STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

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F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances in regards to untimely call bell response for three of three sampled residents (Residents # 92, #18 and # 32). Findings included: The grievance/complaint reports and resident council minutes for the last six months were reviewed. There were five grievances and three resident council minutes with concerns regarding untimely call bell response. On 3/5/15 a family member indicated that " resident waits too long for staff to answer the call bell. " The action taken by the facility to resolve the grievance was " unit manager to speak with staff in response to call bells. " On 3/30/15, a family member indicated " her mother's call bell was going off for an extended period of time. " The action taken by the facility to resolve the grievance was " counseled employees. " On 5/19/15, a resident indicated " call light not answered timely. " The facility's action was " staff educated on call bell response. " On 5/19/15, the resident council minutes indicated " residents stated issue of staff answering call lights and turning off light before resolving the issue still remains. " On 7/21/15, a resident indicated " the staff were slow in answering call bells. " The facility's action was "	F 166	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 166 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #92, #18 and #32 have been re-interviewed by Social Worker and grievances have been resolved. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected.	10/15/15

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

Electronically Signed | 10/08/2015

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F 166	Continued From page 1 staff education. " On 8/18/15, the resident council minutes indicated that " staff turning off call light saying someone will come and they don't and the wait time to get a call light request in a timely manner. " On 8/24/15, a family member indicated " resident stated that no one answered her call light in a timely manner. " The facility action was " call bell replaced by the nurse." On 9/16/15, the resident council minutes indicated " call light issue of staff turning off light before answering continues and wait time for someone to answer continues. " 1. Resident # 18 was admitted to the facility on 8/26/11. The quarterly Minimum Data Set (MDS) assessment dated 9/4/15 indicated that Resident #18 had a brief interview for mental status (BIMS) score of 12. On 9/17/15 at 2:20 PM administrative staff #2 was interviewed. She stated that she was responsible for the resident council meeting every month. She acknowledged that residents had been complaining about the untimely call bell response including Resident #18. She indicated that she mentioned the concerns on the minutes and she had to give the minutes to the department head. The department head had to put the corrective action plan to resolve the concerns. On 9/17/15 at 2:35 PM, Resident #18 was interviewed. She stated that the issue with the call bell response was still an ongoing problem. She added that this issue had been brought up in the resident council meeting several times but had not been resolved. She usually had to use her call light to be put back to bed because she	F 166	Resident interviews completed with all interviewable residents with BIMS score of 8-15 to ensure all grievances have been received. Any grievances received during interviews were placed on grievance form and followed up per grievance policy. The Administrator will review all grievances for completion within 72 hours of receipt of the grievance. The resident or person filing the grievance will be informed of the finding of the investigation as well as any corrective actions recommended within five working days of the filing of the grievance or complaint. The Administrator and/or Social Worker will follow up with resident or person filing the grievance weekly x 4 weeks to ensure that grievance is resolved. Follow up will remain ongoing. On September 25, 2015 education began for all staff in response to call bell response. Education to include that all staff responsible for answering call lights timely, procedure for answering call lights including not turning off call light until all resident¿s needs are met and consequences for failure to answer call lights and meeting residents needs. The Administrator, Department Managers, Nursing Supervisor and/or Manager on Duty will review call light response times for timeliness and meeting of resident needs to include off shifts and weekends daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months.	

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F 166	Continued From page 2 was hurting and staff would not answer the light. At times the staff would come and turned off the light and would say she/he will be back but it would take a long time for them to come back. On 9/17/15 at 3:07 PM, administrative staff #1 was interviewed. She stated that the staff had been in-serviced on call bell response by the staff development coordinator. She added that she had been monitoring the call bell response when she was in the building otherwise there was no quality assurance and performance improvement (QAPI) for it. She stated that she would discuss it with the administrator and would initiate a QAPI. 2. Resident # 92 was admitted to the facility on 2/28/15. The significant change in status Minimum Data St (MDS) assessment dated 7/17/15 indicated that Resident #92 had a brief interview for mental status score of 15. On 9/17/15 at 2:20 PM administrative staff #2 was interviewed. She stated that she was responsible for the resident council meeting every month. She acknowledged that residents had been complaining about the untimely call bell response including Resident #92. She indicated that she mentioned the concerns on the minutes and she had to give the minutes to the department head. The department head had to put the corrective action plan to resolve the concerns. On 9/17/15 at 2:25 PM, Resident #92 was interviewed. She stated that the concerns with the call bell response was still an ongoing problem. She added that the issue with untimely	F 166	Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 25, 2015 education began for all staff as it relates to the grievance process. Education to include the process for receiving grievances from residents and family members, process for investigation of grievances and follow up of grievances. The Administrator will review all grievances for completion within 72 hours of receipt of the grievance. The resident or person filing the grievance will be informed of the finding of the investigation as well as any corrective actions recommended within five working days of the filing of the grievance or complaint. The Administrator and/or Social Worker will follow up with resident or person filing the grievance weekly x 4 weeks to ensure that grievance is resolved. Follow up will remain ongoing. On September 25, 2015 education began for all staff in response to call bell response. Education to include that all staff responsible for answering call lights timely, procedure for answering call lights including not turning off call light until all resident¿s needs are met and consequences for failure to answer call lights and meeting resident needs. The Administrator, Department Managers,	

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F 166	Continued From page 3 call bell response had been brought up in the resident council meeting several times. On 9/17/15 at 3:07 PM, administrative staff #1 was interviewed. She stated that the staff had been in-serviced on call bell response by the staff development coordinator. She added that she had been monitoring the call bell response when she was in the building otherwise there was no quality assurance and performance improvement (QAPI) for it. 3. Resident #32 was readmitted 10/1/14. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact. On 9/16/15 at 7 AM Resident #32 was interviewed. She stated that staff frequently would cut off her call light and say they would be back or get someone else to help them but then they wouldn ' t come back at all or it would take a very long time. She indicated that was an ongoing problem that had not been resolved. Resident #32 said she had verbalized her complaints about this on numerous occasions to multiple staff but nothing had been done. On 9/17/15 at 2:20 PM administrative staff #2 was interviewed. She stated that she was responsible for the resident council meeting every month. She acknowledged that residents had been complaining about the untimely call bell response including Resident #18. She indicated that she mentioned the concerns on the minutes and she had to give the minutes to the department head. The department head had to put the corrective action plan to resolve the concerns.	F 166	Nursing Supervisor and/or Manager on Duty will review call light response times and meeting of resident needs to include off shifts and weekends daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. Resident interviews will be completed with all interviewable residents with BIMS score of 8-15 monthly as part of quality assurance room rounds to ensure all grievances have been received, prior grievances have been resolved, staff are responding to call lights timely and resident needs are being met prior to staff turning off call light. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Administrator will report the findings of grievance investigation and grievance follow up, call bell response audits and summary of resident interviews to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. Date of Completion: October 15, 2015	

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F 166	Continued From page 4 On 9/17/15 at 2:35 PM, Resident #18 was interviewed. She stated that the issue with the call bell response was still an ongoing problem. She added that this issue had been brought up in the resident council meeting several times but had not been resolved. She usually had to use her call light to be put back to bed because she was hurting and staff would not answer the light. At times the staff would come and turned off the light and would say she/he will be back but it would take a long time for them to come back. On 9/17/15 at 3:07 PM, administrative staff #1 was interviewed. She stated that the staff had been in-serviced on call bell response by the staff development coordinator. She added that she had been monitoring the call bell response when she was in the building otherwise there was no quality assurance and performance improvement (QAPI) for it. She stated that she would discuss it with the administrator and would initiate a QAPI.	F 166		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 observation, record review, resident and staff interview the facility failed to have an	F 224	F-224	10/15/15

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F 224	Continued From page 5 assigned Nursing Assistant available to check on and meet the needs of 7 (Resident #32, #18, #55, #27, #104, #132 and #31) of 57 residents on 300 and 400 halls (Station Two) for a period of between two to three hours. The findings included: 1. Resident #32 was readmitted 10/1/14. The resident ' s cumulative diagnoses included diabetes, spinal stenosis, cardio vascular disease and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact. The MDS also indicated Resident #32 required extensive assistance for bed mobility, transfers, toileting and personal hygiene; had impairment of both upper and lower extremities and was incontinent of bladder and bowel. Review of the Care Plan last updated 9/3/15 revealed a plan of care for incontinence of bowel and bladder. The approaches included: " give perineal care when the resident is incontinent " and " assess for incontinence on routine rounds and as needed " . Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #32 was one of the residents on her assignment. There was no indication on the assignment regarding who would take over the care of Resident #32 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM. On 9/16/15 at 4:44 PM resident #32 was observed up in her wheelchair near the nurse ' s station speaking on a portable telephone. Nursing Assistant #3 (NA #1) was also observed at this time and stated to the resident " I know	F 224	Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Residents #32, #18, #55, #27, #104, #132, #31 have an assigned nursing assistant each shift to meet their needs. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. Nurse Aide #4 is no longer employed by facility. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. All residents have an assigned nursing assistant each shift to meet their needs. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 17, 2015 the Director of nursing received directed in-service training by the administrator in response to reporting employee absences and tardies. The Director of Nursing to report absences and tardies immediately to unit	

