STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345314	A. BUILDING _____ B. WING _____	C 11/20/2014

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FOREST CITY HEALTH AND REHABILITATION CENTER	830 BETHANY CHURCH ROAD FOREST CITY, NC 28043

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to assist a resident to the bathroom resulting in incontinence episodes for 1 of 3 residents (Resident #45) reviewed for dignity and respect. The findings included: Resident #45 was admitted to the facility on 04/30/10 with diagnoses of Alzheimer's disease, anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed Resident #45 was cognitively intact and able to understand and be understood. The MDS further revealed Resident #45 required extensive assistance with toileting and was occasionally incontinent of bladder. Review of Resident #45's care plan dated 05/14/14 revealed she was care planned for incontinence with a goal to be continent during waking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as needed after incontinence episodes. An interview was conducted with Resident #45 on 11/20/14 at 9:00 AM. She stated she did not have	F 241	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or 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.** F241 1. Corrective action has been accomplished for the alleged deficient practice for Resident # 45 by providing timely toileting assistance on care rounds and as needed to maintain their dignity. DHSR NH L&C Black Mountain WRO Received DEC 17 2014 by: ycl	12-18-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Fitzgerald | TITLE: Administrator | (X6) DATE: 12-17-2014

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

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F 241	Continued From page 1 incontinent episodes if staff answered her call light in time for her to get to the bathroom. She stated she had been having 1 to 2 incontinence accidents a week that required her bed sheets and gown to be changed due to long call light waits during the night. She further stated she felt very embarrassed when she had accidents in the bed. An interview was conducted on 11/20/14 at 6:40 AM with NA #4. She stated she worked the 11:00 PM to 7:00 AM shift on B hall and the Rehabilitation hall. She stated she had up to 32 residents per shift and didn't feel like they received the care they needed because of staffing. She reported if she was on the Rehabilitation hall she could not see the call lights on B hall and residents had long wait times for call lights to be answered. An interview was conducted on 11/20/14 at 6:45 AM with NA #1. She stated she worked the 11:00 PM to 7:00 AM shift on Resident #45's hall and it was very difficult to keep all the residents toileted, clean, dry, turned and repositioned. She stated she answered call lights as quickly as she could but some residents were soaked to the mattress by the time she was able to get to their room. NA #1 stated Resident #45 had several incidents of incontinence because she wasn't able to answer her call light soon enough. An interview was conducted on 11/20/14 at 6:50 AM with NA #2. She stated she worked the 11:00 PM to 7:00 AM shift. She reported she has 25 to 32 residents to care for during her shift and it was very difficult to keep them clean and dry, help them to the bathroom and answer call lights quickly. She stated some residents were soaked	F 241	2. Residents who require assistance with toileting have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director has conducted an audit of current residents' toileting needs. C.N.A. Care Grids have been reviewed and updated, as needed, to reflect the residents' current toileting needs. The Social Services Director has identified Residents who are capable of participating in interviews regarding timeliness of toileting assistance. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: in-service for nursing staff related to the	

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F 241	Continued From page 2 through to the mattress due to having to wait so long to be changed. An interview was conducted with the Director of Nursing (DON) on 11/20/14 at 2:30 PM. He stated it was his expectation that resident call lights be answered in a timely manner so incontinence episodes could be avoided.	F 241	promotion of care for residents in a manner and in an environment that maintains or enhances residents' dignity and respect in full recognition of his or her individuality; specifically, offering timely toileting assistance as needed to aid in the prevention of incontinence. Residents will be assessed upon admission, quarterly, annually and with significant change via the MDS process with care plan interventions identified per individual. C.N.A. Care Grids will be updated by Nursing Administration as changes in toileting assistance are identified. At least 25% of interviewable residents who require toileting assistance will be interviewed by the Social Services Director to identify concerns related to timely toileting assistance on a monthly basis for three months. Resident Council meetings will include	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide positioning in a wheelchair that allowed a resident's feet to touch in floor at a 90 degree angle for 1 of 2 residents reviewed for well being (Resident #101). The findings included: Resident #101 was readmitted to the facility 04/29/14 with diagnoses which included Alzheimer's disease, history of falls, and muscle weakness. An annual Minimum Data Set (MDS) dated 10/28/14 indicated the resident's cognition was severely impaired, could be understood, and understands others. The MDS specified	F 309		12-18-14

