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	345045	A. BUILDING _____ B. WING _____	03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK REHAB DAVANT EXTENDED CARE CTR	418 CHESTNUT STREET BLOWING ROCK, NC 28605

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to promote dignity during dining for 6 of 6 residents in the restorative dining room by seating residents at tables, with their food in front of them, with staff seated when assisting residents and not constantly leaving residents during feeding to assist others (Residents #12, #22, #78, #79, #111 and #116). In addition, the facility failed to promote the dignity of 1 of 1 sampled resident with a urinary catheter by covering the collection bag (Resident #81). The findings included: 1. Observations were made of dining in the restorative dining room. This room consisted of 2 long tables placed in an "L" shape. Residents were not all positioned at the tables, facing their food, positioned so that staff were seated close to each resident to provide assistance and cuing without disruptions. Residents were interrupted during dining as staff had to set up other residents who were brought to the room after some residents were already being assisted. Resident #12's Minimum Data Set (MDS), a quarterly dated 02/16/16, coded her with long and short term memory impairment and severely	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance with the State and Federal regulations as outlined. To remain in compliance with all Federal and State regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been completed by 4-7-16. 241 How the corrective action will be accomplished for the resident(s) affected. On 3-9-16, immediate education was provided to the Nursing Assistants providing meal assistance to the residents in the restorative dining room. Residents #12, #22, #78, #79, #111, and #116 were immediately repositioned to ensure they were at the table, resident meals were positioned directly in front of residents, staff was positioned at eye level and were seated close to each resident when	4/7/16

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

Electronically Signed | 04/07/2016

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F 241	Continued From page 1 impaired decision making abilitities. Resident #22's MDS, a significant change assessment dated 12/25/15, coded her with moderately impaired cognitive impairment. Resident #78's MDS, a significant change assessment dated 11/16/15, coded her with moderately impaired cognitive impairment. Resident #79's MDS, a quarter dated 10/20/15, coded her with long and short term memory impairment and severely impaired decision making abilitities. Resident #111's MDS, an admission assessment dated 12/28/15, coded him with long and short term memory impairments and moderately impaired decision making abilities. Resident #116's MDS, an admission dated 01/27/16, coded him with short term memory impairments and modified decision making abilities. Observations revealed the following: a. On 03/07/16 at 11:52 AM Residents #12, #79 and #78 were the only residents in the restorative dining room. Resident #79 was at one long table. Residents #12 and #78 were at the other long table at opposite ends and opposite sides of the table. Nurse aide (NA) #1 proceeded to set up Resident #12 with her meal at 11:54 AM, then at 11:55 AM she set up Resident #79 and then Resident #78. At 11:56 AM, NA #2 came to the room and sat to feed Resident #79 and NA #1 sat to feed Resident #78. Resident #12 was cued to eat. At 11:58 AM, Resident #111 was brought in and positioned sidewise at the end of the table with Resident #79. Resident #111's tray was positioned on the table on his left side. NA #2 sat	F 241	assisting with the meal, and no interruptions during meal time. On 3-11-16, the foley catheter privacy bag cover was provided for Resident #81. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. All residents that require assistance with meals in the restorative dining room were evaluated to ensure resident dignity and respect to individuality was achieved. Appropriate resident placement within the dining room to allow staff to assist with meals in a respectful manner; i.e. resident positioned at the table, meal in front of the resident, all residents at the table before the meal starts, staff positioned at eye level and within arm□s reach, and minimal interruptions. Visual audits of the dining room process and resident/staff seating arrangement were completed as of 4-1-16. A visual audit of all current residents with foley catheters was completed on 3-29-16 to ensure foley catheter bags were covered to maintain resident dignity. Measures put in place to ensure practices will not occur. All nursing staff was educated with regard to Dignity and Respect of Individuality as it relates to resident meal assistance was completed on 4-7-16. All nursing staff also completed a return demonstration with the	

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F 241	Continued From page 2 between Resident #79 and Resident #111 and fed Resident #79. At 12:00 PM Resident #116 was brought into the room. Resident #116 was placed in the corner of the room next to the window, facing the door. NA #1 left Resident #78 and set up Resident #116 with an overbed table, which his tray was placed upon and he began to feed himself. At 12:01 PM Resident #22 was brought into the room and was set up at 12:03 AM with another overbed table facing Resident #111. Resident #22 was left to feed herself. Throughout the meal, NA #1 sat on a rolling stool. NA #1 would wheel toward Resident #78, wipe her face, then roll back to Resdient #12 rub her leg to encourage her to eat, roll over to Resdient #22 to provide hand over hand assistance, then roll back to continue the assistance to all three residents, rolling form person to person as she was not in arm's reach of any 2 residents at once. At 12:31 PM, NA #2 stopped assisting Resident #79, as Nurse #6 took over feeding Resdient #79, and NA #2 went over to Resident #22. NA #2 repositioned her with a pillow and then stood in front of her and fed her the remainder of her meal. Resident #111 was left at the table with no one attempting to assist him. At 12:41 a nurse entered and took over feeding Resdient #79. At 12:46 PM, NA #1 rolled to try to feed Resident #22 and then rolled to try to wake Resident #78. She then instructed NA #2 to take Resident #78 back to her room. NA #2 stopped feeding Resident #22, took Resident #78 from the dining room, returned and put a pillow under Resident	F 241	Staff Development Nurse. Education included the Federal and State regulations in preserving resident□s dignity during meal time. General orientation of new nursing employees will include a return demonstration of assisting a resident(s) with their meal adhering to the Federal and State regulations in preserving resident□s dignity during meal time. The DON/designee educated the nursing staff regarding the Federal and State regulations of dignity in that each resident has the right to have their dignity maintained while if a foley catheter is in place by ensuring it is covered for the duration of the residents stay. Education included resident□s right to have their dignity and respect is maintained in full recognition of his or her individuality utilizing the urinary collection privacy bag. Any new foley catheters initiated and new residents admitted with a foley catheter will be assessed and the appropriate privacy collection bag be applied. The general orientation for all new employees will include Resident Dignity and Right to Individuality as it relates to covering foley catheters. Education will be ongoing. The current foley catheter product was reviewed with the Materials Management team. Action will be taken to ensure each foley catheter kit will include the urinary privacy collection bag to maintain resident dignity. This will ensure any new catheter inserted within the facility has the appropriate privacy cover in place to maintain dignity. Residents that are	

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F 241	Continued From page 3 #116's head returned to feed Resident #22 while standing in front of her at 12:52 PM. No one was observed speaking to Resident #111 during this time until 12:54 PM when NA #2 went over and Resident #111 would not swallow the food placed in his mouth. b. On 03/09/16 at 11:44 PM Resident #116 was seated at the end of a long table and was feeding himself. Resident #78 and Resident #12 were at the other long table on opposite sides and opposite ends of the table. At 11:45 AM, NA #2 sat with Resident #78 to assist her. NA #2 called to Resident #116 at the other table cueing him to drink between bites. NA #2 left Resident #78 at 11:48 AM to get coffee for Resident #116. At 11:49 AM, Resident #22 was brought into the room. NA #2 left Resident #78 to set up Resident #22 at an overbed table and left her facing the wall. Resident #22 proceeded to fall asleep immediately. At 11:56 AM, Resident #79 was brought into the room, positioned at the table with Resident #116. Resident #79 was positioned with her back to the table, NA #2 positioned her food to the resident's left and out of her line of vision, and with her back to Resident #116. NA #2 was positioned on Resident #79's left side and fed her. NA #1 was observed sitting on a rolling stool cueing Resident #12 encouraging her to eat, and then rolling over to Resident #22 encouraging her to wake up and then rolling over to Resident #78 to assist with a bite of food. Resident #22 continued to sleep. NA #1 was not in a position to	F 241	admitted with a foley catheter in place will be assessed on admission and the appropriate privacy cover will be applied. All foley catheter products will include the foley privacy bag urinary collection device as of 4-4-16. How the facility plans to monitor and ensure correction is achieved and sustained. The ADON/Restorative Care RN will conduct random audits of the Restorative Dining room care for at least one meal each day (Monday-Friday), daily X (2) weeks; then weekly X (2) months; then monthly. Failure of compliance with the expectation will result in immediate action to include education and/or disciplinary action. The ADON/Restorative Care RN will review the audits with the restorative care nursing assistants and the DON on a weekly basis X (4) weeks to identify any additional improvement opportunities with the input of direct care staff for implementation. The Administrator will conduct a weekly audit X (4) weeks, then monthly of the restorative dining room to ensure the quality improvement measures are consistently followed. The Administrator/ADON/Restorative Care RN will report results of the audits, any improvement opportunities and plan for implementation at the Quality Assurance Performance Improvement Committee (QAPI) monthly meeting. This will occur for 3 months, or until all	

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F 241	Continued From page 4 assist Resident #12, #78 or Resident #22 while remaining in one spot as no two residents were within an arm's reach of NA #1. At 12:04 AM the Rehabilitation Director entered and began to feed Resident #78. Then at 12:14 AM the Rehabilitation Director began to feed Resident #22 as NA #1 took over feeding Resident #78. At 12:15 PM, NA #2 left Resident #79, got ice, moved Resident #22 away from he closet she was sitting in front of to obtain a cola and returned to Resident #116 to offer him the cola. NA #2 sat back to continue feeding Resident #79. At 12:22 PM NA #1 rolled her stool to offer Resident #12 a bite of sandwich at the other table then rolled back to continue with Resident #78. At 12:23 PM NA #2 stood, handed Resident #79 an egg roll as he assisted Resident #116 out of the dining room. Resident #79 immediately began to feed herself the egg roll. At 12:26 NA #1 stopped assisting Resident #78 and assisted Resident #12 out of the room. She had to move Resident #79 out of the way in order to get Resident #12 out of the room. At 12:31 PM NA #2 removed Resident #22 from the room as NA #1 sat to assist Resident #79 with the rest of the food on the plate behind her. On 03/09/16 at 12:36 PM NA #2 was interviewed relating to the restorative dining. He stated there were really only 3 residents who were in the room for "restorative" services and staff tried to keep those 3 residents on one side of the room. He identified them as Residents #116, #78, and #22.	F 241	improvement opportunities identified have been met. The facility Team Leaders will audit all residents with a foley catheter each day to ensure the catheter privacy bag is in use and catheter is covered appropriately to maintain resident dignity. This will take place daily X (2) weeks, then weekly X (2) months. The Administrator/DON/designee will do weekly audits of all residents with a foley catheter to ensure the catheter has the privacy cover to appropriately maintain resident dignity. This will take place for 4 weeks, then monthly X (2) months to ensure compliance with changes are sustained. The Administrator/DON/designee will report the findings to Quality Assurance Performance Improvement Committee (QAPI) monthly X (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed. Failure to achieve compliance will result in education and/or disciplinary action and continuation of monitoring.	

