STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	C 12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		1/1/16

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

Electronically Signed | 12/28/2015

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

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F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide complete information in the Notice of Medicare Provider Non-Coverage and provide a minimum of 2 days notification of non-coverage. This affected 3 of 3 sampled residents. (Residents #66, #125, and #156). The facility also failed to post the required Medicaid Fraud Unit phone number. The finding included: 1. Resident #66's Notice of Medicare Provider Non-Coverage stated that Medicare covered services of physical therapy were to end 07/21/15. Resident #66 signed that he received this notice on 07/21/15 which indicated he was not provided the required 2 day notice. Interview with the Discharge Planner on 12/02/15 at 3:25 PM revealed that she normally received notice from therapy of the discharge date and reason about a week in advance of non-coverage. She could not recall if she provided this notice or if the social worker, who also was involved in the notification process at that time, provided this notice. She was unable to explain why Resident #66 did not receive a 2 day notice. Interview with the Social Worker on 12/03/15 at 10:04 AM revealed he could not recall if he provided the letter to Resident #66 and or why there was no 2 day notice provided to Resident #66. He further stated he had just started	F 156	How will this deficiency be corrected for each resident found ot be affected by the deficient practice? The Medicare Liaison/Discharge Planner was given formal written education on 12/23/15 by the Executive Director regarding inclusion of skilling services that are discontinuing on the Notice of Non-Coverage Letter and the requirement that all notices be given to the beneficiary no later than 48 hours before skilled services are ending. The Medicaid Fraud Unit phone number was corrected during the survey and is posted at the front door with all other required postings. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? The Form Notice of Non-Coverage Letter was given to the Medicare Liaison/Discharge Planner on 12/07/15 in an electronic format, and will be modified as necessary for each resident being given notice of discontinuation of skilled services, listing the specific services that are being discontinued. The Medicaid Fraud Unit phone number was corrected during the survey and is	

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F 156	Continued From page 3 working in the facility around this time and just provided the notice when told to by the Administrator and/or when discussed in morning meeting. 2. Resident #156's Notice of Medicare Provider Non-Coverage stated that Medicare covered services were to end 09/16/15. The notice did not include the reason Medicare covered services were ending. Interview with the Discharge Planner on 12/02/15 at 3:25 PM revealed that she normally received notice from therapy of the discharge date and reason about a week in advance of non-coverage. On follow up interview on 12/03/15 at 10:04 AM, Discharge Planner stated there was a form developed which she received from therapy that indicated the reason for non-coverage and the date when non-coverage would start. She further stated that she was not taught to include the reason for the non-coverage of Medicare in the written notice. 3. Resident #125's Notice of Medicare Provider Non-Coverage stated that Medicare covered services were to end 11/20/15. The notice did not include the reason Medicare covered services were ending. Interview with the Discharge Planner on 12/02/15 at 3:25 PM revealed that she normally received notice from therapy of the discharge date and reason about a week in advance of non-coverage. On follow up interview on 12/03/15 at 10:04 AM, Discharge Planner stated there was a form developed which she received from therapy that indicated the reason for non-coverage and the date when non-coverage	F 156	posted at the front door with all other required postings. The Executive Director will visually inspect the sign weekly for 4 weeks and then monthly for 2 months to ensure that it remains hung in the appropriate location. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The Form Notice of Non-Coverage Letter was given to the Medicare Liaison/Discharge Planner on 12/07/15 in an electronic format, and will be modified as necessary for each resident being given notice of discontinuation of skilled services, listing the specific services that are being discontinued. The Medicaid Fraud Unit phone number was corrected during the survey and is posted at the front door with all other required postings. The Executive Director will visually inspect the sign weekly for 4 weeks and then monthly for 2 months to ensure that it remains hung in the appropriate location. How will the facility monitor the measures to make sure that solutions are sustained? The Executive Director will audit all Notices of Non-Coverage Letters for 4 weeks, then monthly for 2 months, to ensure correctness, completeness and timeliness of notice. The results of the audit will be taken to the Quality	

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F 156	Continued From page 4 would start. She further stated that she was not taught to include the reason for the non-coverage of Medicare in the written notice. 4. During an interview with the Resident Council President on 12/03/15 at 9:10 AM, Resident # 56 stated he was not sure if the residents in the facility understood how the state agency was involved with the facility. On 12/03/15 at 9:18 AM observations revealed that the Medicaid Fraud Unit phone number was not posted in the facility. Interview with the Administrator on 12/04/15 at 8:45 AM revealed she was unaware of the requirement to post the Medicaid Fraud Unit phone number or actual phone number. The Administrator stated she thought the state complaint number included any concerns of Medicaid services.	F 156	Assurance Committee for 3 months. The Medicaid Fraud Unit phone number will be visually inspected weekly for 4 weeks, and then monthly for 2 months, by the Executive Director to ensure that it remains hung in the appropriate location. The results of these audits will be reported to the Quality Assurance Committee for 3 months.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by:	F 167		1/1/16

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F 167	Continued From page 5 Based on observations, resident and staff interviews, the facility failed to post the survey results in a prominent location and post a notice of their availability. The findings included: During the interview with the Resident Council President on 12/03/15 at 9:10 AM, Resident #56 stated he was sure the survey results were posted somewhere in the facility but he could not say where they were located. Observations on 12/03/15 at 9:20 AM revealed there was no notice of the location for the survey results posted near or by the other general information located adjacent to the front office. Upon making further observations, the survey results were found located down the hall, next to the rehabilitation gym. The survey results were in a black binder, in a plastic holder on the wall, behind rehabilitation referral forms. The binder's front cover was labeled as being the survey results, however, this was not visible as the rehabilitation referral forms were located in front of the binder, blocking the view of the binder. The survey results remained in the plastic holder behind rehabilitation forms during observations made on 12/03/15 at 2:48 PM and 12/04/15 at 8:35 AM. Interview with the Administrator on 12/04/15 at 8:35 AM revealed the rehabilitation forms should not be in front of the survey binder and she removed them. Administrator then showed the surveyor the sign located in the enclosed alcove by the front door stating the location of the survey results. This alcove was secured by a code and/or staff releasing a button to access the	F 167	How will this deficiency be corrected for each resident found to be affected by the deficient practice? The survey book was moved to the front lobby and placed in a clear holder. A sign was placed above the holder that indicates that the holder contains our Annual Survey results. The Resident Council President was physically taken to the site of the results book. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? The survey book was moved to the front lobby and placed in a clear holder. A sign was placed above the holder that indicates that the holder contains our Annual Survey results. The Resident Council President was physically taken to the site of the results book. Activities will review this with Resident Council monthly to ensure that new members are also aware. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The survey book was moved to the front lobby and placed in a clear holder. A sign was placed above the holder that indicates that the holder contains our Annual Survey results. The Resident Council President was physically taken to the site of the results book. Activities will review this with Resident Council monthly	

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F 167	Continued From page 6 alcove. Administrator stated that not many residents would probably access the alcove to see the sign related to the location of survey results.	F 167	to ensure that new members are also aware. How will the facility monitor the measures to make sure that solutions are sustained? Activities will review this with Resident Council monthly to ensure that new members are also educated. The Executive Director will audit the location of the survey book weekly for 4 weeks and then monthly for 2 months to ensure that the survey book is visible and not covered. The Executive Director will ask Resident Council President monthly for 3 months to ensure understanding. Findings of these audits will be reported to the Quality Assurance Committee monthly for 3 months.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood on 13 of 59 resident doors (Resident room #101, #104, #105, #106, #108, #109, #110, #111, #114, #208, #404, #406 and #415); failed to repair bathroom doors with broken and splintered laminate and wood in 3 of 59 resident rooms (Room #108, #114 and	F 253	How will this deficiency be corrected for each resident found to be affected by the deficient practice? A Capital Equipment Request for new entry and/or bathroom doors for rooms 101, 104, 105, 106, 108, 109, 110, 114, 208, 404, 406, 415 and each central bath	1/1/16