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F 309	Continued From page 3 Resident #101 did not ambulate during the assessment period and required limited staff assistance of 2 people for transfers from surface to surface. An observation on 11/18/14 at 4:11 PM revealed Resident #101 was sitting in his wheelchair self propelling down the hall. He was observed self propelling by slowly turning the wheelchair wheels with his hands and pulling on the hand rails located on the side of the hallway. His toes were observed pointed downward and touching the floor. His heels were observed suspended above his toes and not touching the floor. No footrests were observed on the wheel chair. An observation on 11/19/14 at 7:26 AM revealed Resident #101 was sitting in his wheelchair self propelling out of his room. The resident self propelled by slowly rolling the wheelchair wheels with his hands. His toes were observed pointed downward and touching the floor. His heels were observed suspended off the floor. No footrests were observed on the wheelchair. An observation on 11/19/14 at 8:31 AM revealed Resident #101 was seated in his wheelchair at the breakfast table in the dining room. His toes were observed pointing downward and touching the floor. His heels were suspended above the floor. No footrests were observed on the wheelchair. Continued observations on 11/19/14 at 10:42 AM and 1:25 PM revealed Resident #101 was in the hallway sitting in his wheelchair. His toes were pointed downward and touching the floor. His heels were suspended above his toes and did not touch the floor.	F 309	questions regarding timely toileting assistance bi-weekly for 1 month, then monthly for the next 3 months. The Administrator will review the minutes for concerns and timely response to noted concerns. Care Rounds will be completed by Nursing Administration daily for one week then at least weekly for 3 months to identify concerns with timely toileting assistance to ensure continued compliance. 4. The Director of Nursing and Administrator will review data obtained during rounds, Resident Council minutes and Resident interviews, analyze the data and report	

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F 309	Continued From page 4 An interview with the Occupational Therapist (OT) on 11/19/14 at 1:28 PM revealed when positioned properly in a wheelchair, the resident's back, hips, knees, and ankles should be at 90 degree angles. During the interview, the OT observed Resident #101 sitting in his wheelchair with his heels not touching the floor. The OT confirmed Resident #101 was not seated with his ankles at 90 degree angles. When the resident was asked if he could self propel his wheelchair with his feet, he was unable to place his heels on the floor. The resident was observed moving his wheelchair by turning the chair wheels with his hands while his heels remained off the floor. An interview was conducted with Nursing Assistant (NA) #4 on 11/19/14 at 3:01 PM. NA #4 stated she had worked in the facility since the middle of September 2014. She added she had never seen Resident #101's feet fully touch the floor. NA #4 stated his toes touched the floor but his heels don't. An interview was conducted with the Director of Nursing (DON) on 11/20/14 at 8:42 AM. The DON stated Resident #101's feet should touch the floor at a 90 degree angle. He added he expected nurses to observe residents for problems with positioning. An interview with Unit Manager on 11/20/14 at 4:08 PM revealed she was unaware Resident #101's feet did not touch the floor at a 90 degree angle.	F 309	patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		12-18-14