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F 224	Continued From page 6 (name of resident) the person you had isn ' t here yet so they are redoing the assignment " . On 9/16/15 at 5:00 PM Nursing Assistant #4 was observed accompanying the resident to her room. She placed a clean incontinent pad on the resident ' s bed and told the resident that the Nursing Assistant assigned to her would be coming in at 6 PM. Interview with NA #4 on 9/16/15 at 5:05 PM revealed that she was aware the resident was wet and wanted incontinent care. She stated that it was the resident ' s habit to return to the nurse ' s station around 4 PM and that Resident #32 always wanted to go back to bed at that time and would need incontinent care. She stated that she was not Resident #32 ' s assigned NA for the shift, although she was her roommate ' s NA, and had already given the roommate incontinent care. On 9/16/15 at 5:25 PM Resident #32 was observed in her room sitting in her wheel chair. She stated that she was very wet and had not received incontinent care since before lunch when she got up. A urine odor was noted at this time. Resident #32 stated that since around 4 PM she had told several NA ' s that she wanted to go back to bed and said they knew that she needed to be changed. She added that she was told the NA assigned to her (NA #6) would be in at 6 PM and would put her back to bed when she arrived. On 9/16/15 at 5:30 PM NA#4 stated that she was going to the dining room to feed other residents and that the NA assigned to Resident #32 would be in at 6 PM and take care of her then. On 9/16/15 at 5:45 PM NA #3 was observed in Resident #32 ' s room adjusting the resident ' s over-bed table. Resident #32 was observed in bed at this time. Interview with NA #3 revealed that she had not helped the resident to bed but	F 224	manager and/or nurse on duty. Staffing assignments will be adjusted immediately to ensure person centered care delivery. On September 17, 2015 education by Staff Development Coordinator began for all nursing staff in reference to reporting absences and tardies to the Director of Nursing. Education completed October 12, 2015. Staff members not receiving in service education by October 12, 2015 will be required to receive inservice education prior to beginning of scheduled shift. Education to include staff member physically speaking to the Director of Nursing. If Director of nursing is unable to be reached staff are to report to Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Administrator. Education also includes upon arrival to facility staff are to initial beside their name on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will complete assignment for nursing assistants using a resident census at the beginning of each shift to ensure all residents in the facility have an assigned nursing assistant. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. On September 17, 2015 education by	

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F 224	Continued From page 7 had volunteered to take Resident #32 on her assignment. She wasn ' t sure what time she volunteered but said it was just before the dinner meal trays came out. NA #3 added that she had other residents with pressing needs at that time so NA #4 offered to put Resident #32 back to bed, and give the resident incontinent care, before going to the dining room to help feed other residents. On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated that around 5:00 PM she had become aware that Resident #32 ' s NA (NA #6) was not able to come in until 6 PM, for the 3 - 11 PM shift. Nurse #3 said she found out NA #6 had not arrived yet when Resident #32 was asking who her NA was because she wanted to go back to bed. Nurse #3 recalled it was around 5:00 PM because one of the NA ' s said the dinner trays would be out soon so they might as well wait until NA #6 came in at 6:00 PM, as it wouldn ' t be long and NA #6 could take care of Resident #32 then. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment. She added that NA #3 volunteered to have Resident #32 on her assignment at that time. On 9/17/15 at 11:57 AM Resident #32 was observed in the dining room awaiting her lunch meal. Interview with Resident #32 at this time revealed she did not like being left wet in her wheelchair for so long the previous evening while they figured out who was going to take care of her. She had been tired and soaking wet and just wanted to go back to bed and it made her feel bad to wait so long. On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she	F 224	Staff Development Coordinator began for all nursing staff in reference to reporting absences and tardies to the Director of Nursing. Education completed October 12, 2015. Staff members not receiving in service education by October 12, 2015 will be required to receive inservice education prior to beginning of scheduled shif. Education to include staff member physically speaking to the Director of Nursing. If Director of nursing is unable to be reached staff are to report to Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Administrator. Education also includes upon arrival to facility staff are to initial beside their name on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will complete assignment for nursing assistants using a resident census at the beginning of each shift to ensure all residents in the facility have an assigned nursing assistant. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months to ensure staff have initialed that they have reported	

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F 224	Continued From page 8 would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program. 2. Resident #18 was admitted 2/19/15 and had diagnoses including diabetes, anxiety and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/9/15, revealed Resident #18 was cognitively intact. It also revealed the resident required extensive assistance with all activities of daily living except for eating, for which she required supervision. The MDS also indicated Resident #18 was incontinent of bowel and bladder. Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #18 was one of the residents on her assignment. There was no indication on the assignment regarding who would take over the care of Resident #18 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM. On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6	F 224	for duty and that assignment was completed accurately to reflect staff that have reported for duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to the Administrator for review daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s and person centered care to include responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager, and/or Nursing Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care. Walking rounds will continue daily x 4 weeks and weekly thereafter. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will report findings of the assignment sheet checks and summary of walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six	

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F 224	Continued From page 9 was expected to arrive since it was almost dinner time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment. On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program. 3. Resident #55 was admitted 11/26/16 and had diagnoses including anemia and hypertension. She was also on oxygen for a respiratory disease. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/2/15, revealed Resident #55 was cognitively intact. It also revealed the resident required extensive assistance for toileting, bed mobility, transfers and personal hygiene, as well as supervision for eating. The MDS also indicated Resident # 55 was frequently incontinent of bowel ad bladder. Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #55 was one of the residents on her assignment. There was no indication on the	F 224	months or until a pattern of compliance is achieved. Date of Completion October 15, 2015.	

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assignment regarding who would take over the care of Resident #55 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM.
On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6 was expected to arrive since it was almost dinner time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment.
On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.
4. Resident #27 was admitted on 4/17/12 and had diagnoses including diabetes, hypertension and arthritis.
The most recent Minimum Data Set (MDS) Assessment, an Annual MDS dated 6/9/15 revealed Resident # 27 was cognitively impaired and required extensive assistance with bed mobility, toileting, and personal hygiene, as well as supervision for eating. The MDS also

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indicated Resident #27 was always incontinent of bowel and bladder.
Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #27 was one of the residents on her assignment. There was no indication on the assignment regarding who would take over the care of Resident #27 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM.
On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6 was expected to arrive since it was almost dinner time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment.
On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.

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5. Resident #104 was admitted 5/1/13 and had diagnoses including congestive heart failure, arthritis and anxiety. Resident #104 was also under the care of hospice services.
The most recent Minimum Data Set (MDS), a Significant Change MDS dated 7/28/15 revealed Resident #104 was cognitively impaired and requires extensive assistance for bed mobility, toileting and personal hygiene, she was also totally dependent for transfers and eating. The MDS also indicated Resident #104 was incontinent of bowel and bladder.
Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #104 was one of the residents on her assignment. There was no indication on the assignment regarding who would take over the care of Resident #104 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM.
On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6 was expected to arrive since it was almost dinner time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment.
On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff

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#1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.

6. Resident #132 was admitted 8/3/15 and had diagnoses including hypertension, arthritis and Alzheimer ' s disease.

Review of the most recent Minimum Data Set (MDS), an Admission MDS dated 9/7/14 revealed Resident #132 had memory problems and significantly impaired decision making. The MDS also revealed Resident #132 required extensive assistance for bed mobility, transfers, eating, toileting and personal hygiene. The MDS further indicated Resident #132 was always incontinent of bladder and frequently incontinent of bowel.

Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #132 was one of the residents on her assignment. There was no indication on the assignment regarding who would take over the care of Resident #132 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM.

On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6 was expected to arrive since it was almost dinner

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time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment.
On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.
7. Resident #31 was admitted 10/15/13 and had diagnoses including dementia, anxiety and hypertension.
Review of the most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 6/9/15, revealed Resident #31 had memory problems and significantly impaired decision making. The MDS also revealed Resident #31 required extensive assistance for bed mobility, transfers, toileting and personal hygiene, as well as limited assistance for eating. The MDS further indicated Resident #31 was frequently incontinent of bowel and bladder.
Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. Resident #31 was one of the residents on her

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F 224	Continued From page 15 assignment. There was no indication on the assignment regarding who would take over the care of Resident #31 or the other resident ' s on her assignment between 3:00 PM and 6:00 PM. On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated she had become aware that NA #6 was not going to be late coming in for the 3 PM - 11 PM shift at around 5:00 PM. She added that one of the Nursing Assistants had suggested that the residents could wait until 6 PM when NA #6 was expected to arrive since it was almost dinner time and NA #6 would be there soon. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility to ensure their care needs would be met and that she would readjust the assignment. On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.	F 224		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		10/15/15

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F 241	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to treat a resident with dignity by taking more than an hour to provide incontinent care, to a resident who was known to have been incontinent for 1 of 3 sampled residents (Resident #32) reviewed for dignity, and failed to knock before entering a resident room for 1 of 1 residents observed during wound care (Resident #119). The findings included: 1. Resident #32 was readmitted 10/1/14. The resident ' s cumulative diagnoses included diabetes, spinal stenosis, cardio vascular disease and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact. The MDS also indicated Resident #32 required extensive assistance for bed mobility, transfers, toileting and personal hygiene; had impairment of both upper and lower extremities and was incontinent of bladder and bowel. Review of the Care Plan last updated 9/3/15 revealed a plan of care for incontinence of bowel and bladder. The approaches included: " give perineal care when the resident is incontinent " and " assess for incontinence on routine rounds and as needed " . On 9/16/15 at 7 AM Resident #32 was interviewed. She stated that staff frequently would cut off her call light and say they would be back or get someone else to help them but then they wouldn ' t come back at all or it would take a very long time. The resident attributed this in part to the fact that NA staff often needed another NA	F 241	F241 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #32 is receiving incontinent care. Resident #119 staff are knocking on door and asking permission prior to entering the resident¿s room. Nursing Assistant #2 was counseled and re-educated on resident privacy to include knocking on door and asking permission prior to entering the resident¿s room. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. All residents have an assigned nursing assistant each shift to meet their needs. Residents are receiving assistance with ADL¿s including incontinent care. Staff are knocking on resident doors and asking permission prior to entering the resident¿s room. Measures put into place or systemic	

