STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	C 04/24/2015

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BRIAN CTR HEALTH & REHABI HICK	3031 TATE BOULEVARD SE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159		5/22/15

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

Electronically Signed | 05/22/2015

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interviews, record reviews and staff interviews, the facility failed to have resident fund accounts accessible on the weekends to 3 of 3 sampled residents. (Residents #41, #63, and #70). The findings included: 1. Resident #63 was admitted to the facility on 11/24/14. Her admission Minimum Data Set dated 12/03/14 coded her as being cognitively intact. Resident #63 stated during interview on 04/20/15 at 12:05 PM that the facility held a personal fund account for her. She stated that she could not access her money after noon on Saturdays or anytime on Sundays. She stated she had gone to get money from her account on Sundays but the door has been closed and locked. She further stated that she had to remember to get money out a day or two before the weekend if she wanted money over the weekend. Interview with the Business Office Manager (BOM) on 04/23/15 at 3:16 PM confirmed that Resident #63 had a personal funds account with the facility. Per BOM, residents wishing to withdrawal money from their personal funds	F 159	F 159 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents # 41, #63, and #70 by ensuring that they have access to their funds on the weekends. 2. Facility residents who have a resident trust account have the potential to be affected by the same alleged deficient practice. Therefore, the Business Office Manager has implemented a process to provide access to resident trust accounts on the weekends. An audit of the resident trust account roster has been completed by the Business Office Manager and she has provided these residents with information on how to access their funds. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator and Director of Nursing will conduct in-service/re-education for the Business Office Manager and Weekend Charge Nurses regarding the process for accessibility of residents¿ funds on weekends. The Resident Council will meet in the month of May to review the residents¿ right to access their personal funds. The facility¿s Ambassadors will	

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F 159	Continued From page 2 account could come to the office themselves or send a request from nurse aide to the office and staff would go to the resident. She stated money was available between 8 AM and 6 PM Monday through Fridays. She further stated no one was in the office during the weekends and that residents were aware they could get their money on Fridays if they needed it over the weekend. A follow up interview with Resident #63 on 04/24/15 at 2:13 revealed that she was unhappy with not having access to her money on the weekends and stated she recently could not go shopping with a family member due to not having access to her money. Interview with the Administrator on 04/24/15 at 1:14 PM revealed that residents have not expressed concerns about not being able to get their money on the weekends in resident council or via grievance forms. He stated that residents were probably not getting money over the weekends. 2. Resident #70 was admitted to the facility multiple times including 12/20/14. Her most recent Minimum Data Set, a 60 day assessment dated 02/14/15, coded her with intact cognition. Resident #70 stated during interview on 04/21/15 at 8:42 AM that she had a personal fund account with the facility and could not get her money on the weekends. A follow up interview was conducted with Resident #70 on 04/23/15 at 11:35 AM during which she stated she wanted to be able to get her money on the weekends if she needed it. She further stated it was her money and she should be able to get it any time.	F 159	conduct visits at least weekly for two months with assigned residents to include questions regarding access to their resident trust account, if applicable. New admissions will have information regarding resident trust accounts provided to them or their responsible party as part of their admission paperwork. The Administrator will review concerns during the morning stand up meeting to identify issues with funds availability and ensure prompt follow up with concerned individuals. On a monthly basis, the Administrator will review Resident Council meeting minutes to identify concerns regarding funds availability to ensure continued compliance. 4. The Administrator or Director of Nursing will review data obtained during audits of concerns and resident council meetings, analyze the data and report patterns/trends to the QAPI committee every other monthly for six months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 159	Continued From page 3	F 159		

Interview with the Business Office Manager (BOM) on 04/23/15 at 3:16 PM confirmed that Resident #70 had a personal funds account with the facility. Per BOM, residents wishing to withdrawal money from their personal funds account could come to the office themselves or send a request from nurse aide to the office and staff would go to the resident. She stated money was available between 8 AM and 6 PM Monday through Fridays. She further stated no one was in the office during the weekends and that residents were aware they could get their money on Fridays if they needed it over the weekend.

Interview with the Administrator on 04/24/15 at 1:14 PM revealed that residents have not expressed concerns about not being able to get their money on the weekends in resident council or via grievance forms. He stated that residents were probably not getting money over the weekends.

3. Resident #41 was admitted to the facility most recently on 06/23/14. Her most recent Minimum data Set, a quarterly dated 02/20/15 coded her as having intact cognition.

On 04/21/15 at 9:53 AM, Resident #41 stated she had a personal fund account with the facility but could not get money on the weekends. She stated that she had to withdrawal money on Fridays if she wanted money available on the weekend.

Interview with the Business Office Manager (BOM) on 04/23/15 at 3:16 PM confirmed that Resident #41 had a personal funds account with the facility. Per BOM, residents wishing to withdrawal money from their personal funds

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F 159	Continued From page 4 account could come to the office themselves or send a request from nurse aide to the office and staff would go to the resident. She stated money was available between 8 AM and 6 PM Monday through Fridays. She further stated no one was in the office during the weekends and that residents were aware they could get their money on Fridays if they needed it over the weekend. Interview with the Administrator on 04/24/15 at 1:14 PM revealed that residents have not expressed concerns about not being able to get their money on the weekends in resident council or via grievance forms. He stated that residents were probably not getting money over the weekends.	F 159		
F 171 SS=D	483.10(i)(2) ACCESS TO STATIONERY/POSTAGE/PENS, ETC The resident has the right to privacy in written communications, including the right to have access to stationery, postage, and writing implements at the resident's own expense. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to deliver mail 1 day out of 6 days that mail came to the facility. The findings included: Resident #97 was admitted to the facility on 05/27/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 12/12/14 revealed Resident #97 was cognitively intact.	F 171	F 171 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #97 by ensuring that he/she receives mail that is addressed to him/her on Saturdays. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore the Activities Manager has established a process for delivery of mail on Saturdays via the Manager on	5/22/15

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F 171	Continued From page 5 An interview was conducted on 04/23/15 at 2:30 PM with Resident #97. She stated if she had mail delivered to the facility on Saturday she would like receive it on Saturday. Resident #97 stated she received her Saturday mail at the same time she received her mail on Mondays. An interview was conducted on 04/23/15 at 2:58 PM with the Activity Director. He stated he delivered the resident mail at the facility Monday through Friday and the mail that came on Saturday was locked in an office and delivered on Monday. An interview was conducted on 04/24/15 at 3:51 PM with the Director of Nursing (DON). She stated the resident mail was delivered Monday through Friday and the Saturday mail was locked in an office and delivered on Monday. The DON stated a resident should be able to get their mail on Saturday if they wanted it.	F 171	Duty. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Administrator will conduct in-service/re-education for the Activities Manager, Activities Assistant, and Interdisciplinary Team regarding the requirement to provide mail to residents on weekends. A Resident Council meeting will be conducted in the month of May to review the residents¿ right to have their mail delivered timely. The facility¿s Ambassadors will conduct visits at least weekly for two months with assigned residents to include questions regarding mail delivery. The Administrator will review concerns during the morning stand up meeting to identify issues concerning mail delivery. On a monthly basis, the Administrator will review Resident Council meeting minutes to identify concerns with mail delivery on Saturdays to ensure continued compliance. 4. The Administrator or Director of Nursing will review data obtained during audits of concerns, Ambassador rounds, and resident council meetings; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		5/22/15

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F 225	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 225	F 225	

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F 225	Continued From page 7 facility failed to report to the state allegations of abuse and investigation results within the required time frames for 1 of 5 sampled residents (Residents #82) and failed to investigate an allegation of misappropriation of property for 1 of 5 sampled residents (Resident #210). The findings included the following: 1. Resident #82 was readmitted to the facility on 10/10/14. The Admission Minimum Data Set dated 10/17/14 coded her with long and short term memory deficits, having no behaviors, being nonambulatory, and requiring extensive assistance with most of her activities of daily living skills (ADLs). Review of grievances revealed that on 11/03/14, Resident #82's family filed a written grievance which stated Resident #82 stated that nurse aide (NA) #3 "beat on her while changing her or interacting with her." The grievance also stated that NA #3 told Resident #82 that "she was a cry baby (verbal abuse)." An additional note written on the grievance form, from the former Assistant Director of Nursing (ADON), stated this occurred around breakfast that the specified nurse aide "slammed her against the wall & twisted her legs, called her Ms. Priss & a cry baby." Attached to the grievance were interviews with 3 staff members, an interview with Resident #82, and a reinterview with the family who initially reported the abuse. There was no evidence that the allegation of abuse was reported to the state as required within 24 hours of the allegation and no evidence that a 5 day report of the investigation was reported to the state as required.	F 225	1. Corrective action could not be accomplished for Resident #82 as no 24-hr or 5-Working Day report was located for the allegation of 11/3/2014. Resident # 201 was discharged from the facility; therefore, no corrective action could be accomplished for this resident with regard to missing jewelry. The new Administrator and Director of Nursing were educated by the District Clinical Director regarding the requirement for reporting allegations according to the facility¿s Abuse Prohibition Policy. 2. Facility residents have the potential to be affected by the same alleged deficient practice therefore, the Administrator has conducted an audit of the last 30 days of concerns and last 30 days of reported allegations to ensure that reporting and investigation occurred timely and appropriately. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The District Clinical Director will conduct in-service/re-education for the Interdisciplinary Team, including the Administrator, Director of Nursing, Social Services Director, Activities Manager, Rehab Manager, Care Management Director, and Nurse Managers regarding the facility¿s policy on Abuse & Neglect Prohibition, specifically, that when an allegation of this nature is received, the Abuse Coordinator is to be notified immediately, an investigation is to begin, and proper reporting is to be accomplished. In addition, the Administrator and Director of Nursing will conduct in-service/re-education for facility	

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F 225	Continued From page 8 An interview was conducted with the interim Administrator and the Division Director of Clinical Education on 04/23/15 at 1:50 PM. The Administrator stated that initially the facility would ensure that the resident making an allegation of abuse was removed from threat and interviews would be conducted of appropriate staff, covering questions of who, what where, when and why. He stated that a 24 hour report would be sent to the state and then another report would be sent to the state with the investigation information within 5 days. The Division Director of Clinical Education stated there was no 24 or 5 day report sent to the state agency as required. On 04/24/15 at 10:10 AM, the Director of Nursing (DON) stated all reports of abuse were given to the Administrator who initiated the investigation piece. The DON stated she followed the instructions of the Administrator and if asked to investigate, she interviewed the resident and follow up with any staff that was on duty at the time of the allegation. She then followed up with her findings with the Administrator. Regarding the grievance of Resident #82, DON stated the former ADON called the DON at home to report family's allegation and she in turn reported it to the former Administrator. The former Administrator instructed the DON to conduct interviews in the morning. DON stated her interviews concluded there were inconsistencies, the resident had a history of delusions, and the family did not believe these allegations, so abuse was unsubstantiated. The District Clinical Director present during this interview stated the former Administrator was the abuse coordinator and was responsible for filing the 24 hour and 5 day reports with the state which was not done.	F 225	staff regarding the facility¿s Abuse & Neglect Prohibition policy. The Administrator will review concerns during the morning stand up meeting to identify potential reportable issues and ensure that reporting and investigation is completed per policy. On a monthly basis, the Administrator and Director of Nursing will review any reports to the State Agency to ensure that all components of the report are present to ensure continued compliance. 4. The Administrator or Director of Nursing will review data obtained during concern and report audits; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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2. Resident #201 was admitted to the facility on 02/11/14. Review of the facility's abuse investigations revealed a 24 hour report submitted to the state which indicated Resident #201 reported that while she was at church, a zip lock bag of jewelry went missing from her room on 03/02/14.