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He stated that the room was small and the broda chairs took up a lot of space and could not always fit at the tables which was why the overbed tables were used. NA #2 stated he should not have stood when he fed Resident #22 and he was trained to sit when he fed a resident. He stated as residents entered the room, it was like a puzzle trying to get residents to fit in the room and then assisting them out of the room as they finished their meal. He also stated that Resident #22 was distracted if she faced the door. NA #2 also stated that Resident #111 had to be very alert when fed so that was shy he was left to the end to try to eat. Resident #111 was admitted to the hospital before the second observation was made on 03/09/16.

On 03/11/16 at 9:25 AM the Assistant Director of Nursing stated she had not spent much time in the restorative dining room. The dining rom was determined to be too crowded so the smaller room was being utilized as the restorative room. This was a work in progress as it had changed several times over the last few months. She stated she expected staff to position residents at the tables versus over bed tables, she expected staff to sit during feeding, have residents positioned so that the environment was calm and residents could be helped without a lot of moving around. She also stated food should always be placed in front of the resident.

2. Resident #81 was admitted to the facility on 12/01/15 with diagnoses of thyroid disorder and a sacral pressure ulcer. The significant change Minimum Data Set (MDS) dated 01/02/16 revealed Resident #81 was moderately cognitively impaired and had an indwelling urinary catheter.

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Review of the care plan dated 12/15/16 revealed Resident #81 had the potential for urinary tract infection (UTI) related to the presence of an indwelling urinary catheter. The goal was for Resident #81 to show no signs or symptoms of a UTI. The interventions included to tell the resident what care was to be given prior to initiating care, position catheter tubing below the level of the bladder, position resident so urine would drain from the bladder and check tubing for kinks as needed.

Observations of Resident #81 as follows:

· 03/09/16 at 8:40 AM observed Resident #81's urinary catheter bag hanging on the side of her bed facing the hallway with no privacy cover over the bag filled with amber colored urine.

· 03/10/16 at 11:45 AM observed Resident #81's urinary catheter bag hanging on the side of her bed facing the hallway with no privacy cover over the bag with light yellow urine.

· 03/11/16 at 8:35 AM observed Resident #81's urinary catheter bag hanging on the side of her bed facing the hallway with no privacy cover over the bag with light yellow urine.

An interview conducted on 03/11/16 at 8:22 AM with Nurse Aide (NA) #6 revealed all residents with indwelling urinary catheters were supposed to have a privacy cover over the bag. NA #6 stated she had provided care for Resident #81 on 03/11/16 and had not noticed she didn't have a privacy cover over her catheter bag. NA #6 further stated Resident #81's catheter bag should have had a privacy cover over the bag.

During an interview conducted on 03/11/16 at 8:32 AM Nurse #2 stated she wasn't sure what the facility policy was for privacy bags to cover catheter bags. She stated she had only been at the facility for 1 month. Nurse #2 stated Resident #81 had not had a privacy cover over her catheter

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F 241	Continued From page 7 bag since she had worked at the facility. An interview conducted on 03/11/16 at 9:48 AM with the Staff Development Nurse stated it was her expectation that all residents with indwelling urinary catheters have a privacy cover over the catheter bag. She further stated staff are taught to use privacy covers for catheter bags. An interview conducted with the Assistant Director of Nursing on 03/11/16 at 11:00 AM revealed it was her expectation for all residents with indwelling urinary catheters have a privacy cover over the catheter bag.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews, the facility failed to honor the choices of 3 of 4 sampled residents. Residents #24 and #67 were not provided the number of showers they preferred each week and Resident #3 was not provided the oxygen in a portable tank as she requested. The findings included: 1. Resident #3 was most recently readmitted on 07/04/15. Her diagnoses included major	F 242	242 How the corrective action will be accomplished for the resident(s) affected. Resident #3 was provided with the choice of oxygen delivery method on 3-24-16. Residents #24 and #67 were interviewed and their choice of the number of bath/shower per week per their request which was corrected on 4-1-16. How the corrective action will be	4/7/16

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F 242	Continued From page 8 depressive disorder, anxiety and chronic obstructive pulmonary disease. The annual Minimum Data Set dated 09/02/15 coded her with intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status, having no moods, no psychosis, no behaviors and requiring limited assistance with walking, locomotion, dressing and toileting. Physician orders revealed Resident #3 was ordered oxygen therapy at 2 liters per minute continuous in order to maintain her oxygen saturation levels above 92% since 07/04/15. Review of progress notes revealed the following: *on 02/26/16 at 4:33 PM, written by the Assistant Director of Nursing (ADON), Resident #3 came to the office to discuss her concern that she felt sorry for staff as they had to push her oxygen concentrator to activities and meals. ADON assured the resident it was for her safety and the oxygen concentrator was the safest mode of oxygen delivery in this setting. ADON assured Resident #3 that pushing the oxygen concentrator was not an inconvenience for staff and that the portable oxygen tanks were not safest for long term use. *02/29/16 at 3:42 PM, written by the Social Worker (SW), met with the resident due to making statements that no one cared for her. She stated she felt as though her being on he oxygen concentrator was limiting her ability to be out of her room. Assured her that staff will assist with transport to activities with the concentrator. *on 03/07/16 at 2:50 PM, written by ADON, res stated she could not get her hair done due to not being allowed to have oxygen concentrator in the beauty shop. Determined that she could get hair	F 242	accomplished for those residents with the potential to be affected by the same practice. All residents were interviewed by the Social Worker on 3-23-16 to address the resident□s right to choose the number of baths per week each resident requests. All bath requests were met and future schedules documented on 4-1-16. All residents that require the use of oxygen were interviewed by the Social Worker and given the choice of using a portable oxygen tank or the oxygen concentrator. All resident requests for oxygen delivery method were met. Measures in place to ensure practices will not occur. Nursing was educated that each resident has a right to make choices about aspects of his/her life in the facility that is significant to the resident. Education of all current staff by the Staff Development RN was completed on 3-31-16. Education included the definition of Resident Rights and choices as defined by the State and Federal regulations. Resident Rights and choices education will be reviewed in general orientation for all new employees. On admission, the Activities Director/designee will ask the residents choice of how many baths per week the resident prefers. Resident choice will be reviewed during Care Plan quarterly, and as needed. Residents that require the use of oxygen will be given the choice of oxygen delivery	

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F 242	Continued From page 9 done in beauty shop with the oxygen concentrator and reeducated the resident on the safety of the oxygen concentrator. *on 03/07/16 at 8:37 PM, written by Nurse #4, resident complained about the oxygen concentrator and did not understand it was for safety that she only used the portable oxygen tank for out of facility appointments. *on 03/07/16 at 9:30 AM, written SW, resident continues to be angry over not being able to use the portable oxygen tank and having to use the oxygen concentrator. Explained to her this was the safest route of oxygen as the tank could run out and she or staff not know she was not getting the oxygen therapy she needed. This was not the answer she was looking for and the resident continued to complain to all who would listen. On 03/08/16 at 8:53 AM, Resident #3 stated during interview she disliked using the oxygen concentrator because she had to have someone push her around from place to place. At this time, she was in her room getting ready to go to the beauty shop. She had a portable oxygen tank on the back of the wheelchair she was sitting in, however, she was using the oxygen from the oxygen concentrator in her room. On 03/08/16 at 11:16 AM, Resident #3 stated during interview that she wanted to use the portable oxygen which was observed located on the back of her wheelchair. She was observed at this time using the oxygen connected to the oxygen concentrator in her room. She had a portable oxygen tank located on the back of her wheelchair. She stated that she felt like she was tethered to her room because of the oxygen concentrator. She stated it hurt her feelings to be tethered via the oxygen concentrator and wanted	F 242	method. Resident choice will be reviewed during Care Plan quarterly, and as needed. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/DON/designee will conduct random resident interviews to ensure resident(s) choice regarding number of baths per week and choice of oxygen delivery method are being met. Audits will be done weekly X (1) month, then monthly X (3) months, then quarterly. Failure of compliance with the expectation will result in immediate action to include education and/or disciplinary action. The Administrator/DON/designee will report the findings to the Quality Assurance Performance Improvement Committee (QAPI) monthly X (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed. Failure to achieve compliance will result in education and/or disciplinary action and continuation of monitoring.	

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to be able to move freely wherever and whenever she wanted without having to have staff assist her with the oxygen concentrator.

Resident #3 was observed with the portable oxygen tank on the back of her wheelchair but connected to the oxygen concentrator on 03/08/16 at 4:26 PM while in her room, on 03/09/16 at 8:33 AM while in her room, and on 03/09/16 at 8:37 AM when she asked staff to untangle the oxygen tubing from the wheelchair she was sitting in. Resdient #3 was observed in an activity with the oxygen concentrator in use ad the portable oxygen tank on the back of her wheelchair on 03/09/16 at 11:17 AM.

On 03/09/16 at 11:20 AM, Nurse Aide (NA) #3 was interviewed. She revealed that Resident #3 was able to do for herself, however, sometimes expected staff to do things for her she was capable of doing herself. NA #3 stated that staff used the portable oxygen tank to transport her to activities and the beauty shop and once she there, staff would connect Resident #3 to the oxygen concentrator.