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F 328	Continued From page 5 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide clean tubing utilized for intermittent administration of an antibiotic before administering the medication via intravenous infusion for 1 of 1 resident observed during intravenous medication administration. (Resident #58). The findings included: A review of a Medication Administration Policy revised June 2012 and related to intravenous administration of medications via intermittent infusion revealed in part intermittent administration sets will be changed every 24 hours. The policy also contained licensed nurse will be knowledgeable regarding the safe and aseptic intermittent administration of intravenous medications and fluids. Resident #58 was admitted to the facility 09/04/14 with diagnoses which included aortic valve disorder. A current diagnosis included urinary tract infection.	F 328	F309 1. Corrective action was accomplished on 11/20/14 for the alleged deficient practice in regards to Resident # 101 by completing a Physical Therapy evaluation to determine positioning needs while in the wheelchair. Resident # 101 is able to propel his wheelchair with his feet fully touching the floor at a 90 degree angle. 2. Residents who utilize a wheelchair for mobility have the potential to be affected by the same alleged deficient practice; therefore, the Rehab Program Manager and/or Occupational Therapist have identified residents who will require evaluation of their seating	

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F 328	Continued From page 6 A review of Resident #58's medical record revealed a physician's order dated 11/15/14. The order specified to administer Fortaz (an antibiotic) 2 grams intravenously (IV) every 12 hours for 7 days for a urinary tract infection. On 11/19/14 at 9:20 AM Nurse #1 was observed administering Fortaz to Resident #58. An empty bag labeled as Fortaz was observed hanging from an IV holder with the tubing from the bag threaded through an infusion pump. Nurse #1 was observed removing the empty bag and inserting the existing tubing into a full bag labeled with Fortaz and dated 11/19/14. She followed the proper procedure of priming the existing IV tubing with the new Fortaz mixture, flushing the reusable needle already inserted in the resident's arm, and starting the current administration of Fortaz. When asked, Nurse #1 stated IV tubing should be changed every 72 hours. Nurse #1 was unable to find any indication/date of when the existing IV tubing was last changed. A review of Resident #58's Medication Administration Record, Treatment Administration Record, and nurses notes revealed no documentation of when intermittent IV tubing was last changed. An interview with the Unit Coordinator and the Corporate Nurse Consultant on 11/19/14 at 10:48 AM revealed the facility pharmacy provided the policy the facility followed for intravenous fluid/medication administration. She stated the policy included time frames regarding changing IV tubing. The Unit Coordinator stated intermittent IV medication administration required changing IV tubing every 24 hours and	F 328	to ensure they can propel with their feet fully on the floor. 3. Measures put in place to ensure the alleged deficient does not recur include: In-service education will be conducted by the Director of Nursing & Rehab Program Manager for nursing and rehabilitation staff regarding the provision of services to attain or maintain the highest practicable level of physical, mental, and	

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F 328	Continued From page 7 continuous IV fluid administration required changing IV tubing every 72 hours. The Corporate Nurse Consultant added the tubing should be labeled with the date it was changed. An interview with Nurse #2 on 11/19/14 at 12:09 PM revealed IV tubing should be changed every 72 hours for intermittent IV medication administration. An interview with Nurse #3 on 11/19/14 at 12:10 PM revealed IV tubing should be changed every 24 hours for intermittent IV medication administration. An interview was conducted with the Director of Nursing (DON) on 11/20/14 at 9:45 AM. The DON stated his expectation was for all nurses to know when IV tubing should be changed during intermittent and continuous IV medication/fluid administration.	F 328	psychosocial well-being , specifically, that residents who self-propel in a wheelchair are capable of doing so with their feet fully on the floor and that if/when a resident exhibits a change in this ability then communication will be provided to the therapy department for screening or evaluation to address the need. The Occupational Therapist or other appropriate therapy discipline will continue to review the identified residents noted above until all have been screened and/or evaluated. Residents will be reviewed at least quarterly via the MDS process to assess locomotion/mobility status. Care Rounds will be conducted daily for one	
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	F 353		12-18-14

