STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. BUILDING ______ B. WING ______	C 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F 225 Investigation/Report Allegations/Individuals** A.) A 24 hour initial report for alleged neglect on Resident #154 was submitted to the North Carolina Health Care Personnel Registry by the Executive Director on November 5, 2015. A 5 day investigative report for alleged neglect on Resident #154 was submitted to the North Carolina Health Care Personnel Registry by the Executive Director on November 8, 2013. Resident #154 went to the hospital Emergency Room for further evaluation and treatment on October 20, 2013. Resident #154 no longer resides in the facility. B.) The Vice President of Clinical Services VPCS) re-educated the Executive Director (ED), the Director of Clinical Services (DCS), the Social Services Director (SSD), and the Regional Director of Clinical Services (RDCS) on regulation F 225 and the facility's Policy and Procedure for Abuse and Neglect on November 5th through November 8th, 2013. The Executive Director/Director of Clinical Services/Nurse Manager has re-educated facility staff on abuse and neglect November 5th through November 15th, 2013 and November 19th through November 20th, 2013. The facility Interdisciplinary Team interviewed current inter-viewable residents to determine if there were any additional allegations of abuse and/or neglect that needed to be reported November 4th through November 8th,	

Corrected copy

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gary D. Catlett NHA [signature] TITLE: Executive Director (X6) DATE: 12/6/13

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

Original Signature Date: 11/22/13

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and family interviews the facility failed to report within 24 hours and failed to submit a 5 working day report for an allegation of neglect to the North Carolina Health Care Personnel Registry in 1 of 3 residents reviewed for neglect. (Resident #154). The findings included: Resident #154 was admitted to the facility on 09/26/13 and readmitted to the facility on 10/25/13 with diagnoses that included senile dementia, osteoarthrosis and aortic valve disease. The most recent annual Minimum Data Set dated 10/03/13 indicated Resident #15 had short and long term memory impairment and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #15 required extensive assistance by staff for activities of daily living. Review of bathing documentation for Resident #154 for September and October of 2013 revealed the following documentation of baths: 09/26/13: Resident admission 09/27/13: Resident bed bath 10/04/13: Resident bed bath 10/07/13: Resident bed bath 10/20/13: Resident discharged to hospital with rash to leg and UTI Review of Resident #154's medical record revealed no documentation in nursing notes of any refusals of baths, showers, clothing changes, or other care during the month of October, 2013. Review of the facility's grievance log for October,	F 225	2013. Any further allegations were documented on a 24 hour report to be investigated and followed by a 5 day report to the North Carolina Health Care Personnel Registry by the Executive Director on November 5th through November 15th, 2013 The Executive Director/Nurse Manager interviewed current staff regarding abuse and neglect and no further concerns were voiced on November 3rd through November through November 8th, 2013. Skin sweeps were performed on current residents by a licensed nurse on November 1st through November 7th, 2013 to ensure that there were no suspicious marks or injuries; and none were noted.. Additionally, the Vice President of Clinical Services has reviewed the facility's residents' concerns since October 15, 2013 to determine if any additional concerns need to be reported using a 24 hour report to be followed by a 5 day investigative report to the North Carolina Health Care Personnel Registry for resident abuse and/or neglect on November 21, 2013. One discrepancy was identified and a 24 hour report was filed by the Executive Director on November 21, 2013 to the North Carolina Health Care Personnel Registry-to be followed by an investigative 5 day report by November 28, 2013. C.) The Vice President of Clinical Services (VPCS)/Regional Vice President of Operations (RVPO)/Regional Director of Human Relations (RDHR) will conduct Quality Improvement (QI)	

