STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to notify a resident's responsible party (RP) of refusals of medication	F 157	Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of	7/18/14

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

Electronically Signed | 07/16/2014

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F 157	Continued From page 1 and changes in dosage of psychotropic medication for 1 of 1 resident reviewed for notification of family. (Resident #76). The findings included: Resident #76 was admitted to the facility 03/15/14 with diagnoses which included anxiety, psychosis, and delirium. An admission Minimum Data Set (MDS) dated 03/21/14 indicated the resident's cognition was severely impaired. The MDS specified the resident exhibited behaviors of rummaging and confusion 1 to 3 days during this assessment period. The MDS coded Resident #76 as requiring extensive to limited assistance of staff for activities of daily living. A care plan initiated 04/09/14 specified Resident #76 was adjusting to new surrounding and required help getting comfortable in the facility. The resident was described packing her belongings and her roommates believing she would be returning home. The care plan goal was for the resident to be comfortable in the facility. Interventions included assisting the resident to maintain her preferences in daily living. a. A review of Resident #76's Medication Administration Record (MAR) dated 06/01/14 through 06/30/14 revealed 2 medications to decrease memory loss were ordered by the physician to be administered at bedtime. Further MAR review revealed the resident had refused to take these medications on 06/09/14 and 06/10/14. A review of Resident #76's medical record revealed no documentation of notification of the RP regarding the refusals.	F 157	the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident # 76's family was notified of the medication change and refusals of psychotropic meds during the survey on 6/19/14. 2. Physician orders/progress notes will be reviewed Monday through Friday by Interdisciplinary team members to assure resident's responsible party has been notified with 24 hrs of any changes regarding order changes and or refusals of psychotropic medications. 3. Nurses will be educated by the DNS or designee to notify resident's responsible party within 24 hrs of any medication changes and or refusal of psychotropic medications. DNS or designee will monitor IDT findings regarding notification of resident's responsible party within 24 hrs of any medication changes and or refusal of psychotropic medications daily for one month then weekly for two month. 4. Findings of audits will be presented to the QAPI meetings by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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An interview was conducted with Resident #76's RP on 06/16/14 at 3:58 PM. The RP stated she was informed by Nurse #5 on 06/13/14 that the resident had refused her bedtime medications for 3 nights. The RP stated she wanted to be notified when this happened. The RP added she could talk the resident into taking the medications because the resident trusted her. The RP further explained Resident #76 had been very confused and these medications were important and she felt they helped the resident with her memory.

An interview was conducted with the Director of Nursing (DON) on 06/18/14 at 11:28 AM. The DON confirmed Resident #76 had refused the bedtime medications on 06/09/14 and 06/10/14 and had received the medications on 06/11/14. The DON stated she was unable to find any documentation indicating the RP had been notified of these refusals. She stated Resident #76's RP was in the building daily and sometimes twice a day. The DON added she expected Resident #76's RP be notified of medication refusals. The DON explained the RP might have been able to get the resident to take the medications.

A interview via phone was conducted with Nurse #5 on 06/19/14 at 1:54 PM. Nurse #5 stated Resident #76 missed 2 doses of her bedtime medications. He stated he notified the RP after the second missed day. Nurse #5 added he did not think to notify the RP before then.

b. A review of Resident #76's medical record revealed a progress note written by a Psychiatric Mental Health Nurse Practitioner (PMHNP) on 03/19/14. The PMHNP evaluated Resident #76 on this date. The note specified Resident #76

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currently received the medication seroquel which was likely started during the resident's hospital stay prior to admission to the facility. The note further indicated through staff reports, the family believed Resident #76 had become increasingly confused since initiation of the seroquel. Continued medical record review revealed the PMHNP wrote an order for the seroquel to be discontinued on 03/19/14.

Additional medical record review revealed a physician's order dated 06/12/14 for seroquel 25 milligrams (mg) to be administered at bedtime. Further medical record review revealed a physician's order dated 06/16/14 to increase the seroquel to 50 mg at bedtime. No documentation could be found regarding notification of the RP that the seroquel had been restarted on 06/12/14 and the dose increased on 06/16/14.

An interview was conducted with Nurse #6 on 06/19/14 at 4:15 PM. Nurse #6 stated she did transcribe the order for the initiation of seroquel on 06/12/14. She explained she did not notify the RP because Resident #76 was not her resident at that time. Nurse #6 stated she also transcribed the order on 06/16/14 for the increase of the dosage of seroquel. She added Resident #76 was her resident on the 16th, but she did not notify the RP of the dose increase.

An interview was conducted with the Director of Nursing (DON) on 06/19/14 at 4:20 PM. The DON instructed Nurse #6 to notify the RP of the seroquel initiation and present dose. She stated she expected nurses to notify all residents' guardians or family contacts of medication changes when they occur.

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F 225	Continued From page 4	F 225		
F 225 SS=E	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		7/18/14

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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, facility failed to submit a 24 hour report or a 5-day report to the North Carolina Health Care Personnel Registry and to investigate allegations of abuse for 3 of 4 residents (Resident #19, #25, and #67) reviewed with allegations of abuse. The findings included: 1. Resident #19 was admitted to the facility on 09/16/10 with diagnosis including chronic heart failure, chronic airway obstruction, and generalized pain. The most recent quarterly Minimum Data Set (MDS) dated 5/08/14 assessed Resident #19 as moderately cognitively impaired, able to understand others and able to be understood. Review of Grievance form submitted by Nurse Aide (NA) #3 on 12/12/13 revealed Resident #19 had reported to NA #3 on morning of 12/12/13 that another Nurse Aide had come in to Resident #19's room earlier that morning, was "jerking her around and being rough with her". The grievance form also revealed Resident #19 had reported to NA #3 that the NA was also ignoring her requests for assistance getting toothpaste. The grievance form revealed the nature of resolution was to remove that staff member from assignment with Resident #19. Interview with the current director of nursing (DON) on 06/18/14 at 3:47 PM revealed she had been unaware of the grievance filed by Resident	F 225	1. Resident # 19 was interviewed, continues to feel safe in facility, allegation was investigated and was reported to state, and staff member who was named in the grievance is no longer employed with the company. #25-Resident was interviewed by ADNS about alleged allegation. Resident feels safe in the facility at present, allegation was investigated and was reported to state. Employee has completed customer service training. #67- Resident was interviewed. Resident stated that he feels safe in the facility. Allegation was investigated and was reported to state. Employee that was involved with the alleged allegation is no longer employed with the company. 2. The Executive Director or designee will conduct resident interviews with those residents capable of an interview, regarding the resident's rights to be free of abuse to insure that all allegations are known, investigated, and reported. 3. ED and DNS educated regarding their responsibilities for reporting and investigating allegations of abuse or neglect in North Carolina. Allegations and investigations of abuse will be discussed in the morning stand up. Executive Director or designee will bring	

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F 225	Continued From page 6 #19 on 12/12/13. After reviewing the grievance form, the files of 24-hour reports that were sent to the North Carolina Health Care Personnel Registry (NCHCPR) and seeing none regarding this allegation, and reviewing the abuse investigation log for the previous year and seeing no abuse investigation related to this allegation, the DON stated the allegation had not been handled correctly. The DON stated her expectation was if an allegation was received by a resident that described an NA "jerking" or "being rough", a 24-hour report would be submitted to the NCHCPR and a complete abuse investigation initiated. Review of the NCHCPR records sent from the facility revealed no 24-hour report or 5-day report was sent regarding this allegation made by Resident #19. Further review of the facility's abuse investigation logs and investigations revealed no abuse investigation documented as completed. Interview with the Administrator on 06/20/14 at 10:45 AM revealed his understanding that Resident #19 had made an allegation of possible physical abuse on 12/12/13, and staff had not filed a 24-hour report to the NCHCPR, nor had staff completed a thorough abuse investigation regarding this allegation. The administrator said his expectation was that any allegation of abuse by a resident was to be submitted to the North Carolina Healthcare Registry within 24 hours and thoroughly investigated by facility staff 2. Resident #25 was admitted to the facility on 10/04/13 with diagnosis including diabetes, hypertension, peripheral vascular disease, and paralysis. The most recent quarterly Minimum	F 225	completed abuse and investigation reports to the meeting to ensure accurate completion. Social Services Director will monitor the completion of investigations daily as allegations arise until the investigations are completed on an ongoing basis. 4. Allegations of abuse will be protected by HIPPA. The number and type of reported allegations will be presented to the QAPI for review and compliance verification monthly for 3 months then ongoing as needed to ensure compliance.	

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Data Set (MDS) dated 03/31/14 assessed Resident #25 as cognitively intact, able to understand others and able to be understood.

Review of Grievance Form submitted by Assistant Director of Nursing Services (ADNS) on 02/18/14 revealed Resident #25 had reported to the ADNS that on the morning of 02/16/14, Nurse #7 had come into his room, "grabbed and jerked him around, making his shoulder hurt worse." The grievance form also revealed Resident #25 had reported to the ADNS that Nurse #7 had "jammed a pillow by his side 'to make me sit up straight'." The grievance form revealed the action plan was that Resident #25 had requested the Nurse #7 not work with him anymore, and that Nurse #7 was given training in customer service.

Interview with Social Worker on 06/18/14 at 3:30 PM revealed the previous director of nursing (PDON) had completed the grievance investigation regarding Resident #25's allegation on 02/18/14. After reviewing the grievance form, the SW stated the allegation met the definition of abuse allegation and should have been reported to the North Carolina Health Care Personnel Registry within 24 hours and fully investigated. The SW stated when receiving grievance forms, she is to pass the grievance on to the director of nursing if the grievance involves a nurse or nursing issue, and the DON made the decisions regarding the investigation.

