STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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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 observation, record reviews, staff and resident interviews the facility failed to honor a choice for an activity program for 1 of 1 resident reviewed for activities. (Resident #32) Findings included: Resident #32 was admitted to the facility on 11/22/14 with the diagnosis of cerebrovascular disease, major depressive disorder and atrial fibrillation. The most recent annual Minimum Data Set (MDS) dated 8/19/16 indicated that Resident #32 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s) and was independent with eating. Review of the activity interview for daily and activity preference dated 8/18/16 revealed, in part, that it was very important for Resident #32 to choose her clothing to wear, to do things with a group of people and to do her favorite activity. The care plan initiated on 10/22/15 revealed a focus that Resident #32 was dependent on staff for meeting emotional, intellectual, physical and social needs. The goal indicated that Resident #32 would maintain involvement in cognitive stimulation, social activities as desired through review date of 11/30/16. The interventions	F 242	Brian Center Health and Rehabilitation/Salisbury acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extend that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 form the survey conducted on November 14-18, 2016. Brian Center Health and Rehabilitation/Salisbury's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, the Brian Center Health and Rehabilitation/Salisbury reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other	12/23/16

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

Electronically Signed | 12/14/2016

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F 242	Continued From page 1 included to invite resident to scheduled activities, provide resident with activity calendar and notify the resident of any changes to the calendar of activities. During an interview with Resident #32 on 11/15/16 at 3:50 PM revealed that she was not able to attend activities over the weekend of 11/12/16 and 11/13/16 because she did not have any clothes to wear, all her clothes were in the laundry and not clean. She further indicated that she does participate in activities and was a bingo caller on the weekends, specifically on Saturdays. She wasn ' t able to call bingo on Saturday 11/12/16 and the residents did not have a bingo game as scheduled on the calendar. Review of a nurse progress note dated 11/16/17 revealed that Resident #32 was seen by the laundry/housekeeping manager who informed her that her clothes were not lost but would be arriving soon as they were a little backed up with laundry. Resident stated she understood and was reassured that she would get all her clothing back as soon as possible. An interview on 11/17/16 at 1:35 PM with Resident #32 ' s assigned nurse aide on 11/12/16 confirmed that Resident #32 was in bed all day because she did not have any clothes to wear. The nurse aide went to the laundry and could not find anything for her to wear. The nurse aide indicated that Resident #32 didn ' t seem upset, but that she was the bingo caller on Saturdays. During an interview with the laundry/housekeeping manager on 11/18/16 at 8:45 AM revealed that he had a washing machine to go down for 2 days and needed repair. A work order was completed on 11/9/16 and the washing machine was repaired on 11/11/16. Resident #32 ' s clothes were washed and delivered on 11/15/16.	F 242	administrative or legal procedures. F242 Corrective action accomplished for those residents found to have been affected by the deficient practice: Clothes were returned to resident #32 on 11/15/16. Resident currently receiving clothing promptly from laundry. Resident has adequate clothing to allow her to attend activities of her choice. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Audit completed of residents clothing to ensure adequate supply available to allow for attendance of activities of choice. Resident Council will review each month to ensure laundry services are meeting this requirement. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: In the event laundry equipment is out of order, resident clothing will be sent out to a sister facility to be laundered via facility van or other means of transportation. Monitoring Process: The process of washing and returning resident's clothing will be monitored weekly x 4 weeks, then randomly.	

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F 242	Continued From page 2 During a second interview with Resident #32 on 11/18/16 at 9:00 AM revealed that she does not recall any staff letting her know that the washing machine needed repair. She indicated that she was in bed all weekend wearing a hospital gown, she felt upset about it because that is what she enjoys on the weekend. She indicated that she told the nurse aide and the nurse and never got any clothes. An interview with the activity manager on 11/18/16 at 9:05 AM revealed that there are no activity staff scheduled on the weekends. On Saturdays Resident #32 calls the bingo and on Sundays church comes in for church services. The activity manager understood that Resident #32 was not able to call bingo this past Saturday 11/12/16 but wasn ' t sure why. She stated that Resident #32 loves to get up and call bingo, she looks forward to it. Residents didn ' t get to play on Saturday (11/12/16). Review of the Activity Calendar provided by the activity manager on 11/18/16 at 9:05 AM revealed an activity program scheduled on 11/12/16 at 3:15 PM for Bingo and at 4:15 PM Bingo Bucks. During an interview with the administrator on 11/18/16 at 11:15 AM revealed that he was aware that a washing machine needed repair but was not aware that a resident did not have clothing and was unable to attend activities. If he was aware he would have sent the clothes to the contract services and indicated that the weekend manager on duty should have addressed it. He revealed that he has been administrator for three weeks and plans to have a weekend manager on duty and activity staff on duty on the weekends. His expectation is that residents have clean clothing and activities as scheduled.	F 242	The results of the system monitoring will be discuss in QA x 3 months, the quarterly with the Quality Assurance and Performance Improvement Committee responsible for on-going compliance.	

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F 248	Continued From page 3	F 248		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews the facility failed to ensure attendance of an activity program for 1 of 1 resident reviewed for activities. (Resident #32) Findings included: Resident #32 was admitted to the facility on 11/22/14 with the diagnosis of cerebrovascular disease, major depressive disorder and atrial fibrillation. The most recent annual Minimum Data Set (MDS) dated 8/19/16 indicated that Resident #32 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s) and was independent with eating. Review of the activity interview for daily and activity preference dated 8/18/16 revealed, in part, that it was very important for Resident #32 to choose her clothing to wear, to do things with a group of people and to do her favorite activity. The care plan initiated on 10/22/15 revealed a focus that Resident #32 was dependent on staff for meeting emotional, intellectual, physical and social needs. The goal indicated that Resident #32 would maintain involvement in cognitive stimulation, social activities as desired through review date of 11/30/16. The interventions included to invite resident to scheduled activities,	F 248	F248 Corrective action accomplished for those residents found to be affected by the deficient practice: Weekend activities are occurring per calendar. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Administrator implemented weekend activities staff rotations. Administrator educated Activities Manager and Department Heads that cover Manager on Duty program, to ensure that weekend activities occur as scheduled. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Activities staff will alternate weekends to ensure activities are conducted as scheduled. Manager on Duty to validate	12/23/16