On 03/09/16 at 11:34 AM, after Resident #3 asked to speak to the surveyor, Resident #3 stated she wanted something done about the oxygen concentrator. She stated she felt tethered to her room, had to stay in the activity room until staff could assist her with the oxygen concentrator, and she stated she got tangled in her oxygen tubing frequently. She further stated that she wanted to use the oxygen concentrator at night and the portable oxygen during the day.

On 03/10/16 at 8:39 AM the ADON was interviewed. She stated the facility decided that

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portable oxygen tanks were to be used when in therapy, while with restorative and when on appointments. She stated this was for safety as the oxygen tanks did not have alarms to alert staff they were empty. ADON stated Resident #3 had complained about the oxygen but never stated she felt like she was tethered only that she felt bad for staff convenience. ADON further stated that sometimes the resident took herself to activities and sometimes she wanted staff to take her places.

On 03/10/16 at 11:34 AM Resident #3 was observed being pushed in her wheelchair down the hall by one staff while another staff pushed the oxygen concentrator behind her as the resident was using the oxygen from the oxygen concentrator and not the portable oxygen that was located on her wheelchair.

The Administrator was interviewed on 03/10/16 at 2:15 PM. The Administrator stated the change from the portable oxygen tanks to widespread use of the oxygen concentrators was made for safety reasons.

Interview with the SW on 03/11/16 at 11:54 AM revealed she was aware that Resident #3 was not happy using the oxygen concentrator.

2. Resident #67 was admitted to the facility on 05/06/13.

Review of Resident Council Meeting notes revealed a special resident council meeting was held on 07/24/15. At that meeting, the previous Assistant Director of Nursing explained the new bath schedule which guaranteed every resdient would get 2 showers/baths per week on

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specifically scheduled days.

The most recent Minimum Data Set (MDS), a quarterly dated 02/04/16, coded him as having intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status. He was also coded as requiring total assistance with bathing.

During interview on 03/08/16 at 10:14 AM, Resident #67 stated that he received a bath on Mondays, Wednesdays and Fridays but would like a bath every day.

During follow up interview on 03/08/16 at 4:17 PM, Resident #67 stated he had taken a bath daily his entire life but did not want "to go against the grain" by asking for more showers.

On 03/10/16 at 8:51 AM the Assistant Director of Nursing (ADON) stated residents were asked by the Activity Director on admission about shower preferences and that she often asked during care plan meetings. She stated she asked general questions such as if the shower schedule was alright with the resident.

Interview with the Activity Director on 03/10/16 at 9:10 AM revealed she asked the preferences for showers versus baths per the MDS preference section. She also asked frequently in resident council meetings if the residents' baths were going ok. She further stated that she generally told residents that the facility schedules 2 showers/baths per week. If a resident stated they want showers more often, the facility will accommodate that request.

During follow up interview on 03/11/16 at 9:14 AM, Resident #67 stated he was never asked

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how many showers he wanted per week. He further stated he was not aware of when he would be showered on the 3 days scheduled and wanted a more accurate time to expect a shower.

The ADON stated during follow up interview on 03/11/16 at 9:23 AM that questions about showers were general such as how are your showers going. No specific question was asked relating to the number of showers a resident wanted per week. She further stated she had many conversations with Resident #67 about how his showers were going, but was unaware he wanted a shower daily.

3. Resident #24 was admitted to the facility on 03/08/13. A review of a diagnosis list in the electronic medical record revealed diagnoses of dementia, depression and paralysis from a stroke.

A review of the most recent quarterly Minimum Data Set (MDS) dated 12/08/15 indicated Resident #24 was cognitively intact for daily decision making. The MDS also indicated Resident #24 required limited assistance with activities of daily living and exhibited no behaviors or rejection of care.

A review of the Resident Council Meeting notes revealed a special resident council meeting was held on 07/24/15. At that meeting, the previous Assistant Director of Nursing explained the new bath schedule which guaranteed every resident would get 2 showers/baths per week on specifically scheduled days.

During an interview on 03/08/16 at 08:54 AM Resident #24 stated he received 2 showers a

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week but he would like 3. He further stated he had asked staff for 3 showers a week but was told he could only have 2 showers a week.

During an interview on 03/10/16 at 8:51 AM the Assistant Director of Nursing (ADON) stated residents were asked by the Activity Director on admission about shower preferences and that she often asked during care plan meetings. She stated she asked general questions such as if the shower schedule was alright with the resident.

During an interview on 03/10/16 at 9:10 AM the Activity Director stated she asked the preferences for showers versus baths per the MDS preference section. She explained she also asked frequently in resident council meetings if the residents' baths were going ok. She stated that she generally told residents that the facility scheduled 2 showers/baths per week. She further stated if a resident said they wanted showers more often, the facility would accommodate that request.

During a follow up interview on 03/11/16 at 9:46 AM with Resident #24 he stated he wanted 3 showers a week. He further stated no one had asked him how many showers he wanted and they just give him 2 showers a week.

During a follow up interview on 03/11/16 at 9:23 AM the ADON stated that questions about showers were general such as how are your showers going and there was no specific question asked that related to the number of showers a resident wanted per week. She further stated she was unaware Resident #24 wanted more than 2 showers a week.

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F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		4/7/16

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to complete comprehensive Care Area Assessments (CAA) which included a description specific to the resident's possible problems, causes and contributing factors, and risk factors related to the presence of the condition and an analysis of the information as it pertains to the staff's decision to proceed to care planning. This affected 12 of 19 CAAs reviewed. (Residents #111, #3, #22, #57, #37, #14, #74, #19, #24, #32, #23 and #75).

The findings included:

1. Resident #111 was admitted to the facility on 12/21/15 with diagnoses including fractured femur neck, unspecified dementia, dysphagia, and basal cell cancer.

The initial Minimum Data Set (MDS) dated 12/28/15 coded him with long and short term memory impairment, modified decision making ability, requiring extensive assistance for all activities of daily living skills (ADLs), being frequently incontinent of bladder, having a stage 2 pressure ulcer and exibiting other behaviors 1-3 times in the review period.

CAA for the triggered areas dated 01/01/16 did not analyze Resident #111's individual problems, strengths and weakness, and possible causes and often just repeated what was coded on the MDS as follows:
a. Cognition: The resident did not answer any of

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How the corrective action will be accomplished for the resident(s) affected.

Comprehensive assessments were completed in MDS on 4-7-16 for 10 of the 12 residents to address the incomplete CAA□s for Residents #3, #22, #57, #37, #14, #19, #24, #32, #23, #75. The CAA□s will be individualized to identify resident□s possible problems, causes and contributing factors, risk factors related to the condition, with an analysis of the information and the decision to proceed to care planning. Resident□s #111, and #74 have been discharged from the facility.

How the corrective action will be accomplished for those residents with the potential to be affected by the same practice.

A review of all Care Area Assessments (CAA) will be conducted by the MDS Coordinator moving forward to ensure a complete and accurate assessment. A complete CAA will be written for each triggered area listing individual resident strengths, weaknesses, and causes of the problems with a decision to proceed to care plan or not. The audit process will begin on 4-4-16 and will be on-going. If any incomplete CAA□s are identified, a significant correction assessment will be

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F 272	Continued From page 17 the staff interview questions. Staff did not believe he can recall after 5 minutes. He did not seem to know the season or recognize staff members. He seemed to have short and long term memory impairments and poor decision making skills and required supervision. He was inattentive when being asked questions. b. Communication: The resident had dementia, was taking an antibiotic, and he was unable to complete the staff interview. He required extensive assistance with ADLs. c. ADLs: Resident had recent falls and a hip fracture. He had pain with medication ordered. He had stage 2 pressure on left heel and was frequently incontinent of bowel and bladder. d. Incontinence: Resident had pain with medication ordered, he required extensive assistance with transfers and toileting and was frequently incontinent of bowel and bladder. e. Behavioral symptoms: Resident was a new admit after falling at home and fracturing his hip. He was able to ambulate and assist in his care prior to admission but he was more confused. He often moaned and was quite fidgety, trying to get up on his own though he was not able. He was monitored for safety concerns. f. Falls: Resident required extensive assistance with transfers of 2 persons. He was frequently incontinent and had a recent hip fracture with 1-2 falls at home in the previous 90 days. He had dementia and pain. g. Pressure Ulcer: Resident had stage 2 that was present on admission on left heel. He required extensive assistance with transfers and toileting and was incontinent. He also had a surgical incision on his left hip, a skin tear on the right elbow and received an antibiotic. Interview with the MDS coordinator on 03/10/16	F 272	initiated and completed per the RAI manual guidelines. Measures in place to ensure practices will not occur. The MDS Coordinator will utilize the support services of the North Carolina QIES Coordinator. This will be on-going. The MDS Coordinator had a telephone training session with state coordinator on 4-4-16. The MDS Coordinator will review the power points offered on-line and completed 4-4-16. The MDS Coordinator will review the power points offered on-line as a self-study. Completed 3-30-16. A complete CAA will be written for each triggered area listing individual resident strengths, weaknesses, and causes of the problems with a decision to proceed to care plan or not. How the facility plans to monitor and ensure correction is achieved and sustained. A weekly audit of initial and periodic comprehensive assessments will be conducted by the MDS Coordinator and ADON. 2 charts per week will be audited to ensure compliance changes are met. The MDS Coordinator/ADON will review the audits with the DON on a monthly basis.	

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F 272	Continued From page 18 at 3:35 PM revealed when she completed a CAA summary, she looked at the medical record, asked the resident questions if able, then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals. The MDS coordinator was able to tell the surveyor Resident #111's individual strengths, weakness and causes of the problems. She stated she just did not know she had to write this information in the CAA. 2. Resident #3 was most recently readmitted on 07/04/15. Her diagnoses included major depressive disorder, anxiety and chronic obstructive pulmonary disease. The annual Minimum Data Set dated 09/02/15 coded her with intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status, having no moods, no behaviors and requiring limited assistance with walking and toileting. She was coded as being frequently incontinent of bladder and receiving antipsychotic medication, antianxiety medication and antidepressant medication daily. CAA for the triggered areas dated 09/08/15 did not analyze Resident #3's individual problems, strengths and weakness, and possible causes and often just repeated what was coded on the MDS as follows: *Incontinence: she was mostly incontinent of bladder, had limited mobility and pain and had potential for skin breakdown related to incontinence. It did not analyze her strengths, weaknesses or causes for incontinence. *Activities of daily living skills: She needed some assistance with ADLs daily and was incontinent of	F 272	The results of the audits will be submitted to the QAPI committee on a monthly basis for (3) months, with a decision for continued monitoring if needed.	