Interview with the current director of nursing (DON) on 06/18/14 at 3:47 PM revealed she was unaware of the grievance filed by Resident #25 on 02/18/14. The DON stated her expectation was if any allegation was received by a resident that described a nurse "grabbing and jerking" a

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resident, a 24-hour report would be submitted to the NCHCPR and a complete abuse investigation initiated. After reviewing the grievance form, the files of 24-hour reports that were sent to the North Carolina Health Care Personnel Registry (NCHCPR) and seeing none regarding this allegation, and reviewing the abuse investigation log for the previous year and seeing no abuse investigation related to this allegation, the DON stated the allegation had not been handled correctly.

Interview with Resident #25 on 06/19/14 at 3:58 PM revealed he remembered the incident with Nurse #7 that had occurred in February. Resident #25 described the incident and said Nurse #7 had entered his room, grabbed him and jerked his arm around. Resident #25 stated the actions taken by Nurse #7 had caused him a lot of pain and Nurse #7 had been temporarily moved from his hall because of it. Resident #25 stated he had not been interviewed after filing the grievance except to be told Nurse #7 was being reassigned.

Review of the NCHCPR records sent from the facility revealed no 24-hour report or 5-day report was sent regarding this allegation made by Resident #25. Further review of the facility's abuse investigation logs and investigations revealed no abuse investigation documented as completed.

Interview with the Administrator on 06/20/14 at 10:45 AM revealed his understanding that Resident #25 had made an allegation of possible physical abuse on 02/18/14, and staff had not filed a 24-hour report to the NCHCPR, nor had staff completed a thorough abuse investigation

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regarding this allegation. The administrator said his expectation was that any allegation of abuse by a resident was to be submitted to the North Carolina Healthcare Registry within 24 hours and thoroughly investigated by facility staff.

3. Resident #67 was admitted to the facility on 07/26/14 with diagnosis including atrial fibrillation, congestive heart failure, hypertension, and diabetes. The most recent quarterly Minimum Data Set (MDS) dated 04/23/14 assessed Resident #67 as cognitively intact, able to make decisions of daily care.

Interview with Resident #67 on 06/17/14 at 9:22 AM revealed in the beginning of this year, either January or February, he was punched in the arm by Nurse #1, causing a bruise. Resident #67 said he had reported the incident to the administrator at the time of the incident. Resident #67 stated he had not been interviewed about reporting the incident to the director of nursing (DON) except to be told Nurse #1 would no longer be working with him.

Interview with the director of nursing (DON) on 06/18/14 at 9:03 AM revealed she had spoken to Nurse #1 who confirmed the incident had occurred. The DON stated the incident may have occurred around October 26, 2013 because that was when Nurse #1's assignment had been changed to another hall from the hall on which Resident #67 lived.

Interview with Social Worker on 06/18/14 at 3:30 PM revealed the previous director of nursing (PDON) would have completed the grievance investigation regarding Resident #67's allegation in October of 2013. The SW stated when

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F 225	Continued From page 10 receiving grievance forms, she is to pass the grievance on to the director of nursing if the grievance involves a nurse or nursing issue. Interview with the current director of nursing (DON) on 06/18/14 at 3:47 PM revealed she was unaware of the grievance filed by Resident #67 in October of 2013 but that Nurse #1 was still employed at the facility and had confirmed the grievance had been filed. The DON stated her expectation was if any allegation was received by a resident that described a nurse "punching" a resident, a 24-hour report would be submitted to the North Carolina Health Care Personnel Registry (NCHCPR) and a complete abuse investigation initiated. Review of the NCHCPR records sent from the facility revealed no 24-hour report or 5-day report was sent regarding this allegation made by Resident #67. Further review of the facility's abuse investigation logs and investigations revealed no abuse investigation had been completed regarding this allegation. Interview with the Administrator on 06/20/14 at 10:45 AM revealed his understanding that Resident #67 had made an allegation of possible physical abuse during the past year, and staff had not filed a 24-hour report to the NCHCPR, nor had staff completed a thorough abuse investigation regarding this allegation. The administrator said his expectation was that any allegation of abuse by a resident was to be submitted to the North Carolina Healthcare Registry within 24 hours and thoroughly investigated by facility staff.	F 225		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		7/18/14

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F 242 SS=D	Continued From page 11 MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide residents with choices of significant aspects of life for three of three residents reviewed for choices regarding time to get up, time to go to bed, frequency of showers, and type of bath/shower (residents #26, #39, and #16). The findings included: 1. Resident #26 was admitted to the facility on 03/17/13 with diagnoses which included dementia, chronic pain, acute renal failure, and hypertension. The most recent quarterly Minimum Data Set (MDS), dated 04/23/14, indicated the resident was moderately cognitively impaired, is usually able to understand and is usually understood. Interview with Resident #26 on 06/17/14 at 10:01 AM revealed Resident #26 was told by staff when to get up in the morning, when to go to bed at night, how many showers she would be assisted with each week, and that she would get showers and not tub baths. Resident #26 stated each morning, staff came into her room and told her to	F 242	1. Resident's #16 interviewed by SW. Per resident preference showers have been set a two x per week in the am. Resident #26 was interviewed by SW. Resident has requested a tub bath on Saturday night and a shower once per week. Resident #26□s stated preference is to be asked daily when she want to rise and go to bed. Staff was instructed to ask resident daily.. Resident #39 was interviewed by SW. Resident requested showers 3 times per week and the schedule has been adjusted accordingly. The care plans and card were updated with the preferences of residents #16, #26, and #39. 2. The Social Services Director conducted interviews with residents and or RPs, as appropriate to ensure residents understand that they have a choice regarding their showers or baths and preference for get up and go to bed times. Included in the interview was the time of day and day preference for their showers, shower or bath and how many	

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F 242	Continued From page 12 get up about 5:00 or 5:30 each morning. Resident #26 stated staff also came into her room each night at 7:00 or 7:30 and told her it was time to go to bed and proceeded to put her into bed. Resident #26 stated she had never been asked what time she wanted to get up in the morning or what time she wanted to go to bed at night. Resident #26 stated she believed she had never had a choice in the matter. When asked what time she would like to get up in the morning and go to bed at night, Resident #26 stated she might choose a different time each day, but wanted to be asked by staff what she wanted and not told what to do. Resident #26 said she felt it was disrespectful the way staff told her when to get up and when to go to bed and she felt they were treating her as you would a child. During the same interview, Resident #26 stated her whole life she had taken one bath per week on Saturday nights. Resident #26 stated she still believed she needed one good bath each week, and preferred them on Saturday evenings. Resident #26 also stated she loved to take a tub bath, and that is what she had always taken when she lived at home. She said she had always been told there was a rule that she had to take 2 showers each week, and she had never been offered a tub bath. Review of the West Hall Shower book, kept at the west hall nurse's station, Resident #26's room was scheduled for showers on Thursdays and Sundays. Review of the facility dining schedule sheet revealed Resident #26 was schedule to eat all meals in the assisted dining room. Interview with the Speech Language Pathologist	F 242	per week. Care plans updated to reflected resident preferences. 3. Staff were educated on resident rights and their rights to make choices concerning their activities of daily living including that all residents always have a choice and have the right to change choices and preferences at anytime. The shower/bath schedule was revised to allow resident choices. To ensure new residents are given the choice of how many and time of day for their showers they will be interviewed by activities or the manager on duty. All residents shower/bath and get up/ go to bed preferences will be reviewed by Activity Director or designee quarterly. Their choices will be given to the ADNS or designee for updates to the shower schedule. A shower audit will be conducted randomly with 8 residents weekly for 1 month then 4 residents weekly for 2 months by the social services director or designee to ensure residents preferences are being honored. 4. Findings of this audit will be presented to the QAPI 3 months meeting by the Social Services Director or designee for compliance verification then ongoing as needed to ensure compliance.	

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(SLP) on 06/18/14 at 6:16 AM she had not referred Resident #26 to eating in the assisted dining room and did not feel she required that level of eating assistance. The SLP said she knew Resident #26 did not like to get up in the mornings and get out of bed, and she had been told Resident #26 had been scheduled to eat in the assisted dining room to get her up and going in the mornings.

Interview with Nurse Aide (NA) #5 on 06/18/14 at 7:16 AM revealed they have a list of residents to get up first in the morning, based on their dining room assignment. NA #5 said all residents who ate in the assisted dining room were gotten up during 3rd shift. NA #5 stated most of the residents who were gotten up early, during 3rd shift, and ate breakfast in the assisted dining room, were then returned to their beds after breakfast. NA #5 stated the residents in assisted dining room all looked sleepy during and after breakfast because they ' d all been awake since around 4:30 or 5:00 in the morning. NA #5 stated she had been told they had to get at least a certain number of residents up during 3rd shift to alleviate the work on 1st shift. NA #5 stated if one resident vehemently refused to get up when scheduled, she had been told she had to get another resident up to take their place on the early get up list for that morning. NA #5 stated all residents got 2 showers each week, based on the posted shower schedule for the hall. NA #5 stated she wasn ' t aware of any resident taking or being offered tub baths and she had never known a resident in the facility to get a tub bath. NA #5 stated she reminded residents frequently of their room's scheduled shower days.

Interview with Nurse #8 on 06/18/14 at 3:26 PM

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revealed each resident was assigned 2 showers per week based on their room number. Nurse #8 stated if a resident asked for an extra shower, her expectation was that nurse aides would try to work that shower in after getting their daily scheduled showers completed. Nurse #8 stated residents were not asked when they wanted to take showers but were told about the shower schedule, designed around their room numbers and staffing capabilities.

Interview NA #6 on 06/19/14 at 11:02 AM revealed all residents get 2 showers per week based on the shower schedule, which is set up according to each resident's room number. NA #6 stated she frequently reminded residents of their set shower days when they asked about getting showers. Regarding the ability of residents to take tub baths, NA #6 stated there is a tub in the facility and residents were asked by someone when they were first admitted to the facility, and after that, they are put on the schedule to receive 2 showers each week. NA #6 stated she was not aware of any residents in the facility who were offered tub baths.