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F 253	Continued From page 7 #403); failed to repair broken and splintered laminate and wood on 4 of 4 central bath doors on 100, 200, 300 and 400 halls; failed to label and cover personal care equipment in 2 resident bathrooms (Resident rooms 310 and 313) on 300 hall and 2 resident bathrooms on 400 hall (Resident rooms 401 and 402) and failed to keep 2 resident wheelchairs clean on 400 hall (Residents #126 and #156). The findings included: 1. Resident room doors were observed as follows: a. Observations of Room 101 on 12/02/15 at 9:14 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 3:58 PM revealed the door of resident room 101 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:20 AM revealed the door of resident room 101 had broken and splintered laminate on the front of the bottom half of the door. b. Observations of Room 104 on 12/02/15 at 3:35 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 3:58 PM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:21 AM revealed the door of resident room 104 had broken and splintered laminate on the front of the bottom half	F 253	door was submitted in December, 2015, and they will be replaced as soon as they can be delivered. A 100% audit of resident's personal items was completed and all personal items not labeled were labeled appropriately on 12/28/2015. All Nursing staff will be in-serviced on the labeling and storage policy for personal items beginning 12/28/15 and cleaning of equipment beginning 12/22/2015. Any staff who have not completed education by 1/1/15 will not work until education has been completed. Nursing staff will begin washing wheelchairs during the routine shower schedule on 12/22/2015. A sign off sheet will be placed in each shower room to validate that the wheelchair has been washed. The Maintenance Director conducted a 100% audit of wheelchairs to visualize for needed repairs or cleaning. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? All Nursing staff will be in-serviced on the labeling and storage policy for personal items beginning 12/28/15 and cleaning of equipment beginning 12/22/2015. Any staff who have not completed education by 1/1/15 will not work until education has been completed.	

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F 253	Continued From page 8 of the door. c. Observations of Room 105 on 12/02/15 at 3:40 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 3:59 PM revealed the door of resident room 105 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:22 AM revealed the door of resident room 105 had broken and splintered laminate on the front of the bottom half of the door. d. Observations of Room 106 on 12/02/15 at 3:39 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:00 PM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:22 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. e. Observations of Room 108 on 12/02/15 at 3:41 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:01 PM revealed the door of resident room 108 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:25 AM revealed the door of resident room 108 had broken and splintered laminate on the front of the bottom half	F 253	Newly admitting residents are given a personal items kit on admission that is labeled by the Admissions staff or RN Supervisor. The Nursing Administration Team will round each hall every weekday inspecting for unlabeled personal items. Nursing staff will begin washing wheelchairs during the routine shower schedule on 12/22/2015. A sign off sheet will be placed in each shower room to validate that the wheelchair has been washed. The Maintenance Director will utilize the shower schedule to audit 5 wheelchairs per hall once a month to ensure that wheelchairs are in working order and clean. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The Maintenance Director and/or designee will make a monthly inspection of the doors in the facility and report any findings to the Safety Committee during the monthly meeting. Any replacement needs identified will be reported to the Executive Director for submission of a Capital Equipment Request. A member of the Nursing Administration Team will round every weekday with audit tool which includes labeling of personal items and cleanliness of equipment, and will turn in findings daily to the DON or designee. Any deficiency will be	

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F 253	Continued From page 9 of the door. f. Observations of Room 109 on 12/02/15 at 3:45 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:01 revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:25 AM revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door. g. Observations of Room 110 on 12/02/15 at 3:46 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:02 PM revealed the door of resident room 110 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:26 AM revealed the door of resident room 110 had broken and splintered laminate on the front of the bottom half of the door. h. Observations of Room 111 on 12/02/15 at 3:47 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:02 PM revealed the door of resident room 111 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:27 AM revealed the door of resident room 111 had broken and splintered laminate on the front of the bottom half	F 253	addressed with written education and/or corrective action until deficient practice is corrected. Nursing staff will begin washing wheelchairs during the routine shower schedule. A sign off sheet will be placed in each shower room to validate that the wheelchair has been washed. Nursing staff education began 12/22/15. Any staff who have not completed education by 1/1/15 will not work until education has been completed. The Maintenance Director and/or designee will make a monthly inspection of the doors in the facility and report any findings to the Safety Committee during the monthly meeting. Any replacement needs identified will be reported to the Executive Director for submission of a Capital Equipment Request. How will the facility monitor the measures to make sure that solutions are sustained? The Maintenance Director and/or designee will make a monthly inspection of the doors in the facility and report any findings to the Safety Committee during the monthly meeting. The audits will be reviewed by the Quality Assurance Committee for 3 months. Director of Nursing will review findings of Nursing Administration Team Round Sheets daily until deficient practice is corrected and report to Quality Assurance	

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F 253	Continued From page 10 of the door. i. Observations of Room 114 on 12/02/15 3:48 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 4:03 PM revealed the door of resident room 114 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:28 AM revealed the door of resident room 114 had broken and splintered laminate on the front of the bottom half of the door. j. Observations of Room 208 on 12/02/15 at 4:05 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:03 PM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:32 AM revealed the door of resident room 208 had broken and splintered laminate on the front of the bottom half of the door. k. Observations of Room 404 on 12/02/15 at 4:06 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/03/15 at 4:11 PM revealed the door of resident room 404 had broken and splintered laminate on the front of the bottom half of the door. Observations on 12/04/15 at 8:42 AM revealed the door of resident room 404 had broken and splintered laminate on the front of the bottom half	F 253	Committee monthly for 3 months. The Maintenance Director and/or designee will utilize shower schedule to audit cleanliness and inspect for repairs as needed. Findings will be presented monthly to Safety Committee and Quality Assurance for 3 months.	

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of the door.

l. Observations of Room 406 on 12/02/15 at 4:07 PM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/03/15 at 4:12 PM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/04/15 at 8:43 AM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door.

m. Observations of Room 415 on 12/02/15 at 4:09 PM revealed the door of the resident's room had broken and splintered laminate with a large area of laminate broken off on the front of the bottom half of the door.
Observations on 12/03/15 at 4:16 PM revealed the door of resident room 415 had broken and splintered laminate with a large area of laminate broken off on the front of the bottom half of the door.
Observations on 12/04/15 at 8:47 AM revealed the door of resident room 415 had broken and splintered laminate with a large area of laminate broken off on the front of the bottom half of the door.

2. Resident bathroom doors were observed as follows:

a. Observations of Room 108 on 12/02/15 at 3:41 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the front of the bottom half of the door.

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Observations on 12/03/15 at 4:01 PM revealed the bathroom door inside resident room 108 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/04/15 at 8:25 AM revealed the bathroom door inside of resident room 108 had broken and splintered laminate on the front of the bottom half of the door.

b. Observations of Room 114 on 12/02/15 at 3:48 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/03/15 at 4:03 PM revealed the bathroom door inside resident room 114 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/04/15 at 8:28 AM revealed the bathroom door inside of resident room 114 had broken and splintered laminate on the front of the bottom half of the door.

c. Observations of Room 403 on 12/02/15 at 4:07 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/03/15 at 4:10 PM revealed the bathroom door inside resident room 403 had broken and splintered laminate on the front of the bottom half of the door.
Observations on 12/04/15 at 8:41 AM revealed the bathroom door inside of resident room 403 had broken and splintered laminate on the front of the bottom half of the door.