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F 248	Continued From page 4 provide resident with activity calendar and notify the resident of any changes to the calendar of activities. During an interview with Resident #32 on 11/15/16 at 3:50 PM revealed that she was not able to attend activities over the weekend of 11/12/16 and 11/13/16 because she did not have any clothes to wear, all her clothes were in the laundry and not clean. She further indicated that she does participate in activities and was a bingo caller on the weekends, specifically on Saturdays. She wasn ' t able to call bingo on Saturday 11/12/16 and the residents did not have a bingo game as scheduled on the calendar. Review of a nurse progress note dated 11/16/17 revealed that Resident #32 was seen by the laundry/housekeeping manager who informed her that her clothes were not lost but would be arriving soon as they were a little backed up with laundry. Resident stated she understood and was reassured that she would get all her clothing back as soon as possible. An interview on 11/17/16 at 1:35 PM with Resident #32 ' s assigned nurse aide on 11/12/16 confirmed that Resident #32 was in bed all day because she did not have any clothes to wear. The nurse aide went to the laundry and could not find anything for her to wear. The nurse aide indicated that Resident #32 didn ' t seem upset, but that she was the bingo caller on Saturdays. During an interview with the laundry/housekeeping manager on 11/18/16 at 8:45 AM revealed that he had a washing machine to go down for 2 days and needed repair. A work order was completed on 11/9/16 and the washing machine was repaired on 11/11/16. Resident #32 ' s clothes were washed and delivered on 11/15/16.	F 248	that weekend activities are occurring per calendar, and make necessary arrangements if a concern is noted. Monitoring Process: Administrator or designee will make random weekend visits to ensure activities are conducted as scheduled. Results of these audits to be brought to QAPI committee monthly with the QAPI committee responsible for on-going compliance.	

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F 248	Continued From page 5 During a second interview with Resident #32 on 11/18/16 at 9:00 AM revealed that she does not recall any staff letting her know that the washing machine needed repair. She indicated that she was in bed all weekend wearing a hospital gown, she felt upset about it because that is what she enjoys on the weekend. She indicated that she told the nurse aide and the nurse and never got any clothes. An interview with the activity manager on 11/18/16 at 9:05 AM revealed that there are no activity staff scheduled on the weekends. On Saturdays Resident #32 calls the bingo and on Sundays church comes in for church services. The activity manager understood that Resident #32 was not able to call bingo this past Saturday 11/12/16 but wasn ' t sure why. She stated that Resident #32 loves to get up and call bingo, she looks forward to it. Residents didn ' t get to play on Saturday (11/12/16). Review of the Activity Calendar provided by the activity manager on 11/18/16 at 9:05 AM revealed an activity program scheduled on 11/12/16 at 3:15 PM for Bingo and at 4:15 PM Bingo Bucks. During an interview with the administrator on 11/18/16 at 11:15 AM revealed that he was aware that a washing machine needed repair but was not aware that a resident did not have clothing and was unable to attend activities. If he was aware he would have sent the clothes to the contract services and indicated that the weekend manager on duty should have addressed it. He revealed that he has been administrator for three weeks and plans to have a weekend manager on duty and activity staff on duty on the weekends. His expectation is that residents have clean clothing and activities as scheduled.	F 248		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		12/23/16

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F 280 SS=D	Continued From page 6 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record reviews the facility failed to invite the responsible party to a care plan meeting for one of three sampled residents (Resident #183) and failed to update a care plan for one of one residents with an indwelling catheter (Resident #64). The findings included: 1. Resident #183 was admitted to the facility on 7/26/16 with diagnosis including dementia. The most recent Minimum Data Set (MDS), a	F 280	F280 Corrective action accomplished for those residents found to have been affected by the deficient practice: Social Worker resumed practice of sending out care plan invitations to resident responsible party. Resident #183 and their responsible party will be invited to attend all upcoming care conferences. Corrective action accomplished for those	

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F 280	Continued From page 7 quarterly, dated 9/23/16 indicated she had long and short term memory impairments. Review of the e-chart revealed the social worker notes included one note for the date of 8/2/16 of a meeting with Resident #183's family member. Review of the nurse's notes revealed the care plan team had no documentation regarding the care plan meeting and who attended. Interview with the family member on 11/15/16 at11:13 AM revealed she had not attended a care plan conference and had not been invited. Further interview revealed she would have preferred to attend, but did not know when the meeting was held. Interview with the Social Worker on 11/17/16 at 10:30 AM revealed he was responsible for inviting families/residents to the care plan conferences. He explained he used to send out letters, but recently he had been making phone calls. The system he used included printing off the MDS list and check when the call had been made. Information could not be provided Resident #183 ' s family member had been invited to the care plan meeting. The social worker explained documentation of the care plan conference would be in the progress notes for the social worker. He remembered having a meeting with Resident #183's family member, but did not remember when it occurred. He explained it would be in the e-chart. A sign in sheet at the care conference was started two weeks ago. Before that date, the families/residents did not sign an attendance sheet. 2. Resident #64 was admitted to the facility on 2/6/15 with the diagnosis of congestive heart	F 280	residents having the potential to be affected by the deficient practice: Social Worker resumed practice of sending out care plan invitations to resident responsible party. All residents who can participate will be invited to care plan conferences quarterly. All responsible parties will be invited to participate in care plan conferences quarterly. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Social Worker educated by Administrator on process and regulation for inviting residents/responsible parties to care plan conferences. Confirmation of care plan invitations being sent will be discussed in daily clinical meeting. Invitation and attendance to be documented in medical record. Monitoring Process: Results of the care plan invitation confirmation discussions in daily clinical meeting will be reviewed in QA monthly x 3 months, then quarterly with the Quality Assurance and Performance Improvement Committee responsible for on-going compliance.	

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F 280	Continued From page 8	F 280		

failure, hypertension and urinary tract infection.
The significant change Minimum Data Set (MDS) assessment dated 11/1/16 revealed that Resident #64 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s), was always incontinent and had no appliances for the bladder.
The Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 11/9/16 revealed, in part: resident was noted with complicated urinary tract infection. She was followed by urologist with stents removed 10/18/16. Foley Catheter discontinued at that time.
During a record review on 11/17/16 at 10:00 AM revealed a physicians order dated 10/24/16 that indicated that the foley catheter was discontinued at the appointment at named urology clinic.
Review of the care plan revised on 11/9/16 revealed a focus for a foley catheter, at risk for complications and infections. The goals indicated that Resident #64 would remain free from catheter related trauma with interventions to change catheter as order, check tubing for kinks during care, observe and report any symptoms of urinary tract infection.
An interview with the MDS coordinator on 11/17/16 at 1:00 PM confirmed the physicians order that the foley catheter had been discontinued on 10/18/16 at the urology appointment and confirmed that the care plan had not been updated and current to indicate that the foley catheter has been discontinued. He further revealed that care plans are updated based on MDS reviews and assessments, any changes with physician ' s orders and any changes discussed during clinical morning meeting, it must have been an oversight that the care plan was not updated.