Interview with NA #7 on 06/19/14 at 11:22 AM revealed showers were scheduled so that each resident was assigned 2 showers each week. NA #7 stated a resident could get an additional shower if they had vomited or been sick and if staff had time. NA #7 stated that residents sometimes asked for more showers, and she would reassure them that they were still clean, and remind them of when their next shower was scheduled. NA #7 stated that residents were awakened in the morning according to a "get up list" that was at the nurse's station. NA #7 stated she understood the list was made according to

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where residents ate breakfast and how many residents needed to be awakened on each shift to make sure nurse aides had enough time to get all residents up and cared for. NA #7 stated she had worked in the evening frequently and nurse aides routinely began to put residents to bed shortly after dinner because they looked tired. NA #7 stated she did not ask residents what time they wanted to get up or go to bed because they needed to be encouraged to get up for breakfast and go to bed early to get enough rest.

Interview with the Assistant Director of Nursing (ADON) on 06/19/14 at 11:31 AM revealed a facility shower schedule had been developed to allow each resident to receive 2 showers weekly, based on their room number. The ADON stated this schedule was developed so that shower loads would be evenly distributed between first and second shift. The ADON stated if a resident or family requested an extra shower, the staff would do their best to accommodate the request. The ADON said she did not assess resident preferences for daily routines. The ADON stated the nurses were available to the residents and families if they wanted to make a special request regarding time to get up, go to bed, extra or fewer showers, or tub baths.

Follow up interview with Resident #26 on 06/19/14 at 11:33 AM revealed she still felt strongly she would like to be asked about her preferences regarding times to get up and go to bed, how often to be assisted with bathing, and what type of bath/shower to get. Resident #26 stated the way staff told her what to do made her feel like she was dumb and she wasn't dumb.

Interview with the MDS Coordinator on 06/19/14

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at 1:12 PM revealed residents were assessed upon admission regarding how important it was for them to make choices about significant aspects of life, but they were not assessed regarding their personal choices.

Interview with Nurse #4 on 06/19/14 at 1:31 PM revealed residents were each given 2 showers weekly based on their room number. Nurse #4 stated if resident spoke up with preferences, staff were to try to meet their needs but would assist them in getting at least their 2 scheduled showers per week. Nurse #4 stated residents had to be gotten up in time to provide care to them all before their scheduled breakfast time in the morning. Nurse #4 stated staff also encouraged residents to go to bed early in the evening to allow each resident to get plenty of rest.

Interview with social worker (SW) on 06/19/14 at 4:51 PM revealed she had a form to assess resident preferences upon admission, but she documented by exception. The SW explained that meant she routinely asked residents about their previous routines and preferences, described the facility ' s schedules, and if the resident or family expressed specific requests for exceptions in the facility schedule, she would document those requests and pass on to other staff. The SW stated she did not specifically ask residents to tell her their preferences regarding times to get up, go to bed, shower frequency, or type of bath/shower preferred unless the resident voiced concerns about the given schedules.

2. Resident #39 was admitted to the facility on 12/23/11 with diagnoses which included chronic kidney disease, chronic pain, and paralysis. The most recent quarterly Minimum Data Set (MDS),

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dated 05/30/14, indicated the resident was moderately cognitively impaired, was usually able to understand and was usually understood.

Interview with Resident #39 on 06/17/14 at 10:01 AM revealed Resident #39 had taken at least 2 showers a day before he moved into the facility. Resident #39 stated he had always been a frequent shower taker, and had always enjoyed feeling cleaned and refreshed each day. Resident #39 stated he had been told in the facility, he could only get 2 showers each week and no one had ever asked him if he'd like more or when he wanted them. Resident #39 stated he understood having daily showers in a facility might take up too much time, but he would want to be asked about his shower choices, and would like a shower at least 3 times weekly.

Review of the West Hall Shower book, kept at the west hall nurse's station, Resident #39's room was scheduled for showers on Wednesdays and Sundays.

Interview with Nurse Aide (NA) #5 on 06/18/14 at 7:16 AM revealed all residents got 2 showers each week, based on the posted shower schedule for the hall. NA #5 stated she reminded residents frequently of their room's scheduled shower days.

Interview with Nurse #8 on 06/18/14 at 3:26 PM revealed each resident was assigned 2 showers per week based on their room number. Nurse #8 stated if a resident asked for an extra shower, her expectation was that nurse aides would try to work that shower in after getting their daily scheduled showers completed. Nurse #8 stated residents were not asked when they wanted to

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take showers but were told about the shower schedule, designed around their room numbers and staffing capabilities.

Interview NA #6 on 06/19/14 at 11:02 AM revealed all residents get 2 showers per week based on the shower schedule, which is set up according to each resident ' s room number. NA #6 stated she frequently reminded residents of their set shower days when they asked about getting showers.

Interview with NA #7 on 06/19/14 at 11:22 AM revealed showers were scheduled so that each resident was assigned 2 showers each week. NA #7 stated a resident could get an additional shower if they had vomited or been sick and if staff had time. NA #7 stated that residents sometimes asked for more showers, and she would reassure them that they were still clean, and remind them of when their next shower was scheduled.

Interview with the Assistant Director of Nursing (ADON) on 06/19/14 at 11:31 AM revealed a facility shower schedule had been developed to allow each resident to receive 2 showers weekly, based on their room number. The ADON stated this schedule was developed so that shower loads would be evenly distributed between first and second shift. The ADON stated if a resident or family requested an extra shower, the staff would do their best to accommodate the request. The ADON said she did not assess resident preferences for daily routines. The ADON stated the nurses were available to the residents and families if they wanted to make a special request regarding extra or fewer showers.

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Follow up interview with Resident #39 on 06/19/14 at 11:40 AM revealed he still felt strongly about wanting more frequent showers in the facility. Resident #39 stated when he had asked staff for additional showers, they had told him they didn ' t have time. Resident #39 stated there were weeks the staff didn ' t have time to give him 2 showers per week and waiting days for a shower left him feeling greasy and uncomfortable. Resident #39 stated he liked to go to bed clean, and now he feels dirty and sweaty a lot of the time. Resident #39 stated he had never been asked how many showers he would like, but had been told the schedule was for him to have 2 showers per week.

Interview with Nurse #4 on 06/19/14 at 1:31 PM revealed residents were each given 2 showers weekly based on their room number. Nurse #4 stated if resident spoke up with preferences, staff were to try to meet their needs but would assist them in getting at least their 2 scheduled showers per week.

Interview with social worker (SW) on 06/19/14 at 4:51 PM revealed she had a form to assess resident preferences upon admission, but she documented by exception. The SW explained that meant she routinely asked residents about their previous routines and preferences, described the facility's schedules, and if the resident or family expressed specific requests for exceptions in the facility schedule, she would document those requests and pass on to other staff. The SW stated she did not specifically ask residents to tell her their preferences regarding shower frequency preferred unless the resident voiced concerns about the given schedules.

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3. Resident #16 was admitted to the facility on 04/12/13 with diagnoses which included end stage renal disease, chronic respiratory failure, chronic heart failure, and hypertension. The most recent quarterly Minimum Data Set (MDS), dated 05/07/14, indicated the resident was cognitively intact, is able to understand and is understood.

Interview with Resident #16 on 06/16/14 at 11:06 AM revealed Resident #16 did not get to choose how often she got a bath or shower. Resident #16 stated she had been told repeatedly by staff she only got showers on Mondays and Fridays. Resident #16 stated there were many times she did not want a shower at the moment staff came to get her for her shower but once she told them she wasn ' t ready they would leave and not come back to offer her an alternative time. Resident #16 stated she would prefer to get about 3 showers each week, but at times she wasn't doing something else. Resident #16 stated at home she took a shower every morning or at least every other morning, and in the facility, she missed showers frequently and said she felt uncomfortable and unclean because of it. Resident #16 stated she would really like to choose how often and when she got to take showers but had been told in the facility she could only have them on Mondays and Fridays when the staff were ready to assist her.

Review of the West Hall Shower book, kept at the west hall nurse's station, Resident #16's room was scheduled for showers on Mondays and Fridays.

Interview with Nurse Aide (NA) #5 on 06/18/14 at 7:16 AM revealed all residents got 2 showers each week, based on the posted shower

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schedule for the hall. NA #5 stated she reminded residents frequently of their room's scheduled shower days.

Interview with Nurse #8 on 06/18/14 at 3:26 PM revealed each resident was assigned 2 showers per week based on their room number. Nurse #8 stated if a resident asked for an extra shower, her expectation was that nurse aides would try to work that shower in after getting their daily scheduled showers completed. Nurse #8 stated residents were not asked when they wanted to take showers but were told about the shower schedule, designed around their room numbers and staffing capabilities.

Interview NA #6 on 06/19/14 at 11:02 AM revealed all residents get 2 showers per week based on the shower schedule, which is set up according to each resident ' s room number. NA #6 stated she frequently reminded residents of their set shower days when they asked about getting showers.

Interview with NA #7 on 06/19/14 at 11:22 AM revealed showers were scheduled so that each resident was assigned 2 showers each week. NA #7 stated a resident could get an additional shower if they had vomited or been sick and if staff had time. NA #7 stated that residents sometimes asked for more showers, and she would reassure them that they were still clean, and remind them of when their next shower was scheduled.