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F 241	Continued From page 17 to help them turn her because she was heavy and because if it involved getting her in or out of bed they needed to find one of two mechanical lifts in the building and another staff member to help them. She added that she always had a different NA because the staff rotated taking care of her and they seemed like they didn ' t want to do her care because they were worried they would hurt their back. On 9/16/15 at 4:44 PM resident #32 was observed up in her wheelchair near the nurse ' s station speaking on a portable telephone. Nursing Assistant #3 (NA #3) was also observed at this time and stated to the resident " I know (name of resident) the person you had isn ' t here yet so they are redoing the assignment " . Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. She was assigned Resident #32 as well as other residents. There was no indication on the assignment regarding who would take over the care of the residents assigned to NA #6 between 3:00 PM and 6:00 PM. On 9/16/15 at 5:00 PM Nursing Assistant #4 was observed accompanying the resident to her room. She placed a clean incontinent pad on the resident ' s bed and told the resident that the Nursing Assistant assigned to her (NA #6) would be coming in at 6 PM. Interview with NA #4 on 9/16/15 at 5:05 PM revealed that she was aware the resident was wet and wanted to go back to bed. She stated that it was the resident ' s habit to return to the nurse ' s station around 4 PM and that Resident #32 always wanted to go back to bed at that time and would need incontinent care. NA #4 stated that	F 241	changes made to ensure that the deficient practice will not occur: On September 17, 2015 education began for all nursing staff in reference to reporting absences and tardies to the Director of Nursing. Education to include staff member physically speaking to the Director of Nursing. If Director of nursing is unable to be reached staff are to report to Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Administrator. Education also includes upon arrival to facility staff are to initial beside their name on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months to ensure staff have initialed that they have reported for duty and that assignment was completed accurately to reflect staff that have reported for duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to the	

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F 241	Continued From page 18 she was not Resident #32 ' s assigned NA for the shift, although she was her roommate ' s NA, and had already given the roommate incontinent care. On 9/16/15 at 5:25 PM Resident #32 was observed in her room sitting in her wheel chair. She stated that she was very wet and had not received incontinent care since before lunch when she got up. A urine odor was noted at this time. Resident #32 stated that since around 4 PM she had told several NA ' s that she wanted to go back to bed and said they knew that she needed to be changed. She added that she was told the NA assigned to her (NA #6) would be in at 6 PM and would put her back to bed when she arrived. Resident #32 also said that she was aware the NA ' s took turns taking her on their assignment because she was physically heavy, required a mechanical lift for transfers, and because they thought it took a long time to do her care because she was so particular. Resident #32 denied refusing incontinent care, unless it was during the day and the staff member said they would not be able to get her up again if they put her back to bed for incontinent care. On 9/16/15 at 5:30 PM NA#4 stated that she was going to the dining room to feed other residents and that NA #6 would be in at 6 PM and take care of Resident #32 then. On 9/16/15 at 5:45 PM NA #3 was observed in Resident #32 ' s room adjusting the resident ' s over-bed table. Resident #32 was observed in bed at this time. Interview with NA #3 revealed that she had not helped the resident to bed but had volunteered to take Resident #32 on her assignment. She wasn ' t sure what time she volunteered but said it was just before the dinner meal trays came out. NA #3 added that she had other residents with pressing needs at that time so NA #4 offered to put Resident #32 back to	F 241	Administrator for review daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s including incontinent care to be given at least every 2-3 hours, as requested by the resident or family member and as needed for visual signs of soiling and person centered care to include responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care. Walking rounds will continue daily x 4 weeks and weekly thereafter. On September 25, 2015 education began for all staff as it relates to dignity and privacy. Education to include knocking on doors and asking permission to enter prior to entering a resident room. The Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Manager on Duty will make daily rounds to include off shifts and weekends to ensure that staff are promoting dignity by knocking on doors and asking permission to enter prior to entering a resident room.	

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F 241	Continued From page 19 bed, and give the resident incontinent care, before going to the dining room to help feed other residents. On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated that around 5:00 PM she had become aware that Resident #32 ' s NA (NA #6) was not able to come in until 6 PM, for the 3 - 11 PM shift. Nurse #3 said she found out NA #6 had not arrived yet when Resident #32 was asking who her NA was because she wanted to go back to bed. Nurse #3 recalled it was around 5:00 PM because one of the NA ' s said the dinner trays would be out soon so they might as well wait until NA #6 came in at 6:00 PM, as it wouldn ' t be long and NA #6 could take care of Resident #32 then. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility and that she would readjust the assignment and NA #3 volunteered to have Resident #32 on her assignment at that time. On 9/17/15 at 11:57 AM Resident #32 was observed in the dining room awaiting her lunch meal. Interview with Resident #32 at this time revealed she did not like being left wet in her wheelchair for so long on 9/16/14 while they figured out who was going to take care of her. She had been tired and soaking wet and just wanted to go back to bed and it made her feel bad to wait so long. On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA #6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative	F 241	Daily rounds will continue daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will report findings of the assignment sheet checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Director of Nursing will report the summary of walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Administrator will report the findings of the dignity rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. Date of completion: October 15, 2015	

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F 241	Continued From page 20 Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program. 2. Resident # 119 was admitted to the facility on 5/29/13 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 8/13/15 indicated that Resident #119 had impaired cognition and had a pressure ulcer. On 9/16/15 at 2:55 PM, Resident #119 was observed during a dressing change. While the treatment nurse was providing the treatment to the pressure ulcer, NA #2 opened the door and entered the room without knocking or asking permission to enter the room. He was observed to enter the room and put a disposable brief to the bed of the roommate. On 9/16/15 at 2:58 PM, Nurse #1 was interviewed. She stated that she expected the staff to knock on the door before entering. She added that she already educated NA #2 on knocking and asking permission to enter the room. On 9/17/15 at 3:30 PM, NA #2 was interviewed. He stated that he forgot to knock on the door before entering. He stated that he was going to every room to put a disposable brief for his incontinent care.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		10/15/15

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F 253	Continued From page 21 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews and staff interviews, the facility failed to maintain shower rooms that were clean and in good repair in 2 of 2 resident shower rooms. The findings included: During an interview on 9/15/15 at 11:15AM with Resident #115 he stated that he had staff put a towel on the floor to stand on because the floors were so dirty in the shower room. He stated that there was mold/mildew in the showers. He stated that there were flies and gnats in the shower rooms that he would spray with his hand-held sprayer to get them out of the shower while he was in there. Observations of the shower rooms were made on 9/15/15 at 11:42 AM. A. The shower room that serviced the 300 and 400 halls was observed: -There were 2 pillows, without pillow cases, and a pair of soiled gray sweatpants sitting in an upholstered chair in the shower room. All items were loose and not in a plastic bag. Nurse Aide (NA) #2 saw the pillows and sweatpants and stated she did not know whose they were and that they shouldn't be in the chair. She removed items from the bathroom. -A used bed sheet and white towel were lying in a ball in the tub. They were not in a plastic bag. There was a light brown stain observed on the towel. -There were 2 black flies circling and landing on	F 253	F253 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Shower rooms for unit 1 and unit 2 were deep cleaned by housekeeping. Pest control service treated facility including shower rooms on unit 1 and unit 2 on September 15, 2015 for pests. Pest control returning to treat facility including shower rooms on unit 1 and unit 2 on October 9, 2015 for pests. Shower curtains were placed in shower rooms on unit 1 and unit 2. Maintenance will replace all broken tile to unit 1 and unit 2 shower rooms. Maintenance will repair in plumbing in unit 1 and unit 2 shower rooms. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On September 25, 2015 education began	

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F 253	Continued From page 22 the toilet. Upon closer inspection, there was urine and a moderate size stool (about 10 centimeters by 5 centimeters) in the toilet upon which the flies landed on. There was no toilet paper in the toilet. There were broken tiles at the corner of the toilet area that continued into the first shower stall on the right in a 2 inch by 6 inch area. -The first shower stall on the right had no shower curtain. There was dried hair on top of the drain in the floor. -The first shower stall on the left had a white, dried substance covering the drain in the floor in a 3 foot by 1 foot area. There was a dark brown/black dried substance collected in a corner of the shower and along floor tiles throughout the shower stall. A small web with a spider was located in the left corner. -The last shower stall on the right had water dripping continuously from the shower head at a rate greater than a drop every second. There was yellow " caution " tape across the entrance to the entire stall. Mildew/mold was noted in the shower. There was an area of broken tiles in an approximately 2 square foot area. B. The shower room that serviced the 100 and 200 halls was observed: -There were 2 shower stalls with curtains. Water was dripping from both shower stalls with curtains. -There was pink mold/mildew covering the bottom tiles in the shower stalls. -There were broken tiles across the bottom of the rear wall of the shower room. An interview was conducted with the Account Manager on 9/15/15 at 12:03 PM. The Account Manager stated that he was the Housekeeping Manager. He stated that there were 2 shower rooms in the facility (the 100/200 hall shower	F 253	for all nursing staff in reference to cleanliness of shower rooms. Education to include removing all items including dirty linen, trash and soiled items from the shower room and cleaning up of waste and/or spills immediately. Housekeeping will check shower rooms three times daily in reference to cleanliness at the beginning of shift, mid shift and end of shift. Checks will continue ongoing. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or supervisor will make rounds daily to include off shifts and weekends to monitor cleanliness of shower rooms and any areas in need of repair. Shower room rounds will be done daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. The Maintenance supervisor will monitor shower rooms on unit 1 and unit 2 weekly for needed repairs. Rounds will continue ongoing with preventative maintenance rounds. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 25, 2015 education began for all nursing staff in reference to cleanliness of shower rooms. Education to include removing all items including dirty linen, trash and soiled items from the shower room and cleaning up of waste	