The 5 day report submitted to the state by the former Administrator on 03/07/14 indicated that the police had been contacted, the room was searched, staff on the unit were interviewed and there was no conclusion to the missing bag.

A copy of the police report revealed items missing included pearl earrings, diamond earrings, gold hoop earrings, Avon bumble bee earrings, crystal earrings and gold ball earrings.

The facility was unable to provide information as to who searched the resident's room, what staff were working on that unit, what staff were interviewed, what staff said and or any follow up with the police during the investigation to assure a thorough investigation had been completed.

Interview with the Director of Nursing (DON) and the District Clinical Director on 04/24/15 at 10:10 AM revealed all reports of abuse were given to the Administrator who initiated the investigation piece. The DON stated she followed the instructions of the Administrator and if asked to investigate, she interviewed the resident and any staff that was on duty at the time of the allegation. She then followed up with her findings with the Administrator. DON stated that at the time of this incident, the former Administrator took over the investigation. No specific notes regarding the

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F 225	Continued From page 10 investigation could be located. DON stated she did not conduct any interviews related to the missing jewelry.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their abuse policy and procedures for reporting allegations and investigations of abuse to the state agency and failed to investigate an allegation of misappropriation of property for 2 of 5 sampled residents (Residents #82 and #210). The findings included the following: The facility policy "Abuse & Neglect Prohibition" with a revision date of June 2013 included: *The facility administrator is the Abuse Prevention Coordinator. *The facility will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law. *The facility will report such allegations to the state, in accordance with state regulation. *The facility will report all investigation findings to the stated in accordance with state regulations.	F 226	F226 1. Corrective action could not be accomplished for Resident #82 as no 24-hr or 5-Working Day report was located for the allegation of 11/3/2014. Resident # 201 was discharged from the facility; therefore, no corrective action could be accomplished for this resident with regard to missing jewelry. The new Administrator and Director of Nursing were educated by the District Clinical Director regarding the requirement for reporting allegations according to the facility¿s Abuse Prohibition Policy. 2. Facility residents have the potential to be affected by the same alleged deficient practice therefore, the Administrator has conducted an audit of the last 30 days of concerns and last 30 days of reported allegations to ensure that reporting and investigation occurred timely and appropriately. 3. Measures put into place to ensure	5/22/15

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F 226	Continued From page 11 1. Resident #82 was readmitted to the facility on 10/10/14. The Admission Minimum Data Set dated 10/17/14 coded her with long and short term memory deficits, having no behaviors, being nonambulatory, and requiring extensive assistance with most of her activities of daily living skills (ADLs). Review of grievances revealed that on 11/03/14, Resident #82's family filed a written grievance which stated Resident #82 stated that Nurse Aide (NA) #3 "beat on her while changing her or interacting with her." The grievance also stated that NA #3 told Resident #82 that "she was a cry baby (verbal abuse)." An additional note written on the grievance form, from the former Assistant Director of Nursing (ADON), stated this occurred around breakfast that NA #3 "slammed her against the wall & twisted her legs, called her Ms. Priss & a cry baby." Attached to the grievance were interviews with 3 staff members, an interview with Resident #82, and a reinterview with the family who initially reported the abuse. There was no evidence that the allegation of abuse was reported to the state as required within 24 hours of the allegation and no evidence that a 5 day report of the investigation was reported to the state as required. An interview was conducted with the interim Administrator and the Division Director of Clinical Education on 04/23/15 at 1:50 PM. The Administrator stated that initially the facility would ensure that the resident making an allegation of abuse was removed from threat and interviews would be conducted of appropriate staff, covering questions of who, what where, when and why.	F 226	that the alleged deficient practice does not recur include: The District Clinical Director will conduct in-service/re-education for the Interdisciplinary Team, including the Administrator, Director of Nursing, Social Services Director, Activities Manager, Rehab Manager, Care Management Director, and Nurse Managers regarding the facility¿s policy on Abuse & Neglect Prohibition, specifically, that when an allegation of this nature is received, the Abuse Coordinator is to be notified immediately, an investigation is to begin, and proper reporting is to be accomplished. In addition, the Administrator and Director of Nursing will conduct in-service/re-education for facility staff regarding the facility¿s Abuse & Neglect Prohibition policy. The Administrator will review concerns during the morning stand up meeting to identify potential reportable issues and ensure that reporting and investigation is completed per policy. On a monthly basis, the Administrator and Director of Nursing will review any reports to the State Agency to ensure that all components of the report are present to ensure continued compliance. 4. The Administrator or Director of Nursing will review data obtained during concern and report audits; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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He stated that a 24 hour report would be sent to the state and then another report would be sent to the state with the investigation information within 5 days. The Division Director of Clinical Education stated there was no 24 or 5 day report found in the facility with the grievance.

On 04/24/15 at 10:10 AM, the Director of Nursing (DON) stated all reports of abuse were given to the Administrator who initiated the investigation piece. The DON stated she followed the instructions of the Administrator and if asked to investigate, she interviewed the resident and follow up with any staff that was on duty at the time of the allegation. She then followed up with her findings with the Administrator. Regarding the grievance of Resident #82, DON stated the former ADON called the DON at home to report family's allegation and she in turn reported it to the former Administrator. The former Administrator instructed the DON to conduct interviews in the morning. DON stated her interviews concluded there were inconsistencies, the resident had a history of delusions, and the family did not believe these allegations, so abuse was unsubstantiated. The District Clinical Director present during this interview stated the former Administrator was the abuse coordinator and was responsible for filing the 24 hour and 5 day reports with the state which was not done.

2. Resident #201 was admitted to the facility on 02/11/14. Review of the facility's abuse investigations revealed a 24 hour report submitted to the state which indicated Resident #201 reported that while who was at church, a zip lock bag of jewelry went missing from her room on 03/02/14.

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F 226	Continued From page 13 The 5 day report submitted to the state by the former Administrator on 03/07/14 indicated that the police had been contacted, the room was searched, staff on the unit were interviewed and there was no conclusion to the missing bag. A copy of the police report revealed items missing included pearl earrings, diamond earrings, gold hoop earrings, Avon bumble bee earrings, crystal earrings and gold ball earrings. The facility was unable to provide information as to who searched the resident's room, what staff were working on that unit, what staff were interviewed, what staff said and or any follow up with the police during the investigation to assure a thorough investigation had been completed. Interview with the Director of Nursing (DON) and the District Clinical Director on 04/24/15 at 10:10 AM revealed all reports of abuse were given to the Administrator who initiated the investigation piece. The DON stated she followed the instructions of the Administrator and if asked to investigate, she interviewed the resident and any staff that was on duty at the time of the allegation. She then followed up with her findings with the Administrator. DON stated that at the time of this incident, the former Administrator took over the investigation. No specific notes regarding the investigation could be located. DON stated she did not conduct any interviews related to the missing jewelry.	F 226		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or	F 242		5/22/15

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F 242	Continued From page 14 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 observations, record review and resident and staff interviews the facility failed to accommodate food choices for 2 of 2 residents reviewed for food choices (Resident #20 and Resident #51) and the facility failed to provide residents with their preferred number of showers a week for 2 of 2 residents reviewed for choices (Resident #78, #200). The findings included: 1. Resident #20 was admitted to the facility on 11/28/06 with diagnoses of diabetes, esophageal reflux and quadriplegia. The quarterly Minimum Data Set (MDS) dated 02/28/15 revealed Resident #20 was cognitively intact and was dependent for eating. Review of the facility grievances from 11/2014 through 04/2015 revealed there were 7 grievances related to resident food choices not being honored. An observation was made on 04/22/15 at 1:07 PM of Resident #20 receive his lunch tray. Nurse Aide (NA) #7 assisted Resident #20 with his lunch. Resident #20 asked NA #7 where his side of baked chicken was. Resident #20 told NA #7 he had spoken to the Dietary Manager (DM) earlier that morning and told her he wanted a side	F 242	F 242 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #20 and #51 by interviewing the residents to identify food preferences and documenting the information in the dietary tray card system. Resident # 78 has been interviewed regarding preferences for showers and this information has been added to the shower schedule to accommodate for the resident¿s choices. Resident #200 has been discharged from the facility. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Social Services Director and Assistant Director of Nursing have completed an audit of current residents¿ preferences to include choice related to showers. The Dietary Manager has audited the current resident population to identify that food preferences are documented and honored. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Social Services Director and Dietary Manager will conduct in-service/re-education for dietary and	

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F 242	Continued From page 15 of baked chicken on his lunch tray in case he couldn't eat the liver and onions and she wrote it on his tray card. NA #7 called the kitchen and requested Resident #20's side of baked chicken which was delivered to his room 15 minutes later. An interview was conducted on 04/22/15 at 9:52 AM with Nurse Aide (NA) #9. She stated she received a lot of complaints from her residents regarding not receiving what they ask for on their trays. She stated if a resident asked for a sandwich or a snack throughout the day they are told the kitchen was out of what they wanted. NA #9 stated she has a resident that asked for 2 cups of coffee with each meal and it was documented on her tray card for 2 cups but she received 1 cup of coffee with each meal. An interview was conducted on 04/22/15 at 3:43 PM with Nurse #3. She stated the kitchen ran out of the alternate meal on a daily basis. NA #3 stated if a resident wanted a sandwich the kitchen may or may not be able to provide it due to running out of food used to make it. An interview was conducted on 04/23/15 at 8:52 AM with Resident #20. He stated if he didn't like what was on the menu and asked for a sandwich or the alternate meal he didn't receive it most of the time due to being told the kitchen was out of what he wanted. He stated the kitchen ran out of food all of the time. An interview was conducted on 04/24/15 at 10:13 AM with the Dietary Manager (DM). She stated she interviewed the residents on admission about their likes and dislikes and choices for their tray cards and inputs the information into the computer to be printed on the card. She stated if	F 242	nursing staff regarding the resident¿s right to make choices consistent with their interests, specifically, honoring choices related to food preferences and shower schedules. The Administrator will review concerns during morning stand up meeting to identify opportunities related to providing for resident choices and ensure timely follow up. The Dietary Manager or Registered Dietician will obtain food likes/dislikes/preferences during the admission assessment and document the information in the medical record and dietary tray card system. During the 72-hour Care Conference, the Social Services Director or Social Services Assistant will inquire as to preferences for baths/showers and provide the information to the Director of Nursing for documentation on the shower schedule. The facility¿s Ambassadors (team members who visit with residents routinely to identify concerns/needs) will conduct visits at least weekly for 4 weeks to include questions regarding preferences such as food and shower choices. The Administrator will review the minutes from Resident Council monthly to identify concerns related to food or shower preferences and provide a timely response to ensure continued compliance. 4. The Administrator and Dietary Manager will review data obtained during food/shower preference audits, concerns, and Ambassador rounds; analyze the data and report patterns/trends to the QAPI committee every other month for six months. The QAPI committee will	

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F 242	Continued From page 16 a resident didn't want the regular meal they could choose the alternate and it should be available to them. She stated if a resident wanted 2 cups of coffee with every meal and it was documented on their tray card they should receive 2 cups of coffee with every meal. The DM further stated they have never ran out of food but might run short if there were new admissions to the facility. An interview was conducted on 04/24/15 at 1:45 PM with the Administrator. He stated he was aware of residents not receiving what they requested on their meal trays and was currently working with dietary to improve the issue. He stated resident's food choices should be accommodated. 2. Resident #51 was admitted to the facility on 02/17/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 01/09/15 revealed Resident #51 was cognitively intact. Review of the facility grievances from 11/2014 through 04/2015 revealed there were 7 grievances related to resident food choices not being honored. An observation made on 04/22/15 at 9:45 AM of Resident #51's breakfast tray revealed she had 1 cup of coffee and her tray card indicated she was to have 2 cups of coffee. An interview was conducted on 04/22/15 at 9:52 AM with Nurse Aide (NA) #9. She stated she received a lot of complaints from her residents regarding not receiving what they asked for on their trays. She stated if a resident asked for a sandwich or a snack throughout the day they	F 242	evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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were told the kitchen was out of what they wanted. NA #9 stated Resident #51 asked for 2 cups of coffee with each meal and it was documented on her tray card for 2 cups but she received 1 cup of coffee daily.