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F 280	Continued From page 9 During an interview with the interim director of nurses on 11/18/16 at 11:00 AM revealed that care plans are updated by the MDS coordinators when MDS ' s are completed and with any changes reported in clinical morning meeting. Her expectations were that the care plans are to be current and updated with changes.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident, staff and physician interviews and record reviews the facility failed to provide pain management for one of one residents with pain (Resident # 52) and failed to provide treatment for one of one sampled residents with a possible toenail infection (Resident #114) Findings included: Resident #52 was re- admitted to the facility on 9/16/16 with diagnoses including hypertension, depression and obesity. Review of the Minimum Data Set (MDS) dated 9/23/16, a quarterly indicated Resident #52 had no long or short term memory impairment, required extensive assist of two staff for activities	F 309	F309 Corrective action accomplished for those residents found to have been affected by the deficient practice: Pain medication was given to resident #32 at approx. 4:30pm on 11/14/16. Resident #114 was assessed by RN on 11/16/16 and antibiotic was started on 11/16/16. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Audit of residents with orders for antibiotics in the last 30 days reviewed to	12/23/16

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F 309	Continued From page 10 of daily living. This MDS indicated there were no moods/behaviors exhibited during the assessment timeframe. The care plan dated 8/22/16 included a problem of chronic pain related to disease process spinal stenosis. Interventions included administer pain med as per physician order, evaluate the effectiveness of pain interventions; review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results. The current physician monthly orders included Hydrocodone 5/325 milligram, one tablet every 6 hours as needed (PRN) for pain. This was for breakthrough pain, and Resident #52 received the same medication and dose three times a day on a scheduled basis. Review of the nurse's note dated 11/11/16 revealed " Pain Interview completed. " Resident complained of constant pain all over her body that interrupted her sleep and day to day activities. She complained of a pain level of 9/10 pain during the past 5 days. She was alert, clear speech, able to make self-understood and understands others. She had no problems with hearing. Review of the narcotic count sheet revealed the pain med was given at 4:35 PM on 11/14/16. Interview with Resident #52 on 11/15/16 at 9:42 AM revealed she had pain in her legs. She further explained she had scheduled pain med. On 11/14/16 she had asked for pain med around 11:00 AM and it was not given until 5:00 PM. Her pain level was an " 8. "	F 309	ensure timely delivery and administration. Audit of residents on pain medication audited for the last 30 days to ensure medication availability. Residents are to receive medications as ordered. If medications aren't available on the medication cart, nurse is to use back up supply to obtain medication. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Physician instructed to write telephone orders to ensure orders are processed timely and efficiently. Telephone orders will be reviewed in clinical meeting to ensure they are entered in the electronic system. 24 hour chart checks to be completed to review for new orders to ensure that they were sent to the pharmacy to fill. DON or designee to audit new orders as part of clinical meeting. Monitoring Process: Results of audits will be discussed in QA x 3 months, then quarterly with the Quality Assurance and Performance Improvement Committee responsible for on-going compliance.	

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Interview with nurse #1on 11/16/16 at 2:00 PM revealed the resident had requested a pain pill around 11:00 AM on Monday, 11/14/16. She could not find the narcotic in the med cart and told the resident the medication was not on the med cart. She explained she found the medication later and gave it to Resident #52 around 3:00 PM.

Interview with the Director of Nursing (DON) on 11/16/16 at 2:30 PM revealed the medication error occurred on Monday due to nurse #1 was working with an orientee. Nurse #1 did not usually work the med cart. The PRN meds had been on the nurse's med cart. These are now on the med aide's cart. The med aide was to tell the nurse, which she did. The nurse would get the med and give it to the resident. The nurses assess the resident, tell the med aide to give the med, and document it was given. The nurse could not find it on her cart, then she did treatments and it was late afternoon before she gave the pain med to Resident #52.

2. Resident #114 was admitted to the facility on 6/6/13 with diagnoses including diabetes and hypertension.

Review of the Minimum Data Set dated 8/4/16, a quarterly, indicated moderate problems with long term and short term memory. The MDS assessed Resident #114 as requiring extensive to total assistance of two plus staff for activities of daily living. There were no problems associated with infections or skin integrity of the feet.

Review of the physician ' s progress note dated 11/12/16 revealed an ingrown nail on right great toe. The physician plan included to start

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doxycycline (an antibiotic) 100 milligrams (mg) twice a day for 7 days, podiatry to evaluate and treat, no shoes to the right foot until evaluated by podiatry.

Review of the printed orders in the hard chart revealed the above orders were not present. Review of the e-chart for the physician orders revealed the orders were not present.

Interview with the MDS nurse on 11/16/2016 at 11:16 AM revealed the process for transcription of orders when written by the physician in his/her progress notes included: The physician would communicate with the nurse or would write their own orders. The MDS nurse checked the e-chart and explained there were no orders in the computer for the antibiotic, podiatry consult or not to wear the shoe. The MDS nurse explained he would call the physician.

Review of a nurse ' s note dated 11/16/16 at 12:00 PM revealed the resident was assessed and had no complaints of pain or discomfort. Temperature was 97.9 degrees orally. The right great toe was warm to touch, no redness, swelling or pain to touch. A scant amount of pus drainage with a mild odor present. The physician was called and order clarified. The resident was to see the foot doctor in the AM.

Interview with the Director of Nursing (DON) on 11/16/16 at 12:56 PM revealed she would expect the nurse to write the orders on the telephone order. Further explanation included the physician did give verbal orders to the nurse also. The orders should have gone into the computer.

Interview with the primary care physician on

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F 309	Continued From page 13 11/16/16 at 1:55 PM revealed the orders had been written and this was a transcription error. Further interview revealed he had checked with the nurse practioner who had written the orders, and he was not sure what may have happened. The resident did need the antibiotic and had not received it as ordered. Interview with the DON on 11/16/16 at 2:29 PM revealed with the start of the electronic chart, and computerized orders, the order was missed.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interviews, the facility failed to provide scheduled showers for 1 of 5 residents (Resident # 201) who needed extensive or total assist for bathing. Resident # 201 was admitted to the facility on 10/28/2016 with diagnoses that included schizoaffective disorder, seizures, hypertension (HTN), cerebrovascular disease, cognitive social and emotional deficit, schizophrenia and bipolar disorder. The admission comprehensive Minimum Data set (MDS) dated 11/04/2016 indicated that Resident # 201 was alert and oriented and dependent on 1 staff member for bathing and showering. The	F 312	F312 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #201 was given a shower on 11/18/16 and is currently receiving showers two times per week. Nursing is documenting if resident refuses. Corrective action accomplished for those residents having the potential to be affected by the deficient practice:	12/23/16