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F 253	Continued From page 23 room and the 300/400 hall shower room). He indicated that both shower rooms were utilized. An interview with the Maintenance Director was conducted on 9/16/15 at 10:30AM. He stated that 3 of the 4 shower stalls in the 100/200 hall shower room were being utilized and 3 of the 4 shower stalls in the 300/400 hall shower room were being utilized. He stated that there were 4 shower stalls (2 in the 100/200 hall shower room and 2 in the 300/400 hall shower room) that have had recurring issues with tiles breaking. He stated that over the past 7 years he had been patching the tiles when they broke, but they continued to break in the same places. He stated that the " caution " tape had been secured in the 300/400 hall shower room for over a month. He revealed that plumbing issues had also been ongoing for several months. He stated that he had been repairing the issues to the best of his ability, but that the plumbing needed to be replaced by a professional plumber. He stated that any maintenance request estimated to cost over $500 needed to be authorized by the corporate office. He stated that he contacted the corporate office about a week ago regarding the plumbing issues and broken tiles. He revealed that corporate staff came to the facility on 9/15/15 to view the issues. He revealed that the corporate office authorized the Maintenance Director to obtain price estimates from contractors to fix the plumbing problems and to retile 4 shower stalls with broken tiles. The maintenance director stated that 3 contractors were scheduled to come to the facility that day, 9/16/16. A second interview with the Account Manager was conducted on 9/16/15 at 11:00AM. He stated	F 253	and/or spills immediately. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or supervisor will make rounds daily to include off shifts and weekends to monitor cleanliness of shower rooms and any areas in need of repair. Daily rounds will be done daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. Shower rooms will be checked daily during Quality Assurance Room rounds for cleanliness and areas in need of repair. Checks will continue ongoing. Housekeeping will check shower rooms three times daily in reference to cleanliness and areas in need of repair at the beginning of shift, mid shift and end of shift. Checks will continue ongoing. The Maintenance supervisor will monitor shower rooms on unit 1 and unit 2 weekly for needed repairs. Rounds will continue ongoing with preventative maintenance rounds. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing and Housekeeping Director will report findings of the shower room rounds to the Quality Assurance and Performance Improvement Committee monthly for six	

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F 253	Continued From page 24 that the housekeeping staff was responsible for cleaning the shower rooms. He stated that the shower rooms were cleaned every morning at 7:00AM. He stated that the shower rooms were cleaned during the day if housekeeping was notified of a problem. He stated that this was not a common occurrence that housekeeping would need to clean the shower rooms again during the day. He stated that the housekeeping staff completed a walkthrough of the shower rooms at the end of their shift around 2PM. He stated that he was not aware of any issues regarding the cleanliness of the shower rooms. An interview with the Activities Director was conducted on 9/17/15 at 8:45AM. The Activities Director indicated that the shower rooms had been discussed in the resident council meetings. She stated that the shower room on the 300/400 hall was indicated to be dirty. She stated that she believed this issue came up a couple of months ago and it was again brought up yesterday. She stated that she reported this to the Director of Nursing and to the Account Manager because she " wanted nursing to know if they didn't already know that residents were using a bathroom that they think is dirty " . A review of the Resident Council minutes from 9/16/15 indicated that residents discussed the shower room at station #2 (the 300/400 hall shower room) needing to be cleaned. An interview was conducted with Resident #28 on 9/17/15 at 9:35AM. Resident #28 stated that sometimes there was " something " left in the toilet in the shower room. An interview was conducted with Resident #34 on	F 253	months or until a pattern of compliance is achieved. The Maintenance Supervisor will report findings of the shower room rounds and repairs completed to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Administrator will report findings of quality assurance room rounds completed to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. Date of Completion October 15, 2015.	

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F 253	Continued From page 25 9/17/15 at 10:40AM. Resident #34 stated that he used the shower room on the 300/400 hall. He stated that the shower room " ain't fit for nobody to take a shower in it. " He stated that it was dirty most of the time. He stated that one time " there was doo-doo on the floor in the shower stall. " A second interview was conducted with Resident #115 on 9/17/15 at 11:00AM. He stated that the shower room had standing water in the stalls that did not drain. He stated that this was ongoing for 5-6 months. He stated that one of the showers was full of mold. He stated that he saw "manure " on the floor in the shower room.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		10/15/15

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F 278	Continued From page 26 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 3 sampled residents (Resident #1, #9, and #154) with level II Preadmission Screening and Resident Reviews (PASRR) and 1 of 1 sampled resident with a pressure ulcer (Resident # 119). The findings included: 1. Resident #1 was initially admitted to the facility on 9/9/03 and was readmitted to the facility on 12/18/14 with multiple diagnoses that included late effects of cognitive vascular disease with cognitive deficits and depressive disorder. The annual MDS dated 5/5/14 indicated a " No " to question A1500 which asked if Resident #1 had been evaluated by a level 2 PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Record review indicated that Resident #1 was a level 2 PASRR. Resident #1's level 2 PASRR was initially received 2/23/10. An interview was conducted on 9/16/15 at 4:10PM with the MDS Coordinator. She stated that she is responsible for answering question A1500 on the MDS for all residents. She	F 278	F 278 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #1, #9 and #154 assessments were modified to reflect accurate PASRR level. Resident #119 assessment was modified to reflect accurate status of pressure ulcer. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On September 21, 2015 all resident with level two PASSR were reviewed for accuracy with modifications to MDS done as indicated. On September 18, 2015 audit of all residents with pressure ulcers were reviewed for accuracy with modifications	

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F 278	Continued From page 27 revealed that if question A1500 indicated a " no " answer that she answered the question " no " . 2. Resident #9 was admitted to the facility on 9/24/03 with multiple diagnoses that included muscular dystrophy and depressive disorder. The annual MDS dated 7/23/15 indicated a " No " to question A1500 which asked if Resident #9 had been evaluated by a level 2 PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Record review indicated that Resident #9 was a level 2 PASRR. Resident #9's level 2 PASRR was initially received 4/13/09. An interview was conducted on 9/16/15 at 4:10PM with the MDS Coordinator. She stated that she is responsible for answering question A1500 on the MDS for all residents. She revealed that if question A1500 indicated a " no " answer that she answered that question " no " . 3. Resident #154 was admitted to the facility on 4/23/15 with multiple diagnoses that included chronic ischemic heart disease, altered mental status, and anxiety state. The admission MDS dated 4/30/15 indicated a " No " to question A1500 which asked if Resident #154 had been evaluated by a level 2 PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Record review indicated that Resident #154 was a level 2 PASRR. Resident #154's level 2 PASRR was initially received 4/22/15.	F 278	to MDS done as indicated. Audit of most recent MDS for all active residents completed to ensure coding accuracy. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 20, 2015 education was completed with MDS nurse, Business Office Manager and Admissions Coordinator. Education completed using state RAI coordinator education materials on the MDS assessment and care plan process, how to identify level two PASSR numbers and entry into electronic record. Beginning September 21, 2015 upon admission Business Office Manager and/or Admission Coordinator will enter PASSR numbers into the electronic record and provide hard copy of level two PASSR numbers to MDS coordinator to ensure accurate coding to MDS. MDS nurse to use wound report and nursing wound assessment prior to coding of section M. Director of Nursing will review coding of PASSR and Section M of MDS for accuracy prior to closing of assessment. Review will continue daily x 4 weeks, weekly x 4 weeks, monthly x 3 months. Facility plans to monitor its performance to make sure that solutions are sustained.	

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F 278	Continued From page 28 An interview was conducted on 9/16/15 at 4:10PM with the MDS Coordinator. She stated that she is responsible for answering question A1500 on the MDS for all residents. She revealed that if question A1500 indicated a " no " answer that she answered the question " no " . 4. Resident # 119 was admitted to the facility on 5/29/13 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 8/13/15 indicated that Resident #119 had impaired cognition and had 2 stage II and 1 stage III pressure ulcers. The weekly pressure ulcer assessments were reviewed. The assessment indicated that Resident #119 had developed a stage III pressure ulcer on the left heel on 12/2/04. On 7/9/15, Resident #119 had developed a stage II pressure ulcer on his sacrum. The assessments revealed that during the period of the quarterly assessment dated 8/13/15, Resident #119 had 1 stage III and 1 stage II pressure ulcers. On 9/16/15 at 11:50 AM, the MDS Nurse was interviewed. She reviewed the records and indicated that it was an error on her part, Resident #119 had 1 stage III and 1 stage II pressure ulcer and she would correct the assessment.	F 278	The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the MDS accuracy audits as it relates to coding of level two PASSR and section M to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		10/15/15

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F 280	Continued From page 29 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to review and revise 2 (Resident # 32, and #84) of 14 care plans in the areas of activities of daily living and medications. The findings included: 1. Resident #32 was readmitted 10/1/14. The resident's cumulative diagnoses included diabetes, spinal stenosis, cardiovascular disease and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact and required extensive assistance for bed mobility and transfers. The MDS also indicated the resident used a wheelchair, did not walk, was totally dependent for locomotion and had bilateral impairment of her upper and lower extremities. Review of the care plan last updated 9/3/15	F 280	F 280 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #32 care plan was revised to reflect the current resident status related to activities of daily living. Resident #84 care plans was revised to reflect the current status as it relates to medication therapy. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	

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F 280	Continued From page 30 revealed a plan of care for " I require assistance for all ADL (Activities of Daily Living) " . Interventions included " I prefer morning showers, I prefer evening showers, I prefer bathing in the tub in the morning, I prefer bathing in the tub in the evening, I prefer a bed bath " , " Occupational Therapist to work with me on transfers and ambulation " , Occupational Therapist to work with me on ADL retraining " . Interview with Administrative Staff #1 on 9/17/15 at 2:45 PM revealed Resident #32 was not able to ambulate and required a mechanical lift. She stated that the Resident could have worked with OT on ambulation, transfers and self ADL care during a previous admission but that would have been a long time ago. She stated that these interventions were no longer accurate and the resident ' s care plan needed to be updated for accuracy. In addition she acknowledged that Resident #32 currently received a bed bath daily on third shift around 4 AM which was the resident ' s preference. Administrative Staff #1 added that the conflicting bathing preferences also needed to be updated in the care plan. On 9/17/15 at 11:57 AM resident #32 stated her preference was to have a bad bath on night shift around 4 AM every morning. She indicated staff were aware of this and she did get her bed bath daily. On 9/17/15 at 1:15 PM Occupational Therapist #1 was interviewed. She stated that the resident was not physically capable of ambulating and required a mechanical lift. Interview with the MDS Nurse on 9/17/15 at 2:45 PM revealed that she did not know how the inaccuracies in the care plan were missed each time she updated the care plan. The updates were done on 3/13/15, 6/6/15, 6/25/15 and 9/3/15 according to her hand written note on the care	F 280	All residents have the potential to be affected. Audit of all resident care plans were completed to ensure that care plan is person centered and reflects current resident status. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 21, 2015 education was completed with interdisciplinary team related to accuracy of care plans. Education completed using the state RAI coordinator education materials on the MDS assessment and care plan process. The Unit Manager, Nursing Supervisor, Staff Development Coordinator, MDS coordinator and/or Director of Nursing will review all admission and readmission charts within 24 hours to verify care plan is person centered and reflects current resident status. The MDS nurse will review telephone orders daily during clinical meeting for changes in care including medication changes. Upon receipt of telephone orders care plans will be updated by the MDS coordinator to reflect changes in resident status. Acute episodes will be reviewed daily during clinical meeting. MDS coordinator will update care plans at that time to reflect current resident status.	