3. Observations of the central bath doors were observed as follows:

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F 253	Continued From page 13 a. Observations on 12/02/15 at 3:39 PM revealed the central bath door on the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/03/15 at 3:59 PM revealed the central bath door on the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/04/15 at 8:23 AM revealed the central bath door on the 100 hall had broken and splintered laminate and wood on the front of the bottom half of the door. b. Observations on 12/02/15 at 4:05 PM revealed the central bath door on the 200 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/03/15 at 4:03 PM revealed the central bath door on the 200 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/04/15 at 8:33 AM revealed the central bath door on the 200 hall had broken and splintered laminate and wood on the front of the bottom half of the door. c. Observations on 12/02/15 at 4:09 PM revealed the central bath door on the 300 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/03/15 at 4:07 PM revealed the central bath door on the 300 hall had broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 12/04/15 at 8:37 AM revealed the central bath door on the 300 hall had broken and splintered laminate and wood on the front of the bottom half of the door.	F 253		

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d. Observations on 12/02/15 at 4:19 PM revealed the central bath door on the 400 hall had broken and splintered laminate and wood on the front of the bottom half of the door.
Observations on 12/03/15 at 4:16 PM revealed the central bath door on the 400 hall had broken and splintered laminate and wood on the front of the bottom half of the door.
Observations on 12/04/15 at 8:47 AM revealed the central bath door on the 400 hall had broken and splintered laminate and wood on the front of the bottom half of the door.

During an environmental tour and interview on 12/04/15 at 10:39 AM the Maintenance Director verified all of the resident room doors on the 100 hall had damaged wood and laminate. He explained he and his assistant tried to sand and patch the doors but they had to be careful when the doors were badly damaged and sometimes the doors needed to be replaced. He also verified the doors that had splintered wood and laminate needed to be sanded to remove any splinters or rough edges. He explained all staff had access to work orders and the forms were kept at the nurse's stations. He stated maintenance staff phone numbers were also posted at each nurse's station and they were on call 24 hours a day for 7 days a week to make repairs. He explained he expected for staff to put work orders on a clipboard at the nurse's station and maintenance staff checked it first thing each morning and several times throughout each day. He stated he also asked staff at the nurse's stations if they had any maintenance issues or repairs that needed to be done on a daily basis. He explained he and his assistant started work each day on work orders they received from the

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night shift then started their big project of the day and the regular preventive maintenance. He stated they tried to work on any new maintenance issues in between the regular preventative maintenance and dealt with big stuff that was broken. He further stated maintenance staff relied on facility staff to tell them what was damaged or broken and he was unaware some of the resident doors and bathroom doors were splintered and so badly damaged. He explained he had sanded all of the central bath doors in the past but when staff bumped lifts and equipment into the edges of the doors it splintered the laminate and wood and they needed to be repaired or replaced.

During an interview on 12/04/15 at 1:57 PM the Administrator stated it was her expectation when maintenance staff made their random rounds they should identify damaged doors and get them corrected at the time it was found. She stated maintenance staff had sanded doors in the past but many of the doors needed to be replaced and doors with splintered wood and laminate should be repaired or replaced.

4. Personal care equipment was observed not labeled, covered, clean and/or stored properly as follows:

a. Room 310's bathroom, shared by 2 residents, was observed on 12/03/15 at 8:58 AM to have an uncovered, unlabeled wash basin which contained 2 unlabeled emesis basins stacked inside the wash basin located on the back of the commode. There was also a triangular specimen cup with urine residue which was not labeled or covered. On 12/04/15 at 10:51 AM there was an unlabeled uncovered bedpan on the back of the

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commode.

b. Room 313's bathroom, shared by 2 residents, was observed on 11/30/15 at 3:44 PM with 2 unlabeled uncovered urinals on the back of the commode and a seat extender with arm supports located directly on the floor. On 12/01/15 at 8:23 AM observations revealed 1 of 2 urinals wre uncovered and unlabeled on the back of the commode. On 12/02/15 at 11:18 AM the back of the commode was observed with 1 unlabeled uncovered urinal on the back of the commode which had urinal residue inside along with 2 covered urinals. There was a commode seat extender with handrails on the floor at this time. These items remained the same during observations made on 12/03/15 at 2:22 PM and on 12/04/15 at 10:52 AM.

c. Room 401's bathroom, shared by 2 residents, was observed on 11/30/15 at 3:19 PM with an unlabeled uncovered wash basin on the back of the commode. The wash basin was observed on the back of the commode, unlabeled and uncovered on 12/02/15 at 11:30 AM, on 12/03/15 at 8:43 AM and at 2:44 PM, and on 12/04/15 at 10:37 AM.

d. Room 402's bathroom, shared by 2 residents, was observed on 11/30/15 at 3:25 PM with unlabeled uncovered urinals located on the back of the commode. On 12/01/15 at 9:35 AM the unlabeled, uncovered urinal was observed on the back of the commode soiled with urine residue. On 12/03/15 at 8:48 AM and at 2:44 PM, and on 12/04/15 at 10:35 AM the urinal remained on the back of the commode, unlabeled and uncovered.

Interview with Nurse #3 on 12/04/15 at 10:38 AM

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revealed personal care equipment should be covered with a paper cover which was labeled with the appropriate resident's name. On 12/04/15 at 10:46 AM, Nurse #3 observed the personal care equipment in Rooms 401 and 402. Nurse #3 confirmed the equipment was not stored and labeled correctly.

Interview with Nurse Aide (NA) #2 on 12/04/15 at 10:40 AM revealed personal care equipment should be stored in the bathroom, covered and labeled. He confirmed that the urinal in Room 401 was improperly stored and the was basin in Room 401 should not be in the bathroom.

On 12/04/15 at 10:54 AM, NA #3 stated personal care equipment was to be covered in bags and labeled with resident names. During observations of equipment on the 300 hall at this time with NA #3, NA #3 stated that the residents in Room 313 used the bathroom independently but the urinals should be covered and labeled and she was unsure if the seat extender was in working order.

Interview with the Director of Nursing on 12/04/15 at 12:03 PM revealed personal care equipment should be kept in the bathrooms covered and labeled if not preferred otherwise. In addition she stated the seat extender should not be kept on the floor.

5. Soiled wheelchairs and worn, cracked, vinyl arm rests on the wheelchairs were observed as follows:

a. Resident #156's wheelchair was observed on 11/30/15 at 3:10 PM with crumbs and sticky residue on, under and on the sides of the seat cushion. This remained the same when

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observed on 12/01/15 at 11:39 AM. On 12/03/15 at 8:24 AM, Resident #156 was observed in the dining room in her wheelchair that had dried food spills on the cushion, down the sides of the wheelchair, and on to the wheelchair's tires. The wheelchair was observed soiled with dried food spills on the sides of the wheelchair, food crumbs and dried spills in and around the seat cushion and along the metal supports on 12/03/15 at 2:42 PM and on 12/04/15 at 10:32 AM. In addition, during all these observations the right arm rest of the wheelchair was observed covered in vinyl which was cracked and split exposing the under layer material.

b. Resident #126's wheelchair was observed on 12/01/15 at 9:35 AM in his wheelchair which had dried food residue on the front metal supports extending from the arm rests on the left side. On 12/01/15 at 11:27 AM the wheelchair remained soiled and the dried food debris was noted on the seat and on the foot rests of the wheelchair. The wheelchair remained soiled with dried food debris and spills on the cushion, and down the supports, foot rests and calf rests during observations made on 12/02/15 at 11:31 AM, and 12/04/15 at 10:35 AM.