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F 353	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with toileting and incontinence care due to insufficient nursing staff for 3 of 3 residents (Resident #45, #73, #47). The findings included: 1. Resident #45 was admitted to the facility on 04/30/10 with diagnoses of anxiety and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 08/18/14 revealed Resident #45 was cognitively intact. The MDS further revealed Resident #45 required extensive assistance with toileting. Review of Resident #45's care plan dated 05/14/14 revealed she was care planned for incontinence with a goal to be continent during waking hours. The interventions included ensure resident had an unobstructed path to the restroom, have call light within easy reach and change clothing as needed after incontinence episodes. A review of staffing assignments from May 2014 through November 20, 2014 revealed 3 nurse aides (NAs) were typically scheduled for the	F 353	week then at least weekly for three months to monitor for concerns related to wheelchair positioning. If changes in locomotion using a wheelchair are identified as part of the MDS process or during care rounds, the Interdisciplinary Team will complete a referral to Therapy Service via In-House Communication Form. 4. The Director of Nursing and Administrator will review the results of care rounds and referrals, analyze the data and report patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional	

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F 353	Continued From page 9 11:00 PM to 7:00 AM shift and 12 days out of that time period there were 2 NAs scheduled to work the 11:00 PM to 7:00 AM shift. A review of the Resident Council Meeting minutes dated 05/2014 through 11/2014 revealed residents had complaints about long call bell wait times at each meeting. The August 19, 2014 minutes revealed a complaint that there was not enough staff on the 11:00 PM to 7:00 AM shift and they had to wait too long to be changed. There was no documentation in the minutes of any action taken for long call light wait times or insufficient staffing on the night shift. An interview was conducted on 11/20/14 at 6:40 AM with NA #4. She stated she worked the 11:00 PM to 7:00 AM shift on B hall and the Rehabilitation hall. She stated she had up to 32 residents per shift and didn't feel like they received the care they needed because of staffing. She reported if she was on the Rehabilitation hall she could not see the call lights on B hall and residents had long wait times for call lights to be answered. An interview was conducted on 11/20/14 at 6:45 AM with NA #1. She stated she worked the 11:00 PM to 7:00 AM shift on Resident #45's hall and it was very difficult to keep all the residents toileted, clean, dry, turned and repositioned. She stated she answered call lights as quickly as she could but some residents were soaked to the mattress by the time she was able to get to their room. NA #1 stated Resident #45 had several incidents of incontinence because she wasn't able to answer her call light soon enough. An interview was conducted on 11/20/14 at 6:50	F 353	interventions, based on identified outcomes, to ensure continued F328 compliance. 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #58 by discarding the unlabeled infusion tubing set on 11/19/14. The resident no longer receives intravenous therapy. One to one education with Nurse #1 and Nurse #2 was completed by the Director of Nursing on 11/19/14. 2. Residents who require intravenous medication have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing has completed an audit of residents currently receiving IV medications.	

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F 353	Continued From page 10 AM with NA #2. She stated she worked the 11:00 PM to 7:00 AM shift. She reported she has 25 to 32 residents to care for during her shift and it was very difficult to keep them clean and dry, help them to the bathroom and answer call lights quickly. She stated some residents were soaked through to the mattress due to having to wait so long to be changed. An interview was conducted on 11/20/14 at 8:45 AM with the Activity Director. She stated staffing was a concern at every Resident Council meeting. She reported she took the concerns about staffing to the Director of Nursing (DON). She further stated most of the concerns were not enough staff and long call light waits were on the 3:00 PM to 11:00 PM and 11:00 PM TO 7:00 AM shifts. An interview was conducted with Resident #45 on 11/20/14 at 9:00 AM. She stated she did not have incontinent episodes if staff answered her call light in time for her to get to the bathroom. She stated she had been having 1 to 2 incontinence accidents a week that required her bed sheets and gown to be changed due to long call light waits during the night. She further stated she felt very embarrassed when she had accidents in the bed. An interview was conducted on 11/20/14 at 2:30 PM with the DON. He stated it was his expectation that all care should be provided to residents as quickly as possible. The DON reported there were 3 NAs assigned to the 11:00 PM to 7:00 AM shift with up to 32 residents per NA. He stated the nurses should be assisting with call lights and care. The DON stated he hired NAs as quickly as he could to fill the open	F 353	3. Measures put in place to ensure the alleged deficient practice does not recur include: In-service education for licensed nurses regarding the proper treatment and care for the administration of intravenous medications and/or fluids, specifically, intermittent infusions of medications or fluids require a tubing set change every 24 hours and the tubing sets should be labeled with the date of initiation. The Director of Nursing and/or the Unit	