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F 280	Continued From page 31 plan. She added that it was an oversight and she would correct the care plan. 2. Resident #84 was readmitted 2/23/15 and had cumulative diagnoses that included chronic ischemic heart disease, atrial fibrillation and dementia. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 8/25/15 revealed Resident # 84 was cognitively impaired. Review of the care plan last updated 9/3/15 revealed a plan of care for " I am at risk for bleeding due to antiplatelet therapy (Plavix) " , one of the approaches for this plan of care was " administer my anticoagulant as ordered by my physician " . Review of the physician ' s orders from 2/23/15 through 9/17/15 revealed no orders for Plavix. During interview with Administrative Staff #1 on 9/17/15 at 2:45 PM she indicated that the resident had been on Plavix on a previous admission but, that in reviewing the resident ' s medical record since his most recent admission on 2/23/15, there had not been any orders for Plavix as it had been discontinued during his last hospitalization. Interview with the MDS Nurse on 9/17/15 at 2:45 PM revealed that she did not know how the inaccuracy in the care plan was missed each time she updated the care plan. The updates were done on 3/13/15, 6/6/15, 6/25/15 and 9/3/15 according to her hand written note on the care plan. She added that it was an oversight and she would correct the care plan.	F 280	The MDS coordinator will review all resident care plans monthly x 6 months to verify that care plan is person centered and reflects current resident status including areas of ADL care and medication therapy. After six months the MDS coordinator will review all resident care plans at least quarterly to ensure that care plans are person centered and reflect current resident status including areas of ADL care and medication therapy. The Director of Nursing will review MDS care plan review related to ensuring care plans are person centered and reflect current resident status including areas of ADL care and medication therapy for accuracy monthly x 6 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will report the results of the 24 hour admission readmission chart audit and MDS monthly care plan reviews to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015	

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F 281	Continued From page 32	F 281		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately transcribe and administer a blood pressure medication as ordered by the physician for one of one sampled resident (Resident #63). The findings included: Resident #63 was admitted to the facility 5/19/15 and readmitted on 6/10/15. Resident #63 was discharged to hospital on 9/11/15. Cumulative diagnoses included: congestive heart failure, chronic kidney disease and hypertension. A hospital discharge summary dated 6/10/15 was reviewed and revealed a physician's order for hydralazine 100 milligrams by mouth every eight (8) hours. Hydralazine is medication used for the treatment of moderate to severe hypertension (high blood pressure) and congestive heart failure. Facility physician orders dated 6/10/15 stated hydralazine 50 milligrams by mouth every eight (8) hours. . A review of the Medication Administration Records (MARS) for June, July, August and September 2015 were reviewed and revealed Resident #63 received hydralazine 50 milligrams every eight hours from June 10, 2015 until her discharge from the facility to the hospital on	F 281	F 281 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #63 orders were clarified with the physician. Resident is receiving medications per physician order. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On September 17, 2015 all current residents admitted or readmitted since March 1, 2015 orders were verified and transcribed correctly. Orders clarified with physician as indicated. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Nursing Supervisor will review all admissions or readmission physician orders within 24 hours to ensure orders were verified and transcribed correctly. Orders will be clarified with the physician	10/15/15

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F 281	Continued From page 33 9/11/15. Blood pressures for Resident #63 were documented as follows: 6/15/15 11:20AM--133/65 6/22/15 1:41 PM--165/73 6/30/15 3:06 AM--162/71 7/6/15 4:27 AM--149/67 7/6/15 11:54PM--145/70 7/13/15 11:10AM--160/80 7/20/15 10:57 PM 128/80 7/21/15 12:03AM--142/65 7/27/15 2:09 AM--165/72 8/3/15 6:45AM--142/65 8/10/15 1:56 AM--168/62 8/10/15 11:56 PM--174/90 8/24/15 2:36AM--177/89 8/31/15 3:36AM--173/86 9/1/15 12:17 AM--126/73 9/8/15 1:59 AM--177/80 The physician was unable to be contacted and interviewed. On 09/17/2015 at 9:56 AM, Nurse #1 stated admission orders for a resident being admitted to the facility was obtained from the hospital discharge summary. She stated the physician orders were written from the orders noted on the discharge summary and all orders were verified by the physician via telephone. Any changes made by the physician would be clarified by a handwritten physician's order. Nurse #1 stated the physician's order for hydralazine should have been written as noted on the hospital discharge summary for hydralazine 100 milligrams by mouth every eight hours. Nurse #1 stated Resident #63 had a physician's order for hydralazine 50 milligrams every eight hours when she was in the	F 281	at that time. Review will remain ongoing. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Education began September 25, 2015 for all nursing staff related to admission and readmission orders. Education to include process for reconciliation of physician orders to determine accuracy, verification of orders, comparison of orders on readmission with previous orders, transcription of orders and process for second check of admission and readmission orders. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Nursing Supervisor will review all admissions or readmission physician orders within 24 hours to ensure orders were verified and transcribed correctly. Orders will be clarified with the physician at that time. Review will remain ongoing. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the admission / readmission physician order verification and transcription audit to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is	

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F 281	Continued From page 34 facility 5/19/15 until 6/4/15 when she was discharged to the hospital and she must have reactivated the previous order for hydralazine and did not change the dosage of the medication. On 09/17/2015 at 12:36 PM, Administrative staff #1 stated she expected nursing staff to use the hospital discharge summary when they wrote admission orders for a resident, call the physician and verify the orders and write a clarification order if a medication was changed from the discharge summary order. She said Resident #63 should have received hydralazine 100 milligrams every eight hours as per the hospital discharge summary.	F 281	obtained. Date of completion: October 15, 2015	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview the facility failed to provide incontinent care to a resident who was known to have been incontinent for 1 (Resident #32) of 3 sampled residents and failed to shave 1 (Resident #120) of 1 sampled male resident, reviewed for activities of daily living care. The findings included: 1. Resident #32 was readmitted 10/1/14. The resident ' s cumulative diagnoses included diabetes, spinal stenosis, cardio vascular disease	F 312	F 312 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #32 is receiving incontinent care. Resident #120 was shaved. Nurse Aide #4 is no longer employed at	10/15/15

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F 312	Continued From page 35 and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact. The MDS also indicated Resident #32 required extensive assistance for bed mobility, transfers, toileting and personal hygiene; had impairment of both upper and lower extremities and was incontinent of bladder and bowel. In addition, the MDS revealed the resident did not refuse care. Review of the Care Plan last updated 9/3/15 revealed a plan of care for incontinence of bowel and bladder. The approaches included: " give perineal care when the resident is incontinent " and " assess for incontinence on routine rounds and as needed. " On 9/16/15 at 4:44 PM resident #32 was observed up in her wheelchair near the nurse ' s station speaking on a portable telephone. Nursing Assistant #3 (NA #3) was also observed at this time and stated to the resident " I know (name of resident) the person you had isn ' t here yet so they are redoing the assignment " . Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. She was assigned Resident #32 as well as other residents. There was no indication on the assignment regarding who would take over the care of the residents assigned to NA #6 between 3:00 PM and 6:00 PM. Interview with NA #4 on 9/16/15 at 5:05 PM revealed that she was aware the resident was wet and wanted to go back to bed. She stated that it was the resident ' s habit to return to the nurse ' s station around 4 PM and that Resident #32 always wanted to go back to bed at that time and	F 312	facility. Nurse Aide #1 was counseled and re-educated on providing assistance with ADL¿s including shaving of residents. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On September 16, 2015 all residents were observed for completion of ADL¿s to include incontinent care and shaving. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s including incontinent care to be given at least every 2-3 hours, as requested by the resident or family member and as needed for visual signs of soiling, shaving of residents daily and/or as needed for increased facial hair and person centered care to include responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents	

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F 312	Continued From page 36 would need incontinent care. She stated that she was not Resident #32 ' s assigned NA for the shift, although she was her roommate ' s NA, and had already given the roommate incontinent care. On 9/16/15 at 5:25 PM Resident #32 was observed in her room sitting in her wheel chair. She stated that she was very wet and had not received incontinent care since before lunch when she got up. A urine odor was noted at this time. Resident #32 stated that since around 4 PM she had told several NA ' s that she wanted to go back to bed and said they knew that she needed to be changed. She added that she was told the NA assigned to her (NA #6) would be in at 6 PM and would put her back to bed when she arrived. On 9/16/15 at 5:30 PM NA#4 stated that she was going to the dining room to feed other residents and that the NA assigned to Resident #32 would be in at 6 PM and take care of her then. On 9/16/15 at 5:45 PM Resident was observed in bed and indicated she had received incontinent care. On 9/16/15 at 5:50 PM during interview with Administrative Staff #1 she indicated that she expected all residents to have an assigned NA, expected residents to receive incontinent care when they needed it, and expected residents to be assisted in going back to bed, or getting up, according to their preferred schedule keeping in mind the needs of other residents. On 9/16/15 at 7 PM NA #4 was interviewed. She stated that she had provided incontinent care to Resident #32 before going to the dining room because the Resident ' s originally assigned NA wasn ' t going to be in until 6:00 PM and someone needed to cover that assignment. NA #4 also stated that Resident #32 was very wet when she changed her.	F 312	including incontinent care and shaving. Walking rounds will continue daily x 4 weeks and weekly thereafter. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present a summary of the walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015.	