Interview with the Assistant Director of Nursing (ADON) on 06/19/14 at 11:31 AM revealed a facility shower schedule had been developed to allow each resident to receive 2 showers weekly,

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F 242	Continued From page 22 based on their room number. The ADON stated this schedule was developed so that shower loads would be evenly distributed between first and second shift. The ADON stated if a resident or family requested an extra shower, the staff would do their best to accommodate the request. The ADON said she did not assess resident preferences for daily routines. The ADON stated the nurses were available to the residents and families if they wanted to make a special request regarding extra or fewer showers. Interview with Nurse #4 on 06/19/14 at 1:31 PM revealed residents were each given 2 showers weekly based on their room number. Nurse #4 stated if resident spoke up with preferences, staff were to try to meet their needs but would assist them in getting at least their 2 scheduled showers per week. Interview with social worker (SW) on 06/19/14 at 4:51 PM revealed she had a form to assess resident preferences upon admission, but she documented by exception. The SW explained that meant she routinely asked residents about their previous routines and preferences, described the facility's schedules, and if the resident or family expressed specific requests for exceptions in the facility schedule, she would document those requests and pass on to other staff. The SW stated she did not specifically ask residents to tell her their preferences regarding shower frequency preferred unless the resident voiced concerns about the given schedules	F 242		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	F 244		7/18/14

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F 244	Continued From page 23 must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to act upon concerns raised by the resident council regarding not having enough nursing staff available to meet resident needs. Findings included: Record review of the Resident Council minutes dated 10/29/13 revealed residents concerns there were not enough nurse aides available to meet the needs of the residents. No documented response to this concern was in the minutes of the October or November Resident Council meeting minutes. Record review of the Resident Council minutes dated 11/26/13 revealed concerns including nurse aides not being able to meet the needs of the residents and delayed call bell response times. There was no documented response to the concerns in the December 2013 Resident Council meeting minutes. Record review of the Resident Council minutes dated 12/31/13 revealed concerns including nurse aides not being able to meet the needs of the residents. There was no documented response to the concerns from the November 2013 meeting in the minutes of the December	F 244	1. The acting Activities Director met with Resident #2 to discuss the concerns about grievances not being addressed appropriately from resident council. A special Resident Council meeting was held to address these concerns with the Resident Council members. No additional concern regarding staffing except call light responses remain from the October grievances. Appropriate staff inserviced to respond immediately when call lights are observed, to get up or put to bed and to toilet or provide incontinent care, as soon as possible when resident requests. 2. The day following Resident council meeting, resident council grievances will be discussed at the morning stand-up meeting with the interdisciplinary team. Grievances will be presented and logged by the Social Services director or designee. The grievance investigations will be completed by the appropriate department head or designee and resolved within 5 business days. Resolutions requiring greater than 5 business days will be documented and reviewed by the ED for approval. Results of investigations and resolutions will be	

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F 244	Continued From page 24 2013 Resident Council meeting. Record review of the Resident Council minutes dated 05/27/14 revealed concerns including delayed call bell response time. Interview with Resident #2 on 06/08/14 at 3:51 PM revealed he had been the resident council President for several years. Resident #2 stated he was very frustrated because the same issues were brought up by residents as concerns at every monthly Resident Council meeting and nothing was ever done to change anything about the concerns. Resident #2 stated the same people from the staff attended the resident council meetings, heard the same concerns, and gave the same responses, but he had felt after a while that the council's concerns "fell on deaf ears." Resident #2 stated he was never given anything in writing about the concerns he had discussed in the resident council meetings and no staff member had come to him to discuss any concern resolutions. Resident #2 stated he had been considering stopping attendance at the resident council meetings because he felt it didn ' t help to express concerns when the facility staff wasn't going to make changes. After reviewing the resident council minutes, Resident #2 stated even when resident concerns about nurse aides not being able to meet needs of residents was not in the minutes, these were concerns that were brought up every month by resident council members. Resident #2 stated he had brought up issues about nurse aide care of residents at every resident council meeting he had attended. Interview with the Activities Assistant (AA) on 06/18/14 at 12:08 PM revealed she and 2 other Activities staff members shared the responsibility	F 244	discussed in the daily stand up meeting. 3. All employees will be educated regarding Golden Living's Grievance policy by the DNS or designee. Activities Director (who is the person responsible for conducting the resident council meetings) was inserviced by ED to: 1. Bring the resident council grievances to morning meeting the day following the RC meeting. 2. Report the investigations and resolutions of the RC grievances back to RC during their next meeting to ensure RC satisfaction with resolutions. The Executive Director or designee will audit the Activity Directors RC grievances monthly for 3 months to ensure that RC grievances where recorded, reported/discussed in stand up meeting, and resolution were report back to RC in the next meeting. 4. Findings of the audit will be discussed in the monthly QAPI meeting for 3 months for compliance verification and ongoing as needed to ensure compliance.	

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of attending and coordinating the resident council monthly meetings. The AA stated at most of the meetings she had attended, the same type of complaints were raised by the council members, including concerns about call bell response and residents having to wait too long to have their needs met. The AA stated that when she communicated with department heads about the concerns expressed by the resident council members, they did make efforts to improve issues that the council members complained about but members continued to complain at each meeting.

When asked what care needs residents said weren't being met in the council meetings, Resident #2 said they had to wait too long to be changed, taken to the bathroom, gotten up and put to bed.

Interview with Unit Manager (UM) on 06/19/14 at 1:35 PM revealed she was aware that residents at resident council frequently complained about nurse aide staffing and call bell response. The UM stated she had not attended the resident council meetings but had been told by the activity department staff that it was a concern of the resident council. The UM stated she heard frequent concerns from residents about having to wait too long for care, and she had to frequently explain to residents the nurse aide assignments, how care tasks are divided, and why at times it takes longer for nurse aides to respond to them than other times.

Interview with Social Worker on 06/19/14 at 4:51 PM revealed the activity department staff was responsible for documenting concerns from the resident council and giving information about

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F 244	Continued From page 26 those concerns to the appropriate department head in a grievance form or verbally. The SW also stated the activity department staff was responsible for ensuring each concern addressed by the resident council was responded to in a way that satisfied the resident council members that the concerns were being addressed. The SW stated she was not aware that resident council members were frustrated with the process and did not feel their concerns were addressed adequately. Review of grievance forms revealed no grievances were filed regarding concerns of resident council.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep clean and in good repair walls, floors, an electrical outlet, resident care equipment and furniture for 10 of 41 resident rooms (Rooms 102A, 112A, 113B, 114B, 115A, 204B, 206A, 209A, 211 and 218B). Findings included: During a facility tour on 06/20/14 from 10:00 AM to 10:45 AM with the Maintenance Director (MD), the following environmental concerns were observed:	F 253	1. 102A bedside table was removed and replaced. 112A gashes to wall were repaired and painted. 113B floor tile was replaced, floor was deep cleaned, and toilet was cleaned. 114B BSC was repaired. 115A BCS was replaced. 204B room was deep cleaned. 206A electrical box was secured. 209A wall was repaired and painted. 211 baseboard was repaired and foam to bedrail was replaced. 218B foam was replaced.	7/18/14

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F 253	Continued From page 27 a. In Room 102A, the front of a bedside table was observed with peeling veneer and was heavily scratched b. In Room 112A, gashes were observed in the plaster on the wall behind the head board of the bed c. In Room 113B, missing ceramic floor tiles were observed missing from an area approximately 12 inches by 4 inches and just inside the door jamb to the bathroom. Built up dirt was observed on floor tiles in the area of transition from the bedroom to the bathroom. Black staining was observed around the base of the toilet d. In Room 114B, the portable toilet safety frame was observed with a crack in the right plastic arm rest e. In Room 115A, the portable toilet safety frame was observed with numerous rusted areas on the metal frame and black staining was observed around the base of the toilet f. In Room 204B, the floor next to the resident's bed was observed as sticky with grey dirt build up g. In Room 206A, the electrical outlet box on the wall under and into which was plugged the package terminal air conditioner (PTAC) was observed hanging loose from the wall, approximately 1 inch away and exposing the electrical cable h. In Room 209A, approximately 2 feet of wall under the window sill was observed with crumbling plaster i. In Rm 211, plastic vinyl baseboard was observed loose from the wall to the left of the PTAC unit and foam covers taped over the bed rails at the head of the bed were observed as split with pieces of protruding foam j. In Room 218B, foam covers taped over the bed rails at the head of the bed were observed as split with pieces of protruding foam with foam over	F 253	2. All rooms were inspected by Maintenance Director and Housekeeping Director to identify needed repairs and cleaning issues. 3. Staff have been educated on reporting repair issues to the Maintenance Director via the "building engines" computer program to log work requests by DNS or designee. The Maintenance Director will make repairs as needed and will inspect rooms on a weekly basis. The Director of Housekeeping will see that rooms are cleaned daily and will randomly inspect rooms to assure compliance on a daily basis. Department managers will conduct room checks for maintenance and cleanliness issues five times per week. They will log their findings into the computer system and report their findings to the Executive Director in the daily Manager's meeting. Executive Director will monitor 4 rooms per week for 3 months to ensure repairs and cleaning are being maintained. 4. Findings will be presented to QAPI by the Maintenance Director and Director of Housekeeping monthly for 3 months and then ongoing as needed to ensure compliance.	