On 12/04/15 at 8:05 AM, the Maintenance Director stated he did not keep any work orders as it created too much paperwork. He stated that the maintenance department washed down the wheelchairs by hall every quarter and that the third shift nursing staff were assigned to wipe the wheelchairs down in between. On 12/04/15 at 8:20 AM, the Maintenance Director stated he kept no records of when the last time Residents #126's and #156's wheelchairs were washed by the the maintenance department. As far as a

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F 253	Continued From page 19 schedule, he stated that the wheelchairs were spread out over the course of the quarter but with no set schedule. On 12/04/15 at 10:38 AM, Nurse #3 stated that wheelchairs were generally cleaned during night shift alone with maintenance washing them. If a staff person sees that a wheelchair was dirty, Nurse #3 stated staff would wipe them down. In addition, if the wheelchair arm rests need to be replaced, a work order should be given for maintenance department who will replace cracked vinyl arm rests. On 12/04/15 at 10:40 AM, Nurse Aide (NA) #2 stated night shift has a schedule that designate when the wheelchairs were to be cleaned. NA #2 stated that nurse aides also were to use disinfectant spray to wash wheelchairs when they saw they needed cleaning. Upon observing the wheelchairs for Residents #126 and #156 at this time, he stated they needed to be cleaned. Interview with the Director of Nursing (DON) on 12/04/15 at 12:03 PM revealed wheelchairs were cleaned by nursing staff per a schedule. In addition, staff were to sign a form indicating they cleaned the wheelchair as scheduled. Review of this schedule showed that Residents #156's and #126's wheelchairs were scheduled to be cleaned by third shift each Monday. The DON was unable to find documentation that the wheelchairs were cleaned on Monday. She further stated nursing staff should wipe down soiled wheelchairs as they find them.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		1/1/16

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F 282	Continued From page 20 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to follow the care plan to provide repositioning of a resident at risk for skin breakdown for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #34). The findings included: Resident #34 was re-admitted to the facility on 11/10/10 with diagnoses of dementia, high blood pressure, pain, and depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated 09/13/15 indicated Resident #34 was moderately cognitively impaired and rarely/never understood and/or understand. Further review of the MDS indicated Resident #34 required extensive assistance with bed mobility and eating, and was totally dependent on staff for transfers, dressing, toileting, personal hygiene, and bathing. Resident #34 was also coded as always incontinent of bowel and bladder. Review of a care plan updated on 11/02/15 revealed Resident #34 was at risk for skin breakdown related to impaired mobility which required 1 to 2 person physical assistance to total care. Further review of the care plan indicated approaches to provide weekly skin assessments, pressure reducing mattress to bed, treatments per physician's orders, and provide assistance with turning/repositioning every 2 hours and as	F 282	How will this deficiency be corrected for each resident found to be affected by the deficient practice? Resident #34 was monitored for positioning by the Wound Care Nurse until the wound was healed. She continues to review the resident's positioning frequently and visually inspects the resident weekly to ensure that the resident does not incur further skin breakdown. Resident's weight and nutritional status has improved and resident was immediately placed on a low air loss pressure-relieving mattress. NA #6 was given written corrective action for failure to follow resident's care plan to turn and reposition ever 2 hours or as needed. The CNA who failed to follow the Care Plan was given written corrective action by the Director of Nursing on 12/29/2015. She was instructed that if she was unable to meet the Care Directive, she was to immediately report it to her nurse or supervisor for assistance. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future?	

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F 282	Continued From page 21 needed. On 11/30/15 at 3:51 PM until 4:03 PM, Resident #34 was observed sitting in the day room in a broda chair with the left side of his body leaned over the left side of the chairs armrest. The resident's armpit was touching the chairs armrest and his left hand was touching the floor. Resident #34 was observed to be incapable of repositioning himself upright in the broda chair. On 11/30/15 at 4:03 PM, Nurse #3 was observed to reposition Resident #34 upright in the broda chair and positioned the resident's left arm on the inside next to the armrest. On 12/01/15 at 8:45 AM, Resident #34 was observed setting in a broda chair and was pushed by Nurse Aide (NA) #6 from the dining room into the hallway outside the resident's room. On 12/01/15 with continuous observations from 8:45 AM until 11:15 AM, Resident #34 remained seated in the broda chair outside his room in the hallway asleep. On 12/01/15 at 11:15 AM, NA #6 was observed to push Resident #34 into his room where he was left setting in the broda chair beside his bed. On 12/03/15 from 8:35 AM until 10:50 AM, Resident #34 was observed lying in the bed and was positioned slightly onto his left side. During the continued observation, Resident #34 was unable to reposition himself in bed. On 12/03/15 at 10:50 AM, NA #6 was observed to complete incontinent care for Resident #34. NA #6 was further observed to change the resident's	F 282	All CNA staff began in-services on 12/28/2015 by the Staff Development Coordinator on appropriate ADL assistance for dependent residents, which included turning, repositioning, offering to lay down after meals to limit sitting time, etc. Any CNA staff who are not educated by 1/1/15 will be required to receive education before being allowed to work. The Wound Care Nurse will audit four residents per week for proper positioning and report findings to Director of Nursing for 6 weeks, then two residents for 6 weeks. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? All CNA staff began in-services on 12/28/2015 by the Staff Development Coordinator on appropriate ADL assistance for dependent residents, which included turning, repositioning, offering to lay down after meals to limit sitting time, etc. Any CNA staff who are not educated by 1/1/15 will be required to receive education before being allowed to work. The Wound Care Nurse will audit 1 resident per month ongoing who has specific interventions in the Care Plan related to dependence for turning or repositioning and validate staff's understanding of and implementation of the Care Plan. How will the facility monitor the measures	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 22 soiled bed linens, placed green colored sweatpants on the resident, placed a pillow underneath the resident's left side, and stated to Resident #34 "I will put your sweatshirt on you before I take you to lunch." On 12/03/15 at 3:00 PM, an interview was conducted with NA #6. She confirmed she was responsible for the care of Resident #34 on 12/03/15 from 7::00 AM until 3:00 PM. She indicated the nurse aides were expected to reposition the residents every 2 hours and/or more often if necessary. NA #6 stated she was aware Resident #34 was susceptible to skin breakdown. She confirmed she had been instructed by the wound nurse at the beginning of her shift that Resident #34 had a reddened area to the left buttock and that he was to be kept off of the area and repositioned at least every 2 hours. NA #6 confirmed she had not repositioned Resident #34 every 2 hours and had no explanation as to why she had not repositioned the resident as she had been instructed at the beginning of her shift. On 12/03/15 at 3:55 PM, an interview was conducted with Nurse #5. She stated she expected the NAs to reposition a resident every 2 hours and/or more often should a resident be at risk and/or have skin breakdown. She further stated she expected the NAs to follow the resident's "care plans." On 12/04/15 at 11:50 AM, a telephone interview was conducted with the Wound Treatment Nurse. She indicated she first observed the reddened area on Resident #34's buttocks on 12/02/15. She further indicated the area was considered to be an avoidable stage 1 pressure ulcer. The	F 282	to make sure that solutions are sustained? The Wound Care Nurse will audit four residents per week for proper positioning and report findings to Director of Nursing for 6 weeks, then two residents for 6 weeks. Any identified non-compliance will be addressed with Corrective Action up to and including termination. These audits will be reported to the Quality Assurance Committee for 3 months. The Wound Care Nurse will audit 1 resident per month ongoing who has specific interventions in the Care Plan related to dependence for turning or repositioning and validate staff's understanding of and implementation of the Care Plan. This audit will be reported to the Quality Assurance Committee monthly ongoing.	