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F 225	Continued From page 2 2013 revealed a grievance filed on 10/21/13 by Resident #154's family regarding rash and clothing not being changed in days. The resolution recorded was the regional director of clinical services (RDCS) had spoken with family and arranged for a room change on 10/25/13. Review of the concerns form indicated by the admissions director on 10/21/13 that Resident #154's family had called to inform facility department of their report to social services of facility neglect. Review of interdisciplinary progress notes by nurse aide indicated an entry for 10/23/13 that Resident #154's family member had come into the facility and told the nurse aide Resident #154 had been neglected by staff at the facility. Review of interdisciplinary progress notes by admissions director indicated an entry for 10/23/13 that Resident #15's family member had called and reported Resident #154 was neglected at the facility. Review of the grievance documentation indicated by the RDCS on 10/25/13 that Resident #154's family had reported Resident #154 being in the same clothing and not bathed for 3 days. The document further indicated Resident #154's family reported Resident #15 had been admitted to the hospital with issues including severe urinary tract infection, dehydration, and rash and bruises. The document further indicated Resident #154's family reported they had contacted the department of social services to report the lack of care by the facility staff. Interview with family members of Resident #154	F 225	monitoring of regulation F 225 by conducting interviews of inter-viewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the North Carolina Health Care Personnel Registry. QI monitoring will be conducted 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 4 months using a sample size of 5 inter-viewable residents and 5 staff members. Additionally, the VPCS/RVPO/RDHR will review the facility's residents' concerns to ensure that resident concerns are reported to the North Carolina Health Care Personnel Registry, as appropriate, 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 4 months using a sample size of 5 residents' concerns forms. D.) The VPCS/RVPO/RDHR will report results of QI monitoring to the Quality Assurance Performance Improvement (QAPI) Committee monthly for at least 6 months and/or until continued substantial compliance is obtained. E.) Allegation of Compliance Date: 11-22-13.	11/22/13

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on 10/31/13 at 11:57 AM revealed family had reported to RDCS that Resident #154's pillowcase had stayed soiled with food for 8 days, baths were offered to the resident after 10:00 PM when Resident #154 was asleep, and Resident #154 had worn the same orange suit for 3 days and 3 nights without being changed. Family members reported when they visited the facility on 10/20/13, they had found a red rash from Resident #154's thigh to her ankle when they observed Resident #154 scratching at her leg and had reported to the admissions director that Resident #154 had received the injury due to neglect of the facility staff.

Interview with the director of nursing (DON) on 10/31/13 at 11:46 AM revealed if person reporting issues with care indicated neglect, it was to be investigated as an allegation of neglect, including reporting to the state health care personnel registry within 24 hours of the allegation. The DON also reported she would consider care neglectful if a resident had not changed clothing in 24 hours and there was no reason or refusal documented during that time.

Interview with the social worker on 11/01/13 at 2:23 PM revealed he had received reports from Resident #154's family that soiled sheets had not been changed for days. The social worker also stated if a family reported a resident had not had their clothing changed in 3 days or nights, he would consider that an allegation of neglect and would initiate a 24-hour report to the health care personnel registry. The social worker stated he had not been told the specifics of this case.

Interview with the admissions director on 11/01/13 at 2:44 PM revealed when family of

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Resident #154 reported to her that they felt Resident #154 had been neglected, she had immediately reported that allegation to the morning team, which included the department heads and the administrator.

Interview with the regional director of clinical services (RDCS) on 11/01/13 at 3:14 PM agreed the shower data for October showed there were no documented baths or showers for Resident #154 for a 13-day period. The RDCS reported she had been aware of the allegations that Resident #154 had slept in soiled sheets for several days, had not had clothing changed or bathed for several days. The RDCS stated as a result of these allegations she had filled out the paperwork for a grievance. RDCS stated she had not interviewed any of the nurse aides or nurses who had provided care for Resident #154 during the days before the family found the rash. RDCS stated she had not reviewed Resident #154's skin assessment to see how long it had been since Resident #154's skin had been assessed. RDCS stated she had not studied the bathing data for the days prior to the family's report. When asked why the RDCS did not complete these tasks, RDCS stated she had interpreted the family's concerns as a grievance and not as an allegation of neglect and had followed up by discussing the concerns with the family and suggesting a room change.