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them.
On 06/20/14 at 10:00 AM and during the facility tour the MD was interviewed. He stated he was the only facility employee performing maintenance and repairs. He stated the facility used a computer program for logging of work requests that all staff had access to and the majority of staff knew how to use. He stated he also received requests word-of-mouth but encouraged staff to use the computer system, this system was reviewed by him every day, from it he could prioritize the work requests and life safety issues always received top priority. He stated a majority of staff knew what a facility problem looked like and he participated in the orientation of all new employees. The MD stated if furniture was past the ability to repair, overly scuffed or excessively torn he would replace it. He stated all the rooms had plastered walls and he would spackle gashed areas, smooth this area over then prime and paint. He stated the ceramic tile floors in the bathrooms were old and he would try to keep some missing tiles for repairs. He stated when housekeeping staff were unable to clean blackened areas at the base of toilets he would pull out the caulk and replace it. The MD stated he expected housekeeping staff to help him keep up by reporting facility concerns and department heads performed assigned room rounds every day. He stated the replacement of resident care equipment like portable toilet safety rails and foam padding on bed rails were nursing and rehabilitation issues and his expectation was to fix these issues or remove and replace them. He stated the electrical outlet box servicing the PTAC unit in Room 206A required immediate attention which for which he would be responsible. He stated housekeeping was a contracted service and the dirt built up area on

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F 253	Continued From page 29 the floor in Room 204B required more that mopping. On 06/20/14 at 10:45 AM the Executive Director was interviewed. He stated there was a log book at each nursing station for staff to document facility concerns and computer reporting for department heads. He stated he expected larger facility tasks to be contracted out so the MD could focus on the smaller repairs and concerns.	F 253		
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to initiate a restorative program to prevent worsening of contractures for 1 of 2 residents reviewed for contractures. (Resident #52). The findings included: Resident #52 was admitted to the facility 07/20/10 with diagnoses which included Alzheimer's disease, dysphagia, and failure to thrive. A review of Resident #52's medical record revealed the resident was admitted to hospice in July of 2012. Due to absence of further decline,	F 317	1. Resident # 52 was evaluated by therapy on 6/19/14. Orders were received for PT 5x/wk for 3 wks. Resident was referred to restorative program on 7/10/14 and continues on caseload at present. 2. All residents will be assessed by nursing and or therapy to determine which residents have contractors or are at risk. Residents determined to have contractors where screened by therapy for possible interventions. Those not placed on therapy caseload where referred to restorative for program to prevent worsening of contractures.	7/18/14

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F 317	Continued From page 30 hospice was discontinued on 03/07/14. A significant change Minimum Data Set (MDS) dated 03/14/14 indicated the resident's cognition was severely impaired. The MDS specified the resident was totally dependent on staff for all activities of daily living and upper and lower extremities on both sides were impaired for range of motion. A Care Area Assessment (CAA) described Resident #52 was unable to participate in cognition assessments related to communication deficits and was unable to make his needs known. Due to hemiplegia, staff has to transfer the resident and provide all direct care needs. The CAA identified the resident as bedfast. A care plan reviewed 03/14/14 described Resident #52 with a physical functioning deficit related to self care impairment and mobility impairment. The care plan goal specified the resident would maintain the current level of physical functioning (hold side rails when assisted to do so). Interventions included monitor and report changes in physical functioning ability. A review was conducted of physician progress notes dated 04/30/14 and 06/17/14. In both notes the physician specified in the assessment plan that further therapy may be indicated focusing on comfort. An observation on 06/18/14 at 11:05 AM revealed Resident #52 was lying in bed on his right side. Legs were observed under the sheet and were bent at the hip and knees. The resident provided no response to verbal stimuli. An interview was conducted with Physical	F 317	3. Staff will be educated by the DNS or designee to report changes in residents ROM to an nursing supervisor or DNS to ensure appropriate interventions are initiated to prevent worsening of contractures. Weekly, the MDS coordinator or designee will bring to the clinical start up meeting at list of residents identified by data in the 802 and the MDS, as being at risk for contractures. These residents will be referred to therapy for screening. Those not placed on therapy caseload will be reviewed by IDT to determine if restorative program to prevent worsening of contractures is appropriate. DNS or designee will monitor for compliance weekly x 3 months. 4. Review of residents with a decline will be presented to the QAPI meeting by the DNS or designee monthly for 3 months and then ongoing as need to ensure compliance.	

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Therapist (PT) #1 on 06/19/14 at 9:23 AM. PT #1 stated she was currently the facility Therapy Department manager. During this interview, therapy notes regarding Resident #52's treatments were reviewed. PT #1 stated Resident #52 received various therapy disciplines in 2010, 2011, and 2012. PT #1 identified knee contractures were addressed on these therapy notes. Continued interview at 1:02 PM with PT #1 revealed Resident #52 received a therapy evaluation on 06/19/14 for leg contractures. PT #1 stated the resident came off hospice on 03/07/14 after 2 years of hospice services. She stated before hospice, Resident #52 received restorative therapy set up by the therapy department with the goal of preventing knee contractures from getting worse. PT #1 stated restorative therapy was discontinued when hospice was initiated. She added when hospice was stopped, restorative was not restarted.

A review of a physical therapy evaluation conducted 06/19/14 by PT #2 revealed Resident #52 had received no therapies including restorative therapy since 2012 when hospice was initiated. The present evaluation dated 06/19/14 specified Resident #52 was assessed with increasing contractures in his lower extremities. The evaluation further specified the resident had decreased range of motion in the left shoulder making it difficult to clean under the left arm. Also, the knee contractures made it difficult to position the resident comfortably in bed. In the report PT #2 concluded Resident #52 needed skilled physical therapy to decrease contractures of both lower extremities and the left shoulder to allow for proper positioning and hygiene and to establish a restorative program to maintain.

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F 317	Continued From page 32 An additional interview with PT #1 on 06/20/14 at 8:55 AM revealed a therapist screened each resident in the facility quarterly. PT #1 stated a therapy screen differed from a therapy evaluation in that only 4 questions were addressed with therapy screens and the therapist could not touch the resident. PT #1 provided copies of therapy screens dating back to 11/17/13. No status changes were noted on the screens. An interview was conducted with Nurse Aide (NA) #2 on 06/20/14 at 9:00 AM. NA #2 stated Resident #52's legs were definitely getting tighter. He added it was more difficult to position the resident in bed because his legs would not straighten. NA #2 stated he had not noticed changes in the resident's arms or shoulders. NA #2 stated the nurse that was usually on the resident's hall helped him to position and care for Resident #52. NA #2 stated he was afraid to move the resident's tight joints. NA #2 explained he didn't want to hurt the resident. An interview was conducted with the Director of Nursing (DON) on 06/20/14 at 9:52 AM. The DON stated she expected residents' comfort be maintained at all times. She added she considered positioning and cleanliness as part of comfort. The DON stated nurses were responsible for residents and should look at the resident's needs and report these needs so the best care could be provided for that resident.	F 317		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		7/18/14

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F 329	Continued From page 33 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, mental health professional, staff, and resident interview the facility failed to monitor for side effects of psychotropic medications for 1 of 5 sampled residents. (Resident # 67). Findings included: Resident # 67 was admitted to the facility on 07/26/13. Diagnoses included: psychosis, bi-polar disorder, and extrapyramidal syndrome (EPS). The most recent Minimum Data Set (MDS) dated 04/23/14 revealed Resident # 67 had been identified as cognitively intact with decisions of	F 329	1. Resident # 67 had medications reviewed. The monitoring of medication side effects was put into place. Resident was evaluated by NP from psych services on 6/23/14. New orders were received and initiated. 2. All residents who receive psychoactive medications were assessed for side effects by licensed nursing staff. 3. The DNS or designee will educate licensed nurses regarding the importance of monitoring and documentation of side	

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F 329	Continued From page 34 daily living. A record review of a care plan for Resident # 67 revealed a problem identified on 05/01/14 of potential for drug related complications associated with use of psychotropic medications. Interventions included: monitor for side effects and report to physician. A record review of current physician ' s orders revealed the following medications for Resident # 67: Lexapro 15 mg (milligram) by mouth daily, Clonazepam 0.5 mg by mouth 3 times a day as needed, Trazadone 50 mg by mouth every day at bedtime, Seroquel 25 mg by mouth at bedtime, and Cogentin 0.5 mg by mouth every 12 hours as needed. A record review of a progress note from the Mental Health Practitioner revealed that Resident # 67 had been seen on 04/15/14. Further review revealed that medications were reviewed and she observed that Resident # 67 had abnormal tongue movements and ordered a decrease in the Seroquel to 25 mg by mouth at bedtime, as she felt the Seroquel could be contributing to the tongue movement. She also ordered Cogentin 0.5 mg by mouth twice a day as needed for EPS symptoms, and monitor for medication side effects. A record review of the Behavior Monthly Flow Sheet for Resident # 67 revealed that no monitoring documentation could be found for the month of May and June, 2014. On 06/19/14 a record review of the Facility Behavior Management Guideline dated 2013 revealed that a monitoring system would be	F 329	effects of psychoactive medications. Education included: 1.The use of side effects flow sheet for documentation every shift. 2. Reporting noted side effects to the MD immediately. The DNS or designee will conduct an audit of 5 residents 2 times a week for 3 months who are on psychoactive medications to ensure side effects are being monitored. 4. Findings of these audits will be presented to QAPI by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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established for medication effectiveness, and side effects.

On 06/19/14 at 3:30 PM a telephone interview was conducted with the Mental Health Practitioner. She revealed that when she gives a recommendation to monitor the side effects of medication it is her expectation for licensed nurses to monitor those side effects on a daily basis and document those findings.

On 06/19/14 at 3:45 PM Resident # 67 was observed to have involuntary tongue movements. Further observation on 06/20/14 at 10:40 AM revealed that Resident # 67 had involuntary tongue movements.

On 06/19/14 at 3:45 PM an interview conducted with Resident # 67 revealed that he had been having difficulty with his mouth being dry and was having more tongue movements. Further interview on 06/20/14 at 10:40 AM revealed that he continued to have a dry mouth and tongue movements, and he felt that it was from taking a medication since his admission to the facility. He revealed he never had the problem before.

