert	

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F 679	Continued From page 11 residents went from going on outings, to the Social Worker shopping for them and then the facility stopped all outings. He said they also used to go to see Christmas lights and parades as well as have cook outs. During an interview on 6/12/19 at 9:22 AM, the Activity Director stated the last time she took residents on community outings was 2 1/2 years ago. She stated they had been having transportation problems with their own van and had been sharing a van with another facility. She revealed the shared van was used for appointments. The Activity Director stated the facility van had been broken for a month or two and now it was fixed. She stated she had been goggling on the computer in search of activities for Resident #19, such as spades and poker night. She stated she tried to get an idea of what Resident #19 liked to do. She stated her one-on-one with Resident #19 included talking to him about his family and about what happened during the day. During an interview on 6/12/19 at 1:55 PM the Administrator stated the reason Resident #19 could not use the facility transport was because it was used for transporting residents to doctor appointments. She stated they have plans to work with Resident #19 to get him placement home. She said Resident #19 was aware of the facility's plans for him. 2. Resident #26 was originally admitted to the facility on 2/4/16 with diagnoses including Schizophrenia, Anxiety Disorder, Osteoarthritis and Pain in left shoulder. According to the most recent Quarterly Minimum Data Set dated 3/7/19 revealed Resident #26 had cognitively impaired	F 679	and oriented residents to review activities of interest likes and dislikes for residents residing in the facility. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents' activities of interest as well as community outings. h) The Activity Director or Social Services Director will review activities of interest likes and dislikes for newly admitted residents on admission to determine activities of interest and if the newly admitted residents would like to participate in Community outings. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents' activities of interest as well as community outings. i) The Activity Director or Social Services Director will review activities of interest likes and dislikes for newly admitted residents resident representatives, for residents who are not alert and oriented, to determine a baseline of activities of interest and if the resident representative would like the newly admitted residents to participate in Community events. The Activity Director or Minimum Data Set Coordinator will update the residents' care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents'	

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cognition. He required extensive to total dependence in most areas of activities of daily living.

Review of Resident #26's Care Plan dated 2/15/19 revealed he attended activities of choice, liked choirs, dances and large groups. Resident #26 was to participate in movies with dancing in it 1 time a week. The goal was Resident #26 would enjoy activities three times a week over the next 90 days, which was revised on 4/13/19. Interventions included remind and encourage to attend, assist in activities as needed. Provide in room activities as needed and required.

Review of the activity calendar revealed a bingo activity was scheduled on 6/10/19 at 2:00 PM.

During an observation on 6/10/19 at 2:08 PM Resident #26 and other residents were sitting out in the hallway next to the nursing station. There were no residents in the dining room or activity room.
Staff member took Resident #26 in dining room to purchase item from vending machine.

During an observation on 6/10/19 at 2:25 PM, the facility Social Worker and other staff started going from room to room asking residents if they wanted to play bingo.

During an observation on 6/10/19 at 2:35 PM the Social Worker and other staff took residents to the activity room to play bingo.

During an observation on 6/10/19 at 3:15 PM, four residents were in the activity room playing bingo and Resident #26 was not in the activity room.

activities of interest as well as community outings.
3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.
a) The Administrator will audit the Resident Council Meeting Minutes after each Resident Council Meeting for three months to determine any concerns with residents regarding community outings or activity programming. If concerns are noted, the Administrator will request to attend the next Resident Council Meeting to address the concerns.
b) The Administrator will audit the Activity Calendar monthly for three months, then as needed ongoing, to ensure the Activity Calendar includes community outings that meet the residents' interest.
c) The Social Services Director will randomly interview three alert and oriented residents per week for twelve weeks, then as needed, to validate activities being provided are meeting the residents' interest.
d) The Administrator will randomly observe two activities per week for twelve weeks to validate residents are attending activity programming per their individual choice.
e) The Administrator will report audit findings from the Resident Council Meetings, review of the Activity Calendar, resident interviews and activity observations monthly, for three months, to the Quality Assurance Performance Improvement (QAPI) Committee. The