Interview with the administrator on 11/01/13 at 4:27 PM revealed any allegation of neglect was to be reported to the health care personnel registry within 24 hours and investigated thoroughly. The administrator stated he had interpreted the concerns of Resident #154's family members as a grievance and not as an allegation of neglect.

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 record reviews, family and staff interviews the facility failed to bathe a resident who required assistance with activities of daily living for 1 of 5 residents sampled for activities of daily living. (Resident #154). The findings included: Resident #154 was admitted to the facility on 09/26/13 with diagnoses which included dementia, peripheral neuropathy (nerve damage with weakness, numbness and pain in hands and feet), heart disease and arthritis. Resident #154 was sent to the hospital emergency room on 10/20/13 due to a rash, was re-admitted to the facility on 10/25/13 and was discharged to another facility on 10/31/13. The admission Minimum Data Set (MDS) dated 10/03/13 indicated Resident #154 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #154 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included bathing and dressing, was occasionally incontinent of urine and frequently incontinent of bowel and had no documented behaviors or refusal of care.	F 312	**F 312 ADL Care Provided for Dependent Residents** A.) Resident #154 went to the hospital Emergency Room for further evaluation and treatment on October 20, 2013. Resident #154 suffered no harm. Resident #154 no longer resides in the facility. B.) The Interdisciplinary Team conducted interviews with inter-viewable residents/ residents' Responsible Party to determine residents' preferences with regard to baths/showers on November 20, 2013. From this information gathered, the DCS/Nurse Manager initiated a shower schedule based on residents' preferences November 21, 2013. Showers are being given according to the facility shower schedule by the facility nursing staff daily. Current residents care plans and Kardexes have been updated accordingly by the Minimum Data Set (MDS) Nurse/Nurse Manager to reflect this information on November 20th through November 21st, 2013. New Admissions will be asked about bath/showers upon admission and then the shower schedule and the resident's care plan and Kardex will be updated accordingly by the DCS/Nurse Manager. The DCS/Nurse Manager has re-educated current facility nursing staff on provision of baths/showers for residents requiring assistance with activities	

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F 312	Continued From page 6 A review of a facility document titled "Resident Bathing Type by Day Chart" revealed Resident #154 had a bed bath documented on 09/27/13, 10/4/13 and 10/7/13. There was no documentation of showers from 09/26/13 through 10/20/13 when Resident #154 was transferred to the hospital. The document further revealed Resident #154 returned to the facility on 10/25/13 and had a shower recorded on 10/26/13; 10/27/13 and 10/29/13. There was no documentation of bed baths or showers on 10/28/13; 10/30/13 or 10/31/13. A review of 24 hour communication reports revealed there was no documentation that Resident #154 had refused baths or showers. A review of nurse's notes revealed there was no documentation that Resident #154 had refused baths or showers. A review of care plans for incontinence care dated 10/14/13 indicated approaches to assist Resident #154 with ADL's. A review of nurse's notes dated 10/20/13 at 5:15 PM indicated Resident #154 had a bright red rash from her left ankle up the front of her left leg and a very large red area to the back of her left leg that started at her calf and went up the back of her thigh. The notes revealed Resident #154's right leg did not have the same rash but had several bruises on her right lower leg. The notes further indicated Resident #154 was transported to the hospital. During an interview with family members on 10/31/13 at 11:57 AM they explained at least one	F 312	of daily living on November 7th through November 21st, 2013. C.) The DCS/Nurse Manager will conduct QI monitoring of baths/showers, oral care and residents' finger nails being trimmed and clean 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then 2 x weekly for 4 months using a sample size of 10 residents to ensure Activities of Daily Living are provided for dependent residents. D.) The DCS/Nurse Manager will report results of QI monitoring to the QAPI Committee monthly for at least 6 months and/or until continued substantial compliance is obtained. E.) Allegation of Compliance Date: November 22, 2013	11/22/13