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F 353	Continued From page 11 positions. He further stated he had not addressed the staffing concerns with the Resident Council. An interview conducted with Administrator on 11/20/14 at 2:55 PM revealed she received a copy of the monthly Resident Council Meeting minutes and had addressed staffing concerns with them in August 2014 to inform the residents they were hiring staff. She further stated she was not aware of resident complaints related to long call light wait times or incontinence episodes due to long call light waits. She further stated residents should not have incontinence episodes due to long call light wait times. 2. Resident #73 was admitted to the facility on 02/11/11 with diagnoses of hypertension, peripheral vascular disease and hemiplegia. Review of the Minimum Data Set (MDS) dated 10/01/14 indicated Resident #73 was cognitively intact. The MDS further revealed Resident #73 was completely dependent for toileting and was incontinent of bowel and bladder. Review of the care plan dated 06/24/14 revealed Resident #73 had bowel and bladder incontinence with interventions to provide care after each incontinent episode and wear briefs. A review of staffing assignments from May 2014 through November 20, 2014 revealed 3 nurse aides (NAs) were typically scheduled for the 11:00 PM to 7:00 AM shift and 12 days out of that time period there were 2 NAs scheduled to work the 11:00 PM to 7:00 AM shift. A review of the Resident Council Meeting minutes dated 05/2014 through 11/2014 revealed residents had complaints about long call bell wait	F 353	Managers will conduct care rounds daily for one week then at least weekly for three months to identify that tubing sets for intravenous medications or fluids have been labeled with the appropriate date and changed according to policy. Licensed Nurses will have a medication pass observation completed at least annually to include intravenous tubing set labeling and changing according to facility policy. 4. The Director of Nursing and Administrator will review the results of care rounds and medication pass observations, analyze the data and report patterns/trends to the QAPI committee every other month for 6 months. The QAPI committee will evaluate the effectiveness of the above	

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F 353	Continued From page 12 times at each meeting. The August 19, 2014 minutes revealed a complaint that there was not enough staff on the 11:00 PM to 7:00 AM shift and they had to wait too long to be changed. There was no documentation in the minutes of any action taken for long call light wait times or insufficient staffing on the night shift. An interview was conducted on 11/20/14 at 6:40 AM with NA #4. She stated she worked the 11:00 PM to 7:00 AM shift on B hall and the Rehabilitation hall. She stated she had up to 32 residents per shift and didn't feel like they received the care they needed because of staffing. She reported if she was on the Rehabilitation hall she could not see the call lights on B hall and residents had long wait times for call lights to be answered. An interview was conducted on 11/20/14 at 6:45 AM with NA #1. She stated she worked the 11:00 PM to 7:00 AM shift and it was very difficult to keep all the residents toileted, clean, dry, turned and repositioned. She stated she answered call lights as quickly as she could but some residents were soaked to the mattress by the time she was able to get to their room. An interview was conducted on 11/20/14 at 6:50 AM with NA #2. She stated she worked the 11:00 PM to 7:00 AM shift. She reported she has 25 to 32 residents to care for during her shift and it was very difficult to keep them clean and dry, help them to the bathroom and answer call lights quickly. She stated some residents were soaked through to the mattress due to having to wait so long to be changed. An interview was conducted on 11/20/14 at 8:45	F 353	plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance. F353 1. Corrective action for the alleged deficient practice for Resident 45, Resident #73, and Resident #47 has been accomplished by providing assistance with toileting and incontinence care in a timely manner. Staffing levels have been reviewed and adjusted to provide for care needs on third shift. 2. Residents who require assistance with toileting or incontinence care have the potential to be affected by the same alleged deficient practice; therefore, the Director of	