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F 679	Continued From page 13 During an interview on 06/10/19 at 8:08 PM, Resident #26's family member said she had never seen him in the activity room playing bingo. Review of the Individual Activity Participation Record for Resident #26 from January through June, 2019 are noted as follows: January, 2019- Blank Activity Participation Record No month or year listed- 1st-Arts/Crafts-observed, exercise sports-active, bingo-observed 3rd- Arts/crafts-active, bingo-active, 5th-Spiritual/Religious-active, 6th-bingo-observed 7th-Exercise/sports-active, Nails-observed, 8th-Nails-observed, 9th-Exercise/religious-observed, 10 th-bingo-observed, 12 th-Spiritual/religious-active, 13 th-exercise/sports-active, bingo-observed No month or year listed- 17 th- cards/other games/bingo-wanders in & out, 8th-Music-active, Spiritual/religious activities- Active- 7th, 14 th, 1st and 28 th Parties/Socials/Special events- Active-11 th and 12 th Pet visits- Active-30 th, Nails- Active-2nd, 9th, 16 th, 23rd, and 30 th New chat- Wandering in and out- 1st, 3rd, 5th, 9th, 11 th, 15 th, 17 th and 19 th No month or year listed-Blank Activity Participation Record No Activity Participation Record June, 2019- Blank Activity Participation Record During an interview on 6/12/19 at 1:15 PM, the Activity Director stated she still came in and helped with activities, such as charting on the computer. She stated she tried to come in twice a	F 679	QAPI Committee will analyze the data and provide any necessary recommendations to ensure sustained compliance ongoing. 4. Title of person responsible for implementing the acceptable POC. The Administrator will be responsible for the implementation of the acceptable plan on correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.	

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week and every other weekend. She stated random staff carried out activities and volunteers come in during the week. She stated documentation and activity calendars was something the staff did everyday. She stated the staff would write down each activity and list names below and put the information in her notebook. The Activity Director stated one-on-one had a book too. She stated she went to each room and she would document which rooms she went to such as doing nails. The Activity Director stated she had taken Resident #26 to bingo and he would not stay in the room. She stated she had Resident #26 participate in bingo at the table with her while she called out numbers. She stated Resident #26 liked to be out of his room socializing with other residents.

3. Resident #31 was admitted to the facility on 1/10/2019 with diagnoses to include paraplegia, multiple pressure ulcers and hypertension.

Resident #31's admission Minimum Data Set (MDS) assessment date 1/17/2019 revealed his cognition to be intact. He required extensive assistance to total assistance from staff for activities of daily living. His activities preferences were noted to be very important for having reading material, music, pets, news, being in groups, doing favorite activities, going outside when the weather was good and religions services as being very important.

Resident #31's Care Plan for Activities was initiated on 1/21/2019 and had as a Focus: I prefer to go to group activities. Interventions for Activities included: I need encouragement to go

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to activities I enjoy, I need reminder to go to activities I enjoy, and I need someone to take me to the activities I enjoy.

A review of the activity book revealed monthly individual activity participation records as follows:

January 2019 revealed no documentation of any activity for Resident #31 noted on the form.

February 2019 revealed dates of 4/5/2019, 4/12/2019, 4/19/2019 and 4/27/2019 listed as Active Participation for "Nails".

March 2019 revealed no documentation of any activity for Resident #31 noted on the form.

Undated form revealed no documentation of any activity for Resident #31 noted on the form.

May 2019 revealed no documentation of any activity for Resident #31 noted on the form.

June 2019 revealed no documentation of any activity for Resident #31 noted on the form.

On 6/11/2019 at 11:33 AM an interview was conducted with Resident #31, who stated the facility did not have any activities for his age. The resident stated he did have his nails cleaned a few times one month, but he did not realize that was considered an activity. The Resident stated he had called out bingo numbers for the other residents one time, but the facility had not offered him any activities that he felt were something for younger people to do. The resident stated he could not remember if the Activity Director (AD) had talked to him when he was admitted, but he had not had one to one talks with her, and she

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had not offered him anything else to do.

On 6/12/2019 at 9:59 AM, an interview was conducted with Nurse #1 who stated Resident #31 had told her there were only activities for old people and he wanted something to do. The nurse stated she responded for the resident to give the facility some ideas, but she had not yet heard of anything he had thought of to do.

On 6/12/2019 at 9:22 AM, an interview was conducted with the Activity Director (AD) who stated she had resigned her position on 5/13/2019 but came back part time to help with activities and do the charting required. The AD stated Resident #31 was care planned for group activities and she encouraged him to come to group activities. The AD stated she did not do a one to one activity in his room, but she did talk to him in the hallway or out when he was smoking and considered that his one to one, although she had not documented that. The AD stated she had googled some activities to do with the younger residents of the facility and asked another facility for ideas for younger residents, but so far nothing had been done. The AD stated some residents had gone out to a basketball game 3 years ago, but the residents had not been taken out on an outing for 3 years as the facility van was being fixed. The SW stated there was a van available for appointments, but she had not asked if the van was available for outings.

On 6/13/2019 at 11:55 AM, an interview was conducted by the Administrator. The Administrator stated she expected there to be an Activity Calendar posted in the hallway and residents' room monthly. The Administrator stated the facility did their best to announce an

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F 679	Continued From page 17 activity before it started, and she had nursing assistants and other staff to volunteer to run the activity for the residents. The Administrator stated the van available for use by the facility could not accommodate 2 power wheelchairs and Resident #31 could participate in group activities but chose not to and stated he did not want one to one activity and that was in his care plan.	F 679		