An interview was conducted on 04/22/15 at 10:12 AM with Resident #51. She stated she had spoken with the DM many times about getting 2 cups of coffee with each meal and wrote it on her tray card and underlined it on her tray card everyday but continued to receive 1 cup of coffee. She stated she shouldn't have to ask for a 2nd cup of coffee every day.

An interview was conducted on 04/24/15 at 10:13 AM with the Dietary Manager (DM). She stated she interviewed the residents on admission about their likes and dislikes and choices for their tray cards and inputs the information into the computer to be printed on the card. She stated if a resident didn't want the regular meal they could choose the alternate and it should be available to them. She stated if a resident wanted 2 cups of coffee with every meal and it was on their tray card they should be receiving 2 cups of coffee with every meal. The DM further stated they have never ran out of food but they might run short if there are new admissions to the facility.

An interview was conducted on 04/24/15 at 1:45 PM with the Administrator. He stated he was aware of residents not receiving what they requested on their meal trays and was currently working with dietary to improve the issue. He stated resident's food choices should be accommodated.

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2. Resident #78 was admitted to the facility on 09/08/14. His diagnoses included dementia, chronic airway obstruction, diabetes, right sided weakness, cerebral vascular accident and depression.

The admission Minimum Data Set (MDS) dated 09/15/14 coded him with severely impaired cognition, requiring extensive assistance with most activities of daily living skills (adls), and not having received a bath during this assessment period.

The quarterly MDS dated 12/05/14 coded him with long and short term memory impairment, moderately impaired decision making skills and requiring total assistance with bathing.

The quarterly MDS dated 03/03/15 coded him with severely impaired cognition and requiring total assistance with bathing.

During a family interview conducted by phone on 04/21/15 at 1:23 PM, the responsible party stated that the resident did not receive showers per his choice and that at home he would have showered daily.

Interview with Nurse Aide (NA) #1 on 04/24/15 at 9:29 AM revealed that a shower schedule was set up according to room numbers by the unit manager and Director of Nursing (DON). If a resident requested an extra shower then they tried to fit it in with their regular schedule. If a resident was to request more than 2 showers

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weekly on a regular basis, that request would be forwarded to the DON or unit manager.

Interview with the Unit Manager #1 on 04/24/15 at 9:32 AM revealed that there was a schedule for two showers per week. If there was a request to change to a different day or a different time of day, then a switch would be made to accommodate that request. She further stated that upon admission the resident and or responsible party was informed of the set schedule.

The Social Worker was interviewed on 04/24/15 at 10:05 AM. She stated that the MDS nurses asked residents and responsible parties their preferences for showers.

The Activity Director stated during interview on 04/24/15 at 11:13 AM that when he completed the preference section on the MDS, he only asked the resident or responsible party how important it was to choose between a bed bath, shower or tub bath. He stated the MDS preference section did not direct him to ask how many showers or baths they preferred to receive each week.

Interview with the Director of Nursing (DON) on 04/24/15 at 1:17 PM revealed that there was a 72 hour meeting with all disciplines to meet with family and the resident to see how thing were going. At that time preferences would be discussed.

Follow up interview with the Social Worker on 04/24/15 at 3:22 PM revealed the residents and or responsible party were not asked how many baths or showers they received weekly. The MDS coordinator who was in the room at the time

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F 242	Continued From page 20 of this interview interjected that showers were added to the schedule if a resident asked for more showers to be given. 3. Resident #200 was admitted on 03/28/15 with diagnoses that included gout, kidney disease, high blood pressure, stroke, and dizziness. Review of the admission Minimum Data Set (MDS) indicated he was cognitively intact. Resident #200 required extensive assistance with most activities of daily living (ADL's) with 1 to 2 person assist, was noted to not be steady with transfers, and was only able to transfer safely with staff assistance. He was revealed to always be incontinent of urine and frequently incontinent of bowels. The MDS indicated Resident #200 had a fall since admission and received therapy 5 days a week. Resident #200 was noted to have participated in the completion of the MDS assessment and it was very important for him to choose the type of bath he received. Review of the care plan dated 04/09/15 indicated Resident #200 received further assessment and care planning for the care areas triggered by the MDS assessment and included a notation the he was to receive a shower 2 times weekly. On 04/22/15 at 8:30 AM during an interview with Resident #200, he indicated he would like to take a shower every day. He stated he took a shower	F 242		

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every day when he was at home and he would prefer to have a shower more often than he does now. He indicated he was not asked how often or what type of bath he would prefer. Resident #200 revealed he was told by a nurse he would take a shower twice a week and he could get a bed bath in between.

On 04/22/15 at 3:45 PM an interview was conducted with Nurse Aide #6 (NA#6). She stated Resident #200 received a shower 2 times a week. She revealed he had a shower in his room, as did all residents on the 500 Hall. NA #6 indicated there was no bathtub on the 500 Hall.

On 04/23/15 at 1:25 PM an interview was conducted with Nurse #3. She indicated nursing staff did initial assessments on residents when they were admitted to the facility. Nurse #3 revealed that residents were told they would receive 2 showers a week and what their shower days were. The residents were asked if that was alright with them. She revealed residents were not asked how many days a week they would like a shower. Nurse #3 indicated if a resident wanted an extra shower they would try to accommodate them. She stated there were no baths on the 500 Hall and all residents got a shower or a bed bath.

On 04/23/15 at 1:30 PM an interview was conducted with NA #7. She indicated residents are not asked now many showers a week they would like. She stated residents were told what their shower days would be and if they requested a different day, staff would try to accommodate them.

On 04/23/15 at 1:35 PM an interview was conducted with NA #8. She revealed residents

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F 242	Continued From page 22 were given a shower 2 times a week and offered a bed bath on the other days. She stated if a resident wanted another shower and could do it on their own, the staff would assist with set-up. NA #8 indicated if a resident could not shower without assistance, they were offered a bed bath. On 04/24/15 at 1:55 PM an interview was conducted with Nurse #4. She stated the activities department questioned residents about their preferences. Nurse #4 indicated residents were told they would get 2 showers a week on the scheduled days. She revealed residents get a bed bath on the non-shower days. Nurse #4 acknowledged residents were not asked how many days a week they would like to receive a shower. On 04/24/15 at 2:25 PM and interview was conducted with the Director of Nursing (DON). She stated the facility conducts a meeting 72 hours after a resident has been admitted that includes the entire team including activities and social work personnel. She revealed resident preferences are discussed. The DON indicated residents were told what day their 2 showers were to be given, and if they preferred another day or shift the staff would try to accommodate them. The DON acknowledged residents were told when they would receive a shower, but were not asked how often they would like a shower.	F 242		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas.	F 256		5/22/15

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F 256	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews the facility failed to provide adequate lighting for reading in a resident's room for 1 of 1 resident reviewed for lighting levels (Resident #24). The findings included: Resident #24 was admitted to the facility on 06/05/14. Review of the annual Minimum Data Set dated 5/23/15 revealed Resident #24 was cognitively intact and indicated reading books was very important to her. A resident interview was conducted on 04/20/15 at 11:28 AM. Resident #24 reported that she had spoken to the facilities Maintenance Director and requested additional lighting by her bed so that she could read more comfortably but none had been provided. An observation of Resident #24's room was conducted on 04/20/15 at 11:28 AM. The lighting provided by the facility was limited to only one overhead light and no supplemental lighting was available by Resident #24's bed. An interview was conducted on 04/23/15 at 11:18 AM with the facility's Maintenance Director. The facility's Maintenance Director reported that Resident #24 had initially asked him to provide lighting by her bed approximately one month ago and added that Resident #24 had also reminded him of her request the previous week. The Maintenance Director verbalized that he had not taken any action to provide Resident #24 with lighting by her bed because he had forgotten about Resident #24's request. A staff interview was conducted with the DON on 04/24/15 at 9:58 AM. The DON verbalized that it was her expectation that each resident would have adequate lighting in their room for reading.	F 256	F 256 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #24 by providing a reading lamp for the resident¿s need for additional lighting. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Maintenance Director and Maintenance Assistant have completed an audit of the facility to ensure that adequate lighting is provided in each room. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator will conduct in-service/re-education for the Maintenance Director and Maintenance Assistant regarding adequate and comfortable lighting levels, specifically, that each room should include an over-bed light or other supplemental lighting source. The Maintenance Director will conduct rounds weekly for four weeks, then at least monthly as part of the preventive maintenance program to identify that adequate lighting is present in each room. The Administrator will conduct rounds weekly for four weeks then at least monthly for 3 months to monitor that lighting is adequate in residents¿ rooms to ensure continued compliance. 4. The Administrator and Maintenance Director will review data obtained during facility audits and rounds; analyze the data and report patterns/trends to the QAPI committee every other month for six	

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F 256	Continued From page 24	F 256	months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		5/22/15

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F 272	Continued From page 25 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to analyze residents' strengths, weaknesses, and how these affected the residents' functionality in the care area assessments for 7 of 26 sampled residents. (Residents #11, #57, #63, #78, #108, #109, and #135). The findings included: 1. Resident #63 was admitted to the facility on 11/24/14 with diagnoses including diabetes, chronic pain, anxiety, and depressive disorder. The admission Minimum Data Set (MDS) dated 12/03/14 coded her with intact cognition, exhibiting other behaviors that significantly disrupted care or the living environment of others, and nearly every day having little interest in doing things, feeling down, being tired, having appetite issues, having trouble concentrating and moving or speaking so slowly others may notice. The Care Area Assessments (CAA), dated 12/05/14 and written by the Social Worker (SW), did not analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows: a. Cognition CAA noted the resident had a diagnoses of anxiety disorder and it was	F 272	F 272 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents # 57, #63, #78, #108, and #109 by reassessing the Care Area Assessments (CAAs) and making addendum documentation to support the findings. Action could not be taken for Residents #11 and #135 as they are discharged from the facility. 2. Residents who have comprehensive assessments completed have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director and MDS Coordinator have reviewed the last 30 days of comprehensive assessments and CAAs to ensure that triggered areas have information present that describes the resident¿s strengths, weaknesses, and functionality. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The District Director of Care Management has conducted in-service/re-education for the Resident Care Management Director, MDS Coordinator, and Social Services Director regarding CAA completion expectations	

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F 272	Continued From page 26 documented in the nurses noted on 11/28/14 that Resident #63 was yelling and screaming. The care plan decision was no care plan would be developed and staff would continue to provide redirection when behaviors arise. b. Psychosocial Well-Being CAA noted the date the resident was admitted, her diagnoses, that she was alert and able to make her needs know and was independent in decision making. This CAA reiterated the MDS information related to mood issues. There was no analysis of why she had mood issues, what caused them, or how she was affected by them. The care plan decision was no care plan would be developed as staff would continue to invite her to activities and socials and assist her to activities if she chose to attend. c. Mood CAA repeated what was written in the Psychosocial Well-Being CAA. The decision was made to not proceed with a care plan as staff were going to invite to activities. d. Behavior CAA noted she had the diagnoses of anxiety disorder and that in the nursing notes on 11/28/14 she was yelling and screaming. No care plan was going to be developed as staff were to continue to provide redirection when behaviors arose. Interview with SW on 04/24/15 at 2:54 PM revealed she had participated in company training on the computer related to completion of CAA's. She further stated there was no oversight from the corporation to assist her with social work responsibilities including the completion of CAA's. She said she normally looked at the nursing notes for information and put whatever information she found in the CAA. She stated that she will gather information from a resident if able but for most things such as the case with	F 272	as described in the RAI manual. The Resident Care Management Director will audit at least 5 comprehensive assessments and CAAs per month for six months to ensure that information is present according to the assessment of the individual and that the information addresses the analysis of the resident¿s strengths, weaknesses, and how these areas affect the resident¿s functionality to ensure continued compliance. 4. The Resident Care Management Director will review data obtained during comprehensive assessment audits, analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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Resident #63 she just repeated what information she found in the nursing notes on the CAA. She stated she did not know she needed to put more information in the CAA.