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F 353	Continued From page 13 AM with the Activity Director. She stated staffing was a concern at every Resident Council meeting. She reported she took the concerns about staffing to the Director of Nursing (DON). She further stated most of the concerns were not enough staff and long call light waits were on the 3:00 PM to 11:00 PM and 11:00 PM TO 7:00 AM shifts. An interview was conducted on 11/20/14 at 11:38 AM with Resident #73. He stated he had to wait between 45 minutes to hour for his call light to be answered on the 11:00 PM to 7:00 AM most nights. He stated he rang his call light because he knew he was wet and if they didn't change him soon enough the urine soaked through his brief to the bed. He further stated he knew how long he waited for his light to be answered because he had a clock on his wall in front of his bed. An interview was conducted on 11/20/14 at 2:30 PM with the DON. He stated it was his expectation that all care should be provided to residents as quickly as possible. The DON reported there were 3 NAs assigned to the 11:00 PM to 7:00 AM shift with up to 32 residents per NA. He stated the nurses should be assisting with call lights and care. The DON stated he hired NAs as quickly as he could to fill the open positions. He further stated he had not addressed the staffing concerns with the Resident Council. An interview conducted with Administrator on 11/20/14 at 2:55 PM revealed she received a copy of the monthly Resident Council Meeting minutes and had addressed staffing concerns with them in August 2014 to inform the residents they were hiring staff. She further stated she was not aware of resident complaints related to long	F 353	Nursing has completed an audit of current residents to identify their toileting/incontinence needs. The Interdisciplinary Team has reviewed Care Grids for the identified residents to ensure the Resident Care Specialists are provided with communication related to toileting/incontinence needs. The Administrator and/or Director of Nursing have evaluated staffing levels based on care needs and made adjustments where necessary. The Social Services Director has completed an audit of current residents who are capable of participating in interviews regarding	

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F 353	Continued From page 14 call light wait times or incontinence episodes due to long call light waits. She further stated residents should not have incontinence episodes due to long call wait times. 3. Resident # 47 was admitted to the facility on 09/01/09 with diagnoses of hypertension, anxiety and hyperlipidemia. Review of the Minimum Data Set dated 09/09/14 indicated Resident #47 was cognitively intact. The MDS further revealed Resident #47 required extensive assistance with toileting and was frequently incontinent of bladder. Review of Resident #47 ' s care plan revealed there was no care plan for urinary incontinence. A review of staffing assignments from May 2014 through November 20, 2014 revealed 3 nurse aides (NAs) were typically scheduled for the 11:00 PM to 7:00 AM shift and 12 days out of that time period there were 2 NAs scheduled to work the 11:00 PM to 7:00 AM shift. A review of the Resident Council Meeting minutes dated 05/2014 through 11/2014 revealed residents had complaints about long call bell wait times at each meeting. The August 19, 2014 minutes revealed a complaint that there was not enough staff on the 11:00 PM to 7:00 AM shift and they had to wait too long to be changed. There was no documentation in the minutes of any action taken for long call light wait times or insufficient staffing on the night shift. An interview was conducted on 11/20/14 at 6:40 AM with NA #4. She stated she worked the 11:00 PM to 7:00 AM shift on B hall and the Rehabilitation hall. She stated she had up to 32	F 353	timely toileting assistance and/or incontinence care. 3. Measures put in place to ensure the alleged deficient practice does not recur include: In-service education will be conducted for nursing staff regarding the provision of toileting/incontinence care in a timely manner and maintaining adequate staffing levels to provide for care needs. The Division Director of Clinical Services will conduct In-service education for the Director of Nursing and Administrator regarding review of staffing patterns and the provision of care on all shifts. The Director of Nursing or Administrator will review nursing staffing schedules daily, Monday through	