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F 312	Continued From page 37	F 312		

2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The quarterly Minimum Data Set (MDS) assessment dated 7/7/15 indicated that Resident #120 had severe cognitive impairment and needed extensive assistance with personal hygiene. The assessment also indicated that Resident #120 did not resist care.
The care plan dated 7/7/15 indicated that " I need assistance of one staff to perform my activities of daily living related to history of stroke and left hemiparesis. "

On 9/14/15 at 1:28 PM, Resident #120 was observed up in wheelchair in his room unshaven. His beard was approximately ½ inch in length.

On 9/15/15 at 8:51 AM, a family member of Resident #120 was interviewed. The family member indicated that when she came to visit, she found Resident #120 not shaved. She added that she had discussed this issue with the administrative staff. She added that Resident #120 did not want his beard long.

On 9/16/15 at 11:42 AM and 3:05 PM, Resident #120 was observed up in wheelchair in his room still not shaved, his beard was approximately ½ inch in length.

On 9/16/15 at 3:05 PM, NA (nurse aide) #1 was interviewed. He stated that he was assigned to Resident #120. He indicated that the resident was scheduled to have a shower on Thursday and Saturday. He added that he had given Resident #120 a bed bath that morning but did not shave him. He agreed that the resident

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F 312	Continued From page 38 needed a shave and he didn ' t realize that his beard was that long. On 9/16/15 at 3:10 PM, Nurse #1 was interviewed. She stated that she had seen Resident #120 and agreed that he needed to be shaved. She added that she had told NA #1 not to leave until he had shaved the resident.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview the facility failed to provide a hand roll/palm guard for 1 (Resident #15) of 1 resident with a hand contracture who had been discharged from Occupational Therapy with instructions for hand roll/palm guard application. The findings included: Resident #15 was admitted 2/15/01 and had cumulative diagnoses including hemiplegia, vascular dementia and joint contracture. Review of the most recent Minimum Data Set (MDS) Assessment, a Significant Change Assessment dated 7/21/15 revealed Resident #15 was cognitively impaired and had upper and lower extremity impairment on one side. Review of an Occupational Therapy Progress and	F 318	F 318 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #15 has hand roll in place. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 17, 2015 all residents with hand rolls / palm guards were reviewed. All residents requiring the use of hand rolls / palm guards have hand rolls / palm guards in place.	10/15/15

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F 318	Continued From page 39 Discharge Summary dated 5/13/14 revealed the following short term goal " the patient will have decreased pain in L (left) hand to 6 out of 10 in order to tolerate ROM (Range of Motion) and roll to palm with use of most appropriate modality. " In addition, a long term goal was " the patient will tolerate roll to L hand with decreased pain to decrease the risk for skin breakdown " . The summary indicated these goals were met on 5/13/14. Review of the Discharge Plans and instructions section of this report revealed " Pt (patient) to utilize palm guard to L hand " and the Patient/Caregiver section indicated " Nursing staff educated on palm guard purpose " . On 9/16/15 at 4:02 PM Resident #15 was observed sitting in her wheel chair in her room. Her left arm was bent at the elbow and held against her chest with a small clutch purse underneath. Her left wrist was bent in a downward position and her left hand was closed tightly with her fingers flat and her thumb inside. When asked she attempted to open her fingers using her right hand but was unable to do so. She said she did not think she had any problems with the skin of her left palm as it felt fine but added that sometimes her hand was painful. The resident did not recall ever using a hand roll but stated " it might help " . On 9/17/15 at 1:20 PM interview with Occupational Therapist #1 (OT #1) revealed Resident #15 had been on the Occupational Therapy (OT) case load most recently in 2014. She stated Resident #15 had been picked up by OT for management of left hand pain and after working with her they were able to increase her range of motion enough so she could comfortably use a hand roll. OT #1 stated that the resident was then referred to Restorative Therapy for ongoing assistance with the hand roll.	F 318	Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 25, 2015 education began for all nursing staff in relation to application of hand rolls / palm guards. Education to include restorative nursing to apply hand rolls / palm guards. Nurse to monitor hand rolls / palm guards to ensure in place. Nurse to document on medication administration record monitoring and application of hand rolls / palm guards. The Staff Development Coordinator, Unit Manager and / or Nursing Supervisor will review medication administration record for documentation of hand roll / palm guard placement and to include physical observation of hand roll / palm guard placement daily x 2 weeks, weekly x 4 weeks then monthly x 4 months. The Director of Nursing will review Medication Administration Record audits and observations of hand roll / palm guard placement daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Rehab Director will deliver new restorative referrals including recommendations for hand rolls / palm guards to Director of Nursing daily during clinical meeting. Facility plans to monitor its performance	

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F 318	Continued From page 40 On 9/17/15 at 3:30 PM interview with Administrative Staff #1 revealed that she could not locate a Restorative Nursing Referral for the resident that would have instructed staff to assist the resident with a hand roll/palm guard. She acknowledged the resident had not been using these devises and did not know where the breakdown occurred. Administrative Staff #1 stated that there were two Restorative Aides that worked in the facility and she provided their contact information however they could not be reached for interview.	F 318	to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the Medication Administration Record and hand roll / palm guard application audits to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		10/15/15

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

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F 353	Continued From page 41 duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, the facility failed to have an assigned Nursing Assistant for 7 (Resident #32, #18, #55, #27, #104, #132 and #31) of 57 residents on the 300 and 400 halls (Station Two), failed to provide sufficient nursing staff to provide incontinent care without a dependent resident having to wait an hour or more for 1 of 1 resident (Resident #32) and failed to have sufficient nursing staff to maintain the dignity of a resident dependent on staff for incontinent care for 1 of 1 resident (Resident #32). The findings included: This citation is cross referenced to F224 - the facility failed to have an assigned Nursing Assistant available to check on and meet the needs of 7 (Resident #32, #18, #55, #27, #104, #132 and #31) of 57 residents on 300 and 400 halls (Station Two) for a period of between two to three hours. This citation is cross referenced to F312 - facility failed to provide incontinent care to a resident who was known to have been incontinent for 1 (Resident #32) of 3 sampled residents and failed to shave 1 (Resident #120) of 1 sampled male residents, reviewed for activities of daily living care. Resident #32 was readmitted 10/1/14. The resident ' s cumulative diagnoses included diabetes, spinal stenosis, cardio vascular disease and hypertension. The most recent Minimum Data Set (MDS) Assessment, a Quarterly MDS dated 7/30/15, revealed Resident #32 was cognitively intact.	F 353	F 353 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Residents #32, #18, #55, #27, #104, #132, #31 have an assigned nursing assistant each shift to meet their needs. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. Nurse Aide #4 is no longer employed by facility. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. All residents have an assigned nursing assistant each shift to meet their needs. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. Measures put into place or systemic changes made to ensure that the deficient practice will not occur:	

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F 353	Continued From page 42 The MDS also indicated Resident #32 required extensive assistance for bed mobility, transfers, toileting and personal hygiene; had impairment of both upper and lower extremities and was incontinent of bladder and bowel. Review of the Care Plan last updated 9/3/15 revealed a plan of care for incontinence of bowel and bladder. The approaches included: " give perineal care when the resident is incontinent " and " assess for incontinence on routine rounds and as needed " . On 9/16/15 at 7 AM Resident #32 was interviewed. She stated that staff frequently would cut off her call light and say they would be back or get someone else to help them but then they wouldn ' t come back at all or it would take a very long time. The resident attributed this in part to the fact that NA staff often needed another NA to help them turn her because she was heavy and because if it involved getting her in or out of bed they needed to find one of two mechanical lifts in the building and another staff member to help them. She added that she always had a different NA because the staff rotated taking care of her and they seemed like they didn ' t want to do her care because they were worried they would hurt their back. On 9/16/15 at 4:44 PM resident #32 was observed up in her wheelchair near the nurse ' s station speaking on a portable telephone. Nursing Assistant #3 (NA #3) was also observed at this time and stated to the resident " I know (name of resident) the person you had isn ' t here yet so they are redoing the assignment " . Review of the Station Two NA (Nursing Assistant) Assignment for 3 PM - 11 PM on 9/16/15 revealed there were 6 NA ' s listed on the assignment. One of the NA ' s (NA #6) was listed as coming in at 6:00 PM instead of 3:00 PM. She	F 353	On September 17, 2015 the Director of nursing received directed in-service training by the administrator in response to reporting employee absences and tardies. The Director of Nursing to report absences and tardies immediately to unit manager and/or nurse on duty. Staffing assignments will be adjusted immediately to ensure person centered care delivery. On September 17, 2015 education by Staff Development Coordinator began for all nursing staff in reference to reporting absences and tardies to the Director of Nursing. Education completed October 12, 2015. Staff members not receiving in service education by October 12, 2015 will be required to receive inservice education prior to beginning of scheduled shift. Education to include staff member physically speaking to the Director of Nursing. If Director of nursing is unable to be reached staff are to report to Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Administrator. Education also includes upon arrival to facility staff are to initial beside their name on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will complete assignment for nursing assistants using a resident census at the beginning of each shift to ensure all residents in the facility have an assigned nursing assistant. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that	

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F 353	Continued From page 43 was assigned Resident #32 as well as other residents. There was no indication on the assignment regarding who would take over the care of the residents assigned to NA #6 between 3:00 PM and 6:00 PM. On 9/16/15 at 5:00 PM Nursing Assistant #4 was observed accompanying the resident to her room. She placed a clean incontinent pad on the resident ' s bed and told the resident that the Nursing Assistant assigned to her (NA #6) would be coming in at 6 PM. Interview with NA #4 on 9/16/15 at 5:05 PM revealed that she was aware the resident was wet and wanted to go back to bed. She stated that it was the resident ' s habit to return to the nurse ' s station around 4 PM and that Resident #32 always wanted to go back to bed at that time and would need incontinent care. NA #4 stated that she was not Resident #32 ' s assigned NA for the shift, although she was her roommate ' s NA, and had already given the roommate incontinent care. On 9/16/15 at 5:25 PM Resident #32 was observed in her room sitting in her wheel chair. She stated that she was very wet and had not received incontinent care since before lunch when she got up. A urine odor was noted at this time. Resident #32 stated that since around 4 PM she had told several NA ' s that she wanted to go back to bed and said they knew that she needed to be changed. She added that she was told the NA assigned to her (NA #6) would be in at 6 PM and would put her back to bed when she arrived. Resident #32 also said that she was aware the NA ' s took turns taking her on their assignment because she was physically heavy, required a mechanical lift for transfers, and because they thought it took a long time to do her care because she was so particular. Resident #32 denied refusing incontinent care, unless it	F 353	time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months to ensure staff have initialed that they have reported for duty and that assignment was completed accurately to reflect staff that have reported for duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to the Administrator for review daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s and person centered care to include responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager, and/or Nursing Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care. Walking rounds will continue daily x 4 weeks and weekly thereafter.	