On 06/20/14 at 12:35 AM the Director of Nursing was interviewed. She revealed that her expectations of the licensed nursing staff would be to follow the Mental Health Practitioner or the physician's recommendations regarding any orders or recommendations on the progress notes and orders. She further revealed that it is the expectation of the licensed nurses to document the behaviors and side effects of medications on the Behavior Monthly Flow Sheet on a daily basis and to notify the health care practitioner right away if there are medication side

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F 329	Continued From page 36 effects. Further interview verified that documentation on the Behavior Monthly Flow Sheet was missing for the month of May and June, 2014 for Resident # 67.	F 329		
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 observation, record review, resident interview, staff interviews and a psychiatric mental health nurse practitioner interview, the facility failed to adjust medication administration times, in response to routine dialysis outside the facility, for 1 of 5 residents (Resident #16). Findings included: Resident #16 was admitted to the facility on 04/12/14 with diagnoses including depressive disorder, end stage renal disease (requiring dialysis outside of the facility with the resident leaving at 6:00 AM and returning at 12:30 PM every Tuesday, Thursday and Saturday), hypertension (HTN) and congestive heart failure (CHF). Her most recent Minimum Data Set (MDS) of 05/07/14 assessed the resident as feeling down and depressed for 2 to 6 days of the assessment period. The resident's pain was assessed as occasional, making it hard to sleep and was rated on a 0 to 10 scale as 5 out of 10. The MDS coded the resident as receiving an antidepressant medication 7 out of 7 days of the assessment period. Review of Resident #16's care plan revealed a review dated 10/10/13 of the	F 333	1. Resident # 16 had her medication times orders changed during survey to prevent conflict with her dialysis schedule. 2. All dialysis residents medications were reviewed and there was no conflict in scheduling times. 3. Nurses will be educated by the DNS or designee: 1.To review medication administration times to ensure that those times do not conflict with dialysis appointments. 2. Notify MD for new orders for any conflicting administration times. The DNS or designee will audit all dialysis residents medication administration orders weekly for 3 months to ensure medication times do not conflict with resident scheduled dialysis appointments. 4. Findings will be presented to QAPI monthly x 3 months by the DNS or designee then ongoing as needed to	7/18/14

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F 333	Continued From page 37	F 333	ensure compliance.	

problem of pain management with an intervention to administer pain medication as ordered. Another care plan problem revealed a review dated 04/23/14 of the potential for drug related complications associated with antidepressant use, with an intervention to provide medications as ordered.

Review of Resident #16's medical record revealed a medication order dated 12/26/13 for carvedilol 25 milligrams (mg) twice a day (BID) for HTN and CHF. On Sundays, Mondays, Wednesdays and Fridays the carvidilol was scheduled for administration at 8:00 AM and 8:00 PM while on Tuesdays, Thursdays and Saturdays the scheduled administration times were 5:00 AM and 4:00 PM. Review of medication administration records (MARs) for the months of March, April, May and June 2014 to date for the carvedilol revealed all dosages were documented as given with this pattern of administration times.

Further review of Resident #16's medications revealed an order dated 03/03/14 for escitalopram oxalate 15 mg once a day (QD) for depressive disorder. On all days the escitalopram oxalate was scheduled for administration at 9:00 AM. Review of MARs for the months of March, April, May and June 2014 to date revealed 45 out of a total of 108 possible daily doses of the escitalopram oxalate were not documented as given on Tuesdays, Thursdays and Saturdays.

Further review of Resident #16's medications revealed an order renewed on 04/15/14 for the pain medication acetaminophen 500 mg administered BID. On all days the acetaminophen was scheduled for administration

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at 8:00 AM and 8:00 PM. Review of MARs for the months of April, May and June 2014 to date revealed 24 out of a total of 65 possible AM timed doses of the acetaminophen were not documented as given on Tuesdays, Thursdays and Saturdays.

Further review of Resident #16's medications revealed an order dated 04/17/14 for a multivitamin (MVI) supplement formulated for patients with renal disease to be administered QD. On all days the MVI was scheduled for administration at 8:00 AM. Review of MARs for the months of April, May and June 2014 to date for the MVI revealed 24 out of a total of 63 possible daily doses of the MVI were not documented as given on Tuesdays, Thursdays and Saturdays.

Review of a doctor's note dated 05/21/14 revealed the presence of chronic pain. Review of a psychiatric mental health nurse practitioner (PMHNP) note dated 05/22/14 revealed escitalopram oxalate 15 mg QD in the medication review list. Review of an order summary report dated 05/27/14 and signed by the attending physician revealed Resident #16 required dialysis treatment outside of the facility every Tuesday, Thursday and Saturday and was completed by 12:00 PM.

An interview on 06/16/14 at 6:00 PM with Resident #16 revealed she went to dialysis treatments on Tuesdays, Thursdays and Saturdays, leaving at 6:00 AM and returning to the facility between 12:30 PM and 1:00 PM. Another interview on 06/18/14 at 2:00 PM revealed she had to get up early to get to the dialysis center by 6:30 AM on her scheduled

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days.

A phone interview 06/19/14 at 3:21 PM with the PMHNP revealed her expectation that when her residents left the facility for dialysis treatment she expected them to continue receiving ordered antidepressant medications within an 8 hour window of time even if that meant adjusting the administration time of the medication. She stated that from a psychiatric medication perspective, she wanted Resident #16 to receive antidepressant medication every day, which was more important than the actual time it was administered, which could be in the evening or after lunch.

An interview on 06/20/15 at 7:38 AM with Nurse #1 revealed she worked the 11:00 PM to 7:00 AM shift Sunday through Thursday nights. She stated she readied Resident #16 for dialysis treatment outside of the facility every Tuesday and Thursday morning, which included providing breakfast, checking a blood glucose level and administering insulin and other medications. Nurse #1 stated the resident did not take any medication to dialysis treatments to be taken later in the morning. She stated the computer system generated the MARs monthly from computerized orders so there was no need for "old fashioned checks" of MARs against the orders. She stated the computer on her medication cart only displayed medications ordered for administration on her shift, but nurses could go into the computerized order and get more detail to see how medications were ordered throughout the 24 hour period. Nurse #1 stated if a nurse consistently documented a regularly scheduled medication as not given then they should know to adjust administration times, like for Resident

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#16's antidepressant, for the mornings the resident was out of the facility for dialysis treatments.

An interview on 06/20/14 at 8:10 AM with Nurse #2 revealed she usually worked day shifts on Saturdays, she knew Resident #16 received medications before leaving for dialysis treatments but the resident did not take any medication to the treatments. She stated she knew the carvedilol was adjusted so that the resident did not miss a dose on dialysis treatment days. Nurse #1 reviewed printed MARs for escitalopram oxalate and identified her initials on some of the Saturday 9:00 AM administration times, stating the codes in the blocks were correct and the escitalopram oxalate was not given as the resident was at the dialysis center on Saturday mornings. She stated there was no reason why the resident could not have received this medication on dialysis days either in the morning before leaving the facility or upon returning at an alternate time.

An interview on 06/20/14 at 8:23 AM with the assistant director for nursing services (ADNS) revealed her expectation for nurses to attempt administration of medications to residents prior to their leaving the facility for regularly scheduled treatments by looking for an alternate administration time. She stated if nurses wanted to see what medications were ordered on these mornings they would specifically have to look in the computer for the affected shift or day. She stated orders were reviewed monthly but staff did not look specifically at administration times on the MARs. She stated she would have expected a nurse who experienced a pattern of not giving a medication routinely, due to a resident being out

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F 333	Continued From page 41 of the facility, to call a doctor and request an alternate administration time for that medication. The ADNS stated Resident #16 needed to receive a daily dose of escitalopram oxalate, the MVI and the acetaminophen. An interview 06/20/14 at 9:50 AM on with DNS revealed if a resident were to be routinely out of the facility for treatments or personal reasons then she expected nurses to identify this, call a doctor and obtain permission to give these missed medications at an alternate time.	F 333		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		7/18/14

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F 353	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews, the facility failed to provide enough staff to adequately attend to resident needs during 2 of 2 meal observations in restorative dining. The findings included: An observation was conducted of the lunch meal in restorative dining on 06/16/14 from 12:10 PM to 1:13 PM. Residents #43, #15, and #58 were observed sitting on 1 side of a large table with Residents #8 and #70 sitting on the opposite side of the table. Resident #35 was sitting at the end of the table with a visitor sitting next to her. Resident #69 was in a high backed wheel chair behind Resident #35. Restorative Nurse Aide (RNA) was observed setting up trays for all 6 of these residents. As the residents received their trays, they started attempting to feed themselves. Residents #43 and #8 were observed asking for butter for their rolls. RNA told both residents they would have to wait until someone came to help because she could not leave them unattended. The last tray set up was for Resident #69. RNA was observed instructing Resident #69 to eat his food before eating his yogurt. She placed the yogurt on the back of the tray out of reach of the resident. While RNA was attending Resident #69, Resident # 58 was pouring her tea over the food on her plate. The visitor sitting next to Resident #35 alerted RNA regarding Resident #58's actions. A speech therapist passed by and offered to get Resident #58 another tray. Resident #15 was observed sleeping and not eating. While RNA was sitting by Resident #15 and encouraging him to eat, Resident #69	F 353	1. The Restorative dining room staffing ratio was corrected during the survey. We are now offering two seating times in the Main Dining Room so that all residents who desire can eat in the Main Dining Room instead of splitting the residents between two Dining Rooms, allowing for appropriate increased staffing during meal service times to provide feeding assistance to residents. 2. Daily a manager will be assigned to ensure adequate staffing is available to meet the needs of the residents during meal times in the main dining room and on the halls. 3. The DNS or designee will: 1. Randomly observe the meal time processes in the main dining room to ensure staffing is adequate to meet the needs of the residents. 2. Randomly observe meal time processes on the halls to ensure staffing is adequate to meet the feeding assistance needs and requests of the residents. Observations will be 2 times per week for 3 months. The DNS or designee will educate staff on the new two seating time process for main dining room and that staff is to notify meal time manger of any immediate staffing needs. 4. Findings of the observations will be presented to QAPI by the DNS or	

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F 353	Continued From page 43 reached the yogurt container and managed to get it open. Resident #69 was eating yogurt out of the container not using a spoon. Yogurt was observed all over his shirt and face. Resident #58 received a new plate of food. While RNA was attending to Resident #69 and his yogurt, Resident #58 was pouring milk over the new plate of food. Resident #43 started asking for chocolate ice cream. The resident's tray card indicated a regular mechanical soft diet with no listed restrictions was ordered for her. RNA instructed Resident #43 to eat the fruit cup provided on her tray. RNA stated the fruit was her desert. Resident #43 stated she was not going to eat until she got coffee. The speech therapist came by once more and got coffee for Resident #43. RNA was attempting to get Resident #69 to eat his food. She fed him a bite of pureed chicken and the resident began violently coughing. While RNA was attending him, Resident #58 continued pouring milk on her plate of food and Resident #15 continued to sleep. By the end of the meal, Resident #43 had eaten very little and did not receive butter for her roll or chocolate ice cream, Resident #15 had continued to sleep even with limited encouragement from RNA, Resident #58 had eaten a few bites, Resident #35 had eaten approximately half her food with the assistance of her visitor, Resident #69 ate very little of his food but all of his yogurt, and Residents #8 and #70 had eaten well. Residents #8 and never got butter for her roll. An observation was conducted in restorative dining of the breakfast meal on 06/17/14 beginning at 8:43 AM. At the start of the observation, several residents had their trays. RNA was present and had several other staff	F 353	designee monthly for 3 months and then ongoing to ensure compliance.	