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	345203	A. BUILDING _____ B. WING _____	C 12/04/2015

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F 282	Continued From page 23 treatment nurse stated she had instructed the NAs and would have expected Resident #34 to have been repositioned every 2 hours. On 12/04/15 at 1:00 PM, the Director of Nursing (DON) was interviewed. The DON stated she expected the NAs to reposition the residents every 2 hours. The DON further stated she would have expected Resident #34 to have been repositioned every 2 hours per the care plan.	F 282		
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 observations, resident interview, staff interview and record review, the facility failed to cut the toenails of 1 of 4 sampled residents reviewed for activities of daily living skills (ADLs). Resident #183). The findings included: Resident #183 was admitted to the facility on 11/25/15 with diagnoses including acute gastric ulcer with hemorrhage, anemia, hypertension, and pain. The initial Nursing Service Data Collection Tool dated 11/25/15 noted she was alert and oriented, and understood others. Under the skin	F 312	How will this deficiency be corrected for each resident found to be affected by the deficient practice? The resident's toenails were clipped on 12/4/2015. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? All CNA staff begin in-services on 12/28/2015 by the Staff Development Coordinator on provision of ADL assistance for dependent residents at all times, especially nail care, even if the	1/1/16

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F 312	Continued From page 24 assessment section of this form was noted redness to her heels but nothing about her toenails. Review of the shower documentation revealed Resident #183 received a sponge bath on 11/27/15, 11/28/15, and 11/29/15. On 11/30/15 she received a sponge bath in the morning and refused her evening shower. Nursing notes were reviewed and revealed no uncooperative behaviors or refusals. Resident #183 was observed on 11/30/15 at 3:50 PM barefooted with very long toenails. On 12/01/15 at 11:09 AM she was observed barefooted revealing very long toenails, several extending a quarter of an inch beyond the end of her toes. Resident #183 stated at this time that staff had not gotten around to cutting them yet. Observations on 12/02/15 at 11:24 AM revealed Resident #183 was lying across the bed without wearing shoes or socks. Her toenails were observed to extend beyond the end of her toes. She stated she had felt too sick to shower since coming to the facility and she usually just gave herself sponge baths as she tried to do as much for herself as possible. She stated that staff helped her as needed and stated she needed assistance putting on her jacket this morning. Her toenails remained long when observed on 12/02/15 at 2:49 PM as she lay on the bed without shoes or socks. Review of the shower documentation revealed Resident #183 received a sponge bath on 12/02/15. On 12/03/15 at 11:00 AM, Resident #183 stated	F 312	resident refused his/her assigned shower time. Further, they were educated they were able to clip toenails for non-diabetics, and that if they are unable to provide ADL assistance for any reason, it is to be reported to the hall nurse for assessment and follow-up. For new admissions, the initial skin assessment will include toenails/fingernails to identify any special grooming needs, such as diabetes. For existing or long-term residents, if a shower is refused, the nurse will be notified and the resident will be assessed for nail grooming at that time. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? All CNA staff begin in-services on 12/28/2015 by the Staff Development Coordinator on provision of ADL assistance for dependent residents at all times, especially nail care, even if the resident refused his/her assigned shower time. Further, they were educated they were able to clip toenails for non-diabetics, and that if they are unable to provide ADL assistance for any reason, it is to be reported to the hall nurse for assessment and follow-up. For new admissions, the initial skin assessment will include	

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F 312	Continued From page 25 during interview that no one had offered to cut her toenails. She stated she did not have the strength in her fingers to cut them herself and they needed to be cut. She stated she needed her toenails soaked as they were hard to clip. On 12/03/15 at 11:04 AM, Nurse Aide (NA) #1 stated during interview the nurse aides were responsible for toenail care. NA #1 stated nail care was provided during showers and as they had time to do this care. She stated that if a resident refused a shower, then the nail care would be done during the bed bath. NA #1 stated this was the first time she had been assigned to Resident #183 and had not observed her toenails this date. Together the surveyor and NA #1 observed Resident #183's toenails at this time. Observations revealed 8 toenails extended beyond the ends of her toenails approximately a quarter of an inch. Resident #183 stated at this time that her toenails got caught on her briefs when she put them on. NA #1 stated that Resident #183 had already had socks on this morning when she assisted her. Nurse #2 was interviewed on 12/03/15 at 11:12 AM. He stated that upon admission the nurses completed the Nursing Service Data Collection Tool. Review of this form revealed Nurse #1 completed this form concerning Resident #183. Nurse #2 further stated that toenails were to be cut with showers twice a week or the resident could see the podiatrist if the resident was diabetic or there was difficulty cutting the toenails. He further stated that if a resident refused showers, it was still the nurse aide's responsibility to look at the nails. If the nurse aide was unable to cut a resident's nails, then the nurse aide would bring that to the attention of the nurse.	F 312	toenails/fingernails to identify any special grooming needs. For existing or long-term residents, if a shower is refused, the nurse will be notified and the resident will be assessed for nail grooming at that time. The Nursing Administration Team began daily Rounding Audits to be performed Monday-Friday that address multiple care areas, including proper grooming. During these audits, they will select 2 different residents per hall for 6 weeks and visually inspect for proper grooming. They will audit 1 resident per hall for the next 6 weeks. These audits will be turned in to the Director of Nursing for review and deficiencies identified will be addressed through disciplinary action until deficiencies are corrected. How will the facility monitor the measures to make sure that solutions are sustained? Director of Nursing and/or designee will review Nursing Administration Round Audits of grooming for two different residents per hall Monday-Friday for 6 weeks, then 1 resident per hall for 6 weeks. Any deficiencies identified will be addressed through disciplinary action until deficiencies are corrected. The results of these audits will be reported to the Quality Assurance Committee for 3 months.	

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F 312	Continued From page 26 On 12/03/15 at 11:18 AM interview with Nurse #1, who completed the initial Nursing Service Data Collection Tool, revealed she assessed Resident #183 upon admission. She stated that she could not recall the condition of her toenails but would have thought she saw them when assessing her heels. At this time Nurse #1 observed Resident #183's toenails and Nurse #1 stated that her nails definitely needed to be cut. Interview with the Director of Nursing on 12/03/15 at 2:06 PM revealed toenail care should be offered with every shower and any refusals of care should be documented in a nursing note. On admission, nurses should look at the resident's toenails but would only trim them if they were very bad. She further stated that staff should have offered to cut Resident #183's toenails before this date.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to reposition a	F 314	How will this deficiency be corrected for each resident found to be affected by the	1/1/16

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F 314	Continued From page 27	F 314		

resident in order to prevent a newly developed pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #34).

The findings included:

Resident #34 was re-admitted to the facility on 11/10/10 with diagnoses of dementia, high blood pressure, pain, and depressive disorder.

The quarterly Minimum Data Set (MDS) dated 09/13/15 indicated Resident #34 was moderately cognitively impaired and rarely/never understood and/or understand. Further review of the MDS indicated Resident #34 required extensive assistance with bed mobility and eating, and was totally dependent on staff for transfers, dressing, toileting, personal hygiene, and bathing. Resident #34 was also coded as always incontinent of bowel and bladder.

A care plan was developed with a revised date of 11/02/15 revealed Resident #34 was at risk for skin breakdown related to impaired mobility which required 1 to 2 person physical assistance to total care. Further review of the care plan indicated approaches to provide weekly skin assessments, pressure reducing mattress to bed, treatments per physician's orders, and provide assistance with turning/repositioning every 2 hours and as needed.

Resident #34 was observed on 11/30/15 at 3:51 PM until 4:03 PM sitting in the day room in a broda chair with the left side of his body leaned over the left side of the chairs armrest. The resident's armpit was touching the chairs armrest and his left hand was touching the floor. Resident #34 was observed to be incapable of

deficient practice?