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bowel and bladder some of the time. She was obese, had pain and was sometimes affected by a slightly depressed, hopeless mood. *Psychotropic medications: Resident took antipsychotics, antidepressants and hypnotics. Her depression, anxiety and insomnia were controlled on this regimen.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA summary, she looked at the medical record, asked the resident questions if able, then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals. The MDS coordinator was able to tell the surveyor Resident #3's individual strengths, weakness and causes of the problems. She stated she just did not know she had to write this information in the CAA.

3. Resident #22 was readmitted to the facility on 03/29/15 with diagnoses of chronic obstructive pulmonary disease, diabetes, neoplasm of the brain and muscle wasting.

The annual Minimum Data Set dated 11/23/15, coded her with moderately impaired cognitive skills, scoring a 10 out of 15 on the Brief Interview for Mental Status (BIMS).

The CAA for cognition dated 12/07/15 stated she had pain and received pain medication she asked for, used oxygen at night and required extensive assistance with bed mobility, transfers and toileting. She was receiving psychiatric services and scored a 10 on the BIMS. The analysis stated she had impaired thought process related to her disease process. The CAA did not explain

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how she was affected by her cognitive deficits.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA summary, she looked at the medical record, asked the resident questions if able, then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals. The MDS coordinator was able to tell the surveyor Resident #22's individual strengths, weakness and causes of the problems. She stated she just did not know she had to write this information in the CAA.

4. Resident #57 was readmitted to the facility on 12/23/14. His diagnoses included chronic obstructive pulmonary disease, and dementia with behaviors.

The annual MDS dated 07/30/15 coded Resident #57 with moderately impaired cognition, having little interest in the previous 2-6 days, had sleep issues in the previous 2-6 days and required limited assistance or supervision with most activities of daily living skills (ADLs).

The CAA completed in conjunction with the 07/30/15 MDS did not analyze Resident #57's individual problems, strengths and weakness, and possible causes and often just repeated what was coded on the MDS as follows:
*Cognitive: Resident with congestive heart failure and chronic obstructive pulmonary disease, scored a 9 on the Brief Interview for Mental Status, had been sleeping more and eating less. He has had occasional incontinence and has had impaired cognitive function due to short term memory loss.

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*ADLs: Required supervision to limited assistance with transfers, toileting, bed mobility and getting supplies set up for grooming. Resident had not been eating as much as he used to and sleeping more. His ADL self performance deficit was related to weakness.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA summary, she looked at the medical record, asked the resident questions if able, then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and goals. The MDS coordinator was able to tell the surveyor Resident #57's individual strengths, weakness and causes of the problems. She stated she just did not know she had to write this information in the CAA.

5. Resident #37 was admitted to the facility on 07/09/15 with diagnoses of hypertension and diabetes.
Review of the quarterly Minimum Data Set (MDS) dated 01/14/16 revealed Resident #37 was moderately cognitively impaired and required extensive assistance with most activities of daily living (ADL).
The ADL Care Area Assessment (CAA) was dated 07/16/15. The analysis of findings stated the resident has an ADL self-care performance deficit related to weakness and blindness. The ADL CAA did not analyze the circumstances of her ADL deficit to adequately assess Resident #37's individual strengths, weaknesses and any other associated causes of the ADL deficit and the effects they have had on Resident #37.
Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA

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analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #37's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.

6. Resident #14 was admitted to the facility on 04/18/15 with diagnoses of hypertension and depression.

Review of the quarterly Minimum Data Set (MDS) dated 01/21/16 revealed Resident #14 was cognitively intact and required extensive assistance with most activities of daily living (ADL).

The ADL Care Area Assessment (CAA) was dated 04/25/15. The analysis of findings stated the resident required extensive assistance with most ADL including toileting, transfers and bed mobility. She was at risk for loss of independence due to decreased mobility. Will proceed with care plan. The ADL CAA did not analyze the circumstances of her ADL deficit to adequately assess Resident #14's individual strengths, weaknesses and any other associated causes of the ADL deficit and the effects they have had on Resident #14.
Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the

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questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #14's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.

7. Resident #74 was admitted to the facility on 12/30/16 with diagnoses of heart failure, urinary tract infection and muscle weakness.
Review of the admission Minimum Data Set (MDS) dated 01/06/16 revealed Resident #74 was severely cognitively impaired. The MDS further revealed Resident #74 had an unstageable pressure ulcer and a stage 2 pressure ulcer on admission to the facility.
The pressure ulcer Care Area Assessment (CAA) was dated 01/06/16. The analysis of findings stated the resident had pressure ulcers. The pressure ulcer CAA did not analyze the circumstances of his pressure ulcer to adequately assess Resident #74's individual strengths, weaknesses and any other associated causes of the pressure ulcer and the effects they have had on Resident #74.
Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #74's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information

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in the CAA analysis of findings.

8. Resident #19 was admitted to the facility on 07/04/15 with diagnoses of diabetes and end stage Multi-Sclerosis.

Review of the quarterly Minimum Data Set (MDS) 02/12/16 revealed Resident #19 was severely cognitively impaired. The MDS further revealed Resident #19 had no pressure ulcers but had a pressure reducing device for her bed.

The pressure ulcer Care Area Assessment (CAA) was dated 11/13/15. The analysis of findings stated the resident had a stage 1 pressure ulcer on admission on her sacrum, a rash on her back and was incontinent of bowel and had a urinary catheter. She had a feeding tube and oxygen via nasal cannula. She is total care with activities of daily living. Resident will show signs of improvement of stage 1 pressure ulcer by next review. The pressure ulcer CAA did not analyze the circumstances of his pressure ulcer to adequately assess Resident #19's individual strengths, weaknesses and any other associated causes of the pressure ulcer and the effects they have had on Resident #19.
Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #19's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information

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in the CAA analysis of findings.

9. Resident #24 was admitted to the facility on 03/08/13. A review of a diagnosis list in the electronic medical record revealed diagnoses of dementia, depression and paralysis from a stroke.

A review of the most recent annual Minimum Data Set (MDS) dated 03/17/15 indicated Resident #24 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #24 required limited assistance with activities of daily living and a section labeled dental indicated obvious or likely cavity or broken natural teeth.

The Care Area Assessment (CAA) for Dental was dated 03/17/15. The analysis of findings was blank. The dental CAA did not analyze the circumstances of his dental deficit to adequately assess Resident #24's individual strengths, weaknesses and any other associated causes of the dental deficit and the effects it had on Resident #24.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #24's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.

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10. Resident #32 was re-admitted to the facility on 09/25/15. A review of a diagnosis list in the electronic medical record revealed diagnoses of heart disease, muscle weakness, type 2 diabetes, dementia and Alzheimer's disease.

A review of the admission Minimum Data Set (MDS) dated 10/02/15 indicated Resident #32 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #32 required extensive assistance with activities of daily living (ADLs).

The Care Area Assessment (CAA) for Communication was dated 10/02/15. The analysis of findings indicated Resident #32 had a communication deficit related to disease process. The communication CAA did not analyze the circumstances of her communication deficit to adequately assess Resident #32's individual strengths, weaknesses and any other associated causes of the communication deficit and the effects it had on Resident #32.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #32's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.

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11. Resident #23 was admitted to the facility on 06/05/15. A review of a diagnosis list in the electronic medical record revealed diagnoses of pain, muscle weakness, anxiety and dementia.

A review of the admission Minimum Data Set (MDS) dated 06/12/15 revealed Resident #23 was cognitively intact for daily decision making. The MDS also revealed Resident #23 required limited assistance with activities of daily living.

The Care Area Assessment (CAA) for Pain was dated 06/12/15. The analysis of findings indicated Resident #23 had pain related to deconditioning. The pain CAA did not analyze the circumstances of her pain deficit to adequately assess Resident #23's individual strengths, weaknesses and any other associated causes of the pain and the effects it had on Resident #23.

Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #23's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.

12. Resident #75 was re-admitted to the facility on 04/11/14. A review of a diagnosis list in the electronic medical record revealed diagnoses which include arthritis, chronic pain, diabetes,

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F 272	Continued From page 28 lung disease and anxiety. A review of the most recent annual Minimum Data Set (MDS) dated 08/03/15 revealed Resident #75 was cognitively intact for daily decision making. The MDS also revealed Resident #75 required extensive assistance for activities of daily living (ADL). The Care Area Assessment (CAA) for ADL Functional/Rehabilitation Potential was dated 08/03/15 (verify date). The analysis of findings indicated Resident #75 had pain related to deconditioning. The ADL CAA did not analyze the circumstances of her ADL deficit to adequately assess Resident #75's individual strengths, weaknesses and any other associated causes of her ADL function and the effects it had on Resident #75. Interview with the MDS coordinator on 03/10/16 at 3:35 PM revealed when she completed a CAA analysis of findings, she looked at the medical record, asked the resident questions if they were cognitively intact, and then answered the questions on the CAA form. She stated during care plan meetings, the team discussed individual problems and developed goals for each resident. The MDS coordinator was able to tell the surveyor Resident #75's individual strengths, weakness and causes of the problems but stated she did not know she had to write this information in the CAA analysis of findings.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		4/7/16

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F 279	Continued From page 29 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to develop a comprehensive care plan for 1 resident for activities of daily living (Resident #32), failed to develop a comprehensive care plan for 1 resident for dental care (Resident #24) and failed to accurately develop a comprehensive care plan care for 1 resident with a feeding tube (Resident #19). This affected 3 of 23 sampled residents whose care plans were reviewed. Findings included: 1. Resident #32 was re-admitted to the facility on 09/25/15. A review of a diagnosis list in the electronic medical record revealed diagnoses of heart disease, muscle weakness, type 2 diabetes,	F 279	279 How the corrective action will be accomplished for the resident(s) affected. Resident(s)#32, #24, and #19 care plans were updated on 3-30-16. Care Plan for resident #32 was corrected to address ADL self-care deficit with appropriate resident specific interventions effective 3-30-16. Care Plan for resident #24 was corrected to address dental carries and broken teeth with appropriate resident specific interventions effective 3-30-16. Care Plan for resident #19 was corrected to address contradictory interventions implemented specific to resident care needs effective 3-30-16.	