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F 312	Continued From page 14 Care Area Assessment (CAA) dated 11/10/2016, revealed that Resident # 201 used a rolling walker for ambulation and was receiving physical therapy and occupational therapy to promote independence with activities of daily living (ADLs) and currently needed extensive staff assist for bathing and hygiene. A care plan (CP) was initiated on 11/18/2016 which revealed that Resident # 201 required supervision with most ADLs, except extensive assist with bathing and hygiene related to a history of a cerebrovascular accident (CVA), confusion at times and diagnoses of schizophrenia. The CP goal indicated that Resident # 201 would have improved functional level with toileting and bathing. Interventions included to encourage active participation in tasks, provide cueing with tasks as needed, assist with bathing and showering as needed. Review of the facility shower schedule revealed that Resident # 201 was scheduled for showers during the evening on Tuesdays and Fridays. A document titled " Completed Showers " was reviewed and revealed that there were no daily completed shower sheets dated for Friday, October 28, 2016 and Friday, November 11, 2016 available for review. The daily completed shower sheets dated 11/01/2016, 11/04/2016 and 11/08/2016 did not indicate if Resident # 201 received a shower or refused a shower. The daily completed shower sheet dated 11/15/2016 revealed that Resident # 201 did receive a shower. Resident # 201 ' s name was not documented on any other daily completed shower sheets reviewed dated 10/31/2016, 11/03/2016, 11/07/2016 and 11/10/2016,to indicate that Resident # 201 had been offered, received or refused a shower on any of those dates. A review of the nurse progress notes dated from	F 312	An audit of all shower sheets within the last 30 days will be conducted to ensure all residents received a shower on their scheduled day. Residents who missed scheduled showers have documentation related to the refusal or offered another day/time for shower. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Shower sheets will be reviewed in clinical meeting by DON or designee to ensure all residents received a shower on their scheduled day. Resident Council will review monthly to be sure residents are pleased with their shower schedules. Monitoring Process: Results of the daily shower sheet review will be reported to QA monthly x 3 months, quarterly with the Quality Assurance and Performance Improvement Committee responsible for on-going compliance.	

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10/28/2016 through 11/16/2016 did not include any documentation that revealed Resident # 201 had been offered a shower and received a shower or refused a shower.
On 01/16/2016 a review of the Resident Care Specialist Assignment Sheet for Resident # 201 did not include any specific bath or shower information.
During an interview with Resident # 201 on 11/15/2016 at 1:19 PM, Resident # 201 stated that she liked showers better than a bed bath and that she was scheduled to receive showers 2 evenings a week and thought the days were Tuesday and Friday. Resident # 201 stated that she had not received a shower since she had been admitted and that she had asked for a shower, but had not received one. Resident # 201 stated that she washed herself every day at the sink in her room.
An interview conducted on 11/16/2016 at 10:36 AM with nurse assigned to Resident # 201 revealed that each resident was scheduled for showers 2 days a week either on day shift or evening shift, but the schedule could always be changed if either the resident or resident family member requested a change. Nurse also provided a shower schedule form which revealed that Resident # 201 was scheduled for showers every Tuesday and every Friday on the evening shift. Nurse assigned to Resident # 201 stated that she was not aware that Resident # 201 did or did not receive any showers as she was not the regular evening shift nurse. The scheduled nurse also explained that each nurse assistant (NA) received a completed shower sheet attached to their assignment sheet and that each NA was to document completed showers on that form and to also document shower refusals on the same form after asking the resident at least twice during that

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shift and then report any refusal to the nurse. The nurse was to ask the resident if they wanted a shower and find out why the shower was being refused and then the nurse was to review and sign off on the shower sheet and they were turned in to the Director of Nurses (DON).
An interview conducted with NA assigned to Resident # 201 on 11/16/2016 at 1:10 PM revealed that Resident # 201 required only limited assist with ADLs and mainly just needed verbal cues to perform ADL tasks. The NA stated that Resident # 201 had refused showers on some evenings when her showers were due. The NA stated that she often worked day shift and stayed on evening shift and that on the evening of 11/15/2016, she was certain that Resident # 201 head received a shower because she had worked that evening. The assigned stated each NA received an assignment sheet and a completed shower sheet at the beginning of each shift and documented showers that they gave or showers that were not given to include the reason why and then to turn the shower sheet over to the nurse and explain why any showers were not given.
The assigned NA also revealed that NAs were to ask the resident to take their shower at least two times or more and to notify the nurse of resident refusal. The NA stated that resident shower schedules were listed for each resident on the Resident Care Specialist assignment and gave shower dates for each resident.
An interview with the second NA assigned to care for Resident # 201 conducted on 11/17/2016 at 3:37 PM revealed that she was aware that Resident # 201 was to receive showers during the evening shift on Tuesday and Friday. The second NA stated that there was a shower sheet attached to the NA assignment sheets which is where they documented any showers given or

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refused and the form was given to the nurse at the end of the shift. The second NA stated that the NAs asked residents that refused a shower at least 2 times and to report refusals to the nurse. The second NA that cared for Resident # 201 stated that she did know for certain that Resident # 201 did receive a shower last Friday evening, but could not recall if Resident # 201 had received a shower on any of the other dates because she was not on that assignment.
On 11/18/2016 at 9:11 AM an interview was conducted with the DON. The DON stated that it was her expectation that each NA would complete a shower completion form each shift and to notify the nurse if showers or baths were refused so the nurse could make another attempt to ask the resident if they wanted a shower or not and that the nurse also reviewed each shower completion form and signed it. The nurse would also document in the progress note to give detailed information of refusal and reason for refusal. The DON stated that residents should also be asked on alternate days if they refused a shower or to change the shower schedule if needed. The DON revealed that she had not been aware that Resident # 201 had been refusing showers on 11/01/2016, 11/04/2016 or 11/08/2016 or that there were no completed shower sheets available for 10/31/2016, 11/03/2016, 11/07/2016 and 11/10/2016. The DON was not aware that there were no nurse progress notes for dates that showers were refused that included the shower refusal and reason and that there was no progress note for the dates that the completed shower forms were unavailable for review. The DON was to review all shower completion forms as they were turned in to her. The DON was not aware that Resident # 201 had only received 1 shower since admission.