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F 312	Continued From page 7 family member visited with Resident #154 on a daily basis at various times of the day. They further explained they had reported to the administrator and social worker that Resident #154 was not getting baths or showers and they had been told by nursing staff that Resident #154 was sometimes offered a bath after 10:00 PM when the resident was asleep. The stated they had complained that Resident #154 had worn the same orange suit for 3 days and 3 nights without being changed. They further stated they kept complaining but they did not feel their complaints were being addressed. Family members explained when they visited the facility on 10/20/13, they saw a red rash from Resident #154's thigh to her ankle because she was scratching at her leg and they were concerned that Resident #154 had not had a bath or shower for several days so they requested the resident be sent to the hospital emergency room. During an interview on 11/01/13 at 8:35 AM with Nurse Aide (NA) #1 she stated she had been assigned to care for Resident #154 and confirmed the resident required assistance with bathing but sometimes she was agitated and combative during care and they were not able to bathe her. During an interview on 11/01/13 at 8:57 AM Nurse #1 stated it was her expectation that residents should be showered two times a week as scheduled but if they could not shower they should receive a bed bath. She stated if a bath or shower was refused it should be reported to the floor nurse and documented in the medical record. She further stated she was not aware Resident #154 had not received baths or showers.	F 312		

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F 312	Continued From page 8 During an interview on 11/01/13 at 2:45 PM with NA #2 she stated when Resident #154 was first admitted to the facility she could not take a shower because she had eye surgery and could not get her eyes wet. She explained Resident #154 was supposed to get bed baths but confirmed they were not given to Resident #154 because she was agitated and combative when they tried to bathe her. She stated when Resident #154 was combative they left her alone and did not go back to attempt to bathe her. During an interview on 11/01/13 at 3:41 PM the Regional Director of Clinical Services (RDCS) verified she was in charge of nursing staff and provided oversight of nursing services in the facility. She stated it was her expectation for residents who could not shower to have a daily bed bath and it should be documented in the computer system. She further stated it was her expectation for NAs to report to a nurse when a resident refused baths or showers and the nurse should talk with the resident to encourage them to take a bath or shower and refusals of baths or showers should be documented.	F 312		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to prevent a significant medication error by not administering 4 doses of eye drops	F 333	**F 333 Residents Free of Significant Med. Errors** A.) Resident #100's physician was notified along with Resident #100's Responsible party regarding the 4 missed doses of eye drops being administered, as indicated by the lack of documentation on the Medication Administration Record (MAR) on November 20, 2013 by Nurse Manager. Resident #100's physician did not give any new orders at that time. The nurses identified as failing to document the eye drop administration on Resident #100's MAR have been re-educated by the DCS/Nurse Manager regarding medication administration and documentation November 12th through November 21st, 2013. Resident #100 suffered no harm.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 9 for glaucoma as ordered in 1 of 4 sampled residents reviewed for medication errors. (Resident #100). The findings included: Resident #100 was admitted to the facility on 03/07/13 with diagnoses which included heart disease, kidney disease and glaucoma. The most recent quarterly Minimum Data Set (MDS) dated 10/16/13 indicated Resident #100 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #100 required extensive assistance with activities of daily living and had no behaviors for rejection of care. A review of a physician's order dated 03/07/13 indicated Latanoprost (Xalatan) 0.005 percent eye drops to reduce pressure in the eyes related to glaucoma and instill 1 drop in both eyes daily at bedtime. A review of Medication Administration Records (MARs) dated 09/21/13 through 10/31/13 indicated there were no nurses initials in the space for the 9:00 PM dosage of Latanoprost eye drops on 09/29/13, 09/30/13, 10/07/13 and 10/14/13. A further review of the MARs revealed there was no documentation that Resident #100 had refused the medication or explanation regarding why the medication was not given. During an interview on 11/01/13 at 8:57 AM Nurse #1 verified there were no nurse's initials for the Latanoprost eye drops at 9:00 PM on 09/29/13; 09/30/13; 10/07/13 or on 10/14/13 and stated the medications had not been given as	F 333	B.) The DCS/Nurse Manager has re-educated the Licensed Nursing Staff on administering medications and documentation on the Medication Administration Record November 12th through November 21st, 2013. The DCS/Nurse Manager/Pharmacy Nurse/RDCS conducted medication pass observations on current nurses to ensure that they were compliant with medication administration on November 12th through November 21st, 2013. Any discrepancies identified were immediately re-educated upon by the DCS/Nurse Manager/Pharmacy Nurse/RDCS November 12th through November 21st, 2013. C.) The DCS/Nurse Manager/RDCS will conduct QI monitoring of medication administration using medication pass observation. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, and then 1 time weekly for 4 months using a sample of 3 nurses (1 nurse on 7-3, 1 nurse on 3-11 and 1 nurse on 11-7 shifts). D.) The DCS/Nurse Manager will report results of QI monitoring to the QAPI Committee monthly for at least 6 months and/or until continued substantial compliance is obtained. E.) Allegation of Compliance Date: November 22, 2013	11/22/13