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F 279	Continued From page 30 dementia and Alzheimer's disease. A review of the admission Minimum Data Set (MDS) dated 10/02/15 indicated Resident #32 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #32 required extensive assistance with activities of daily living (ADLs). A review of the most recent Care Area Assessment Summary (CAAs) dated 10/02/15 revealed a care area titled ADL Functional/Rehabilitation Potential which indicated the care area did not trigger, care planning decision was not checked and a section labeled location and date of CAA documentation was blank. A review of care plans revealed there was no comprehensive care plan for activities of daily living. During an interview on 03/10/16 at 3:36 PM the MDS nurse explained they had care plan meetings and discussed the problems, goals and interventions for resident care. She confirmed Resident #32 required extensive assistance for ADLs but did not have a care plan for ADLs. She stated did not know why Resident #32 did not have a care plan for ADLs because usually every resident triggered for ADLs. She further stated care plans should be individualized and specific for each resident. During an interview on 03/11/16 at 10:52 AM with the Assistant Director of Nursing (ADON) she stated care plan meetings were conducted weekly to review resident's care plans. She	F 279	How the corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of the remaining care plans will begin on 4-7-16 to ensure each care plan is individualized to each resident. Measures in place to ensure practices will not occur. The Interdisciplinary Team, in conjunction with the MDS Coordinator, will review each resident care plan, at a minimum of quarterly. Care plans will be individualized and specific for each resident. How the facility plans to monitor and ensure correction is achieved and sustained. Resident Care Plan audits will be conducted weekly by the Interdisciplinary Team during the Care Plan meeting. Using the MDS findings, and the CAA analysis, and resident individuality, a Care Plan will be developed specific to the resident(s) needs. Audits will be ongoing. The results of the audits will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis for (3) months, with a decision for continued monitoring if needed.	

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stated the MDS nurse read the care plans at the meeting and they looked at problems and goals and whether the interventions were appropriate for the resident. She stated if changes were needed on the care plan it was modified and changed. She further stated Resident #32 should have an ADL care plan and confirmed Resident #32 required extensive assistance for ADLs. She stated it was her expectation that care plans be resident specific and individualized for each resident.

2. Resident #24 was admitted to the facility on 03/08/13. A review of a diagnosis list in the electronic medical record revealed diagnoses of dementia, depression and paralysis from a stroke.

A review of the most recent annual Minimum Data Set (MDS) dated 03/17/15 indicated Resident #24 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #24 required limited assistance with activities of daily living and a section labeled dental indicated obvious or likely cavity or broken natural teeth

A review of the most recent Care Area Assessment dated 03/17/15 revealed a care area titled Dental Care. A check mark indicated the care area triggered but care planning decision was not checked. A section labeled location and date of CAA documentation indicated will not proceed at this time, weight change history and resident interview.

A review of care plans revealed there was no comprehensive care plan for dental care or any references to dental care in the care plans.

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During an interview on 03/10/16 at 3:36 PM the MDS nurse explained they had care plan care plan meetings and discussed the problems, goals and interventions for resident care. She confirmed the CAAs for Resident #24 had triggered for dental but was not care planned. She stated she was not sure why he did not have a care plan for dental but his teeth were visibly broken with cavities. She further stated care plans should be individualized and specific for each resident.

During an interview on 03/11/16 at 10:52 AM with the Assistant Director of Nursing (ADON) she stated care plan meetings were conducted weekly to review resident's care plans. She explained the MDS nurse read the care plans at the meeting and they looked at problems and goals and whether the interventions were appropriate for the resident. She further explained if changes were needed on the care plan it was modified and changed. She stated Resident #24's dental needs should be addressed somewhere on a care plan either on a dental care plan or in ADLs or nutrition. She further stated it was her expectation that care plans be resident specific and individualized for each resident.

3. Resident #19 was admitted to the facility on 07/04/15 with diagnoses of Multiple Sclerosis (MS) and diabetes. The quarterly Minimum Data Set (MDS) dated 02/12/16 revealed Resident #19 was severely cognitively impaired and had a feeding tube.
Review of the care plan dated 02/15/16 revealed Resident #19 required a feeding tube related to end stage MS. The goal was to maintain

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adequate nutritional and hydration status with no significant weight change and no signs and symptoms of malnutrition or dehydration through the next review. The interventions included diabetic source 65 milliliters every hour with a 200 milliliter water flush four times a day, observe skin condition around insertion site and document, report any increased redness or temperature to physician and dietician to review resident dietary regime and document. Resident #19 was also care planed for the potential for skin breakdown related to decreased mobility with a goal to maintain skin integrity through the next review. The interventions included to assess skin weekly (body audit), assess skin daily with morning care and report any abnormalities to the nurse, assist with personal hygiene after each incontinent episode, provide diet as ordered, record food intake % at each meal, report decline in intake to the physician and offer food substitutes if resident refuses to eat.

An interview conducted on 03/10/16 at 3:35 PM with the MDS Nurse revealed she created the feeding tube and skin integrity care plan for Resident #19. The MDS Nurse stated Resident #19 did not take anything in by mouth and all of her nourishment and medications were given through her feeding tube. She stated the interventions for the skin impairment care plan to provide diet as ordered, record food intake % at each meal, report decline in intake to the physician and offer food substitutes if resident refused to eat were inappropriate for Resident #19. The MDS Nurse further stated care plans should be individualized and specific for each resident.

An interview conducted with the Assistant Director of Nursing on 03/11/16 at 10:54 AM revealed it was her expectation that care plans be resident

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F 279	Continued From page 34 specific and individualized for every resident.	F 279		
F 312 SS=E	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, record reviews and staff interviews the facility failed to trim and clean under fingernails for 2 residents (Resident #24 and #32) and failed to clean and trim fingernails and toenails for 1 resident (Resident #14). This affected 3 of 4 residents sampled for activities of daily living. Findings included: 1. Resident #24 was admitted to the facility on 03/08/13. A review of a diagnosis list in the electronic medical record revealed diagnoses of dementia, depression and paralysis from a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/08/15 indicated Resident #24 was cognitively intact for daily decision making. The MDS also indicated Resident #24 required limited assistance with activities of daily living and exhibited no behaviors or rejection of care. During an observation on 03/08/16 at 9:04 AM	F 312	312 How the corrective action will be accomplished for the resident(s) affected. On 3-11-16, nail care was immediately provided for Resident #24 and Resident #32. Resident #14 was immediately given nail and toenail care on 3-11-16. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. A visual inspection of all residents□ finger nails and toe nails was completed on 3-29 -16 to ensure all resident nails were clean, trimmed, and filed based on the resident(s) personal preference. Measures in place to ensure practices will not occur. A Nail Care policy and procedure was developed by the Skin Integrity RN using	4/7/16

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F 312	Continued From page 35 Resident #24 was lying on top of his bed in his room with his hands folded across his stomach. The fingernails were jagged and uneven on both hands with brown debris under each of the nails. During an observation on 03/09/16 at 4:13 PM Resident #24 was lying on top of his bed in his room with his hands folded across his stomach. The fingernails were jagged and uneven on both hands with brown debris under each of the nails. During an observation and interview on 03/10/16 at 10:28 AM Resident #24 stated he had his last shower on Tuesday evening on 03/08/16 and staff shaved his facial hair during his shower. He explained the Nurse Aide (NA) who gave him a shower did not trim or clean his fingernails but he could not remember the name of the NA who had given him a shower. Resident #24 held out both hands and the fingernails were jagged and uneven on both hands with brown debris under each of the nails and stated he would like for his nails to be trimmed and cleaned. During an observation and interview on 03/11/16 at 9:25 AM with Nurse #5 she examined Resident #24's fingernails and confirmed they needed to be trimmed and cleaned. She stated it was expected for a resident's fingernails to be trimmed and cleaned during their bath or shower. She further stated if a resident refused to let Nurse Aides (NAs) trim or clean their fingernails they should report it to the nurse. She explained usually if a resident did not want their nails trimmed or cleaned the NAs went back later or the nurse attempted and usually the resident cooperated. She stated if a resident refused to have their fingernails trimmed or cleaned it should be documented. She confirmed Resident #24	F 312	the most current evidenced based practice recommendations. The policy and procedure was adopted and implemented on 4-5-16. Nursing staff was educated on the Resident Nail Care policy/procedure on 4-7-16. Education also included the requirement that resident nail care will be provided with each bath and on an as needed basis, per the residents personal preference. Validation of competency for finger/toe nail care will be documented as part of the new employee orientation process. How the facility plans to monitor and ensure correction is achieved and sustained. The shift supervisor/designee will conduct (10) resident rounds each day to inspect and ensure resident(s) nails are clean and trimmed to the resident(s) choice. Audits will be done 4 times week X (4), then weekly X (2), then monthly. Each RN/LPN will conduct 5 resident audits monthly and submit the audit findings and corrective action taken to correct any findings to the Skin Integrity RN. The Skin Integrity RN/designee will conduct random audits of 10 residents each week X (4) weeks, then monthly to ensure implemented changes will be sustained. The Administrator/DON/designee will conduct random audits to ensure compliance with the expectation. Audits will be done weekly X (4), then monthly X	

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F 312	Continued From page 36 had a shower during the evening on 03/08/16 and she had not received any reports that Resident #24 had refused to have his fingernails trimmed or cleaned. During an interview on 03/11/16 at 9:38 AM with Nurse Aide (NA) #7 who was assigned to care for Resident #24 on the day shift on 03/11/16 she confirmed Resident #24 had received his last shower on Tuesday evening 03/08/16 but she was not sure who had given him a shower. She explained she had not noticed Resident #24's fingernails needed to be trimmed and cleaned. During an interview on 03/11/16 at 10:52 AM the Assistant Director of Nursing stated the expectation was for nail care to be provided to residents on bath days. She further stated if a resident refused to have nails trimmed or cleaned staff was expected to try more than once at a later time. She explained the NAs were also supposed to notify the nurse if the resident refused to have their nails trimmed and cleaned and the refusal should be documented. After review of the shower schedules for the week she confirmed NA #8 had been assigned to give Resident #24 his shower on 03/08/16. On 03/11/16 at 1:22 PM a telephone call was received from NA #8 who stated she did not recall giving Resident #24 a shower on 03/08/16 and was not sure who had given him a shower. She stated Resident #24 was usually cooperative with care and he could express his needs and wants. She explained the NAs were expected to look at resident's nails when they gave them a shower and were expected to clean their fingernails if they needed to be cleaned and trim them if they were jagged or uneven.	F 312	(2). The Administrator/DON/designee will report the findings to Quality Assurance Performance Improvement Committee (QAPI) monthly X (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed.. Failure to achieve compliance will result in education and/or disciplinary action and continuation of monitoring.	