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F 312	Continued From page 18 If a shower schedule change was need, the DON stated that it was expected that the nurse change the schedule on the Resident Care Specialist Assignment and on the resident care plan.	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 staff and resident interview, observation and record review the facility failed to provide adequate supervision to prevent an unobserved resident to resident altercation with minor injury for 2 of 2 sampled residents (Resident #130 and #205), failed to thoroughly investigate a resident to resident incident and to identify and implement intervention strategies to prevent future similar incidents for 2 of 2 residents (Resident #130 and #205) and on 1 of 1 behavioral health units (300 Hall). The findings included: Resident #130 was admitted on 4/8/16 with diagnose including Alzheimer ' s disease, behavioral disturbance and Parkinson ' s disease. The Quarterly Minimum Data Set (MDS) Assessment dated 8/24/16 revealed Resident #130 was cognitively impaired, had behaviors	F 323	F 323 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #130 was assessed by nurse. Family and physician notified. Attempted to move resident, but resident refused to move off unit. Resident is currently monitored closely for potential behaviors, is followed by psych services and has appropriate interventions in place, which are reviewed and updated as needed. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Walking rounds and shift to shift report to	12/23/16

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F 323	Continued From page 19 towards others and had no impairment of upper or lower extremities. Resident #130 ' s Care Plan revealed a plan of care initiated on 4/21/16 and last revised on 9/7/16 for " has behavior problem (physically or verbally aggressive towards staff, hitting kicking or yelling) r/t (related to) new environment, Alzheimer ' s Dementia. " There were no care plan entries in regards to resident to resident altercations. Resident #205 was admitted 11/9/16 with diagnoses including Alzheimer ' s disease, restlessness and agitation and dementia with behavioral disturbance. An MDS assessment was not due for the resident at the time of the survey. The Nursing Admission Assessment indicated Resident #205 was alert to person and non-ambulatory. Nursing Notes dated 11/13/16 and 11/14/16 indicated Resident #205 was ambulatory, wandering the halls and resistive to being redirected from entering other resident ' s rooms. Review of the Incident/Accident Report dated 11/13/16 revealed that at 2:00 PM Resident #130 was " found bleeding from R (right) eye and abrasion to R wrist/forearm, resident states tall, thin hunched over fellow resident was the one who hit him. " Resident #130 ' s cognitive state prior to the incident was checked of as " normal " . First aide was rendered to the resident, a family representative was notified at 2:30 PM and the physician was notified at 3:45 PM. Review of the 11/13/16 Nursing Note at 9:48 PM revealed " (Name of physician) notified of skin tear to pts (patients) right eye and abrasion to	F 323	be completed at the change of every shift with on-coming and off-going staff to ensure all incidents and changes are relayed for appropriate follow up actions. Measure put in place or systemic changes made to ensure that the deficient practice will not occur: Residents with identified behaviors to be reviewed in weekly At Risk meeting to ensure that appropriate interventions are in place. Incident reports will be reviewed in clinical meeting to ensure prompt interventions put in place to address and prevent future occurrences. DON or designee to complete a full investigation into all resident to resident altercations/incidents. Staff educated by DON/designee on appropriate actions and interventions for behaviors and communication of incidents on 24 hour report and incident forms. Monitoring Process: DON or designee to monitor/review all incident reports and 24 hour reports as part of the clinical meeting process to ensure appropriate follow up, investigation and interventions put in place. DON or designee to ensure that all residents with identified behaviors are discussed and have plan of care reviewed weekly in At Risk meeting to ensure the interventions are in place and adequate to prevent future occurrences. Results of these daily/weekly meetings will be report to the QAPI committee monthly with the QAPI	

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F 323	Continued From page 20 right forearm. (Name of physician) stated that we were to move him off the hall once we informed (Resident #130) he got tearful and pleaded to not be moved, he stated that he likes being on the 300 hall, (name of physician) notified of his (Resident #130) wishes and agreed to let him remain on the 300 hall. " Review of the Nursing Note dated 11/14/16 at 2:30 PM revealed " Upon investigation of resident he says ' another resident tall, thin, and hunched over came in and did this to me. I would know him if I see him ' . Resident (#130) was placed on 1:1 observation by the nurse. Resident refused to move to another unit outside of locked doors. ' This is my home and I want to stay right here. I love being on this unit and I feel safe. " Review of the Incident/Accident Investigation Follow-up dated 11/14/16 indicated that Resident #130 said that another resident had entered his room and sat on his bed. Resident #130 " screamed for him to get off and resident hit him. " Under recommendations the following was crossed out with a note that read D/C (discontinued): " Resident (#130) to be moved off the 300 hall. " There was also a handwritten intervention for " resident (#130) placed on 1:1 monitoring. " The form was signed by the Director of Nursing on 11/14/16. On 11/14/16 at 11:15 AM Resident #130 was interviewed. He stated that another resident had come in his room yesterday and beat on him. Resident #130 was observed to have a skin tear on his right cheek with a scabbed over area approximately 1 inch in diameter and a skin tear on his right forearm which was covered with a transparent dressing. There was no bruising to	F 323	committee responsible for on-going compliance.	

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the resident ' s face noted but there was some bruising to his right forearm. The resident explained that he had been in his bed at the time of the incident and a resident he had not seen before sat down on the end of the bed where Resident #130 had his legs outstretched. Resident #130 described the unknown resident as tall, rough looking and able to walk without assistance. He stated the unknown resident sat on his (Resident #130 ' s) right leg and it hurt. He said that he told the unknown resident to leave several times and the man finally got up. Resident #130 said he thought the unknown resident was getting up to leave the room but he suddenly came up beside Resident #130 and beat on him. Resident #130 added that he kept telling the unknown resident to leave and the other resident ended up leaving on his own after the altercation.

On 11/15/16 at 11:00 AM interview with the Director of Nursing (DON) revealed that normally when there was a resident to resident altercation incident two incident reports were completed, one for each resident. She further revealed that in this case only one incident report was completed for Resident #130 because they did not know who the other resident was. The DON indicated that the incident occurred at shift change and none of the staff heard or saw anything.

On 11/16/16 at 1:54 PM Nursing Assistant #1 (NA #1) was interviewed. According to the time detail report for that day she worked from 6:04 AM - 10:09 PM on 11/13/16. She stated that she did not know about the resident to resident altercation until after the incident and speculated that she had been in the courtyard supervising smoking when the incident occurred. She stated

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that she found out about it after the smoke break when she was by the nurse ' s station putting the resident ' s cigarettes. She added that the Nurse was at the Nursing station as well. She did not know where the other Nursing Assistants were.

During this interview NA #1 also explained that staff learned of the incident when one of the resident ' s came to the nursing desk and told the staff that were there that they needed to check on Resident #130 because he was bleeding. She stated that she went to check on Resident #130 at that time and he said that someone walked in his room and when he asked the person to leave the guy attacked and punched him. NA #1 stated she then went and got the nurse.

On 11/16/16 at 2:08 PM NA #2 was interviewed. According to the time detail report she worked 8:10 AM - 6:33 PM on 11/13/16. She added that she learned of the resident to resident altercation after the fact but that she did not know much about it. NA #2 stated that at some point she became aware that an incident had occurred around shift change (2:00 PM) on 11/13/16 and that Resident #130 stated that another resident hit him. However NA #2 could not recall what she had been doing around 2:00 PM that day or when she heard than an incident had occurred. She thought she had probably been doing her NA charting in the care tracking system as she typically did that near the end of the shift. When asked about staffing and if it was adequate to provide enough supervision to be able to intervene to prevent or minimize altercation incidents she stated that it could be difficult during break times since they took overlapping breaks, or when staff were supervising the resident smoke breaks.