Resident #34 was monitored for positioning by the Wound Care Nurse until the wound was healed. She continues to review the resident's positioning frequently and visually inspects the resident weekly to ensure that the resident does not incur further skin breakdown. Resident's weight and nutritional status has improved and resident was immediately placed on a low air loss pressure-relieving mattress. NA #6 was given written corrective action for failure to follow resident's care plan to turn and reposition ever 2 hours or as needed.

The CNA who failed to follow the Care Plan was given written corrective action by the Director of Nursing on 12/29/2015. She was instructed that if she was unable to meet the Care Directive, she was to immediately report it to her nurse or supervisor for assistance.

How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future?

All CNA staff began in-services on 12/28/2015 by the Staff Development Coordinator on appropriate ADL assistance for dependent residents, which included turning, repositioning, offering to lay down after meals to limit sitting time, etc. Any CNA staff who are not educated by 1/1/15 will be required to receive education before being allowed to work.

The Wound Care Nurse will audit four

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F 314	Continued From page 28 repositioning himself upright in the broda chair. Nurse #3 was observed on 11/30/15 at 4:03 PM to reposition Resident #34 upright in the broda chair and positioned the resident's left arm on the inside next to the armrest. Resident #34 was observed on 12/01/15 at 8:45 AM setting in a broda chair and was pushed by Nurse Aide (NA) #6 from the dining room into the hallway outside the resident's room. Continuous observations on 12/01/15 from 8:45 AM until 11:15 AM, Resident #34 remained seated in the broda chair outside his room in the hallway asleep. NA #6 was observed on 12/01/15 at 11:15 AM to push Resident #34 into his room where he was left setting in the broda chair beside his bed. The Wound Treatment Nurse was observed on 12/02/15 at 10:55 AM perform Resident #34's preventative wound treatment to the lower back and buttock area. During the observation the wound treatment nurse identified a new reddened pressure ulcer on Resident #34's left buttock area. The wound treatment nurse indicated the area was unopened but was close to being an opened area. The treatment nurse measured the pressure ulcer to be a 2 centimeter (cm) by 1 cm area and classified the pressure ulcer as a stage 1. NA #6 was observed on 12/03/15 at 10:50 AM to provide incontinence care for Resident #34. NA #6 was further observed to have changed the resident's soiled bed linens, placed green colored sweatpants on the resident, placed a pillow	F 314	residents per week for proper positioning and report findings to Director of Nursing for 6 weeks, then two residents for 6 weeks. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? All CNA staff began in-services on 12/28/2015 by the Staff Development Coordinator on appropriate ADL assistance for dependent residents, which included turning, repositioning, offering to lay down after meals to limit sitting time, etc. Any CNA staff who are not educated by 1/1/15 will be required to receive education before being allowed to work. The Wound Care Nurse will audit 1 resident per month ongoing who has specific interventions in the Care Plan related to dependence for turning or repositioning and validate staff's understanding of and implementation of the Care Plan. How will the facility monitor the measures to make sure that solutions are sustained? The Wound Care Nurse will audit four residents per week for proper positioning and report findings to Director of Nursing for 6 weeks, then two residents for 6 weeks. Any identified non-compliance will be addressed with Corrective Action up to and including termination. These audits will be reported to the Quality Assurance	

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F 314	Continued From page 29 underneath the resident's left side, and stated to Resident #34 "I will put your sweatshirt on you before I take you to lunch." An interview was conducted with NA #6 on 12/03/15 at 3:00 PM She confirmed she was responsible for the care of Resident #34 on 12/03/15 from 7::00 AM until 3:00 PM. She indicated the nurse aides were expected to reposition the residents every 2 hours and/or more often if necessary. NA #6 stated she was aware Resident #34 was susceptible to skin breakdown. She confirmed she had been instructed by the wound nurse at the beginning of her shift that Resident #34 had a reddened area to the left buttock and that he was to be kept off of the area and repositioned at least every 2 hours. NA #6 confirmed she had not repositioned Resident #34 every 2 hours and had no explanation as to why she had not repositioned the resident as she had been instructed by the wound nurse. An interview was conducted with Nurse #5 on 12/03/15 at 3:55 PM. She stated she expected the NAs to reposition a resident every 2 hours and/or more often should a resident be at risk for or have skin breakdown. Nurse #5 further stated she was unaware the NAs had not repositioned Resident #34 every 2 hours. A telephone interview was conducted on 12/04/15 at 11:50 AM with the Wound Treatment Nurse. She indicated she first observed the reddened area on Resident #34's buttocks on 12/02/15. She further indicated the area was considered to be an avoidable stage 1 pressure ulcer. The treatment nurse stated she would have expected Resident #34 to have been repositioned every 2	F 314	Committee for 3 months. The Wound Care Nurse will audit 1 resident per month ongoing who has specific interventions in the Care Plan related to dependence for turning or repositioning and validate staff's understanding of and implementation of the Care Plan. This audit will be reported to the Quality Assurance Committee monthly ongoing.	

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F 314	Continued From page 30 hours to prevent the area from becoming worse. She further stated she was unaware the NAs had not repositioned the resident every 2 hours. The treatment nurse further indicated she had not observed a reddened area or a pressure ulcer on Resident #34's buttocks on 12/01/15. She stated the area was considered to be an avoidable pressure ulcer due to Resident #34 not being turned and repositioned every 2 hours. The Director of Nursing (DON) was interviewed on 12/04/15 at 1:00 PM. The DON stated she expected the NAs to reposition the residents every 2 hours. The DON further stated she was unaware Resident #34 was not repositioned every 2 hours.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to maintain safe water temperatures in residents' sinks on 3 of 4 halls. (Halls 100, 300 and 400); and failed to apply a lap tray using the quick release method of the push buckle attached to the lap tray for 1 of 1 sampled resident with a lap tray. (Resident #130).	F 323	How will this deficiency be corrected for each resident found to be affected by the deficient practice? During the survey process, our thermometers were recalibrated per policy in the presence of the surveyors and the temperatures read within 110-116 degree	1/1/16

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F 323	Continued From page 31 The findings included: 1. On the first day of the survey, water temperatures were observed in the sinks of resident rooms to be hot to touch and/or measured as follows: *Room 109 on 11/30/15 at 4:26 PM the water in the sink was observed by the surveyor to be too hot to hold her hand under the water. *Room 309 on 11/30/15 at 3:36 PM the water in the the sink was observed to register 120 degrees Fahrenheit with the surveyor's thermometer and was hot to touch. *Room 310 on 11/30/15 at 3:40 PM the water in the room's sink measured 120 degrees Fahrenheit with the surveyor's thermometer and was hot to touch. *Room 315 on 11/30/15 at 3:48 PM the water in the sink was tested with the surveyor's thermometer and measured 122 degrees Fahrenheit and was hot to touch. On 12/01/15 at 11:09 AM Resident #183 who resided in this room denied the water was too hot. *Room 400 on 11/30/15 at 3:10 PM the water temperature in the room's sink with the surveyor's thermometer measured 120 degrees Fahrenheit and was hot to touch. *Room 401 was observed on 11/30/15 at 3:19 PM to have water temperatures in the room's sink to measure 120 degrees Fahrenheit with the surveyor's thermometer and was was noted hot to touch.	F 323	range per regulation in multiple areas of the facility. No residents were identified as having complained about temperatures being too hot. However, an independent plumber was contacted on 12/18/15 and did an inspection of the water supply/boiler system on 12/19/15. He returned on 12/22/15 and replaced the spring check on the recirculation line, but identified no defective issues with the boiler system. LCC purchased two digital thermometers to verify temperatures after boiler refilled. The Resident in finding #2 (Resident #130) was immediately removed from the lap top table and was laid in bed by the Director of Nursing. The nurse who tied the lap top table to the wheelchair was suspended immediately for resident abuse and subsequently terminated and reported to the Board of Nursing for further review. The table top was repaired on 12/8/15 and all staff was educated from 12/4/15-12/8/15 on abuse/neglect, restraints and inappropriate use of devices. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? The maintenance department began a new documentation process for staff to report necessary work orders. This documentation will be maintained by the Maintenance Director to evidence requests for work. New digital thermometers were purchased on	