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2. Resident #32 was re-admitted to the facility on 09/25/15. A review of a diagnosis list in the electronic medical record revealed diagnoses of heart disease, muscle weakness, type 2 diabetes, dementia and Alzheimer's disease.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/01/16 indicated Resident #32 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #2 required extensive assistance with activities of daily living and exhibited no behaviors or rejection of care.

During an observation on 03/08/16 at 10:04 AM Resident #32 was seated in a wheelchair in her room. She had her hands resting on her lap and the fingernails on each hand were jagged and uneven and had brown debris under each of the nails.

During an observation on 03/08/16 at 4:21 PM Resident #32 was seated in a wheelchair in a lobby area in front of elevators. She had her hands resting in her lap and the fingernails on both hands were jagged and uneven with brown debris under each of the nails.

During an observation on 03/09/16 at 3:33 PM a group activity called "pretty nails" was in progress in the main dining room. Staff were observed as they provided nail care and polished resident's nails. During this time Resident #32 was lying in bed in her room with her hands on top of a blanket and the fingernails on both hands were jagged and uneven with brown debris under each of the nails.

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During an observation on 03/10/16 at 10:08 AM Resident #32 was seated in a wheelchair in her room. She had her hands in her lap on top of a sweater and the fingernails on both hands were jagged and uneven with brown debris under each of the nails.

During an observation and interview on 03/11/16 at 9:25 AM with Nurse #5 she examined Resident #32's fingernails and confirmed they needed to be trimmed and cleaned. She stated it was expected for a resident ' s fingernails to be cleaned and trimmed during their bath or shower. She further stated if a resident refused to let Nurse Aides (NAs) trim or clean their fingernails they should report to the nurse. She explained usually if a resident did not want their nails trimmed or cleaned the NAs went back later or the nurse attempted and usually the resident cooperated. She stated if a resident refused to have their fingernails trimmed or cleaned it should be documented. She confirmed Resident #32 had a shower on 03/10/16 and she had not received any reports that Resident #32 had refused to have her fingernails trimmed or cleaned.

During an interview on 03/11/16 at 9:38 AM with Nurse Aide (NA) #7 who was assigned to care for Resident #32 during the day shift on 03/11/16 she confirmed Resident #32 was scheduled for a shower on Tuesday and Thursday of each week. She explained sometimes Resident #32 did not want staff to trim or clean her nails but usually if they talked with her and tried again later she permitted staff to trim and clean her nails. She stated after they tried twice and the resident still refused they reported it to the nurse and the

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refusal was supposed to be documented. She explained she had not noticed Resident #32's fingernails needed to be trimmed and cleaned.

During an interview on 03/11/16 at 10:52 AM the Assistant Director of Nursing stated the expectation was for nail care to be provided on bath days. She further stated if a resident refused to have nails trimmed or cleaned staff was expected to try more than once at a later time. She explained the NAs were also supposed to notify the nurse when a resident refused to have their nails trimmed or cleaned and the refusal should be documented. After review of the shower schedules for the week she confirmed NA #9 was assigned to give Resident #9 a shower on 03/10/16.

A phone call was made on 03/11/16 at 11:41 AM to NA #9 who was assigned to give Resident #32 a shower on 03/10/16 but there was no answer and no option to leave a message for her to return the call.

On 03/11/16 at 1:22 PM a telephone call was received from NA #8 who stated she had given Resident #32 showers in the past and Resident #32 was usually cooperative and let her trim and clean her fingernails. She explained the NAs were expected to look at resident's nails when they received their shower and were expected to clean them if they needed to be cleaned and trim them if they were jagged or uneven.

3. Resident #14 was admitted to the facility on 04/18/15 with diagnoses of arthritis and fracture. The quarterly Minimum Data Set (MDS) dated 01/21/16 revealed Resident #14 was cognitively intact and required extensive assistance with

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personal hygiene and bathing. The MDS further revealed Resident #14 had one sided upper and lower extremity range of motion impairment.
Review of the care plan dated 01/25/16 revealed Resident #14 had an activities of daily living (ADL) self -performance deficit related to decreased mobility. The goal was for Resident #14 to maintain or improve her current level of function in ADL through the next review. The interventions included: keep call light within reach, give resident choice with ADL care, allow resident opportunity to perform task themselves prior to offering assistance.
Observations of Resident #14's toenails and fingernails revealed the following:
· 03/10/16 at 9:00 AM toenails on both feet were jagged and approximately ¼ inch long. Fingernails had brown debris under each nail on both hands.
· 03/11/16 at 8:33 AM toenails on both feet were jagged and approximately ¼ inch long. Fingernails had brown debris under each nail on both hands.
An interview conducted on 03/07/16 at 2:57 PM with Resident #14 revealed she had asked staff to trim her toenails a couple of times during the past few weeks but they still had not been trimmed. She stated staff told her they would be back later to trim her toenails but never returned. She further stated she needed her fingernails cleaned because they were dirty.
An interview conducted with Nurse #2 on 03/11/16 at 8:33 AM revealed nail care was to be provided by the nurse aides (NA) during showers and as needed unless the resident had diabetes and then the nurse should provide nail care as needed. Nurse #2 was accompanied by the surveyor to Resident #14's room on 03/11/16 at 8:34 AM to observe resident fingernails and

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F 312	Continued From page 41 toenails and confirmed there was brown debris underneath each nail and her toenails were approximately ¼ inch long and needed to be trimmed. An interview conducted with NA #5 on 03/11/16 at 9:54 AM revealed she gave Resident #14 a shower on 03/08/16 but did not provide any nail care. She stated Resident #14 asked her to trim her toenails but she thought only the nurses were allowed to trim toenails. NA #5 stated she forgot to tell the nurse Resident #14 wanted her toenails trimmed. An interview conducted on 03/11/16 at 10:54 AM with the Assistant Director of Nursing (ADON) revealed it was her expectation nail care be performed on resident shower days and as needed. She stated the NAs should clean and trim fingernails and the Staff Development Nurse or the Podiatrist should trim toenails. The ADON stated the NA should have informed the nurse Resident #14 wanted her toenails trimmed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to analyze the root cause of a fall, coordinate interventions with the cause and	F 323	323 How the corrective action will be accomplished for the resident(s) affected.	4/7/16

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F 323	Continued From page 42 evaluate the planned interventions for effectiveness to prevent recurrent falls for 1 of 2 residents sampled for falls (Resident # 111). The findings included: Resident #111 was admitted to the facility on 12/21/15. His diagnoses included a fractured femur with surgical repair and dementia. Review of the Resident Incident Reports revealed on 12/27/15 at 10:34 AM Resident #111's alarm sounded and he was found on the floor. He had fallen from bed. Resident #111's head was bleeding from a small skin tear, he complained of neck pain and he stated his hip hurt a little. Resident #111 was transferred to the hospital for evaluation. Review of the Resident Incident Reports revealed on 12/27/15 at 10:30 PM Resident #111 fell from bed again and the alarm sounded. At this time, the bed was moved to a low position and fall mats were put in place. The tab alarm was changed to a bed alarm. Review of the investigations of the 2 falls on 12/27/15 revealed that coaching was completed when it was determined no other interventions were put into place when Resident #111 fell from bed in the morning. A care plan for having had an actual fall was developed 12/27/15 with no goals but interventions of a low bed, fall mat, bed alarm, broda chair for positioning and staff education for implementing interventions. Resident #111 fell again from bed on 12/28/15 at	F 323	Resident #111 was discharged to the hospital on 3-8-16. Should resident have returned to the facility, all fall prevention interventions would have been evaluated in an effort to prevent recurrent falls, based upon the individual resident needs. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. All falls for current resident(s) within the past 30 days were evaluated. Preventative interventions were reviewed to ensure the intervention is appropriate and effective to prevent recurrent fall(s). Audit complete on 4-7-16. Measures in place to ensure practices will not occur. Nurse supervisors were educated on a Root Cause Analysis tool to help determine the cause of the fall, how to coordinate interventions with the cause, specific to the individual resident(s) need(s), and how to evaluate the intervention for effectiveness. Education completed on 4-7-16. The IDT will review all fall incidents and interventions. The resident care plan will be updated with specific fall prevention and intervention goals. This will occur at daily clinical huddle.	