2. Resident #135 was admitted to the facility on 02/20/15 with diagnoses including alcohol abuse, hypertension, encephalopathy, anxiety, and depression. He sustained a head injury from falling on stairs where he lost consciousness per the hospital records.

The admission Minimum Data Set (MDS) dated 02/27/15 coded him as having intact cognitive skills, having inattention, disorganized thinking, alerted level of consciousness, psychomotor retardation, having physical, verbal and other behavioral symptoms which put both the resident and others at significant risk for physical illness or injury and interfered with Resident #135's care and intruded on the privacy or activity of others. In addition, the MDS coded the resident as feeling down, depressed or hopeless, having sleep issues, and feeling tired or having little energy.

The Care Area Assessments (CAA), dated 03/04/15 and written by the Social Worker (SW), did not describe the extent of the issue, analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows:
a. Cognitive CAA noted he had short term memory problems and repeated his answers from the brief interview for mental status as stated on the MDS. The decision to not proceed with a care plan was made as staff were to continue to provide orientation as needed.
b. Psychosocial Well-Being CAA listed his

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admission date, diagnoses, nursing documentation he was combative, threatening and kicking staff on 02/23/15 and he was very anxious and combative on 02/25/15. The CAA noted he received medication for this agitation and a psychiatry consult had been ordered. There was no analysis of the facts presented. The decision to not care plan this area was made and staff were to continue to provide redirection when behaviors arose.
c. Behavioral CAA only listed his diagnoses of anxiety and the nursing notes of 02/23/15 and 02/25/15 documenting combative behaviors. The decision was made to not care plan this area as staff were to continue to provide redirection when behaviors arose.

Interview with SW on 04/24/15 at 2:54 PM revealed she had participated in company training on the computer related to completion of CAA's. She further stated there was no oversight from the corporation to assist her with social work responsibilities including the completion of CAA's. She said she normally looked at the nursing notes for information and put whatever information she found in the CAA. She stated that she will gather information from a resident if able but for most things she just repeated what information she found in the nursing notes on the CAA. She stated she did not know she needed to put more information in the CAA.

3. Resident #78 was admitted to the facility on 09/08/14 with diagnoses including dementia, chronic airway obstruction, cerebral vascular accident and depression.

The admission Minimum Data Set (MDS) dated 09/15/14 coded him with severely impaired

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cognitive skills, exhibiting no behaviors, requiring extensive assistance for most activities of daily living skills and weighing 142 pounds.

The Care Area Assessments (CAA) did not analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows:
a. Cognition CAA dated 09/18/14 written by the Social Worker (SW) stated the resident had a diagnoses of dementia with short term memory impairments and was unable to recall the correct year, month, or day of the week. There was no analysis of this information and what affect it had on the resident. The care plan decision was to not develop a care plan as staff was to continue to provide orientation as needed.
Interview with SW on 04/24/15 at 2:54 PM revealed she had participated in company training on the computer related to completion of CAA's. She further stated there was no oversight from the corporation to assist her with social work responsibilities including the completion of CAA's. She said she normally looked at the nursing notes for information and put whatever information she found in the CAA. She stated that she will gather information from a resident if able. She stated she did not know she needed to put more information in the CAA.
b. Nutrition CAA dated 09/19/14 written by a former dietary employee revealed the date of admission and diagnoses including diabetes, gastro esophageal reflux disease, and Alzheimer's disease. The analysis of the findings noted he received a regular diet with unsweet beverages and condiments, ate in his room, averaging 62 percent intake, having stable weight, listed laboratory results showing his glucose was high, his HGBA1C was high, his

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thyroid test was high and his creatine was high. There was no analysis which included causes and contributing factors and risk factors and how this information impacted his nutritional status. Interview with the MDS coordinator on 04/24/15 at 2:54 PM revealed that this nutrition CAA did not analyze the information. She stated he'd been skinny since admission and can feed himself if he chose to do so.

4. Resident #57 was admitted to the facility on 10/29/11 with diagnoses including metabolic encephalopathy, dementia, and Alzheimer's Disease.

The significant change Minimum Data Set dated 06/07/14 coded her with severely impaired cognitive skills (missing all the questions on the brief interview for mental status).

The Care Area Assessments (CAA), dated 06/11/14 and written by the Social Worker (SW), did not analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows:
a. Cognition CAA noted the resident had a diagnoses of dementia, had short term memory problems, and was unable to recall the correct year, month and day of the week. There was no information describing how severe the dementia was or how it affected her day to day function. The decision was not to proceed with a care plan as staff was to continue to provide orientation as needed.

Interview with SW on 04/24/15 at 2:54 PM revealed she had participated in company training on the computer related to completion of CAA's. She further stated there was no oversight from

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the corporation to assist her with social work responsibilities including the completion of CAA's. She said she normally looked at the nursing notes for information and put whatever information she found in the CAA. She stated that she will gather information from a resident if able. She stated she did not know she needed to put more information in the CAA.

5. Resident #109 was admitted to the facility on 04/11/11. her diagnoses included altered mental status, delusional disorder and depressive disorder.

The annual Minimum Data Set (MDS) dated 09/26/14 coded her as being cognitively intact, scoring a 9 out of 15 on the brief interview for mental status, and having behaviors of rejecting care.

The Care Area Assessments (CAA), dated 10/03/14 and written by the Social Worker (SW), did not analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows:
a. Cognition CAA noted she had a diagnosis of dementia with delusions, short term memory problems and was unable to recall the correct year or day of the week. There was no information describing how severe the dementia was or how it affected her day to day function. The decision was made to not care plan this area as staff were to continue to provide orientation as needed.
b. Behavior CAA noted she had a diagnoses of dementia and the medication administration records for September 2014 showed she refused medication on 9/20/14 and 9/22/14. It was also documented on the behavior form for September

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2014 she had 5 episodes of hallucinations, delusions and paranoia. There was no information as to how this affected the resident. The decision was made not to care plan as staff were to continue to redirect when behaviors arose and to encourage her to take her medications.

Interview with SW on 04/24/15 at 2:54 PM revealed she had participated in company training on the computer related to completion of CAA's. She further stated there was no oversight from the corporation to assist her with social work responsibilities including the completion of CAA's. She said she normally looked at the nursing notes for information and put whatever information she found in the CAA. She stated that she gathered information from a resident if able but for most things such as the case with Resident #109 she just repeated what information she found in the nursing notes on the CAA. She was unaware she needed to analyze the information obtained.

6. Resident #108 was admitted to the facility on 03/23/11 with diagnoses of cerebrovascular accident, diabetes and Alzheimer's disease. The significant change Minimum Data Set (MDS) dated 03/27/15 revealed Resident #108 was severely cognitively impaired. The MDS further revealed Resident #108 required extensive assistance with bed mobility, transfers, personal hygiene and toileting.

Review of the Care Area Assessments (CAA) dated 04/01/15 revealed no analysis of the areas identified and how they affected Resident #108's function or what direction the care plan would

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take. Examples as follows:

Falls revealed Resident #108 was readmitted to the facility for long term rehabilitation and a list of her diagnoses. The only additional information was that she was on the therapy caseload. This was written by the MDS Nurse.

Pressure Ulcer revealed Resident #108 was readmitted to the facility for long term rehabilitation and a list of her diagnoses. The only additional information was a list of the interventions and treatment for the pressure ulcer. This was written by the MDS Nurse.

The MDS nurse was unavaliable for interview.

An interview was conducted on 04/24/15 at 2:54 PM with the MDS Coordinator. She stated the CAA should contain a summary of how the resident was doing before admission, goals for the resident and expected outcomes. She further stated she would want more information about Resident #108 in the analysis of findings for falls and pressure ulcers.

7. Resident #11 was admitted to the facility on 02/11/14 with diagnoses that included End Stage Renal Disease (ESRD), heart failure, diabetes, and respiratory disease among others. Review of the annual Minimum Data Set (MDS) dated 01/27/15 revealed she was cognitively intact, required extensive assistance with most activities of daily living (ADL's), had moderately impaired vision, and was on a therapeutic diet.

Review of the Care Area Assessments (CAA) dated 01/27/15 indicated Resident #11 triggered areas for further assessment and care planning to include ADL's, pressure ulcers, falls, and nutrition among others. Appropriate analysis for

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F 272	Continued From page 34 the care area of nutrition did not fully describe Resident #11's complex nutritional needs, or what direction the care plan should follow. An example is as follows: Nutritional status indicated Resident #11 had stable weight for the past 6 months, tolerated dialysis well, was not on fluid restrictions, and would continue to be monitored. No further nutritional analysis of Resident #11's complex needs were discussed. This was written by the MDS Coordinator. On 04/24/15 at 3:25 PM an interview was conducted with the MDS Coordinator. She revealed she realized Resident #11 had multiple care issues. She stated the reason the CAA analysis contained little information was due to Resident #11's stable weight. The MDS Coordinator acknowledged Resident #11 had other care issues that were not addressed in the CAA.	F 272		
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, staff and resident interviews, and record reviews the facility failed to schedule a follow-up medical consult, and failed to communicate medication changes for 1 of 1	F 309	F 309 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #121 by	5/22/15