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F 323	Continued From page 32 *Room 402 on 11/30/15 at 3:25 PM the water in the room's sink measured 120 degrees Fahrenheit with the surveyor's thermometer and was hot to touch. *Room 403 on 11/30/15 at 3:29 PM, the water temperature in the room's sink with the surveyor's thermometer registered 120 degrees Fahrenheit and was hot to touch. *Room 411 on 11/30/15 at 3:37 PM the sink in the resident's room felt very hot to the surveyor and the surveyor was unable to keep her hand underneath the running water without her hand becoming very red and hot. On 11/30/15 at 3:29 PM Resident #47 residing in Room 105 stated the water in her sink sometimes got too hot. An interview was conducted with the Assistant Maintenance Director (AMD) on 11/30/15 at 4:01 PM (as the Maintenance Director had gone home with an injury). The AMD stated that maintenance staff check 2 resident rooms per hall and all shower rooms weekly for water temperatures. He stated the rooms generally run between 111 and 113 degrees Fahrenheit. He further stated that the times of the days and locations change each time. On 11/30/15 at 4:05 PM, the surveyor and the AMD checked water temperatures with the calibrated thermometer staff retrieved from the dietary department and found: *Room 306 was 117 degrees Fahrenheit; and *Room 309 was 116 degrees Fahrenheit. On 11/30/15 at 4:09 PM, observations were made of the mixing valve at the boiler and it was noted	F 323	12/22/15 and an audit of water temperatures will be conducted daily with findings recorded by Maintenance Staff and the Manager On Duty for weekend shifts. Any variance below 110 degrees or above 116 degrees will be reported to the Executive Director. For finding #2, all staff was educated from 12/4/15-12/8/15 on abuse/neglect, restraints and inappropriate use of devices. The accused nurse was suspended pending an abuse investigation and subsequently terminated on 12/7/2015 and a 5-Day Working Report was submitted at that time. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The maintenance department began a new documentation process for staff to report necessary work orders. This documentation will be maintained by the Maintenance Director to evidence requests for work. New digital thermometers were purchased on 12/22/15 and an audit of water temperatures will be conducted daily with findings recorded by Maintenance Staff and the Manager On Duty for weekend shifts. Any variace below 110 degrees or above 116 degrees will be reported to the Executive Director. The finding #2, the Staff Development Coordinator or Therapy Department will educate appropriate staff on any newly	

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F 323	Continued From page 33 to be set at 118 degrees Fahrenheit. The AND and surveyor checked more rooms with the staff's thermometer on 11/30/15 at 4:11 Pm and found: *Room 400 was 118 degrees Fahrenheit; *Room 411 was 115 degrees Fahrenheit; *Room 108 was 112 degrees Fahrenheit; and *Room 109 was 114 degrees Fahrenheit. AMD stated he had observed fluctuating temperatures. He reported on 11/30/15 at 4:33 PM that last week the Maintenance Director adjusted the mixing valve due to complaints the water was too cold. Review of the temperature logs revealed weekly temperatures were taken in different rooms but the times were not recorded. The logs showed temperatures ranged from 111 to 113 degrees Fahrenheit. Further interview with the AMD on 11/30/15 at 4:36 PM revealed the highest staff ever turned the mixing valve up to was 120 degrees Fahrenheit. He revealed that the Maintenance Director told him that he turned the mixing valve up after several residents complained their showers were too cold. He stated the water was checked before the adjustment and registered 113 degrees Fahrenheit and after the adjustment the water measured 115 degrees Fahrenheit. AMD stated the temperatures of the water were checked earlier this date and were fine. On 12/01/15 at 7:50 AM AMD stated he readjusted the mixing valve down a few degrees and he would be retesting the water temperatures.	F 323	implemented devices on hire if appropriate, and as needed. All devices and restraints will be reviewed weekly during the Resident At Risk meeting to ensure appropriateness of continued use. The Director of Nursing and/or designee will visually inspect all care planned devices weekly for 4 weeks for correctness of implementation, then 3 residents or 10% of devices (whichever is greater)for 4 weeks, and then monthly ongoing. The results will be discussed weekly in Resident at Risk and monthly at the Quality Assurance Meeting. How will the facility monitor the measures to make sure that solutions are sustained? Findings of the monthly water temperature logs will be taken to the Safety Committee monthly for 3 months and Quality Assurance Committee monthly for 3 months. For finding #2, the Director of Nursing and/or designee will visually inspect all care planned devices weekly for 4 weeks for correctness of implementation, then 3 residents or 10% of devices (whichever is greater)for 4 weeks, and then monthly for one month. The results will be discussed weekly in Resident at Risk and monthly at the Quality Assurance Meeting for 3 months.	

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With the surveyor's thermometer, water in the sink of Room 400 registered on 12/01/15 at 8:54 AM at 120 degrees Fahrenheit and was too hot for the surveyor to keep her hand under the running water, turning the surveyor's hand red.

On 12/01/15 at 9:16 AM the surveyor and AMD went to room 400 and hand tested the water in the sink. The water was too hot for the surveyor to keep her hand under it and AMD agreed the temperature was too hot. With 2 more calibrated thermometers from the dietary department more testing was done in Rooms 412, and 306 on 12/01/15 at 9:50 AM and water ranged from 108 to 110 degrees Fahrenheit.

On 12/02/15 at 8:44 PM AMD stated the last time the mixing valve was cleaned with vinegar per manufacturer's recommendations was about 2 months ago, however, there was no documentation of this cleaning. Together the surveyor and AND hand tested the water in Room 400 and noted as the water ran the temperature of the water heated to the point the surveyor's hand turned red. AMD acknowledged the water was getting hotter. With the staff thermometer the water in this room tested at 8:51 AM at 110 degrees Fahrenheit. The water was observed to fluctuate in temperature as the water ran. AMD stated at this time there were pockets of hot and cold water in the pipes causing the fluctuations.

On 12/02/15 at 9:04 AM, Nurse Aide (NA) #4 stated that the water fluctuates and sometimes gets very hot. She further stated you have to watch it and keep a close eye on the temperature as you use the water. She stated that if the water temperature rises you added cold water. She has reported the hot water to maintenance and they

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adjusted it. She stated she had not noticed the water temperatures being hot for a while.

NA #5 stated during interview on 12/02/15 at 2:33 PM that the water temperatures fluctuated and if she found the water getting too hot, she adjusted it with cold water. She stated she had told maintenance about the water but it had not been an issue lately.

Housekeeping staff #1 stated on 12/02/15 at 10:57 AM that she washed her hands before leaving each resident room. She stated that sometimes the water got hot and she had to add cold water. When this has happened she completed a work order for maintenance to check the water temperatures. The last time she recalled reporting hot water was about a month ago.

On 12/04/15 at 8:05 AM, the Maintenance Director stated he did not keep work orders as it got to be too much paperwork. There was no way to determine the last time someone requested the hot water be adjusted.

2. Resident #130 was admitted to the facility on 01/08/15. His diagnoses included post traumatic stress disorder, traumatic pneumothorax intracranial injury, convulsions, anxiety disorders, psychosis and mood affective disorder.

The initial Minimum Data Set (MDS) dated 01/15/15 coded Resident #130 with long and short term memory impairment, being nonambulatory, and requiring extensive assistance with all activities of daily living skills.

On 03/18/15 the physician ordered a tabletop to

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the wheelchair for positioning.