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F 323	Continued From page 43 8:45 AM per the Resident Incident Report. The alarm sounded and he was found on the fall mat. His brief was dry and he stated he thought he was talking to his uncle. He was placed in a recliner and a nurse aide sat with him. Additional interventions included a 2 hour toileting schedule and a broda chair. There was no analysis to understand the correlation of the toileting plan since he was dry or the broda chair since he fell from bed. Review of nurse aide documentation revealed he was toileted around 7:58 AM before the fall. The care plan for falls was updated 12/28/15 with no goal but interventions added to include at nursing desk for monitoring and take resident to bathroom every two hours. The admission Minimum Data Set (MDS) dated 12/28/15 coded Resident #111 with long and short term memory impairments and moderately impaired decision making abilities. He was coded as requiring extensive assistance for all activities of daily living skills, exhibiting other behavior symptoms 1-3 days in the previous 7 days, being frequently incontinent of bladder and having had a fall in the 30 days prior to admission, 1 fall with no injury since admission and 2 falls with non-major injury since admission. The Care Area Assessment relating to falls dated 01/01/16 stated Resident #111 needed extensive assistance with transfers, was frequently incontinent, had a recent hip fracture and had 1 to 2 falls at home in the past 90 days. He was noted to have pain and had several falls in this facility. There was no analysis of why Resident #111 had falls or any contributing circumstances around his falls.	F 323	An IDT Fall Risk Management committee will meet weekly to review all fall incidents. A Root Cause Analysis will be conducted for each fall. Interventions will be monitored for effectiveness and appropriateness. How the facility plans to monitor and ensure correction is achieved and sustained. Fall incidents will be monitored in the daily clinical huddle. This will be ongoing. The Administrator/DON/designee will report the findings to Quality Assurance Performance Improvement Committee (QAPI) monthly X (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed. Failure to achieve compliance will result in education and/or disciplinary action and continuation of monitoring.	

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Resident #111 experienced another fall on 01/04/16 at 1:07 AM. The Resident Incident Report indicated he had slid from the broda chair while in his room. His pull up and shorts were changed and he was assisted back to the broda chair and placed at the nurses station. There was no additional information to determine the last time he was toileted or what he was doing prior to the fall. No interventions or changes were made to the care plan.

The fall care plan was updated on 01/04/16 with a goal to have no injury through next review. No interventions were added at this time.

Resident #111 was sent to the hospital on 01/05/16 due to critical laboratory values and was readmitted to the facility on 1/20/16.

Review of the Resident Incident Reports noted Resident #111 fell from bed on 01/28/16 at 1:06 AM. The resident was found on the floor by a nurse aide. The fall mat had slid away and he was sitting on the floor between his bed and the fall mat. He was wet with urine and there was urine on the floor and on the floor mat. At this time, he was changed and a pillow was used to assist in defining the bed parameters. The post incident action revealed there was no alarm on the bed because it had not been reordered upon return from the hospital and there was no nonskid silicone for under the fall mattress. The nurse aides were instructed to visualize Resident #111 every 30 minutes. The fall mat was changed to a slim-line model.

The fall care plan was updated to have the bed against the wall per resident's choice and ask him

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if he needed to use the bathroom.

Resident #111 fell on 02/13/16 at 7:01 AM per the Resident Incident Report from his bed. He was found leaning against the bed, on the fall mat and the alarm was sounding. He was placed back in bed. No additional interventions were initiated.

Resident #111 fell again on 02/20/16 at 4:30 AM per the Resident Incident Report when he slid from the broda chair while in the hallway. The report noted he was placed in the broda chair when he attempted several times to climb out of bed. He sustained a skin tear to he left arm, a bruise to the top of his left hand and a knot on the left side of his head. The report noted he was moved to bed for incontinence care. There was no indication of why or how he slid from the broda chair this second time.

The care plan was updated to provide staff education on toileting the resident before getting him up to broda chair.

The Assisted Director of Nursing (ADON) was interviewed on 03/11/16 at 9:32 AM. She stated that upon initial fall assessment, an interim care plan was established. Then if a resident fell, the nurse on duty was to investigate the circumstances and implement an intervention. Falls were discussed at the morning meetings and interventions were discussed for appropriateness. She stated the facility had identified that the fall program used by the facility needed to be revamped via the quality assurance program. She stated that each fall was being evaluated individually and the facility was not looking at the big picture to help determine the root cause analysis for the resident with repeated

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F 323	Continued From page 46 falls. She further stated that trends were not being reviewed. The Quality assurance program was in the beginning stages and no plan had been established.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to follow the physician's order to discontinue a medication for	F 329	329 How the corrective action will be accomplished for the resident(s) affected.	4/7/16

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F 329	Continued From page 47 1 of 6 of sampled residents (#73) reviewed for unnecessary medications. This resulted in an unnecessary continued administration of probiotic to Resident #73 for 14 days. The findings included: Resident #73 was admitted to the facility on 12/03/2015 with diagnoses included Diabetes Mellitus (DM). In addition, Resident #73 was dependent on renal dialysis. The most recent Minimum Data Set (MDS) dated 12/31/15 coded Resident #73 as cognitively intact, able to make self-understood, and understand others. A review of the Physician's Order Sheet (POS) signed by the physician on 02/11/2016 indicated Vancomycin 25 milligram (mg)/milliliter (ml) solution, give 5 ml by mouth 4 times per day for 14 days from 02/11/2016 to 02/25/2016. Review of the POS signed by the physician on 02/11/2016 also revealed probiotic therapy with Florastor 250 mg capsule, give one capsule by mouth three times per day with additional instructions of "While on the Vancomycin." The start date for the probiotic was 02/11/2016. The Medication Administration Records (MAR) for 02/01/2016 to 02/29/2016 and 03/01/2016 to 03/31/16 revealed Resident #73 had received 125 mg of oral Vancomycin four times daily from 02/11/2016 to 02/25/2016. The MAR also indicated Resident #73 had received oral Florastor 250 mg capsule three times daily from 02/11/2016 to 03/10/2016. On 03/10/2016 at 9:30 AM, Resident #73 was observed sleeping in his bed as he was not scheduled for dialysis. He was under enteric contact isolation. Attempt was made to interview Resident #73, he declined to be interviewed. Another attempt to interview Resident #73 was failed on 03/11/2016 at 9:01 AM. Resident #73	F 329	The medication for Resident #73 was discontinued immediately on 3-10-16 after reviewing the medication with the primary care physician. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. A review of all current medication orders for each current resident was completed on 4-3-16 to ensure medication/treatment accuracy. Measures in place to ensure practices will not occur. Education on the Seven Rights of Practice for Order Transcription has been added to the general orientation for all new nurses and will be reviewed quarterly via on-line TEDS modules. Education completed on 4-7-16. Each new order will be reviewed by the Team Leader within 24 hours of the order being entered, if the order was entered by a staff member. Each morning during the daily clinical meeting, all new orders will be reviewed for accuracy by the DON/ADON/Team Leader. Each Monday, all new weekend orders will be reviewed for order entry accuracy. How the facility plans to monitor and ensure correction is achieved and sustained.	

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F 329	Continued From page 48 stated he would like to get some more sleep before leaving the facility for dialysis. An interview was conducted with Nurse #3 on 03/10/2016 at 3:03 PM. She stated if a probiotic was ordered along with an antibiotic without a stop date, it was possible for the nurse to continually administer the probiotic if the nurse did not clarify with the team leader. After reviewing the physician's order for Florastor in MAR, Nurse #3 agreed that the probiotic should have been discontinued on the same day when Vancomycin therapy was stopped on 02/25/2016. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/10/16 at 4:03 PM. She stated it was her expectation that all nurses had to read and verify each medication order and its instructions completely in the MAR prior to medication administration. This was to ensure the right resident, medication, dose, dosage form, quantity, route of administration, and all important special instructions would be followed. She added that all nurses should ensure each resident would receive their medications daily as ordered by the physician. The ADON stated that according to the physician orders, the probiotic therapy with Florastor should have been stopped when the oral Vancomycin was discontinued on 02/25/2016. The ADON further verified that the records in the MAR indicated Resident #73 had received probiotic therapy from 02/11/2016 to 03/10/2016. During a telephone interview on 03/10/2016 at 7:05 PM, the physician stated that he was not aware Resident #73 had been receiving Florastor after the discontinuation of the oral Vancomycin therapy on 02/25/2016. The physician indicated that his order on 02/11/2016 for Florastor clearly stated for Resident #73 was to receive one capsule of Florastor 250 mg by mouth three times	F 329	The DON/ADON/designee completed an audit of the current resident medication orders for the entire facility on 4-3-16 to ensure accuracy of all current orders. The DON/ADON/Team Leader will conduct a daily review during the daily clinical meeting (Monday-Friday). All new medication order entries will be reviewed to ensure accuracy. In the event of a weekend/holiday, all orders from the last day audited will be reviewed on the following business day. A monthly review of the physician monthly summary of the MAR/eTAR will be audited for accuracy. This will be on-going, monthly. The Administrator/DON/designee will report the results of the audits to the monthly QAPI Committee X (3) months to ensure changes are sustained, with a decision for continued monitoring if needed. Failure of compliance will result in immediate action to include education and/or disciplinary action.	

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F 329	Continued From page 49 daily "While on the Vancomycin". He added the probiotic therapy for Resident #73 should have been stopped when Vancomycin was discontinued on 02/25/2016 according to his order.	F 329		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to document intensity of pain levels or location of pain for 1 of 3 residents sampled for pain management for 64 of 86 doses of pain medication given (Resident #23). Findings included: Resident #23 was admitted to the facility on 06/05/15. A review of a diagnosis list in the electronic medical record revealed diagnoses of pain, muscle weakness, anxiety and dementia.	F 514	514 How the corrective action will be accomplished for the resident(s) affected. Resident #23 was assessed for pain following the administration of an as needed (PRN) pain medication. Documentation of the location of the pain and intensity was documented in the resident□s medical record on 4-3-16. How the corrective action will be accomplished for those residents with the	4/7/16