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F 353	Continued From page 15 residents per shift and didn't feel like they received the care they needed because of staffing. She reported if she was on the Rehabilitation hall she could not see the call lights on B hall and residents had long wait times for call lights to be answered. An interview was conducted on 11/20/14 at 6:45 AM with NA #1. She stated she worked the 11:00 PM to 7:00 AM shift and it was very difficult to keep all the residents toileted, clean, dry, turned and repositioned. She stated she answered call lights as quickly as she could but some residents were soaked to the mattress by the time she was able to get to their room. An interview was conducted on 11/20/14 at 6:50 AM with NA #2. She stated she worked the 11:00 PM to 7:00 AM shift. She reported she has 25 to 32 residents to care for during her shift and it was very difficult to keep them clean and dry, help them to the bathroom and answer call lights quickly. She stated some residents were soaked through to the mattress due to having to wait so long to be changed. An interview was conducted on 11/20/14 at 8:45 AM with the Activity Director. She stated staffing was a concern at every Resident Council meeting. She reported she took the concerns about staffing to the Director of Nursing (DON). She further stated most of the concerns were not enough staff and long call light waits were on the 3:00 PM to 11:00 PM and 11:00 PM TO 7:00 AM shifts. An interview was conducted on 11/20/14 at 11:55 AM with Resident #47. She stated she wet herself almost every night waiting on staff to answer her	F 353	Friday, including review of weekend nursing staffing schedules, to ensure that staffing is adequate to provide for the care of residents. The Director of Nursing, Unit Managers, or Social Services Director will conduct interviews with at least 25% of interviewable residents who require toileting assistance or incontinence care to identify concerns related to timely toileting assistance on a monthly basis for three months. Resident Council meetings will include questions regarding timely toileting assistance bi-weekly for 1 month, then monthly for the next 3 months. The	

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F 353	Continued From page 16 call light to help her to the bathroom. She stated the response time is the worst during the night. An interview was conducted on 11/20/14 at 2:30 PM with the DON. He stated it was his expectation that all care should be provided to residents as quickly as possible. The DON reported there were 3 NAs assigned to the 11:00 PM to 7:00 AM shift with up to 32 residents per NA. He stated the nurses should be assisting with call lights and care. The DON stated he hired NAs as quickly as he could to fill the open positions. He further stated he had not addressed the staffing concerns with the Resident Council. An interview conducted with Administrator on 11/20/14 at 2:55 PM revealed she received a copy of the monthly Resident Council Meeting minutes and had addressed staffing concerns with them in August 2014 to inform the residents they were hiring staff. She further stated she was not aware resident complaints related to long call light waits or incontinence episodes due to long call light wait times. She further stated residents should not have incontinence episodes due to long call light wait times.	F 353	Administrator will review the minutes for concerns and timely response to noted concerns. Care Rounds will be completed by Nursing Administration daily for one week then at least weekly for 3 months to identify concerns with timely toileting assistance to ensure continued compliance. 4. The Administrator and DON will review the results of care rounds, interviews, Resident Council minutes, and staffing sheets, analyze the data and report patterns and trends to the QAPI committee every other month for six months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance.	
F 371 SS=E	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	F 371		12-18-14

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F 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep food preparation service equipment clean and dry when stored; failed to keep 2 plastic containers used for ice scoops for 2 of 3 ice chests free from black particles; and failed to label and date stored food in 2 of 2 nourishment rooms. The findings included: 1. Observations of the facility's kitchen on 11/17/14 at 10:00 AM revealed the following problem with stored food preparation equipment. Visual inspection of pans stored stacked together in the food preparation area and identified by the Food Service Director (FSD) and the kitchen cook as ready for use, revealed moisture on the inside of 2 of 6 stacked pans and 1 of 5 pans from another stack of pans contained dried food debris on the outside edge of the pan. On 11/17/14 at 10:29AM visual inspection of the metal slicer, which was covered and ready for use, revealed a white powdery substance over the entire metal surface of the slicer when uncovered. Observations on 11/17/14 at 10:05 AM revealed a blue plastic container that held the ice scoop for the kitchen ice chest. The container was observed to have dark black specks on the bottom and inside edge of the container. An interview on 11/17/14 10:29 AM with the FSD revealed that food storage equipment such as pans should be stored clean, not wet, and air	F 371	F371 1. Corrective action for the alleged deficient practice has been accomplished by washing the identified pans and drying them by arranging separately without stacking. The plastic storage containers for ice scoops were cleaned. The meat slicer was cleaned and covered for the next use. Items in the nourishment rooms were removed and discarded at the time of identification. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Dietary Services Manager has completed an audit of equipment and ice scoop storage containers to ensure their cleanliness. New ice scoops with	