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members assisting with serving trays before leaving the dining area. Resident #43 asked for butter and RNA replied the resident had to wait a minute. She added she had to get everyone their tray then get someone to go get it for you. RNA added "you know the routine". This morning there were 9 residents for RNA to assist. Resident #26 joined the other residents in restorative dining. At 8:46 AM, she did not have her tray and proceeded to self propel her wheel chair back to her room. The Social Worker came by and said she would get her tray. Resident #26 came back to the table. At 8:51 AM she got her tray. Resident #43 was observed attempting to eat unassisted. Her tremors were so severe, she had difficulty keeping food on her spoon. By the time the spoon reached her mouth there was little food left on the spoon and a lot of food in her lap. Again Resident #69 got his yogurt and was eating it out of the carton with yogurt running down his chin. RNA was sitting with Resident #35 instructing the resident to wake up so she could eat. By the end of the meal, Resident #43 had fallen asleep and never got the butter she requested.

An interview was conducted with RNA on 06/17/14 at 1:33 PM. RNA stated she was the only aide in restorative therapy. She stated her duties included bowel and bladder training, ambulation of residents, and attending to the residents in restorative dining at the breakfast and lunch meals. RNA added she worked Monday through Friday and another restorative nurse aide filled in on weekends. RNA stated she was always by herself in restorative dining. She explained if someone asked for butter, she had to wait until a staff member came by to get the butter for the resident. RNA stated if a resident

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F 353	Continued From page 45 got choked, she had to yell for help. An interview was conducted with Resident #8 on 06/18/14 at 9:43 AM. Resident #8 was observed alert and oriented. She stated there were many times when she did not get the butter she requested at meal time. Resident #8 stated she also had to wait a long time to get her tray and watch other residents eat as she waited. An interview was conducted with the Director of Nursing (DON) on 06/19/14 at 4:25 PM. The DON explained RNA was supposed to have a walkie talkie so she could summon help. The DON added a nurse on the hall close to the restorative dining area was supposed to be nearby during restorative dining to assist in an emergency. The DON was unaware the residents were not getting foods they requested nor supervision they required during meals. The DON stated it should not be that way for the residents.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		7/18/14

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F 371	Continued From page 46 Based on observations, record review and staff interview, the Facility failed to (1) properly store or label refrigerated and dry foods (2) perform cleaning and maintenance of the kitchen and equipment and (3) safely and properly store disposable cup lids. Findings included: 1. Observations during the survey revealed the following problems with food storage in the facility's kitchen: a. On 06/16/14 at 8:00 AM were observed in the 2 door reach-in refrigerator 7 vanilla flavored and 17 strawberry flavored ready to use nutritional shakes, each in a prepackaged 4 ounce (oz.) paper carton and all thawed but no thaw date noted on the individual cartons nor the plastic container they were in. On the cartons were the printed instructions "Store frozen. Thaw under refrigeration (40 degrees F or below). After thawing, keep refrigerated, use within 14 days after thawing." Under the printed instructions was the phrase "date thawed" and a line and space. On 06/17/14 at 4:45 PM were observed in a 2 door reach-in refrigerator 6 thawed strawberry flavored and 15 vanilla flavored nutritional shakes, some which had frost on them and were semisolid when the paper cartons were squeezed, but none observed with thaw dates noted on the individual cartons nor on the plastic container they were in. On 06/17/14 at 4:50 PM dietary aide (DA) #1 was interviewed and stated the shake cartons should have been labeled with the date when thawing started but it was hard to write on the wet cartons or keep a label on them. During the interview, DA #1 was joined by the dietary manager (DM) who	F 371	A1. All storage issues found during the survey were corrected during the survey including thawed nutritional shakes with no thawed dates in the 2 door reach in refrigerator were discarded, the cans with dents and bulges where placed in dry storage room in designated area, uncovered strawberry deserts in 2 door reach in refrigerator were discarded. 2. All refrigerated areas, dry storage areas and nutritional rooms on the halls where food is being stored have been inspected to insure compliance. All food is now being stored according to regulations with appropriate covering, labeling and dating. Cans are inspected when removed from boxes for dents and bulges and defective cans are placed in a designated spot in the dry storage room. 3. Staff will be educated to properly cover, label, and date of food items when thawed, opened, or prepared and that cans are to be inspected when removed from boxes for dents and bulges and defective cans are placed in a designated spot in the dry storage room by the DSM. The DSM or designee will audit the refrigerators, dry storage areas, and nutritional rooms on the halls to ensure proper labeling, covering, and storage 5 times per week for 1 month then 3 times per week for 2 months. 4. Findings of this audit will be presented to QAPI by the DM for 3 months and then ongoing as needed to ensure compliance.	

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F 371	Continued From page 47 stated nutritional shakes were used fairly regularly but that the thaw dates should have been noted on them. b. On 06/17/14 at 4:33 PM were observed in the dry storage room can rack the following: a 7 pound (lb.) can of vanilla pudding with a dented rim with a slight bulge in the lid, a 6 lb. 10 oz. can of yellow cling peaches with dent at the bottom of the can, a 6 lb. 3 oz. can of sauerkraut with a handwritten paper label "for Ruben's 6/25 Tues" with a dent in lower third of the can and a 6 lb. 15 oz. can of green lima beans with a dent in the lower rim. On 06/17/14 at 5:00 PM the DM was interviewed and she stated she expected staff upon receiving a food shipment to remove cans from any boxes and inspect them for dents or bulges and to remove these cans to a designated spot in the dry storage room for credit from their supplier. The DM observed the described dented cans and stated they should have never been placed in the rack and she was observed removing them from the rack. c. On 06/17/14 at 4:45 PM were observed in a 2 door reach in refrigerator 2 uncovered and undated strawberry desserts with whipped topping. On 06/17/14 at 4:50 PM dietary aide (DA) #1 was interviewed and upon inspecting the uncovered and unlabeled strawberry desserts stated nothing should be uncovered or unlabeled in the RIF and she removed the two strawberry desserts. During the interview, DA #1 was joined by the dietary manager (DM) who stated foods placed in the reach in refrigerator should be covered and	F 371	B1. All maintenance and cleaning issues were corrected during the survey to include metal ventilation over hand washing sink was cleaned, peeling paint of food prep areas was removed and painted, exit door from kitchen was repaired, vents on the back of oven were cleaned, and crumbling plaster near walk in freezer was repaired. 2. The Maintenance Director and Dietary Manager were educated on adhering to scheduled maintenance and cleaning schedules by the Executive Director. 3. The Dietary Staff will be educated by the DSM to follow the cleaning schedule and to report immediately any maintenance issues using "building engines" in the computer. The Executive Director or designee will audit the Kitchen on a weekly for proper cleaning and maintenance for 4 weeks then monthly for 2 months. 4. Findings of this audit will be presented to QAPI by the Executive Director monthly for 3 months and then ongoing as needed to ensure compliance. C1. The boxes of cup lids were removed from the chemical closet and properly stored during the survey. 2. All dietary storage areas were	

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F 371	Continued From page 48 labeled. 2. On 06/16/14 at 7:50 AM were observed the following kitchen maintenance concerns: a. A metal ventilation grate on the wall over the hand washing sink was observed covered in black substance b. An approximately 8 inch oblong section of ceiling over a food preparation counter was observed with peeling paint, with edges of paint hanging approximately 2 inches from the ceiling. Other smaller and numerous areas approximately 2 inches in diameter were observed over the food preparation area and in vicinity of metal piping suspended from the ceiling c. The metal door to the right of the hand washing sink, leading from the kitchen to the outside concrete deck, was observed partially closed and not fully seated in the door jamb, with no visible light from the outside d. On the back of a free standing oven was observed dust on the vents on back of oven with this area across from a food preparation counter with the top rear edge covered with grease e. Crumbling plaster was observed on the wall over the door to the walk in freezer, measuring approximately 10 inches by 10 inches and in the vicinity of pipes coming down the wall and going into the walk in freezer On 06/18/14 at 9:00 AM an interview with the DM revealed dietary staff had assigned daily cleaning tasks and monthly deep cleaning tasks. She provided a copy of a cleaning list dated 05/15/14	F 371	checked to assure there were no improperly stored items. 3. The Dietary Staff will be educated by the DSM that dry storage products may not be stored in chemical storage areas. . The DSM or designee will audit for compliance 5 times per week for 6 weeks then 3 times per week until the QAPI team determines otherwise. 4. Findings of this audit will be presented to QAPI by the DM for 3 months then ongoing as needed for compliance.	