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On 11/16/16 at 3:24 Resident #130 was again interviewed and said that after the incident he just waited for a staff member to walk by the room so he could call them but he did not see a staff member. He did not yell out or use the call bell. Resident #130 said a resident that he did know, who was a friend of his and who often came in the room to visit, entered the room and Resident #130 asked that resident to get the nurse to come. Resident #130 stated that the Nurse came after about 5 minutes. When asked if an NA had come prior to that he stated ' No ' that it was the Nurse who came. He described the resident who struck him as a tall rough looking guy who was hunched over and walked without assistance. He added that it was a new resident that he did not know and said that he had told the staff that already. He stated that he had not seen that resident since the incident, although he had seen other residents walk by his room (the head of the resident ' s bed was positioned so that he could see directly into the hall when in bed). Resident #130 then revealed that on the morning of 11/14/16 Nurse #2 had told him she knew what Resident he was describing and but said he could not remember the name she had told him.

During a telephone interview with Nurse #1 on 11/17/16 at 12:28 PM she stated that she had worked on 300 hall on 11/13/16 on first and second shift. According to the time detail report she worked 6:59 AM - 11:07 PM but clocked in and out at 2:15 PM. She stated that around 2:00 PM a resident who was a friend of Resident #130 came to the nurse ' s station and reported that Resident #130 was bleeping from his eye. She stated that there were 2-3 Nursing Assistants at

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the Nurses station at the time and she asked them to go check on Resident #130 as she was behind the desk at that time and needed to secure the area. She stated that she arrived at Resident #130 ' s room a couple of minutes later. She added that Resident #130 had not used his call bell. She indicated that Resident #130 told her what happened and said he did not know the name of the resident who had done it. She added that Resident #130 was familiar with the wandering residents on the unit but Resident #205, who fit the resident ' s description was a new admission. She added that they had not identified Resident #205 as being involved in the incident because it was speculation. She added that to keep Resident #130 safe they took turns watching to make sure no one went in his room.

On 11/17/16 at 11:55 PM Resident #205 was observed up walking near the nursing station. He appeared tall and had a hunched over posture.

On 11/17/16 at 2:00 PM telephone interview with Medication Aide #1 (MA #1) she indicated that on 11/13/16 she worked on 300 hall on both first and second shift. According to the time detail report she worked 6:24 AM - 10:12 PM and clocked in and out at 2:15 PM. She revealed that she was at the Nurses Station when a resident came and told them Resident #130 was bleeding. She stated she thought the other first shift staff were around there at the time as well but that NA #3 may have been about to leave (According to the time detail report NA #3 worked 6:07 AM - 2:14 PM). MA #1 said that after the incident they had brought a couple of other residents by Resident #130 ' s room and he had said that neither of them were involved in the incident. She added that they were unable to take Resident #205 by

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the resident ' s room because he was uncooperative. MA #1 said that during shift change the area near the nurse ' s station could become very congested with staff and residents. MA #1 also said that at shift change staff were supposed to wait for the oncoming shift staff members to relieve them. She added that they were expected to give brief report and do a round with the oncoming staff members but said that because of late arrivals, it was difficult to do that.

On 11/17/16 at 2:07 PM interview with the Director of Nursing (DON) indicated she thought all the residents on 300 hall that were potentially involved in the altercation with Resident #130 had been brought by Resident #130 ' s room and that in each case he said it was not that resident who had been involved. She stated that it was unfair to single Resident #205 out or review his care plan in regards to the incident, even though he met the description, since Resident #130 was unable to identify him. Further discussion revealed that she had been unaware that Resident #205 had not been involved in the process to see if Resident #130 could identify him due to being uncooperative as stated by Medication Aide #1. She also acknowledged that Resident #150 had been very consistent in retelling the incident and in his description of the other resident. The DON stated that it was unusual to have an unobserved resident to resident altercation on the unit and that even though it was a behavioral health unit it was her expectation that there was adequate supervision to be able to de-escalate or intervene in resident to resident incidents. The DON also indicated that it was her expectation that outgoing staff not leave the unit until there replacement arrive so they could do a round together. She indicated that

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there had not yet been an effort to explore root causes for the incident but added she was putting plans in place for additional supervision of the unit at shift change.

On 11/17/16 at 3:34 PM during telephone interview with the physician he stated that the 300 hall was a locked behavioral health unit and very special in that there are not a lot of places that would take residents with behaviors. " There is nowhere for them to go. " To minimize behaviors and reduce the likelihood of incidents he stated that medications were not the answer and that dementia behaviors could not be treated with medications. The physician stated that what these residents needed was care and attention; more manpower to be able to provide TLC (tender loving care), interaction and sidetracking that may help with behavior modification. In regards to Resident #130 he said that he had agitated behaviors when he first came to the unit. Resident #130 had been at an Assisted Living Facility and the staff there could not manage his behaviors and sent him hospital and then would not take him back. That was how Resident #130 ended up on the 300 hall behavioral health, locked unit, to begin with. The physician added that since that time Resident #130 had stabilized and was really no longer appropriately placed on the behavioral health unit but they had tried to move him and he got upset. He added that since then the Resident had agreed to be transferred to a facility closer to his family and would be discharged in a couple of weeks. As for Resident #205 the physician said they just determined his involvement in the resident to resident altercation with Resident #130 and would be reassessing and updating the Resident #205 ' s care plan as needed.

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F 323	Continued From page 27 Review of the Incident/Accident Report dated 11/17/16 revealed that on 11/14/16 at 4:30 PM Resident #130 pointed to Resident #205 and told Nurse #2 " that is the resident that scratched my face " over the weekend. It also indicated that the physician had been informed (11/17/16) and would review Resident #205 ' s medications along with the Psychiatric consultant.	F 323		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff,	F 353	F353	12/23/16