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F 333	Continued From page 10 ordered and it was a medication error. She also verified there was no documentation on the MAR with a reason the medication was not given so she could not explain why the eye drops were missed. During an interview on 11/01/13 at 3:30 PM Nurse #2 stated she gave medications to Resident #100 on the 3:00 PM to 11:00 PM shift and verified the 9:00 PM doses of Latanoprost that were not initialed had not been given. She stated she thought the eye drops had been overlooked but there should have been a reason documented for the missed doses. During an interview on 11/01/13 at 3:41 PM the Regional Director of Clinical Services (RDCS) verified Resident #100 missed doses of Latanoprost eye drops on 09/29/13; 09/30/13; 10/07/13 and 10/14/13 and the missed doses were medication errors. She explained if the resident refused the medication or it was not given for some other reason the nurse should have initialed it, put a circle around her initials and documented the reason the eye drops were not given on the back of the MAR. She stated it was her expectation for nurses to look at the MARs each day to make sure they didn't miss doses or miss giving medications prior to the end of their shift and she expected nurses to initial medications after they gave the resident their medications.	F 333		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520	**F 520 Committee-Members/Meet Quarterly/Plans** A.) Resident #154 went to the hospital Emergency Room on October 20, 2013 for further evaluation and treatment. Resident #154 suffered no harm. Resident #154 no longer resides in the facility.	

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	345433	A. BUILDING ______ B. WING ______	C 11/01/2013

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F 520	Continued From page 11 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to include a resident who missed baths or showers while monitoring activities of daily living as part of the facilities quality assurance process for 1 of 5 residents sampled for activities of daily living. (Resident #154). The findings included: Resident #154 was admitted to the facility on 09/26/13 with diagnoses which included dementia, peripheral neuropathy (nerve damage with weakness, numbness and pain in hands and feet), heart disease and arthritis. Resident #154	F 520	B.) The ED/DCS/RDCS have been re-educated on the regulation F 520 and the Facility's Policy and Procedure for Quality Assurance and Performance Improvement by the VPCS on November 20, 2013. The VPCS/ED has re-educated the Interdisciplinary Team members on regulation F520 and the Facility's Policy and Procedure for Quality Assurance Performance Improvement on November 20th and November 21st, 2013. The Interdisciplinary Team Members conducted interviews with inter-viewable residents/ residents' Responsible Party to determine residents' preferences with regard to baths/showers on November 20' 2013. From this information gathered, the DCS/Nurse Manager initiated a shower schedule based on residents' preferences November 21, 2013. Showers are being given according to the facility shower schedule by the facility nursing staff daily. Current residents care plans and Kardexes have been updated accordingly by the Minimum Data Set (MDS) Nurse/Nurse Manager to reflect this information on November 20th and November 21st, 2013. The DCS/Nurse Manager has re-educated current facility nursing staff on provision of baths/showers for residents requiring assistance with activities of daily living November 7th through November 21st, 2013. New Admissions will	