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F 309	Continued From page 35 residents on dialysis (Resident #11) and failed to implement physician orders and care planned interventions to address edema, skin tears and hand plasticity for 1 of 3 residents sampled for skin impairment issues (Resident #121). The findings included: 1. Resident #11 was admitted to the facility on 02/11/14 with diagnoses of renal disease, heart failure, high blood pressure, and diabetes. Review of the annual Minimum Data Set (MDS) dated 01/27/15 indicated she was cognitively intact and required extensive assistance with most activities of daily living (ADL's). She is noted to receive dialysis, and is on oxygen therapy. Review of Resident #11's care plan dated 01/27/15 indicated she received assessment and care planning for dialysis treatment which is noted to have included communication between the dialysis center and the facility, and monitoring her drug regimen for drug interactions. Review of Resident #11's medical record revealed she was scheduled for cataract surgery on 12/23/14. Her cataract surgery had to be postponed due to Resident #11's unstable blood pressure and it was noted that she was to be rescheduled after her blood pressure became more stable. Review of Resident #11's medication regimen indicated she received treatment for her blood pressure. On 01/28/15 an order was written by the facility's Physician's Assistant (PA) to find out from Resident #11's nephrologist at the dialysis center if she was safe for light to heavy intravenous sedation for her cataract surgery.	F 309	completing a therapy screening for the use of a hand splint, high-back wheelchair, dycem, and half lap tray. Resident #121¿s orders for an edema control sleeve to his left arm are implemented per the MD orders. Refusals are documented in the medical record. Resident #11 has been discharged from the facility. 2. Residents who require adaptive equipment for the purposes of positioning and/or skin protection and residents who have consultations with community medical resources have the potential to be affected by the same alleged deficient practice. The Rehab Program Manager and Director of Nursing have completed an audit of current residents who require adaptive equipment to ensure that equipment is available and in use per the MD order and/or care plan. The Director of Nursing has completed an audit of current residents¿ medical records to identify that recommendations and/or orders from consultations within last 30 days with outside medical resources have been followed up and implemented as appropriate. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing and Rehab Program Manager will conduct in-service/re-education for nursing staff regarding the provision of services to maintain wellbeing, specifically, residents who require adaptive/protective equipment are to have this equipment in place per care plan and/or MD order, that equipment meets the needs of the	

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F 309	Continued From page 36 Further review of the medical record revealed Resident #11 was seen by the facility optometrist on 03/10/15. Optometry records indicated Resident #11 was not a candidate for corrective lenses due to her cataracts. He revealed Resident #11 was still waiting for cataract surgery and she wanted to proceed with surgery as soon as she was cleared. On 04/21/15 at 4:10 PM an observation was made of Resident #11 sitting 8 to 10 inches from her television. She stated she had to sit so close to see anything on the TV. Resident #11 revealed she was supposed to have cataract surgery, but it was canceled due to her blood pressure. She stated it was supposed to be rescheduled, but she had not heard anything since it had been canceled. She indicated the eye center would not do her surgery until she was cleared, but she had not talked to anyone since the surgery was canceled. On 04/23/15 at 2:30 PM an interview was conducted with Nurse #1. She stated she could remember when Resident #11 had her cataract surgery postponed due to her issue with high blood pressure, but she did not know if it had been addressed since. On 04/23/15 at 3:10 PM an interview was conducted with Nurse #1. She stated due to Resident #11's renal failure, the facility medical team had requested the decision for her release to have cataract surgery be left up to her nephrologist. Nurse #1 acknowledged the order was written on 01/28/15 by the PA. On 04/24/15 at 9:00 AM an interview was conducted with the PA. She stated she previously	F 309	resident, and that the implementation of such equipment is documented appropriately. If a resident refuses such equipment, then the instance is documented. Repeated refusals should be reported to the physician for possible intervention or discontinuation. The Director of Nursing will review consultation reports during the morning clinical meeting and validate that any new orders/recommendations are implemented based on the MD orders. The Director of Nursing, Assistant Director of Nursing, and Unit Coordinator will conduct care rounds twice weekly for 4 weeks, then once weekly for 4 weeks to identify that adaptive/protective equipment is in place per the care plan and/or MD order. The Assistant Director of Nursing and Unit Coordinator will review Treatment Records twice weekly for four weeks, then once a week for four weeks, then monthly for three months during recapitulation of orders to validate that documentation is in place for adaptive/protective equipment. 4. The Director of Nursing will review data obtained during care rounds and treatment record audits; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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wrote an order for Resident #11 to be evaluated by her nephrologist at the dialysis center for approval for cataract surgery. The PA revealed she did not know if those orders were sent to the dialysis center.

On 04/24/15 at 10:00 AM Nurse #2 called the dialysis center and spoke with the Charge Nurse. Nurse #2 acknowledged the Charge Nurse stated the dialysis center had not received a request for Resident #11 to be evaluated for surgery. Nurse #2 indicated the order was not sent to the dialysis center. She stated she was not present that day, but the nurse on duty that day missed the order.

On 04/24/15 at 10:20 AM an interview was conducted with the PA. She stated when she wrote an order for a consult it was her expectation that the nurses schedule the consultation. The PA indicated for any resident with complex medical issues she would request a specialist consult to clear the resident for anesthesia.

On 04/24/15 at 2:25 PM an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that the nursing staff would take those orders for the consult and fax them to the dialysis center. The DON acknowledged the order written for Resident #11 to be evaluated by her nephrologist for release to have cataract surgery was missed and the dialysis center was not aware of the need for the consult.

2. Resident #11 was admitted to the facility on 02/11/14 with diagnoses of renal disease, heart failure, high blood pressure, and diabetes. Review of the annual Minimum Data Set (MDS)

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dated 01/27/15 indicated she was cognitively intact and required extensive assistance with most activities of daily living (ADL's). She is noted to receive dialysis and is on oxygen therapy.

Review of Resident #11's care plan dated 01/27/15 indicated she received assessment and care planning for dialysis treatment which is noted to have included communication between the dialysis center and the facility, and monitoring her drug regimen for drug interactions.

Review of Resident #11's medical record revealed an order was written on 04/12/15 for a pharmacy exchange; to discontinue the medication Renvela and replace it with Calcium Acetate. On 04/17/15 an order on the dialysis communication sheet was sent from the dialysis center to the facility that the Renvela should not be discontinued and changed to Calcium Acetate. The facility was requested to call the dialysis center for further clarification. The communication record from the dialysis center was signed by the charge nurse at the center. There was no notation on the communication record that the facility took off the order or responded to the request.

On 04/23/15 at 2:00 PM an interview was conducted with Nurse #1. She stated communication between the facility and the dialysis center was completed by documentation on a Dialysis Communication Record that was filled out by the facility with vital signs, medications taken, meals provided, and any other information pertinent to the resident and their care. Nurse #1 indicated this was done each time a resident went for dialysis treatment. She acknowledged the dialysis center responded with

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information and orders concerning the resident after dialysis was completed. This information included any changes to the resident's medication regimen. Nurse #1 indicated the sheet was reviewed by the nurse when the resident returned from dialysis and orders were processed.

On 04/23/15 at 2:25 PM Nurse #1 contacted the dialysis center to discuss Resident #11's medication order for Renvela. Nurse #1 stated she was instructed by the charge nurse at the dialysis center that the nephrologist and the dietician requested the medication change on 04/17/15 due to the excess calcium in the Calcium Acetate, which Resident #11 did not need. Nurse #1 indicated the dialysis center would contact the nephrologist to see if the Calcium Acetate could be substituted for the Renvela.

On 04/23/15 at 3:35 PM an interview was conducted with Nurse #2. She revealed she had just received a call from the dialysis center with instructions to discontinue the Calcium Acetate and restart the Renvela. Nurse #2 acknowledged the nephrologist did not want Resident #11 to receive the excess calcium.

On 04/24/15 at 9:00 AM an interview was conducted with the facility's physician assistant (PA). She indicated if the nephrologist requested that Resident #11 to receive Renvela, that is what she should receive. The PA acknowledged when a resident returned from the dialysis center and has written orders, the staff is supposed to let her know so she can review and sign them off. She stated the order concerning the Renvela written by the dialysis center on 04/17/15 must have been missed by the nurses because it was not

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brought to her attention. The PA indicated she would re-check Resident #11's calcium to be sure her levels were normal. Review of Resident #11's lab performed at the dialysis center on 04/22/15 revealed her calcium levels were within normal limits.

On 04/24/15 at 2:25 PM an interview was conducted with the Director of Nursing (DON). She stated she had spoken with the PA concerning the communication issues between the facility and the dialysis center. The DON indicated there was a breakdown in how resident orders are sent from the center and received by the facility. She revealed there needed to be a better system in place to assure information is transferred correctly. The DON acknowledged it was her expectation that the nurses take off the orders received from the dialysis center and make sure they are seen by the medical staff.

3. Resident #121 was admitted to the facility on 05/14/12 with diagnoses including cerebral vascular accident, hemiplegia, neurologic neglect syndrome, chronic pain, and post traumatic stress.

Review of physician orders revealed Resident #121 was to have a left resting hand splint on 6 to 8 hours per day since ordered on 07/29/13; dycem to keep arm from sliding every shift since ordered on 08/12/12; edema control sleeve left arm and hand every shift since ordered on 08/12/13; and high back wheelchair with left half lap tray every shift since ordered on 01/14/14.

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The therapy notes revealed that occupational therapy and/or physical therapy had not seen Resident #121 since 01/15/14 when he was seen for wheelchair alignment.

The annual Minimum Data Set (MDS) dated 02/27/15 coded Resident #121 as being cognitively intact, having no behaviors, requiring extensive assistance with most activities of daily living skills (ADLs) and being nonambulatory. He was coded also as having no skin tears, needing human assistance to stabilize during surface to surface transitions and being unsteady but able to stabilize himself when moving from a seated to a standing position.

The Care area Assessment dated 03/03/13 for ADLs stated he was alert and oriented and able to voice all needs and wants. During the past year, it has become easier for him to pull himself to a standing position holding side rails in the hall. He thinks he can be ambulatory again but he has spastic hemiplegia of his left leg and a contracture of his left arm.

The care plan for ADLs originating 03/03/15 identified the problem that Resident #121 required staff assistance and intervention for completion of ADL need due to needing supervision, limited assistance and extensive assistance of 1 staff member. The goal was to have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function possible to include standing at hand rails. Interventions included the use of a high back wheelchair with left half lap tray and right foot rest, edema sleeve to left arm as ordered, and a left hand splint 6 to 8

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hours a day.

There was also a care plan dated 03/03/15 related to the potential for skin impairment issues with the goal for Resident #121 to be free of further skin impairment related to risk factors through 90 days. The interventions were to observed skin weekly and document findings as indicated and to document observations of any non-pressure related skin impairments on facility non pressure ulcer wound documentation form.

Review of recent skin assessments revealed on 04/06/15 there were no skin tears; on 04/12/15 there were 2 small healing areas on the left upper arm; on 04/20/15 there were no skin tears but scabs on bilateral arms. there were no descriptions of these skin tears on the Head to Toe skin checks, no incident reports related to skin tears and no non pressure reports related to the skin tears.

There were no nursing notes in the medical record which indicated he refused care and there were no physician progress notes that addressed his arm edema, flaccid arm or skin integrity issues.

Resident #121 was observed on 04/20/15 at 12:42 PM with a short sleeve shirt on, and bandages on his left wrist area and his left elbow area. Blood was visible under the bandage. He had no hand splint on or any edema sleeves in place, the left arm rest was a hard plastic with no dycem. On 04/20/15 at 3:13 PM, when asked how he sustained the skin tears, Resident #121 stated he scraped his hand and arm on the wheelchair when he stood up from the wheelchair. On 04/21/15 at 8:39 AM, Resident

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#121 had no more bandages on his left wrist or upper arm as the areas were scabbed over. He was not wearing a hand splint or any sleeves on his arms and he was wearing a short sleeved shirt. At this time he was observed using his right hand to extend the fingers of his left flaccid hand. The arm rest was without dycem or padding.

On 04/22/15 at 8:15 AM, Resident #121 was by the dining room, in the hall at the hand rails and he pulled himself up from the wheelchair to a standing position. He was wearing a short sleeve shirt and had no hand splint or sleeves in place and no dycem or padding over the left arm rest. His utilized his right hand to pull himself to a standing position. He continued to be observed with no sleeve or hand splint when observed in his wheelchair on 04/22/15 at 9:03 AM while in the hall and at 9:43 AM while in his room. On 04/22/15 at 10:17 AM he was observed standing in the hall out of his wheelchair at the hand rail with his right hand to pull himself up. He again had no sleeves in place, any hand splint, and no dycem or padding on the arm rest.