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F 353	Continued From page 28 family and resident interviews, the facility failed to provide pain management for 1 of 1 residents with pain (Resident #52), failed to provide treatment for 1 of 1 sampled residents with a possible toenail infection (Resident #114), failed to provide scheduled showers for 1 of 5 residents who needed extensive or total assistance (Resident #201), failed to provide sufficient number of direct care nursing staff to meet the needs of residents as evidenced by inadequate supervision to prevent an unobserved resident to resident altercation with minor injury for 2 of 2 sampled residents (Resident #130 and Resident #205), and failed to obtain and administer medications ordered after admission for 1 of 1 sampled residents (Resident #200). The findings included: 1. Cross reference to Tag F309: Based on resident, staff and physician interviews and record reviews the facility failed to provide pain management for one of one residents with pain (Resident # 52) and failed to provide treatment for one of one sampled residents with a possible toenail infection (Resident #114) 2. Cross reference to Tag F312: Based on record review, observation and resident and staff interviews, the facility failed to provide scheduled showers for 1 of 5 residents (Resident # 201) who needed extensive or total assist for bathing. 3. Cross reference to Tag F325: Based on staff and resident interview, observation and record review the facility failed to provide adequate supervision to prevent an unobserved resident to resident altercation with minor injury for 2 of 2 sampled residents (Resident #130 and #205), failed to thoroughly investigate a resident to resident incident and to identify and implement intervention strategies to prevent future similar	F 353	Corrective action accomplished for those residents found to have been affected by the deficient practice: Facility is currently staffed sufficiently to provide pain management and medications as ordered, and staffed sufficiently to provide showers and supervision as indicated. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Staffing to monitored by Administrator and Director of Nursing or designees to ensure adequate staffing in place to meet the needs of the residents. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Daily staffing meeting to be held with Administrator, DON and Staffing Coordinator to review schedule and staffing needs to ensure adequate staff in place and/or take necessary measures to ensure adequate staffing levels. Monitoring Process: Administrator and DON or designees to ensure daily staffing levels appropriate to ensure medications including pain management administered per orders, and that showers are given and residents supervised appropriately. These areas will	

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F 353	Continued From page 29 incidents for 2 of 2 residents (Resident #130 and #205) and on 1 of 1 behavioral health units (300 Hall). 4. Cross reference to Tag 425: Based on observations, staff, physician and pharmacy consultant interviews and record review the facility failed to obtain and administer medications as ordered after admission to the facility for one of one sampled residents (Resident # 200). On 11/18/16 at 11:09 AM the Scheduler was interviewed. She stated that the number of staff scheduled for each unit and each shift depended on the census. She added that there was not a specific written plan or guideline but was just something she knew as to how many staff needed to be scheduled depending on the census. The Scheduler said that if there were 56-60 residents on 100 hall for example she would try to put 5 staff members over there. She added that if she could not find enough people to work then overtime would be offered or she might need to take the shift since she was a Nursing Assistant as well. She also said that they sometimes used agency staff but there were still late calls that affected the staff assignment and hall nurses would have to try and call someone in. She stated that generally on first shift (6 or 6:30 AM - 2 or 2:30 PM) she tried to have 5 Nursing Assistant staff on 100 hall, 3 on 200 hall and 4 on 300 hall. On second shift (2 of 2:30 PM - 10 or 1030 PM) she tried to have 4 Nursing Assistants on 100 hall, 3 on 200 hall and 4 on 300 hall and on third shift (10 or 10:30 PM - 6 or 6:30 AM) she tried to have 3 -4 on 100 hall, 2 on 200 hall and 3 on 300 hall. Review of the Staff Posting for 11/5/16 through 11/16/16 revealed that on 5 of those 12 days the	F 353	be audited as indicated in plan of correction for F309, F312, F323 and F425. Results of audits and staffing meetings to be reviewed monthly in QAPI meeting with QAPI committee responsible for on-going compliance.	

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F 353	Continued From page 30 number of Nursing Assistant staff that the Scheduler indicated was the goal (12 facility wide on first shift, 11 facility wide on second shift and 8-9 facility wide on third shift) was not achieved on one to two shifts for the day. On 11/17/16 at 2:07 PM interview with the Director of Nursing (DON) revealed that she felt that staffing in the facility had improved recently and that she was fairly new to the facility but it was something she was working on. She added that staffing on 300 hall would be increased. She also acknowledged that there were times that there were only 2 Nurses in the facility, without a Medication Aide which meant they had to be off one of the units at times. The DON said that ideally there would be 3 nurses on third shift. On 11/18/16 at 2:00 PM (post facility exit but on the day of exit) telephone interview with Nurse #3 revealed that she worked third shift. She stated that she normally worked on 300 hall but if there were only two nurses in the facility she worked on both 300 hall (the locked unit) and 200 hall. She stated that sometimes there was also a Medication Aide to help out but not always. In addition she stated that sometimes there were only two Nursing Assistants on 200 hall during third shift. If something happened while she was on 200 hall one of them would have to leave the unit to find her.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		12/23/16

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F 356	Continued From page 31 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update the staff posting each shift when changes to the number/hours worked of licensed and unlicensed direct care staff occurred for 2 of 2 sampled days. The findings included: The Staff Schedule and Staff Posting for both 10/17/16 and 11/4/16 were reviewed. On 10/17/16 the Staff Posting indicated that, for licensed nursing staff, only one licensed nurse (an LPN) had been present on third shift that day.	F 356	F356 Corrective action accomplished for those residents found to have been affected by the deficient practice: Staff posting was corrected for 10/17/16 and 11/4/16. Corrective action accomplished for those	

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F 356	Continued From page 32 The Staff Schedule indicated two licensed nurses had been present. On 11/4/16 the Staff Posting again indicated that, for licensed nursing staff, only one licensed nurse (an LPN) had been present on third shift that day. The Staff Schedule indicated two licensed nurses had been present. In addition, the Staff Schedule and the Staff Posting did not indicate that a Medication Aide had also worked for 4 hours on third shift that day but the time detail report, showing when staff clocked in and out revealed that a Medication Aide had worked for 4 hours but it was unaccounted for on the Staff Posting. These documents were not examined for additional discrepancies. During interview with the Director of Nursing (DON) on 11/17/16 2:07 PM the 10/17/16 and 11/4/16 Staff Posting, Staff Assignment and time detail were reviewed. She acknowledged that the information on the Staff Posting was incorrect and had not been updated as it should have been. The DON indicated that the scheduler was responsible for keeping the Staff Posting up to date. During interview with the Scheduler on 11/18/16 at 11:06 AM the 10/17/16 and 11/4/16 Staff Posting, Staff Assignment and time detail were reviewed. She indicated that she printed out the Staff Posting based on the original schedule but stated that when there were call outs and various other changes she only made the changes on the Staff Schedule and did not update the Staff Posting. She stated that she was not aware the Staff Posting needed to be updated every shift with accurate full time equivalent hours and the census.	F 356	residents having the potential to be affected by the deficient practice: Education provided by Administrator on regulation for staff posting. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Posting of daily staffing will meet the regulation and will be monitored daily by DON or designee (Manager on Duty to review on weekends). Monitoring Process: The results of the staff posting monitoring will be discussed in QA x 3 months, then quarterly with the Quality Assurance and Performance Improvement committee responsible for on-going compliance.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		12/23/16

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F 425	Continued From page 33 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff, physician and pharmacy consultant interviews and record review the facility failed to obtain and administer medications as ordered after admission to the facility for one of one sampled residents. Resident # 200. The findings included: Resident #200 was admitted to the facility on 11/12/16 with diagnoses including pneumonia, weakness, chronic lung disease, history of stroke, and diabetes.	F 425	F 425 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #200 was assessed by RN for adverse reaction due to not receiving medications as ordered. RN called physician to make him aware. Resident #200 received new medication orders. Corrective action accomplished for those residents having the potential to be	