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which revealed various pieces of kitchen equipment assigned. The list noted cleaning of a convection oven as "inside" and "outside-control panel". Also listed was "ceiling-peeling paint" and "ceiling vents and HVAC units" and "outside door-in and *out." Upon observing the back of the free standing oven the DM stated it should not be covered with dust and top if it should not have been covered in a greasy substance. She stated the kitchen had been short staffed recently and many tasks such as this one did not get done. Upon observing the ventilation grate over the hand washing sink, the DM stated Maintenance should have been keeping this clean. Upon observing peeling paint on the ceiling the DM stated this had been reported to Maintenance about 5 weeks prior but she stated concerns that paint chips could fall into food in the food preparation area. Upon observing the metal door leading from the kitchen to the outside the DM stated Maintenance would be responsible for repairing this. Upon observing the crumbling plaster on the wall in the vicinity of piping over the walk in freezer, the DM stated this too would have to be addressed by Maintenance.

On 06/18/14 at 9:30 AM an interview with the Maintenance Director and the RD revealed awareness of the peeling paint from the ceiling with plans to paint the ceiling which were delayed due for various reasons. The Maintenance Director stated it was possible to remove loose paint in preparation for a more labor intensive job on the ceiling but he did not do this. The Maintenance Director stated cleaning of vents and pipes on and near the ceiling were done by him every 30 days. Upon observation of the ventilation grate over the hand washing sink he stated it was checked every 30 days and

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sometimes more frequently and stated it was covered in dust and grime. The Maintenance Director was observed leaving the kitchen through the metal back door outside and when he returned with a ladder in the metal door did not close all the way, leaving an approximately 1/4 inch gap along the entire length of the door. The Maintenance Director was observed climbing the ladder and removing the metal ventilation grate which revealed a black greasy substance along the edges of the metal fins and the RD was observed wiping her finger along the edge with a black greasy substance easily removed from vent. After the ventilation grate was removed, a fiberglass filter revealed a brown substance. The Maintenance Director stated the metal door leading to the outside did stick and that the door needed to be adjusted.

3. On 06/16/14 at 8:35 AM observation of items stored inside a closet which was located behind the facility revealed numerous containers of cleaning chemicals and a total of 11 cardboard boxes of disposable cup lids, some of the boxes opened and revealing plastic sleeves of lids. Approximately 6 to 8 inches from the boxes stacked on the top shelf of the wire rack and protruding from the wall above the rack was observed a sprinkler head.

On 06/18/14 at 9:30 AM the Maintenance Director and RD were observed inspecting the facility's outside storage closet and both stated the closet stored cleaning chemicals. 9 boxes of disposable cup lids were observed on the top shelf of the wire rack or stacked on a milk crate resting on the concrete floor and the Maintenance Director and RD stated nothing but cleaning chemicals should have been stored in the closet. On the top shelf

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F 371	Continued From page 51 of wire rack was observed a cardboard box approximately 8 to 12 inches away from the sprinkler head and the Maintenance Director stated there should have been 15 inches between objects and a sprinkler head.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		7/18/14

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F 441	Continued From page 52 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to utilize an EPA(Environmental Protective Agency) approved agent to disinfect a blood glucose meter (glucometer) after use on 1 of 3 residents observed for blood sugar monitoring. (Resident #16). The findings included: Recommendations for Cleaning and Disinfection of Glucometers in North Carolina Statewide Program for Infection Control and Epidemiology (undated) specified to disinfect blood glucometers after each use using an EPA registered detergent/germicide with a tuberculocidal or Hepatitis B and C Virus/Human Immune Virus label claim ....Alcohol is not an EPA-registered detergent/disinfectant. A review of an undated facility policy regarding cleaning of glucometers revealed glucometers were to be cleaned after each resident use with a 10% bleach wipe. A review of the bleach germicidal agent utlized by the facility to disinfect glucometers specified the agent was effective against Hepatitis B and C and Human Immune Virus.	F 441	1. The Glucometer was removed from the medication cart during the survey, disinfected along with the container in which it was housed and resident #16 was given personal meter. 2. During the survey nurses were educated regarding the cleaning to disinfect the glucometers. Manufacturer cleaning to disinfect instructions were placed in the medication cart. Nurses were assessed to ensure knowledge of proper cleaning procedures. 3. The facility will provide each individual diabetic their own personal glucometer which will be housed in it's own container. Glucometer will be discarded if resident expires or given to resident if discharged from facility. Licensed nurses will be educated by the DNS or designee regarding cleaned prior to placing them back on medication cart after use per manufacturer's instructions and processes. And that an individual's meter is not to be used on any other resident. ADNS or designee will perform	

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F 441	Continued From page 53 Resident # 16 was admitted to the facility 04/12/13 with diagnoses which included diabetes mellitus. Review of Resident #16's medical record revealed a physician's order dated 02/15/14. The order specified the resident's blood sugar was to be obtained before meals and at bedtime with insulin administered as needed per sliding scale. An observation was conducted on 06/17/14 at 3:55 PM of Nurse #5 obtaining a blood sugar reading for Resident #16. Nurse #5 used a glucometer provided by the facility that was utilized for monitoring blood sugars on multiple residents. Nurse #5 followed appropriate procedures for obtaining the blood sugar value. After use, the nurse was observed wiping the glucometer with an alcohol swab. Nurse #5 then placed the glucometer in a box located in the medication cart. The box contained supplies for obtaining finger stick blood sugar readings. An interview conducted with Nurse #5 at this time revealed wiping the glucometer with alcohol was his usual practice of cleaning a glucometer after use. He further stated he did not see anything else in the cart to use. Nurse #5 was asked to seek instruction from facility staff before using the glucometer for blood sugar monitoring on another resident. At 4:18 PM on 06/17/14, the Director of Nursing (DON) was observed instructing Nurse #5 on disinfection procedures using an EPA approved bleach wipe. The DON was observed asking Nurse #5 to disposed of the supplies in the medication cart that came in contact with the glucometer. At this time the DON stated she expected glucometers to be disinfected by	F 441	random audits weekly (observation of blood sugar checks) for 3 weeks and then monthly for 3 months to ensure glucometers are for individual use only and that they are cleaned prior to placing them back on medication cart after use. 4. Findings of these medication passes will be presented to the QAPI meeting monthly for 3 month by the ADNS or designee and then ongoing as needed to ensure compliance.	

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F 441	Continued From page 54 utilizing the bleach wipe after each resident use.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and 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 observations, record reviews and staff interviews the facility failed to properly store or label refrigerated and dry foods as part of the monitoring process for quality assurance. The findings included:	F 520	1. A performance improvement plan was developed for F371 and will include at least quarterly review of the concerns to ensure the corrections have been sustained.	7/18/14

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F 520	Continued From page 55 The facility on the previous recertification survey dated 04/26/13 was cited for failure to label, date and cover foods and beverages stored in the nourishment refrigerators/freezers. 1. Observations during the survey revealed the following problems with food storage in the facility's kitchen: a. On 06/16/14 at 8:00 AM were observed in the 2 door reach-in refrigerator 7 vanilla flavored and 17 strawberry flavored ready to use nutritional shakes, each in a prepackaged 4 ounce (oz.) paper carton and all thawed but no thaw date noted on the individual cartons nor the plastic container they were in. On the cartons were the printed instructions "Store frozen. Thaw under refrigeration (40 degrees F or below). After thawing, keep refrigerated, use within 14 days after thawing." Under the printed instructions was the phrase "date thawed" and a line and space. On 06/17/14 at 4:45 PM were observed in a 2 door reach-in refrigerator 6 thawed strawberry flavored and 15 vanilla flavored nutritional shakes, some which had frost on them and were semisolid when the paper cartons were squeezed, but none observed with thaw dates noted on the individual cartons nor on the plastic container they were in. On 06/17/14 at 4:50 PM dietary aide (DA) #1 was interviewed and stated the shake cartons should have been labeled with the date when thawing started but it was hard to write on the wet cartons or keep a label on them. During the interview, DA #1 was joined by the dietary manager (DM) who stated nutritional shakes were used fairly	F 520	2. The QAPI committee will initiate performance plan for each citation from the survey and any other opportunities for improvements as identified from Stand up and Clinical Start Up meetings. 3. The ED/DNS will re-educate the committee on the QAPI process. The ED or DNS will bring newly identified areas requiring performance improvement to the QAPI committee. The QAPI committee will develop a performance improvement plan including establishing ongoing monitoring of corrections. The QAPI committee (QC) will designate committee member(s) to monitor corrections, who will report any identified problem areas during the monthly committee meeting. 4. QC will review of corrections for citations including F371 and improvements, modifying as necessary on at least a quarterly basis for at least one year to ensure corrections have been sustained.	

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regularly but that the thaw dates should have been noted on them.

b. On 06/17/14 at 4:33 PM were observed in the dry storage room can rack the following: a 7 pound (lb.) can of vanilla pudding with a dented rim with a slight bulge in the lid, a 6 lb. 10 oz. can of yellow cling peaches with dent at the bottom of the can, a 6 lb. 3 oz. can of sauerkraut with a handwritten paper label "for Ruben's 6/25 Tues" with a dent in lower third of the can and a 6 lb. 15 oz. can of green lima beans with a dent in the lower rim.

On 06/17/14 at 5:00 PM the DM was interviewed and she stated she expected staff upon receiving a food shipment to remove cans from any boxes and inspect them for dents or bulges and to remove these cans to a designated spot in the dry storage room for credit from their supplier. The DM observed the described dented cans and stated they should have never been placed in the rack and she was observed removing them from the rack.

c. On 06/17/14 at 4:45 PM were observed in a 2 door reach in refrigerator 2 uncovered and undated strawberry desserts with whipped topping.

On 06/17/14 at 4:50 PM dietary aide (DA) #1 was interviewed and upon inspecting the uncovered and unlabeled strawberry desserts stated nothing should be uncovered or unlabeled in the RIF and she removed the two strawberry desserts. During the interview, DA #1 was joined by the dietary manager (DM) who stated foods placed in the reach in refrigerator should be covered and labeled.

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