An interview was conducted with Nurse Aide (NA) #1 on 04/22/15 at 10:40 AM who stated Resident #121 had very soft skin that easily tore when he propelled himself down the hall and pulled himself to a standing position in the hall. She stated he would bump his arm causing skin tears. She further stated staff tried applying sleeves to his arms but he complained and asked staff to take them off.

On 04/22/15 at 11:53 AM, Resident #121 was observed standing and holding onto the rail. Once he reseated himself, he left using the padded half lap tray on his wheelchair which he

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placed upright himself. This was the first time he was observed by the surveyor using the padded half tray. Again he was not wearing the hand splint or sleeves and had on short sleeved shirt. He was observed standing again independently holding to the hand rail in the hall on 04/22/15 at 4:23 PM.

An interview was conducted with NA #11 revealed that Resident #121 scraped his arms on the side of the wheelchair where the half tray hangs. She stated he freely moved the half tray up and down in place at will. She stated he would not allow a cushion on it. She further stated that as he stood up, he scraped his flaccid left arm against the hard plastic causing skin tears.

On 04/23/15 at 8:47 AM Resident #121 was in his room in his wheelchair. He had no sleeves on and no hand splint in place. His left arm was red, edematous and appeared to have a new abrasion on the outer side of his forearm. The lap tray was not in place and the arm rest was noted to be a hard plastic and there was no dycem or padding on the arm rest. The other arm rest was slightly padded. He stated at this time that he was told the facility was going to find something to pad the arm rest because he scraped it against the arm rest when he stood. He was observed to have his flaccid arm resting directly against the hard plastic arm rest. When asked about wearing a sleeve to protect his arm, he stated staff put it on him once in awhile.

On 04/23/15 at 10:26 the left arm rest of the wheelchair was covered in a thin gerisleeve material but no obvious padding. He again was not wearing a arm sleeve or hand splint. He stated that every once in awhile they put his hand

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splint on.

A follow up interview with NA #1 on 04/23/15 at 10:41 AM revealed she had worked with this resident for awhile and had never seen a hand splint for Resident #121. She stated that she did not offer the edema sleeve this morning. When asked about yesterday, she did not answer say she attempted to put them on, she stated he would not keep them on and he just took them off. At 1:18 PM on 04/23/15, Resident #121 was in his wheelchair at the end of the hall wearing edema sleeves to both arms.

The nurse on duty, Nurse #5, was interviewed on 04/23/15 at 1:22 PM. Nurse #5 stated that she obtained a set of edema sleeves this morning for Resident #121. She stated even though she did treatments yesterday and was responsible for making sure his edema sleeves were in place, she got busy and did not put the sleeves on him. She stated the sleeves would protect his skin from skin tears. She further stated she looked for the hand splint and was unable to find the hand splint. She was unable to explain why the dycem was not on the arm rest.

On 04/2415 at 8:25 AM Resident #121 was in his room drinking coffee with the half lap tray in place. He was not wearing the edema sleeves and stated they hurt his hands. He was not wearing the hand splint. At 9:00 AM Nurse #5 stated she could not find the splint and he would not wear it anyway and he should be using the half tray that was padded. She further stated it had been a couple of weeks since she had seen Resident #121 wearing the hand splint. Observation at this time revealed the thinly covered left arm rest had several blood smears

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on it from his left arm near the elbow.

An interview was conducted with the Occupational Therapist (OT) and the Physical Therapist (PT) on 04/24/15 at 9:47 AM. OT stated she had worked with the resident many times for positioning. She stated he did not have a hand contracture that it was flaccid and he had edema and spasticity in his hand. They stated he was noncompliant and they have given him multiple sleeves and splints that disappear. They stated this date they found 4 sleeves and a splint in his room. They stated that in July 2013 he was discharged to restorative wearing a left hand splint and edema glove tolerating for 6 to 8 hours per day. PT stated restorative related that he would allow the splint to be applied and then remove it a short time later. Staff reported he was inconsistently compliant. OT and PT both stated that Resident #121 would benefit from the edema sleeve and hand splint even if he only wore for a short period of time and that these was still beneficial devices. The lap tray was placed on the wheelchair years ago as his arm would get caught in the wheels. Yesterday maintenance came to ask for something to pad the arm of the wheelchair and she gave him a thin sleeve type material with sticky backing to apply to the arm rest. Both stated they were unaware that Resident #121 was getting skin tears from the wheelchair which could be addressed by trying a bolster.

On 04/24/15 at 11:11 AM Resident #121 was observed in his wheelchair sitting in the hall wearing edema sleeves and a left hand splint.

The Director of Nursing (DON) stated on 04/24/15 at 1:20 PM during interview, that she

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F 309	Continued From page 47 expected that the sleeves and splints were being applied to Resident #121 since they were documented on the treatment records as being applied. With the skin tears coming from the wheelchair, she expected maintenance to look to see what could be added to the wheelchair for protection. She further stated that incident reports would trigger a need to address the skin tears but confirmed there were no incident reports relating to Resident #121. On 04/24/15 at 2:09 PM the unit manager #1 stated she did not know how he got his recent skin tears, but admitted that he scraped his arm when he stood up from his wheelchair. She stated the staff and or nurses should alert maintenance to look at the wheelchair to prevent skin tears.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to secure loose bed side rails for 2 of 40 sampled residents (Resident #108 and #28). The findings included:	F 323	F 323 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #108 and #28 by evaluating the beds for repair. When repair was not satisfactory, the	5/22/15

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	345232	A. BUILDING _____ B. WING _____	C 04/24/2015

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F 323	Continued From page 48 1. Resident #108 was admitted to the facility on 03/23/11 with diagnoses of cerebrovascular accident and Alzheimer's disease. The significant change Minimum Data Set (MDS) dated 03/27/15 revealed Resident #108 was severely cognitively impaired and required extensive assistance for bed mobility and transfers. Observations of Resident #108's bilateral full bed side rails were as follows: - On 04/20/15 at 3:45 PM the left side rail was loose and leaned away from the bed approximately 2 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #108 was observed lying in the bed. - On 04/21/15 at 4:10 PM the left side rail was loose and leaned away from the bed approximately 2 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #108 was observed lying in the bed. - On 04/22/15 at 8:33 AM the left side rail was loose and leaned away from the bed approximately 2 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #108 was observed lying in the bed. - On 04/23/15 at 8:54 AM the left side rail was loose and leaned away from the bed approximately 2 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #108 was observed lying in the bed. An interview was conducted on 04/23/15 at 9:10 AM with Nurse Aide (NA) #1. She stated staff notified maintenance of needed repairs by writing	F 323	beds were replaced. 2. Residents who require the use of side rails have the potential to be affected by the same alleged deficient practice; therefore, the Maintenance Director has completed an audit of beds to determine repair or replacement needs related to side rails. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing will conduct in-service/re-education for nursing and maintenance staff regarding the provision of a hazard free environment to the extent possible, specifically; loose side rails should be reported to Maintenance as soon as possible to reduce the potential for injury. If the bed cannot be repaired, then a replacement should be provided. The Director of Nursing, Assistant Director of Nursing or Unit Coordinator will conduct care rounds twice weekly for four weeks then weekly for four weeks to monitor for concerns related to side rail repairs. The Maintenance Director will conduct rounds weekly for four weeks then at least monthly to include evaluation of side rails as part of the preventive maintenance program to ensure continued compliance. 4. The Maintenance Director and Director of Nursing will review data obtained during side rail audits and care rounds; analyze the data and report patterns/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	

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F 323	Continued From page 49	F 323		

them in the maintenance book at the nurse's desk or by calling the Maintenance Director. NA #1 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she called maintenance as soon as possible.

An interview was conducted on 04/23/15 at 10:39 AM with NA #2. She stated she noticed Resident #108's bed side rails were loose that morning and she called the maintenance director. NA #2 stated the Maintenance Director came and looked at Resident #108's bed and tried to tighten the side rails.

On 04/23/15 at 11:10 AM the Maintenance Director and the Director of Nursing (DON) were accompanied to Resident #108's room and examined the left and right bed side rails. The Maintenance Director and the DON confirmed the side rails were loose and needed to be tightened down. He stated he had looked at Resident #108's side rails earlier that morning and was trying to find new parts to repair them as the bed side rails could not be tightened with the existing parts. He further stated the facility was getting 70 new beds but they wouldn't have them until August 2015.

A follow up interview conducted on 04/24/15 at 3:51 PM with the DON revealed it was her expectation that side rails fit properly and NAs to report loose side rails to maintenance to be repaired as quickly as possible.

identified trends/outcomes to ensure continued compliance.

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F 323	Continued From page 50	F 323		

2. Resident #28 was admitted to the facility on 04/16/09 with diagnoses of cerebrovascular accident, seizure disorder and hemiplegia. The quarterly Minimum Data Set (MDS) dated 03/31/15 revealed Resident #28 was severely cognitively impaired and required extensive assistance for bed mobility and transfers.

Observations of Resident #28's bilateral full bed side rails were as follows:
- On 04/20/15 at 3:48 PM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #28 was observed lying in the bed.
- On 04/21/15 at 4:20 PM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #28 was observed lying in the bed.
- On 04/22/15 at 9:59 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #28 was observed lying in the bed.
- On 04/23/15 at 8:55 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches. Resident #28 was observed lying in the bed.

An interview was conducted on 04/23/15 at 9:10 AM with Nurse Aide (NA) #1. She stated staff

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F 323	Continued From page 51 notified maintenance of needed repairs by writing them in the maintenance book at the nurse's desk or by calling the Maintenance Director. NA #1 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she called maintenance as soon as possible. An interview was conducted on 04/23/15 at 10:39 AM with NA #2. She stated she noticed Resident #28's bed side rails were loose that morning and she called the Maintenance Director. NA #2 stated the maintenance director came and looked at Resident #28's bed and tried to tighten the side rails. On 04/23/15 at 11:15 AM the Maintenance Director and the Director of Nursing (DON) were accompanied to Resident #28's room and examined the left and right bed side rails. The Maintenance Director and the DON confirmed the side rails were loose and needed to be tightened down. He stated he had looked at Resident #28's side rails earlier that morning and was trying to find new parts to repair them as the bed side rails could not be tightened with the existing parts. He further stated the facility was getting 70 new beds but they wouldn't have them until August 2015. A follow up interview conducted on 04/24/15 at 3:51 PM with the DON revealed it was her expectation that side rails fit properly and NAs to report loose side rails to maintenance to be repaired as quickly as possible.	F 323		
F 360	483.35 PROVIDED DIET MEETS NEEDS OF	F 360		5/22/15

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F 360 SS=D	Continued From page 52 EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to follow the tray card for 1 of 1 resident reviewed for food allergies (Resident #51). The findings included: Resident #51 was admitted to the facility on 02/17/14 with diagnoses of chronic obstructive pulmonary disease and diabetes. The quarterly Minimum Data Set (MDS) dated 01/09/15 revealed Resident #51 was cognitively intact. Review of Resident #51's allergies on the Medication Administration Record for April 2015 revealed she was allergic to chicken, eggs and artificial sweetener. Review of Resident #51's lunch tray card dated 04/24/15 revealed she was allergic to eggs, poultry and artificial sweetener. An observation made on 04/23/14 at 9:15 AM revealed Resident #51 received French toast on her breakfast tray. Resident #51's tray card indicated she was allergic to eggs and should have received pancakes.	F 360	F 360 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #51 by providing her with meals that follow the tray card in relation to food allergies. The resident does not receive foods to which she is allergic. 2. Residents who have documented food allergies have the potential to be affected by the same alleged deficient practice; therefore, the Dietary Manager has completed an audit of current residents to validate food allergy information is present in the tray card system and entered into the ¿dislike¿ section to prevent these items from printing on the meal tickets. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Dietary Manager will conduct in-service/re-education for dietary staff regarding the provision of foods that meet the needs of residents, specifically, that tray cards should be followed and residents are not to receive foods that have been listed an allergy. The Dietary Manager will post a list of residents with	