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F 371	Continued From page 18 dried. The expectation for the kitchen slicer was that it should be cleaned after each use. The FSD specified that the white powdery substance was thickner. Further interview with the FSD revealed the container which held the ice scoop should be checked every day by the kitchen aides and if it needed cleaning it should be cleaned and sanitized before storing the scoop in the container. 2. Observation of the unit A nourishment room on 11/17/14 at 10:45 AM revealed one quart of opened ice cream stored with no label or date when opened. An interview was conducted with Nurse #4 who was present in the nourishment room at the time. She stated dietary staff have responsibility to clean the nourishment room refrigerators and discard any food not labeled or dated. She said the ice cream should have had a label and date when opened. Observation of the unit B nourishment room on 11/17/14 at 10:47 AM revealed a container of an opened latte coffee creamer with used by date of 10/09/14 with no label or date when opened on the beverage. Further observation of unit B nourishment room revealed a plastic container with ¼ inch water and black particles on the bottom of the container with an ice scoop stored in the container. An interview with Nurse #4 who was present in the nourishment room at the time revealed dietary staff have responsibility to clean the nourishment room refrigerators and discard any food not labeled or dated. She stated that nurse aides were supposed to check the containers holding the ice scoops and make sure they had been cleaned and sanitized before ice gets passed.	F 371	internal drainage trays were purchased and are in use. Nourishment rooms have been audited by the Dietary Services Manager to ensure undated, unlabeled, or expired items are not present. 3. Measures put in place to ensure the alleged deficient practice does not recur include: In-service education for dietary services staff regarding storing, preparing, and distributing food in a sanitary manner, specifically, drying procedures for clean items such as pans; cleaning of ice scoop containers according to a schedule or when soiling is noted; cleaning and storage of kitchen equipment such as meat slicers; and monitoring nourishment rooms for timely discard	

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F 371	Continued From page 19 An interview was conducted with the FSD on 11/19/14 at 11:10 AM. He stated that the dietary aides had the responsibility of keeping the nourishment room refrigerators clean. They were to discard any unlabaed and undated food. He stated the containers for the ice scoops in the nourishment rooms should be cleaned and sanitized by nursing staff before placing the scoops back in the container and before passing ice.	F 371	of expiring items as well as labeling/dating of food items stored in nourishment room refrigerators. The Dietary Services Manager will review cleaning schedules on a weekly basis to ensure adherence. Discrepancies will be corrected at the time of identification. The Dietary Services Manager or Registered Dietician will complete Kitchen Sanitation Checklists at least monthly and submit the checklist to the Administrator for review. Nourishment rooms will be checked daily by Dietary Staff to identify concerns with labeling, dating, or expired items.	

Continuation

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F 371	Continued From page 19 An interview was conducted with the FSD on 11/19/14 at 11:10 AM. He stated that the dietary aides had the responsibility of keeping the nourishment room refrigerators clean. They were to discard any unlabaed and undated food. He stated the containers for the ice scoops in the nourishment rooms should be cleaned and sanitized by nursing staff before placing the scoops back in the container and before passing ice.	F 371	months. The QAPI committee will evaluate the effectiveness of the plan and amend the plan based on identified outcomes to ensure continued compliance. 4. The Administrator and Administrator will review the results of cleaning schedules, kitchen sanitation checklists, and nourishment room audits, analyze the data and report trends and patterns to the QAPI committee every other month for 6	

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