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F 353	Continued From page 44 was during the day and the staff member said they would not be able to get her up again if they put her back to bed for incontinent care. On 9/16/15 at 5:30 PM NA#4 stated that she was going to the dining room to feed other residents and that NA #6 would be in at 6 PM and take care of Resident #32 then. On 9/16/15 at 5:45 PM NA #3 was observed in Resident #32 ' s room adjusting the resident ' s over-bed table. Resident #32 was observed in bed at this time. Interview with NA #3 revealed that she had not helped the resident to bed but had volunteered to take Resident #32 on her assignment. She wasn ' t sure what time she volunteered but said it was just before the dinner meal trays came out. NA #3 added that she had other residents with pressing needs at that time so NA #4 offered to put Resident #32 back to bed, and give the resident incontinent care, before going to the dining room to help feed other residents. On 9/16/15 at 6:50 PM Nurse #3 was interviewed. She stated that around 5:00 PM she had become aware that Resident #32 ' s NA (NA #6) was not able to come in until 6 PM, for the 3 - 11 PM shift. Nurse #3 said she found out NA #6 had not arrived yet when Resident #32 was asking who her NA was because she wanted to go back to bed. Nurse #3 recalled it was around 5:00 PM because one of the NA ' s said the dinner trays would be out soon so they might as well wait until NA #6 came in at 6:00 PM, as it wouldn ' t be long and NA #6 could take care of Resident #32 then. Nurse #3 stated that she had informed the NA that all residents needed an assigned NA in the facility and that she would readjust the assignment and NA #3 volunteered to have Resident #32 on her assignment at that time. On 9/17/15 at 11:57 AM Resident #32 was	F 353	Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will report findings of the assignment sheet checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Director of Nursing will report the summary of walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. Date of Completion October 15, 2015.	

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F 353	Continued From page 45 observed in the dining room awaiting her lunch meal. Interview with Resident #32 at this time revealed she did not like being left wet in her wheelchair for so long on 9/16/14 while they figured out who was going to take care of her. She had been tired and soaking wet and just wanted to go back to bed and it made her feel bad to wait so long. On 9/17/15 at 2:00 PM interview with Administrative Staff #1 revealed that NA#6 had told her, on the morning of 9/16/15, that she would not be able to come in for the 3:00 PM - 11:00 PM shift until 6:00 PM. Administrative Staff #1 indicated that she got busy and neglected to adjust the assignment to ensure each resident had an assigned NA and that they would receive the care they needed until NA #6 arrived. Administrative Staff #1 added that Administrative Staff #2 had already done a reeducation with her to address this issue and had put a plan in place to monitor staffing coverage through the Quality Assurance and Performance Improvement program.	F 353		
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	F 371		10/15/15

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F 371	Continued From page 46 by: Based on record review, observation and staff interview, the facility failed to discard the rotten food and to date the food when thawed in one of one walk in refrigerator and the facility failed to completely cover the hair with the hair net during the tray line. Findings included: On 9/14/15 at 11:22 AM, tour of the kitchen was conducted. Inside the walk in refrigerator, 3 rotten green papers were observed and a 16 ounces (oz.) whipped topping being thawed with no date as to when it was pulled. The instruction on the topping read " use within 14 days after thawed. " On 9/14/15 at 11:25 AM, administrative staff #3 was interviewed. He stated that the cook was responsible for checking the walk in refrigerator every day. He added that the cook had checked the walk in refrigerator that morning but did not open the box where the rotten green peppers were stored. He also indicated that he didn't realize that the whipped topping should be used within 14 days after thawed. On 9/14/15 at 11:34 AM, the cook was interviewed. She stated that she had checked the walk in refrigerator that morning and should have discarded the rotten green peppers. On 9/15/15 at 5:05 PM, observation of the tray line was conducted. Dietary Aide #1 was serving on the tray line. She was wearing a hair net but the hair above her forehead were exposed. On 9/17/15 at 3:25 PM, interview with administrative staff #3 was conducted. He stated	F 371	F 371 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: No specific residents were named. On September 15, 2015 undated, spoiled and expired items were discarded. On September 15, 2015 all staff have hair nets being worn appropriately to cover hair completely while working in the kitchen. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All resident have the potential to be affected. On September 15, 2015 Dietary Manager checked walk in refrigerator and all storage areas for undated, expired or spoiled items. No other items were found to be undated, spoiled or expired. Staff have hair nets being worn appropriately to cover hair completely while working in the kitchen. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 18, 2015 education done	

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F 371	Continued From page 47 that he expected his staff to completely cover their hair with a hair net.	F 371	with all dietary staff. Education to include dating of open items, discarding of undated, spoiled or expired items and appropriate wearing of hair nets. Dietary Manager and/or Administrator will check walk in refrigerator for dating of items, expired items and freshness of items daily. Checks will continue ongoing. Dietary manager and/or Administrator will monitor staff daily to ensure all staff are wearing hair nets covering entire hair. Checks will continue ongoing. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Dietary Manager will report summary findings of all monitoring audits including refrigerator checks and hair net monitoring to Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		10/15/15

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F 463	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain a properly functioning resident call system for 3 of 4 halls (100, 300, and 400). The findings included: On 9/14/15 at 3:25 PM the call bell in room 415 B was checked for proper functioning. The call bell was not functioning, the light outside the room and at the nurse's station did not light up and there was no audible sound heard, when the call light button was pressed. On 9/14/15 at 3:27 PM an interview was conducted with RN #2. RN #2 stated that she was not aware the call bell in room 415 B was not functioning properly. RN #2 contacted the maintenance director to repair the call bell. On 9/16/15 at 10:30 AM an interview was conducted with the maintenance director. He stated that he performed a check of the call bell switch board located at each nurse's station weekly. He stated that this check allowed him to see if any of the lights on the switchboard were burnt out. He stated that this check did not provide information on the functioning of the call bells inside of the resident rooms, bathrooms, or of the call bell notification lights located in the hallways. He stated that he did not have a system in place to check the functioning of call bells in resident rooms, bathrooms, or of the notification lights located in the hallways. He revealed that the only way staff would find out if a resident's call bell was not working would be if the resident pressed the call bell and it did not work. On 9/16/15 at 11:00 AM a review of the maintenance book from 1/1/15 through 9/15/15 was conducted. The maintenance book revealed 30 requests involving call bell maintenance. The	F 463	F 463 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Call bells were repaired and or replaced for rooms 104, 106, 306, 308, 315, 318, 400, 401 and two central bathrooms. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On September 17, 2015 all resident call bells including central bathrooms, shower rooms and hallway notification lights were checked for functioning. Call bells were repaired and or replaced for rooms 104, 106, 306, 308, 315, 318, 400, 401 and two central bathrooms. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 17, 2015 education began for all staff in reference to reporting of broken call bells. Education to include process for notification to maintenance supervisor and/or Administrator immediately for broken call bells and process for ensuring resident call system	

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F 463	Continued From page 49 maintenance book indicated that out of those 30 requests, 11 were completed on the same day, 12 were completed one day later, 5 were completed 2 days later, 1 was completed 3 days later and 1 was completed 6 days later. On 9/16/15 at 11:30 AM the maintenance director was interviewed regarding the maintenance book. He reviewed the process of staff submitting a maintenance request. He stated that if there was a maintenance issue with a resident's call bell that staff would write it in the maintenance book. He stated that he checked the maintenance book a minimum of three times per day. He stated that he worked normal business hours weekly from Monday through Friday and was on-call 24 hours a day 7 days a week for emergencies. He stated that most maintenance needs for call bells were fixed in the same day. He stated that if a maintenance request was written after normal business hours or on the weekend he would not see the request until the next business day. He revealed that he considered a problem with a resident's call bell to be an emergency issue and that if an issue was found with a call bell's functioning after normal business hours or on the weekend he expected to be notified by phone. On 9/17/15 at 10:20AM the maintenance director provided additional information about the call bell system during an interview. He revealed that many of the problems the facility has had with call bells not functioning properly was caused by the magnetic switch pull cord in the resident bathrooms. He stated that there were multiple occurrences where the magnetic switch pull cord became stuck and resulted in the bathroom call bell and room call bells not to work. The magnetic switch pull cord needed to be reset in order for the call bells to begin to function properly. He stated that he had contacted the call	F 463	in place. Maintenance Supervisor and/or Manager on Duty will check call bell system for all residents including common bathrooms, shower rooms and hallway notification lights for functioning daily x 4 weeks, then weekly ongoing with preventative maintenance rounds. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Maintenance Supervisor will report the findings of the call bell system checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 15, 2015.	