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F 360	Continued From page 53 An interview was conducted on 04/22/15 at 10:12 AM with Resident #51. She stated she was allergic to chicken and eggs and she received both on her tray 3 to 4 times a week. Resident #51 stated she received a chicken patty in place of the lasagna on her lunch tray on 04/21/15 and when they sent it back to the kitchen they were told she received the chicken patty because the lasagna had an egg in it. She stated she had spoken to the Dietary Manager about receiving chicken or eggs and being allergic to them numerous times. An interview was conducted on 04/24/15 at 10:13 AM with the Dietary Manager (DM). She stated the resident's food allergies were written on the tray cards and should be observed when staff make the trays. The DM stated she has had several in services with staff regarding how to read the tray card and it was her expectation that resident's did not receive foods they were allergic to. An interview was conducted on 04/24/15 at 1:45 PM with the Administrator. He stated it was his expectation that resident's did not receive food they were allergic to and the tray cards be followed as written.	F 360	food allergies at the tray line for reference and will update the listing with admissions and discharges. The Dietary Manager or assigned dietary staff member will monitor tray accuracy in a rotation of meal times daily for two weeks, then at least three times per week for four weeks, then at least weekly for four weeks. Discrepancies will be corrected at the time of discovery. The facility¿s Ambassadors will conduct rounds at least weekly for three months to identify concerns with meal tray accuracy and report to the Administrator during morning stand up meeting to ensure continued compliance. 4. The Dietary Manager and Administrator will review data obtained during meal accuracy audits and Ambassador rounds; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		5/22/15

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F 363	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to follow the preplanned menu for 2 of 3 residents reviewed for following menus (Resident #134 and Resident #51). The findings included: 1. Resident #134 was admitted to the facility on 02/20/13 with diagnoses of hemiplegia, non-Alzheimer's dementia and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 01/23/15 revealed Resident #134 was moderately cognitively impaired but was able to understand and be understood. Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29 grievances related to food concerns. Resident #134's family member filed food grievances on 01/25/15, 03/12/15, 04/08/15 and 04/13/15. An interview was conducted on 04/22/15 at 9:52 AM with Nurse Aide (NA) #9. She stated she received a lot of complaints from her residents about not receiving what was on their tray card and if they asked for the alternate or a sandwich they were told the kitchen was out. An interview was conducted on 04/22/15 at 3:07 PM with Resident #134's family member. She stated she came to the facility every day and helped Resident #134 with lunch and supper. She stated the facility did not follow the preplanned menus and ran out of food on the weekends. The family member stated on 04/11/15 Resident	F 363	F 363 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #134 and #51 by providing meals according to the pre-planned menu. Food supplies are replenished twice weekly and as needed. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Dietary Manager has completed an audit of the inventory of food items and increased the par levels on staple items. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The new Dietary Services Manager will conduct in-service/re-education for the dietary staff regarding the adherence to pre-planned menus and providing a menu that meets the residents¿ needs, specifically, production sheets and recipes are to be followed and if discrepancies are identified, then the Dietary Manager is made aware immediately in order to provide appropriate substitution. The Dietary Manager provides production sheets and scaled recipes in advance to the staff for daily use. The Dietary Manager will conduct an inventory of food supplies twice weekly, implement food deliveries twice weekly, and increase par levels of staple items to provide for residents¿ needs. The Dietary Manager and Administrator will conduct Food Committee meetings weekly with	

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F 363	Continued From page 55 #134's tray card revealed he was to receive a hot dog in a bun with chili, ½ cup of baked beans, ½ cup of cole slaw and ½ cup cinnamon baked apples and he received a hot dog with chili on 1 piece of white bread and ½ cup of pork and beans and showed the tray card and a picture of the tray to the surveyor. She reported there were no eggs or breakfast meats by Sunday morning. She further stated she had spoken with the Dietary Manager, the Administrator and the corporate office several times with no improvements to the food. An interview was conducted on 04/22/15 at 3:43 PM with Nurse # 3. She stated Resident #134 received a hot dog with chili on 1 piece of white bread and pork and beans on 04/11/15 and his tray card indicated he should have received a bun, cole slaw and cinnamon baked apples. Nurse #3 stated the kitchen ran out of food a lot and it was worse on the weekends. She stated if a resident wanted the alternate the kitchen would tell them they were out and at times they ran out of items to make sandwiches. She further stated staff have gone out and bought dinner for residents before due to not being able to obtain items from the kitchen. An interview was conducted on 04/24/15 at 9:23 AM with the Cook. She stated the kitchen ran out of food every weekend and the menus had to be altered. She stated the facility received 1 food truck a week on Monday mornings and breakfast could not be cooked until the truck had unloaded due to not having food to cook. The Cook further stated they had been told not to worry about what was on the tray cards but to make the trays with what they had. She stated they had a lot of plates returned to the kitchen for wrong foods and a lot	F 363	residents to identify concerns related to meal delivery, menus, or other concerns related to meals. The Administrator will review the Food Committee minutes and Resident Council meeting minutes monthly to identify concerns related to meal service to ensure continued compliance. 4. The Dietary Manager and Administrator will review data obtained during inventory audits, food committee meetings, and resident council minutes; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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of complaints.

An interview was conducted on 04/24/15 at 10:13 AM with the Dietary Manager (DM). She stated she placed a food order on Friday and it was delivered to the facility on Monday morning and she was not aware of ever running out of items every weekend. She stated if the kitchen ran out of an item on the preplanned menu they substituted with another item with the same nutritional value. The DM stated it was her expectation for the preplanned menus to be followed and further stated they had never ran out of food but might run short if there were new admissions to the facility over the weekend.

An interview was conducted on 04/24/15 at 1:45 PM with the Administrator. He stated he was aware of residents not receiving what was on the preplanned menu and food shortages on the weekends and had been working with dietary to improve service.

2. Resident #51 was admitted to the facility on 02/17/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 01/09/15 revealed Resident #51 was cognitively intact.

Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29 grievances related to food concerns.

An observation made on 04/22/15 at 1:00 PM of Resident #51's lunch tray revealed she had a bowl of corn and a mashed potatoes on her plate. Resident #51's tray card indicated she should also have received liver and onions.

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An interview was conducted on 04/22/15 at 9:52 AM with Nurse Aide (NA) #9. She stated she received a lot of complaints from her residents about not receiving what was on their tray card and if they asked for the alternate or a sandwich they were told the kitchen was out.

An interview was conducted on 04/22/15 at 4:40 PM with Resident #51. She stated she checked her tray card against what she received on her trays daily and it very seldom matched. Resident #51 stated she was allergic to chicken and eggs and on days chicken was served she received a plate of vegetables with no meat or they sent her the chicken even though she was allergic to it. Resident #51 further stated the facility ran out of food every weekend, she stated she had pancakes for breakfast last week but they didn't have any syrup and they are out of the alternate meal every time she asked for it.

An interview was conducted on 04/24/15 at 9:23 AM with the Cook. She stated the kitchen ran out of food every weekend and the menus had to be altered. She stated the facility received 1 food truck a week on Monday mornings and breakfast could not be cooked until the truck had been unloaded due to not having food to cook. The Cook further stated they had been told not to worry about what was on the tray cards but to make the trays with what they had. She further stated there were a lot of plates returned to the kitchen for wrong foods and a lot of complaints.

An interview was conducted on 04/24/15 at 10:13 AM with the Dietary Manager (DM). She stated she placed a food order on Friday and it was delivered to the facility on Monday morning and she was not aware of ever running out of items

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F 363	Continued From page 58 on the weekend. She stated if the kitchen ran out of an item on the preplanned menu they substituted with another item with the same nutritional value. The DM stated it was her expectation for the preplanned menus to be followed and further stated they had never ran out of food but might run short if there were new admissions to the facility over the weekend. An interview was conducted on 04/24/15 at 1:45 PM with the Administrator. He stated he was aware of residents not receiving what was on the preplanned menu and food shortages on the weekends and had been working with dietary to improve service.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff and residents the facility failed to serve food at palatable temperatures for 5 of 6 resident's reviewed for food quality (Resident's #134, #20, #51, #63 and #57). The findings included: 1. Resident #134 was admitted to the facility on 02/20/13 with diagnoses of hemiplegia and non-Alzheimer's dementia. The quarterly	F 364	F 364 1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #134, #20, #51, #63, and #57 by providing meals that are palatable and at appropriate temperatures. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Dietary Manager has completed interviews with those	5/22/15

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BRIAN CTR HEALTH & REHABI HICK	3031 TATE BOULEVARD SE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 59 Minimum Data Set (MDS) dated 01/23/15 revealed Resident #134 was moderately cognitively impaired but was understood and was able to understand. Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29 grievances related to food concerns. Observations of lunch trays being taken to resident rooms on the 100 and 500 halls on 04/20/15 revealed trays were taken to the resident rooms as soon as they arrived on the halls. On 4/22/15 at 12:21 PM a test tray was placed 12th on the 100 Hall tray cart. The cart stopped in the Main Dining room where residents in the dining room were served from the cart and at 12:32 PM the remainder of the cart left for the 100 Hall. At 12:39 PM the last tray was served on the 100 Hall and the test tray was observed with the Dietary Manager (DM) as follows: mashed potatoes 129.7 degrees, corn 123.8 degrees, liver 118.4 degrees, coffee 138 degrees. The mashed potatoes were warm but the corn, liver and coffee were described as luke warm by the surveyor and the DM. An interview was conducted on 04/22/15 at 9:05 AM with NA #2. She stated residents complained daily about the food and the coffee being cold and she reheated it daily for them. An interview was conducted on 04/22/15 at 3:07 AM with Resident #134's family member. She stated she was at the facility every day during lunch and supper and 6 days out of 7 she had to warm up Resident #134's food and coffee before	F 364	residents who are deemed interviewable to identify concerns related to food temperatures and palatability. Any concerns identified were addressed at the time of discovery. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Dietary Manager and Director of Nursing will conduct in-service/re-education for dietary and nursing staff regarding palatability of foods including use of the plate warmer and pellet system and timely meal tray delivery to reduce the potential for receiving foods that are not warm/cold according to the menu. The Cook will record temperatures of foods being served prior to meal service to ensure the temperatures are within guidelines. The Dietary Manager has posted a guide for Cooks to access regarding food temperatures in the temperature log book. The Dietary Manager will monitor test trays, on a meal time rotation, five times per week for four weeks, then four times per week for 3 weeks, then three times a week for two weeks, and weekly thereafter for three months. The Dietary Manager and Administrator will conduct a Food Committee meeting weekly to identify concerns related to meal service. The facility¿s Ambassadors will conduct rounds at least weekly for three months to identify concerns related to food temperatures and palatability. The Ambassadors will report findings to the Administrator during the morning stand up meetings. The Administrator will review minutes from the Resident Council to	

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F 364	Continued From page 60 he could eat. She also stated Resident #134 had received grilled cheese sandwiches that were not grilled with butter spread on both sides and frozen tater tots. Resident #134's family member stated she had spoken to the DM, Director of Nursing (DON) and the Administrator several times and there had been no improvement in the food. An interview was conducted on 04/22/15 at 3:43 PM with Nurse #6. She stated the food is always cold in the evenings and she had to reheat it on a daily basis for residents. She further stated staff had voiced concerns about food being cold to dietary but it hasn't gotten any better. An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested. An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated. 2. Resident #20 was admitted to the facility on 11/28/06 with diagnoses of diabetes and esophageal reflux. The quarterly Minimum Data Set dated 02/28/15 revealed Resident #20 was cognitively intact. Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29	F 364	identify concerns related to food palatability or temperature on a monthly basis to ensure continued compliance. 4. The Dietary Manager and Administrator will review data obtained during temperature log audits, Ambassador rounds, Food Committee meetings, and Resident Council meetings; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

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F 364	Continued From page 61	F 364		

grievances related to food concerns.