The last quarterly MDS dated 09/06/15 noted Resident #130 had not had any significant changes since the initial MDS. Physician orders continued with the use of the lap tray for positioning.

The care plan for ADLs, last updated on 09/14/15 included the intervention of a high back wheelchair with a table top for positioning.

On 12/04/15 at 11:35 AM Resident #130 was observed in a high back wheelchair with a lap tray in place. He was pulling up on the tray repeatedly. Upon further observation, the tray consisted of straps on both sides of the tray with a plastic push button buckle located behind the chair back. The right side strap was tied around the arm support tofu the wheelchair and the left strap dangled behind the wheelchair, unattached.

On 12/04/15 at 11:37 AM Nurse #4 stated during interview he will wiggle the lap tray. Observation of the lap tray at this time revealed the left side was not attached and the right side was tied around the right arm support. Nurse #4 proceeded to tie the left strap around the arm support of the wheelchair, leaving the buckle unused. When asked about the buckle, Nurse #4 stated that if the buckle was used, the lap tray would be too tight around his abdomen. While Nurse #4 and the surveyor were examining the lap tray, Resident #130's roommate spoke up and stated the family had been in and left the tray table unattached.

On 12/04/15 at 12:15 PM, the Director of Nursing (DON) and surveyor observed the lap tray tied to

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F 323	Continued From page 37 both arm supports of the wheelchair and the buckle unattached. DON stated the lap tray was not applied correctly with the buckle so that it was able to be immediately removed from the resident. Follow up interview with Nurse #4 on 12/04/15 at 12:26 PM revealed she had not been taught how to apply the lap tray. The Administrator stated on 12/04/15 at 12:38 PM that Nurse #4 had been trained and should have known the lap tray was incorrectly applied when tied to the arm supports of the wheelchair.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility exceeded 5 % medication error rate as evidenced by 2 medication errors out of 28 opportunities resulting in a medication error rate of 7.14 % for 2 of 4 residents randomly observed during medication pass (Residents #8 and #175). The findings included: 1. Resident #8 was admitted to the facility on 06/22/06 with diagnoses which included Alzheimer's disease, pain, high blood pressure, and weight loss.	F 332	How will this deficiency be corrected for each resident found to be affected by the deficient practice? All nursing staff will re-educated on the Medication Administration process by the Staff Development Coordinator on proper medication administration techniques and the importance of self-reporting medication errors. The two nurses affected by this deficiency will have a med pass audited by Director of Nursing or Staff Development Coordinator to ensure specific education is provided. Each error	1/1/16

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F 332	Continued From page 38 The quarterly Minimum Data Set (MDS) dated 10/06/15 coded Resident #8's cognition as severely impaired and daily decision making skills impaired. Further review of the MDS revealed Resident #8 required total assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. On 12/02/15 at 9:02 AM Nurse #1 was observed during medication pass observation to pull from the over the counter (stock) medication drawer with the label affixed on the bottle which read in part Calcium 600 plus (+) Vitamin D removed one pill from the bottle and administered the medication to Resident #8. A review of Resident #8's medical record for medication reconciliation the physician's order read Calcium 600 milligrams (mg) plus Vitamin D 400 international units (IU) one tablet by mouth (PO) twice daily for osteoporosis. A review of Resident #8's Medication Administration Record (MAR) dated for the month of December 2015 revealed the order had been correctly transcribed for administration of Calcium 600 mg plus Vitamin D 400 IU PO twice daily according to the physician's order. An interview was conducted with Nurse #1 on 12/02/15 at 3:20 PM. She stated when the physician's order reads Calcium plus Vitamin D 600 - 400 indicated the pill consisted of 600 mg of Calcium and 400 IU of Vitamin D. Nurse #1 confirmed the stock medication that she had administered to Resident #8 contained 600 mg of Calcium and 200 IU of Vitamin D. She further confirmed the stock medication and the	F 332	made during the survey was reported through our Medication Error reporting process. How will this deficiency be corrected for each resident who could be affected by the deficient practice in the future? All nursing staff will be re-educcated on the Medication Administration process by the Staff Development Coordinator on proper medication administration techniques and the importance of self-reporting medication errors. The two nurses affected by this deficiency will have a med pass audited by Director of Nursing or Staff Development Coordinator to ensure specific education is provided. Each error made during the survey was reported through our Medication Error reporting process. The Pharmacy Consultant will conduct one med pass audit per visit. The Director of Nursing or Staff Development Coordinator will conduct 3 med pass audits per month with different nurses to ensure on-going education is given as needed. Any self-identified Medication Errors reported will be reviewed by the interdisciplinary team. The Medication Error Rate will be calculated every month and reported to Resident At Risk. What measures or systemic changes will be made to ensure that this deficient practice will not occur in the future? The Pharmacy Consultant will conduct	

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F 332	Continued From page 39 physician's order was not the same for the IU of Vitamin D. Nurse #1 stated Resident #8 had received the wrong dosage of Vitamin D. An interview was conducted with the Director of Nursing (DON) on 12/02/15 at 4:30 PM. She stated she expected the nurses to follow the physician's orders and to administer medications with the correct dosages. She further stated she would have expected the nurse and/or nurse's to have read the label affixed to the stock medication as to ensure Resident #8 received the correct dosage amounts of the Vitamin D. 2. Resident #175 was admitted to the facility on 09/25/15 with diagnoses which included multiple sclerosis, muscle weakness, and convulsions/seizures. The admission Minimum Data Set (MDS) dated 10/02/15 coded Resident #175's cognition as moderately impaired and capable of making his needs known. Further review of the MDS indicated Resident #175 required extensive assistance with most all of his activities of daily living (ADLs). On 12/02/15 at 9:25 AM Nurse #6 was observed during medication pass observation to remove one tablet of the medication Keppra (seizure medication) 750 milligrams (mg) from the pharmacy filled bubble packet and administered the medication by mouth to Resident #175. A review of Resident #175's medical record for medication reconciliation the physician's order dated 09/25/15 read in part Keppra 750 mg tablet Give 2 tablets by mouth (PO) twice daily for convulsions.	F 332	one med pass audit per visit. The Director of Nursing or Staff Development Coordinator will conduct 3 med pass audits per month with different nurses to ensure on-going education is given as needed. Any self-identified Medication Errors reported will be reviewed by the interdisciplinary team. The Medication Error Rate will be calculated every month and reported to Resident At Risk monthly and the Quality Assurance Committee for 3 months. How will the facility monitor the measures to make sure that soultions are sustained? Results of the monthly Med Pass audits will be reported to the Quality Assurance Committee monthly for 3 months. Any self-identified Medication Errors reported will be reviewed by the interdisciplinary team. The Medication Error Rate will be calculated every month and reported to Resident At Risk monthly and the Quality Assurance Committee for 3 months.	

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F 332	Continued From page 40 A review of Resident #175's Medication Administration Record (MAR) dated for the month of December 2015 revealed the order had been correctly transcribed for the Keppra 750 mg tablet Give 2 tablets PO twice daily. An interview was conducted with Nurse #6 on 12/02/15 at 10:10 AM. She confirmed she had only administered one tablet of the medication Keppra to Resident #175. She verified the physician's order and the MAR and stated she should have administered 2 tablets of the medication Keppra to Resident #175. She indicated she had administered the wrong dosage amount of the anti-seizure medication to Resident #175. An interview was conducted with the Director of Nursing (DON) on 12/02/15 at 4:30 PM. She stated she expected the nurses to follow the physician's orders and to administer medications as ordered by the physician. She further stated she would have expected the nurse and/or nurse's to have read the pharmacy affixed label to ensure Resident #175 was receiving the correct dosage of the anti-seizure medication, Keppra.	F 332		