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F 463	Continued From page 50 bell company about this issue in the past, but was provided with no solution. On 9/17/15 at 10:30AM all resident call bells were checked for proper functioning. The 100 hall, 300 hall and 400 hall were each found to have call bells that were not functioning properly (rooms 104, 306, 308, and 401). On 9/17/15 at 12:00PM the maintenance director provided a written record of a facility wide internal call bell function audit he completed on 9/17/15. The audit information was reviewed and revealed four additional rooms with call bells that were not functioning properly (rooms 106, 315, 318, and 400). The audit information also revealed that two of three central bath rooms had call systems that were not functioning properly.	F 463		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		10/15/15

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F 520	Continued From page 51 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility ' s Quality Assessment and Assurance committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 9/25/14 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on dignity (F241), housekeeping and maintenance (F253), activities of daily living care for dependent residents (F312) and prevent decrease in range of motion (F318). The findings included: The tag is cross referenced to F241 - the facility failed to treat a resident with dignity by taking more than an hour to provide incontinent care, to a resident who was known to have been incontinent, and by failing to ensure a resident's needs were addressed before turning off the call light and leaving their room, for 1 of 3 sampled residents (Resident #32) reviewed for dignity; and failed to knock before entering a resident room for 1 of 1 residents observed during wound care (Resident #119). This tag is cross referenced to F253 - the facility failed to maintain shower rooms that were clean and in good repair in 2 of 2 shower rooms.	F 520	F 520 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Quality Assurance and Performance Improvement Committee met September 21, 2015 and reviewed and revised QAPI plans related to tags F241, F253, F312 and F318. For tag F241 Resident #32 is receiving incontinent care. Resident #119 staff are knocking on door and asking permission prior to entering the resident¿s room. Nursing Assistant #2 was counseled and re-educated on resident privacy to include knocking on door and asking permission prior to entering the resident¿s room. For tag F253 Shower rooms for unit 1 and unit 2 were deep cleaned by housekeeping. Pest control service to treat shower rooms	

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F 520	Continued From page 52 This tag is cross referenced to F312 - the facility failed to provide incontinent care to a resident who was known to have been incontinent for 1 (Resident #32) of 3 sampled residents and failed to shave 1 (Resident #120) of 1 sampled male residents, reviewed for activities of daily living care. This tag is cross referenced to F318 - the facility failed to provide a hand roll for 1 (Resident #15) of 1 residents with a hand contracture who had been discharged from Occupational Therapy with instructions for hand roll application. An interview was conducted with Administrative Staff #2 on 9/17/15 at 3 PM. She stated that they have not done a Quality Assurance and Performance Improvement (QAPI) plan in regards to activities of daily living for some time because the Staff Development Coordinator reeducated staff frequently and so the staff knew what they were supposed to do. She added that education had also been done on ensuring resident privacy. In regards to the physical environment Administrative Staff #2 stated that daily rounds were done to observe for sanitation issues. She also indicated that Restorative Staff weren ' t being pulled to cover the unit as often as previously so she felt that this was an improvement that would maintain resident ' s range of motion although this was not being monitored through QAPI.	F 520	on unit 1 and unit 2 for pests. Shower curtains were placed in shower rooms on unit 1 and unit 2. Maintenance will replace all broken tile to unit 1 and unit 2 shower rooms. Maintenance will repair in plumbing in unit 1 and unit 2 shower rooms. For Tag 312 Resident #32 is receiving incontinent care. Resident #120 was shaved. Nurse Aide #4 is no longer employed at facility. Nurse Aide #1 was counseled and re-educated on providing assistance with ADL¿s including shaving of residents. For Tag 318 Resident #15 has hand roll in place. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: For tags F241, F253, F312 and F318 all residents have the potential to be affected. For tag F241 All residents have an assigned nursing	

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F 520	Continued From page 53	F 520	assistant each shift to meet their needs. Residents are receiving assistance with ADL¿s including incontinent care. Staff are knocking on resident doors and asking permission prior to entering the resident¿s room. For tag F253 On September 25, 2015 education began for all nursing staff in reference to cleanliness of shower rooms. Education to include removing all items including dirty linen, trash and soiled items from the shower room and cleaning up of waste and/or spills immediately. Housekeeping will check shower rooms three times daily in reference to cleanliness at the beginning of shift, mid shift and end of shift. Checks will continue ongoing. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or supervisor will make rounds daily to include off shifts and weekends to monitor cleanliness of shower rooms and any areas in need of repair. Shower room rounds will be done daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. The Maintenance supervisor will monitor shower rooms on unit 1 and unit 2 weekly for needed repairs. Rounds will continue	

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F 520	Continued From page 54	F 520	ongoing with preventative maintenance rounds. On October 5, 2015 education completed for all members of Quality Assurance and Performance Improvement Committee. Education to include development, modification and monitoring of Quality Assurance plans. Quality Assurance and Performance Improvement Committee will meet monthly to review all current Quality Assurance plans with modifications done as needed at that time. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: For tag F241 On September 17, 2015 education by Staff Development Coordinator began for all nursing staff in reference to reporting absences and tardies to the Director of Nursing. Education completed October 12, 2015. Staff members not receiving in service education by October 12, 2015 will be required to receive inservice education prior to beginning of scheduled shift. Education to include staff member physically speaking to the Director of Nursing. If Director of nursing is unable to be reached staff are to report to Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Administrator. Education also includes upon arrival to facility staff are to initial beside their name	

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F 520	Continued From page 55	F 520	on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will complete assignment for nursing assistants using a resident census at the beginning of each shift to ensure all residents in the facility have an assigned nursing assistant. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months to ensure staff have initialed that they have reported for duty and that assignment was completed accurately to reflect staff that have reported for duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to the Administrator for review daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s including incontinent care to be given at least every 2-3 hours, as requested by the resident or family member and as needed for visual	

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F 520	Continued From page 56	F 520	signs of soiling and person centered care to include responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care. Walking rounds will continue daily x 4 weeks and weekly thereafter. On September 25, 2015 education began for all staff as it relates to dignity and privacy. Education to include knocking on doors and asking permission to enter prior to entering a resident room. The Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Nursing Supervisor and/or Manager on Duty will make daily rounds to include off shifts and weekends to ensure that staff are promoting dignity by knocking on doors and asking permission to enter prior to entering a resident room. Daily rounds will continue daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. For tag F253 On September 25, 2015 education began for all nursing staff in reference to cleanliness of shower rooms. Education to include removing all items including	

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F 520	Continued From page 57	F 520	dirty linen, trash and soiled items from the shower room and cleaning up of waste and/or spills immediately. The Director of Nursing, Staff Development Coordinator, Unit Manager and/or supervisor will make rounds daily to include off shifts and weekends to monitor cleanliness of shower rooms and any areas in need of repair. Daily rounds will be done daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months. Shower rooms will be checked daily during Quality Assurance Room rounds for cleanliness and areas in need of repair. Checks will continue ongoing. Housekeeping will check shower rooms three times daily in reference to cleanliness and areas in need of repair at the beginning of shift, mid shift and end of shift. Checks will continue ongoing. The Maintenance supervisor will monitor shower rooms on unit 1 and unit 2 weekly for needed repairs. Rounds will continue ongoing with preventative maintenance rounds. For tag F312 On September 25, 2015 education began for all nursing staff in reference to providing assistance with ADL¿s including incontinent care to be given at least every 2-3 hours, as requested by the resident or family member and as needed for visual signs of soiling, shaving of residents daily	

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and/or as needed for increased facial hair and person centered care to include responding to all resident needs regardless of assigned area.

The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care and shaving.

Walking rounds will continue daily x 4 weeks and weekly thereafter.

For tag F318

On September 25, 2015 education began for all nursing staff in relation to application of hand rolls / palm guards. Education to include restorative nursing to apply hand rolls / palm guards. Nurse to monitor hand rolls / palm guards to ensure in place. Nurse to document on medication administration record monitoring and application of hand rolls / palm guards.

The Staff Development Coordinator, Unit Manager and / or Nursing Supervisor will review medication administration record for documentation of hand roll / palm guard placement and to include physical observation of hand roll / palm guard placement daily x 2 weeks, weekly x 4 weeks then monthly x 4 months.

The Director of Nursing will review

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F 520	Continued From page 59	F 520	Medication Administration Record audits and observations of hand roll / palm guard placement daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review Medication Administration Record and observation audits daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Rehab Director will deliver new restorative referrals including recommendations for hand rolls / palm guards to Director of Nursing daily during clinical meeting. On October 5, 2015 education completed for all members of Quality Assurance and Performance Improvement Committee. Education to include development, modification and monitoring of Quality Assurance plans. Quality Assurance and Performance Improvement Committee will meet monthly to review all current Quality Assurance plans with modifications done as needed at that time. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: For tag F241	

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F 520	Continued From page 60	F 520	The Director of Nursing will report findings of the assignment sheet checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Director of Nursing will report the summary of walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Administrator will report the findings of the dignity rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. For tag F253 The Director of Nursing and Housekeeping Director will report findings of the shower room rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Maintenance Supervisor will report findings of the shower room rounds and repairs completed to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved.	

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The Administrator will report findings of quality assurance room rounds completed to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved.

For tag F312

The Director of Nursing will present a summary of the walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained.

For tag F318

The Director of Nursing will present the findings of the Medication Administration Record and hand roll / palm guard application audits to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained.

All audit information will be taken to the Quality Assurance and Performance Improvement Committee monthly for review over the next 6 months.

The Quality Assurance and Performance Improvement Committee will review this plan monthly over the next 12 months.

The Quality Assurance and Performance Improvement Committee will continue to

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F 520	Continued From page 62	F 520	meet monthly and ensure that all plans are being monitored as proposed for effectiveness. Date of Completion: October 15, 2015	