Observations of lunch trays being taken to resident rooms on the 100 and 500 halls on 04/20/15 revealed trays were taken to the resident rooms as soon as they arrived on the halls.

On 4/22/15 at 12:21 PM a test tray was placed 12th on the 100 Hall tray cart. The cart stopped in the Main Dining room where residents in the dining room were served from the cart and at 12:32 PM the remainder of the cart left for the 100 Hall. At 12:39 PM the last tray was served on the 100 Hall and the test tray was observed with the Dietary Manager (DM) as follows: mashed potatoes 129.7 degrees, corn 123.8 degrees, liver 118.4 degrees, coffee 138 degrees. The mashed potatoes were warm but the corn, liver and coffee were described as luke warm by the surveyor and the DM.

An interview was conducted on 04/22/15 at 9:05 AM with NA #2. She stated residents complained daily about the food and the coffee being cold she reheated it daily for them.

An interview was conducted on 04/22/15 at 1:07 PM with Resident #20. He stated the food was overcooked or undercooked, not seasoned and it was not hot. He stated he spoke with the DM on a daily basis but the food was not any better. He further stated he had to ask staff to reheat his food 3 to 4 times a week.

An interview was conducted on 04/22/15 at 3:43 PM with Nurse #6. She stated the food is always cold in the evenings and she had to reheat it on a daily basis for residents. She further stated staff

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had voiced concerns about food being cold to dietary but it hasn't gotten any better.

An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.

An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.

3. Resident #51 was admitted to the facility on 02/17/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 01/09/15 revealed Resident #51 was cognitively intact.

Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29 grievances related to food concerns.

Observations of lunch trays being taken to resident rooms on the 100 and 500 halls on 04/20/15 revealed trays were taken to the resident rooms as soon as they arrived on the halls.

On 4/22/15 at 12:21 PM a test tray was placed 12th on the 100 Hall tray cart. The cart stopped in the Main Dining room where residents in the dining room were served from the cart and at

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12:32 PM the remainder of the cart left for the 100 Hall. At 12:39 PM the last tray was served on the 100 Hall and the test tray was observed with the Dietary Manager (DM) as follows: mashed potatoes 129.7 degrees, corn 123.8 degrees, liver 118.4 degrees, coffee 138 degrees. The mashed potatoes were warm but the corn, liver and coffee were described as luke warm by the surveyor and the DM.

An observation was made on 04/24/15 at 8:36 AM of Resident #51's breakfast tray. The oatmeal appeared to be congealed, the butter did not melt in the oatmeal and the eggs looked runny.

An interview was conducted on 04/22/15 at 9:05 AM with NA #2. She stated residents complained daily about the food and the coffee being cold and she had to reheat it for them.

An interview was conducted on 04/22/15 at 3:43 PM with Nurse #6. She stated the food is always cold in the evenings and she had to reheat it on a daily basis for residents. She further stated staff had voiced concerns about food being cold to dietary but it hasn't gotten any better.

An interview was conducted on 04/24/15 at 9:55 AM with Resident #51. She stated her coffee, oatmeal and eggs were cold this morning and she had to ask staff to reheat them. She stated she had to have her coffee reheated daily and her food reheated 3 to 4 times a week.

An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's

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F 364	Continued From page 64 received it. She stated the kitchen would warm up the tray if the resident requested. An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated. 4. Resident #63 was admitted to the facility on 11/24/14. Her admission Minimum Data Set (MDS) dated 12/03/14 and her quarterly MDS dated 02/20/15 coded her as having intact cognition and being independent for eating with set up help only. During an interview on 04/20/15 at 11:34 AM, Resident #63 described the food as "slop" and "pitiful." She stated she got very small portions, it was overcooked and was always cold when she received it. She further stated she usually ate in her room.	F 364		

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On 04/22/15 at 8:43 AM, Resident #63 was observed with her tray in front of her. The grits appeared congealed and she stated they were cold. She tried the scrambled eggs and said they were very cold and then described the coffee as "putrid" due to being cold.

On 04/22/15 at 9:05 AM interview with Nurse Aide (NA) #2 revealed, since the change in dietary companies occurred in November 2014, the residents have voiced a lot of complaints about the food not being good and served cold.

On 04/22/15 at 9:52 AM interview with NA #9 revealed, since the change in dietary companies, residents constantly complain about the food regarding combination of food items, not following the tray cards and about portion sizes.

On 04/22/15 at 3:43 PM Nurse #6 stated the food and coffee was served cold and they have to reheat them on a daily basis. She further stated all residents have food complaints.

An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.
An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.

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5. Resident #57 was admitted to the facility on 02/14/14. Her most recent Minimum Data Set dated 02/06/15 coded her as having intact cognition and eating independently with set up help only.

On 04/22/15 at 8:37 AM Resident #57 was sitting at bedside eating breakfast. She said the food was usually cold. She stated today the grits were warm but the scrambled eggs were "ice cold." She stated she would like them warmer but did not want to trouble the staff by asking them to warm her food.

On 04/22/15 at 9:05 AM interview with Nurse Aide (NA) #2 revealed, since the change in dietary companies occurred in November 2014, the residents have voiced a lot of complaints about the food not being good and served cold.

On 04/22/15 at 9:52 AM interview with NA #9 revealed, since the change in dietary companies, residents constantly complain about the food regarding combination of food items, not following the tray cards and about portion sizes.

On 04/22/15 at 3:43 PM Nurse #6 stated the food and coffee was served cold and they have to reheat them on a daily basis. She further stated all residents have food complaints.

An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.

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F 364	Continued From page 67 An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.	F 364		
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 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure dented cans were not stored ready for use. The findings included: An initial tour of the kitchen was made on 04/20/15 at 9:30 AM. Canned goods stored ready for use in the dry storage area were observed. Observations of canned food items revealed four (4) 5 ½ pound dented cans of pears and one (1) 5 ½ pound can of peaches. One can had approximately a 3 inch dent on the side of the can, the second can had a 3 inch dent on the side of the can, the third can had a 2 inch dent on the	F 371	F 371 1. Corrective action has been accomplished for the alleged deficient practice with regard to dented cans by removing them at the time of discovery. 2. No residents were identified; however, facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Dietary Manager has completed an audit of current inventory items to ensure that dented cans are removed from stock to be returned. 3. Measures put into place to ensure that the alleged deficient practice does not	5/22/15

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F 371	Continued From page 68 upper side of the can near the rim, the 4th can had a 2 ½ inch dent on the side of the can. The can of peaches had a 2 inch dent on the side of the can and the top of the can was protruding out. An interview was conducted on 04/20/15 at 10:00 AM with the Dietary Manager (DM). She immediately removed the dented food items. She reported stock was received every week and staff were responsible for stocking the shelves. She explained all staff were trained on the proper procedures for unloading and stocking canned good items that included rotating canned goods and inspecting cans for dents which were to be removed. The DM stated the dented cans should not have been in the dry storage room ready for use but with the dented cans ready to be returned.	F 371	recur include: The Dietary Manager will conduct in-service/re-education for dietary staff regarding food storage, specifically, that dented cans are to be placed in a designated area to be returned to the vendor and not put into stock rotation. The Dietary Manager will conduct storage room audits to identify that dented cans are not in stock rotation three times per week for four weeks, then twice per week for four weeks, then at least weekly for three months. The District Dietary Manager or Administrator will conduct kitchen sanitation audits to include review of the stock room for dented cans at least monthly to ensure continued compliance. 4. The Administrator will review data obtained during stock room audits and kitchen sanitation audits; analyze the data and report patterns/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 trends/outcomes to ensure continued compliance.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident interview and staff interview, the facility failed to accurately document physician ordered devices on the treatment record of 1 of 4 sampled residents who's treatment records were reviewed. (Resident #121).

The findings included:

Resident #121 was admitted to the facility on 05/14/12 with diagnoses including cerebral vascular accident, hemiplegia, neurologic neglect syndrome, chronic pain, and post traumatic stress.

Review of physician orders revealed Resident #121 was to have a left resting hand splint on 6 to 8 hours per day since ordered on 07/29/13; dycem to keep arm from sliding every shift since ordered on 08/12/12; and an edema control sleeve left arm and hand every shift since ordered on 08/12/13.

The annual Minimum Data Set (MDS) dated 02/27/15 coded Resident #121 as being cognitively intact and requiring extensive assistance with most activities of daily living skills (ADLs) and being nonambulatory.

The care plan for ADLs originating 03/03/15 identified the problem that Resident #121 required staff assistance and intervention for completion of ADL need due to needing supervision, limited assistance and extensive assistance of 1 staff member. The goal was to have ADL needs identified and met with staff assistance and intervention while maintaining highest level of independent function possible to include standing at hand rails. Interventions included the use of an edema sleeve to left arm as ordered, and a left hand splint 6 to 8 hours a day and dycem in the wheelchair to keep his left arm in place.

Resident #121 was observed as follows without an hand splint in place and without the dycem on the wheelchair arm rest and no edema sleeve in place during the following observations:
*on 04/20/15 at 12:42 PM;
*on 04/21/15 at 8:39 AM;
*on 04/22/15 at 8:15 AM;
*on 04/22/15 at 9:03 AM;
*on 04/22/15 at 9:43 AM;

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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*on 04/22/15 at 10:17 AM;
*on 04/22/15 at 11:53 AM;
*on 04/23/15 at 8:47 AM

Review of the treatment administration sheets revealed that in February, March and through April 22nd, the hand splint, dycem and left resting hand splint were in place.

On 04/23/15 at 10:26 the left arm rest of the wheelchair was covered in a thin gerisleeve material but no obvious padding. He again was not wearing a arm sleeve or hand splint. He stated that every once in awhile they put his hand splint on.

A follow up interview with NA #1 on 04/23/15 at 10:41 AM revealed she had worked with this resident for awhile and had never seen a hand splint for Resident #121. She stated that she did not offer the edema sleeve this morning. When asked about yesterday, she did not answer say she attempted to put them on, she stated he would not keep them on and he just took them off.

The nurse on duty, Nurse #5, was interviewed on 04/23/15 at 1:22 PM. Nurse #5 stated that she obtained a set of edema sleeves this morning for Resident #121. She stated even though she did treatment yesterday and was to ensure his edema sleeves were in place, she got busy and did not put the sleeves on him. She further stated she looked for the hand splint and was unable to find the hand splint. She was unable to explain why the dycem was not on the arm rest. she stated she should have gone back and circled the initials indicating the devices were in place.

The Director of Nursing (DON) stated on 04/24/15 at 1:20 PM during interview, that she expected that the sleeves and splints were being applied to Resident #121 since they were documented on the treatment records as being applied. She confirmed the treatment records were not accurate.