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F 520	Continued From page 12 was sent to the hospital emergency room on 10/20/13 due to a rash, was re-admitted to the facility on 10/25/13 and was discharged to another facility on 10/31/13. The admission Minimum Data Set (MDS) dated 10/03/13 indicated Resident #154 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #154 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included bathing and dressing, was occasionally incontinent of urine and frequently incontinent of bowel and had no documented behaviors or refusal of care. A review of a facility document titled "Resident Bathing Type by Day Chart" revealed Resident #154 did not receive a bed bath or shower on the following days: 09/28/13; 09/29/13; 09/30/13; 10/01/13; 10/02/13; 10/03/13; 10/05/13; 10/06/13; 10/08/13; 10/09/13; 10/10/13; 10/11/13; 10/12/13; 10/13/13; 10/15/13; 10/16/13; 10/17/13; 10/18/13; 10/19/13; 10/20/13; 10/28/13; 10/30/13 or on 10/31/13. A review of quality assurance (QA) monitoring tools dated 09/13/13 revealed quality improvement monitoring was to include inspection of residents' fingernails to ensure that they were clean and cut per resident preferences as well as asking residents if their wishes had been honored regarding shower preferences. The plan indicated the results of the quality improvement monitoring would be reported to the Quality Assurance Performance Improvement committee for 6 months and/or until substantial compliance was achieved. A review of audit tools dated 10/05/13 indicated there were no residents	F 520	be asked about bath/showers upon admission and then the shower schedule and the resident's care plan and Kardex will be updated accordingly by the DCS/Nurse Manager. C.) The DCS/Nurse Manager will conduct QI monitoring of showers to ensure that they are given per the facility shower schedule 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then 2 x weekly for 4 months using a sample size of 10 residents. The RVPO will conduct QI monitoring of the facility's QAPI process by attending, to ensure that issues identified are handled appropriately using an action plan. The RVPO will attend QAPI 1 x monthly for 3 months. D.) The DCS/Nurse Manager will report results to the QAPI Committee monthly x 6 months for continued substantial compliance and/or revision. The RVPO will report results of QI monitoring to the QAPI Committee monthly for at least 3 months and/or until continued substantial compliance is obtained. E.) Allegation of Compliance Date: November 22, 2013	11/22/13

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F 520	Continued From page 13	F 520		

listed as being audited; on 10/07/13 and 10/0813 there was incomplete documentation as to whether oral care was provided or specific interventions needed and on 10/09/13 there were 2 residents listed that interventions were needed but there was no indication the interventions were completed or if there was follow-up. A second QA plan dated 10/14/13 indicated monitoring of resident's mouth care and the results of the audits would be reported to the QA committee for 6 months and/or until substantial compliance was obtained. There was no documentation regarding plans to address residents who missed baths or showers.

During an interview on 11/01/13 at 2:43 PM the Administrator stated he coordinated the QA committee meetings and verified the QA committee had met monthly and the last meeting was held on 10/23/13. He explained the committee reviewed audits for activities of daily living that included whether nail care and mouth care had been provided to residents and if resident's shower preferences were honored but they had not discussed monitoring of whether residents had missed baths or showers. He stated if residents had not received baths or showers this information should have been added with QA audits related to activities of daily living for residents. He stated any staff could send concerns to the QA committee and it was his expectation for staff to monitor residents related to their activities of daily living and report any concerns to their supervisor so the issues could be included within the QA process.

During an interview on 11/01/13 at 4:34 PM the Regional Director of Clinical Services confirmed there was no QA monitoring for Resident #154's

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F 520	Continued From page 14 missed baths or showers. She explained the audit tools that were used to monitor compliance for activities of daily living related to mouth care, nail care and resident shower preferences and acknowledged there were areas where additional documentation was needed regarding interventions or actions that had been taken. She stated it was her expectation for staff to monitor residents for activities of daily living and she expected staff to report concerns related to residents' ADLs so that these could be added to the audit tools to ensure resident's ADL needs were met.	F 520		