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F 514	Continued From page 50 A review of the most recent quarterly Minimum Data Set (MDS) dated 01/11/16 revealed Resident #23 was cognitively intact for daily decision making. The MDS also revealed Resident #23 required supervision with activities of daily living, had pain and received scheduled pain medications and as needed pain medications and non-medical interventions for pain. A review of care plans revealed a problem for pain due to deconditioning with an onset date of 06/18/15. The goal was Resident #23 would verbalize adequate level of pain control through next review and interventions were listed in part to give pain medication per orders, pain scale 1-10 every shift and as needed, offer pain medication before therapy and try non pharmacological pain relief such as diversional activities, repositioning and relaxation. A review of physician's orders dated 02/01/16 through 02/28/16 revealed the following: Tylenol 650 milligrams (mg) by mouth (PO) every 6 hours for mild pain Tramadol 50 mg PO 4 times a day as needed for pain A review of electronic Medication Administration Records (MARs) for February 2016 revealed the following: 02/01/16 at 8:22 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/01/16 at 7:05 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst	F 514	potential to be affected by the same practice. An immediate education was communicated to all nursing staff to include in all PRN pain medication the need to document the resident□s location of pain and the intensity of the pain rating. Education of the documentation expectation was completed on 4-7-16. Measures in place to ensure practices will not occur. The current electronic medical record allows staff to acknowledge if a PRN medication was an effective or ineffective intervention. Nursing staff were educated to document the monitoring of the effectiveness of the intervention. Education included documenting in the post PRN pain medication administration follow-up, the pain scale rating and the location of the pain. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will audit 10 charts each week for documentation compliance. Compliance will include documentation of administration of PRN pain medication, pain location and pain intensity. Audits will be done weekly X (4) weeks, then monthly to ensure compliance. Failure to sustain compliance will result in immediate education and/or disciplinary action. The Administrator/DON/designee will	

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F 514	Continued From page 51 pain). 02/02/16 at 7:40 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/02/16 at 3:43 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/03/16 at 8:10 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/04/15 at 8:15 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/05/16 at 5:12 AM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain). 02/05/16 at 9:51 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/05/16 at 2:18 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain). 02/05/16 at 8:24 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain to 10 worst pain). 02/06/16 at 4:38 AM Tylenol 650 mg was given PO but there was no documentation of location of pain. 02/06/16 at 8:13 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain). 02/07/16 at 8:49 PM Tylenol 650 mg was given PO but there was no documentation of location of	F 514	report the results of the audits to the Quality Assurance Performance Improvement Committee (QAPI) monthly X (3) months to ensure compliance with changes have been sustained, with a decision for continued monitoring if needed.	

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pain or pain scale from 0 (no pain) to 10 (worst pain).
02/08/16 at 8:12 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/08/16 at 8:34 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/09/16 at 8:26 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/09/16 at 2:00 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/10/16 at 9:00 AM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
02/10/16 at 2:11 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
02/11/16 at 9:44 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/11/16 at 8:19 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/12/16 at 8:17 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/12/16 at 9:15 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst

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pain).
02/13/16 at 8:14 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 worst pain).
02/14/16 at 8:26 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain to 10 worst pain).
02/14/16 at 2:16 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain to 10 (worst pain).
02/15/16 at 8:02 AM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
02/15/16 at 8:46 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/16/16 at 9:09 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/16/16 at 7:43 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/17/15 at 8:08 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/18/16 at 2:30 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/19/16 at 9:28 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst

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pain).
02/19/16 at 8:26 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 worst pain).
02/20/16 at 2:17 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain to 10 (worst pain).
02/20/16 at 9:28 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/21/16 at 7:49 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/22/16 at 3:23 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/22/16 at 7:33 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/23/16 at 7:57 AM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 worst pain).
02/23/16 at 12:03 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain to 10 (worst pain).
02/24/16 at 8:03 AM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
02/24/16 at 1:48 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
02/24/16 at 8:56 PM Tylenol 650 mg was given PO but there was no documentation of location of

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pain or pain scale from 0 (no pain) to 10 (worst pain).
02/25/16 at 7:55 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/25/16 at 1:47 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/25/16 at 9:26 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
02/29/16 at 8:28 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).

A review of physician's orders dated 03/01/16 through 03/31/16 revealed in part
Tramadol 50 mg by mouth 4 times daily as needed for pain
Tylenol 650 mg by mouth every 6 hours as needed for mild pain

A review of electronic Medication Administration Records (MARs) for March 2016 revealed the following:
03/01/16 at 8:02 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/01/16 at 9:36 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/02/16 at 7:46 AM Tylenol 650 mg was given PO but there was no documentation of location of

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pain or pain scale from 0 (no pain) to 10 (worst pain).
03/03/16 at 8:05 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/04/16 at 1:29 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/04/16 at 8:38 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/06/16 at 7:49 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/06/16 at 2:24 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/06/16 at 7:42 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/07/16 at 8:29 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain to 10 worst pain).
03/07/16 at 9:09 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain to 10 worst pain).
03/08/16 at 2:34 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/09/16 at 6:25 AM Tylenol 650 mg was given

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	345045	A. BUILDING _____ B. WING _____	03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK REHAB DAVANT EXTENDED CARE CTR	418 CHESTNUT STREET BLOWING ROCK, NC 28605

(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 514	Continued From page 57	F 514		

PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/09/16 at 12:54 PM Tylenol 650 mg was given PO but there was no documentation of pain scale from 0 (no pain) to 10 (worst pain).
03/09/16 at 9:29 PM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).
03/11/16 at 7:58 AM Tylenol 650 mg was given PO but there was no documentation of location of pain or pain scale from 0 (no pain) to 10 (worst pain).

During an interview on 03/08/16 at 09:51 AM Resident #23 stated she had constant pain in her neck and head. She further stated she did not like to take strong pain medication but she did take Tylenol even though it did not do much good.

During a follow up interview on 03/10/16 at 9:59 AM Resident #23 stated about 2-3 weeks ago her neck starting hurting worse and it radiated up to the top of her head. She explained she could not lay comfortably in bed except on her left side. She stated when she took strong pain pills they made her real sleepy so she took Tylenol but it didn't do much good.

During an interview on 03/11/16 at 9:25 AM with Nurse #5 who was routinely assigned to care for Resident #23 she stated nurses were expected to document the pain level according to a pain scale from 0 (no pain) to 10 (worst pain) and were expected to document location of the pain on the electronic MAR or in the nurse's progress notes.

During an interview on 03/11/16 at 10:52 AM the

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F 514	Continued From page 58 Assistant Director of Nursing stated it was her expectation for nurses to document pain according to a pain rating of 0 (no pain) to 10 (worst pain) and location of the pain. After review of the electronic MARs for February 2016 and March 2016 for Resident #23 she verified nurses were not consistently documenting the resident's pain according to the pain scale or the location of her pain and nurses should have documented the level of Resident #23's pain and location of her pain for each dose of pain medication that had been given.	F 514		
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 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520		4/7/16

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F 520	Continued From page 59 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in April of 2015. This was for 4 recited deficiencies which were originally cited in April 2015 on a recertification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of dignity, activities of daily living skills, unnecessary medication usage and for accurate and complete medical records. The continued failure of the facility to sustain an effective Quality assurance Program for 4 tags during 2 federal surveys of record show a pattern of noncompliance. The findings included: This tag is cross referred to: 1.a. F241 Dignity: Based on observations, record review and staff interviews, the facility failed to promote dignity during dining for 6 of 6 residents in the restorative dining room by seating residents at tables, with their food in front of them, with staff seated when assisting residents and not constantly leaving residents during feeding to assist others (Residents #12, #22, #78, #79, #111 and #116). In addition, the facility failed to promote the dignity of 1 of 1 sampled resident with a urinary catheter by covering the collection bag (Resident #81).	F 520	520 How the corrective action will be accomplished for the resident(s) affected. All residents have the potential be affected by Quality Assurance determinations. Measures in place to ensure practices will not occur. The Quality Assurance Committee have put in place new focus areas for standing agenda items including tracking of all current deficiencies cited in the annual survey and the actionable items associated with each plan of correction item. A new IDT Fall Risk Management committee has been created to specifically address root cause analysis and actionable items related to falls and fall prevention. The committee will report findings and compliance monitoring to the Quality Assurance Committee on a monthly X (3) months with a decision for continued monitoring if needed. Survey deficiencies and audit results will be discussed in daily leadership meetings and any trends or patterns will be directed to the appropriate parties monitoring compliance and reported to the Quality Assurance Committee.	

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F 520	Continued From page 60 The facility was originally cited during the recertification survey of April 2, 2015 for F241 for failing to change medication times to avoid disrupting a resident's sleep and failed to dress residents in personal clothing. The facility was recited for F241 for failing to manage the restorative dining program in a calm organized manner and for failing to cover a urinary catheter bag. b. F312 Care for Activities of Daily Living: Based on observations, record reviews and staff interviews the facility failed to trim and clean under fingernails for 2 residents (Resident #24 and #32) and failed to clean and trim fingernails and toenails for 1 resident (Resident #14) for 3 of 4 residents sampled for activities of daily living. (Resident #24, #32 and #14). The facility was originally cited during the recertification survey of April 2, 2015 for failing to provide oral care and nail care to residents. The facility was recited for F312 for failure to provide nail care. c. F329 Unnecessary Medications: Based on record review, staff and physician interviews, the facility failed to follow the physician's order to discontinue a medication for 1 of 6 of sampled residents (#73) reviewed for unnecessary medications. This resulted in an unnecessary continued administration of probiotic to Resident #73 for 14 days. The facility was originally cited during the recertification survey of April 2, 2015 for failing to attempt a gradual dose reduction of a hypnotic. The facility was recited for F329 for failing to discontinue a probiotic medication when the	F 520	How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/designee will report all audit findings related to survey compliance and other key clinical initiatives to the system□s Performance Improvement Committee quarterly X (2) quarters. The Process Improvement Committee meeting will include processes at outlined by the State and Federal regulations to review systems, improvement plans, structures, and updates.	

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antibiotic was discontinued as ordered by the physician.

d. F514 Accurate and Complete Medical Records: Based on record reviews and resident and staff interviews the facility failed to document intensity of pain levels or location of pain for 1 of 3 residents sampled for pain management for 64 of 86 doses of pain medication given (Resident #23).

The facility was originally cited during the recertification survey of April 2, 2015 for failing to transcribe a physician's order correctly. The facility was recited for F514 for failing to included documentation of a resident's pain level and location in the medical record.

Interview with the Administrator on 03/11/16 at 12:33 PM revealed compliance rounds were made for 6 to 8 months last year per the plan of correction. It was determined that there was mixed compliance with the monitoring and staff expressed feeling that administrative staff were being punitive when discussing the noncompliance of monitoring. As a result the facility decided to change the Quality assurance program to concentrate on newly identified areas of concern.