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F 425	Continued From page 34 Review of the hospital discharge orders dated 9/12/16 revealed the following medications were to be continued: Armodafinil (narcolepsy), Breo ellipta inhaler (chronic lung disease), Glyburide (diabetes), Prilosec (acid reflux), Hydralazine (hypertension), Sucralfate (stomach ulcers), and Nicotine Patch (smoking cessation). Review the electronic (e) chart revealed the medication administration record and orders indicated the date the medications were entered into the computer to alert the pharmacy to deliver the medications, and the date the medications were administered to Resident #200. Review of the e-chart revealed the following: -Armodafinil 150 milligrams (mg) every day. The order was put in the computer system to the pharmacy on 11/12/16. As of 11/17/16 the medication had not been administered. The nurse ' s notes revealed the medication was " on order. " - Breo ellipta 199-25 inhaler to be used every day. The order was put in computer system to the pharmacy on 11/14/16 and the medication was started on 11/16/16. -Glyburide 2.5 mg one every morning. The order was put in the computer system on 11/12/16 and the medication was started on 11/15/16. -Prilosec 20 mg 1 every day. The order was put in the computer system on 11/12/16 and 11/14/16. The medication was administered on 11/13 and 11/14/16. A dose was missed on 11/15/16. Interview with a nurse manager revealed a substitution by pharmacy was made on 11/14/16, which made the one day of missed doses. The substitution was started on 11/16/16.	F 425	affected by the deficient practice: Medication audit completed for all residents admitted in the last 30 days to ensure medications were received as ordered. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: All medication aides were in-serviced by DON or designee on proper procedures when a medication isn't available. All licensed personnel were in-serviced by DON or designee on the admission process, which includes the process for ordering medications after hours and on weekends. All new admissions will be reviewed in clinical meeting by DON or designee to ensure medications were given as ordered. Monitoring Process: Results of the new admission reviews will be reported to QA x 3 months, then quarterly with the Quality Assurance and Performance Improvement Committee responsible for on-going compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 35	F 425		

-Hydralazine 25 mg three times a day. The order was put in the computer system on 11/12/16. A couple of doses were missed on 11/15/16.

-Sucralfate 1 Gram before meals and at night. The order was put in the computer system on 11/12/16 and two doses were missed on 11/16/16.

-Nicotine Step 2 Patch 24 hour 14mg/24 hour apply 1 every 24 hours and remove old patch. The order was put in the computer system on 11/12/16 and the medication was started on 11/15/16.

Review of the nurse notes revealed medications were not available on 11/14/16 for Hydralazine, Sucralfate, Armodafinil, and nicotine patch " not in yet; waiting on pharmacy. "

Review of the nurse note dated 11/17/16 at 8:28 AM revealed the Armodafinil was "on order".

Observations on 11/17/16 at 8:29 AM of the medications in the cart revealed the Armodafinil was not in the cart. The other medications were in the cart with a date filled of 11/14/16.

Interview with the Director of Nursing on 11/17/16 at 1:36 PM revealed she would expect the nurse to administer the medications as ordered.

Interview with MDS nurse on 11/17/16 at 3:22 PM revealed the usual procedure for obtaining medications would include putting the orders into the computer. If the medications did not come to the facility, the pharmacy would be notified and the medications would be obtained from CVS, the

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	345115	A. BUILDING _____ B. WING _____	C 11/18/2016

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back-up pharmacy. MDS nurse explained he did not know why the medication Armodafinil had not been received at the facility. He did not know if the pharmacy had been notified.

Interview on 11/17/16 at 4:00 PM with the primary care physician revealed the Armadofinil would be a medication he would wean him from. It would not be detrimental if he did not receive the medication. There had been issues with not having a steady unit manager and someone to "dot the I's and cross the t's." He was informed this medication had not been started as ordered, but was not aware other medications were not started as ordered.
Interview with a pharmacist at Omni Care on 11/18/16 at 8:46 AM revealed the medications for resident #200 were filled on 11/14/16. The pharmacy computer access at the time of the interview, was down and she could not check the date the orders were received at the pharmacy. She explained the manifest had the medications were sent out on 11/14/16 at 9:30 PM. The medications would have arrived that night at the facility. She had no information as to communication of the pharmacy to the facility about a hard script for the Armadofinil being required. She had a fill date of 11/17/16 for that medication. The turn-around time for delivery of medications was to fill the meds and send them out the same day. They would have the same procedures for a Saturday or Sunday admission.
Interview on 11/18/16 at 11:06 AM with a unit manager revealed the orders go directly to the pharmacy when put into the resident's e-chart. If a therapeutic exchange had to be made the process included the pharmacy would send back the exchange medication, which occurred on 11/14/16 for Resident #200. She further

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F 425	Continued From page 37 explained she checked the orders in the computer of newly admitted residents and could identify if an exchange medication was provided. When a nurse put the orders in the e-chart, the nurse had to check the box for the nurse or the med aide's MAR. If this was not correct, the nurse would not have the medication on their cart. In reviewing the MAR with the unit manager for Resident #200, she did not know why some of the medications were not administered as ordered or why the medications had not been received in the facility. Interview on 11/18/16 at 11:27 AM with nurse #1 who gave medications on 11/14/16 revealed she was waiting on pharmacy to bring the meds and that was the reason the medications were not administered as ordered. She did not get a chance to call the pharmacy on Monday. Nurse #1 explained the usual turn-around time if orders were in by 4:00 or 5:00 PM, would be in the facility that night. She did not know if the delivery was different on weekends, because she did not work weekends.	F 425		
F 520 SS=D	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	F 520		12/23/16

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F 520	Continued From page 38 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 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place 12/11/15. This was for one recited deficiency that was originally cited 12/11/15 on a recertification survey and subsequently recited in November 2016 on the current follow up recertification survey. The deficiency was in the area of maintaining complete and accurate medical records (F323). The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is crossed referenced to F:323: Based on record review and staff interviews the facility failed to secure a full oxygen tank in 1 of 0 rooms observed (room 124). During the recertification survey of 11/18/16 the facility was cited at F323 due to failure to provide adequate supervision to prevent an unobserved	F 520	F520 Corrective action accomplished for those residents found to have been affected by the deficient practice: Quality Assurance and Performance Improvement committee to meet monthly, with the purpose of identifying areas out of compliance and establishing a plant to correct deficient practice and follow up on areas addressed in Performance Improvement Plans to ensure practices are being maintained (Prevention of Accidents and Hazards to be priority in upcoming meetings.) Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Administrator and Director of Nursing educated by District Director of Clinical	

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F 520	Continued From page 39 resident to resident altercation with minor injury for 2 of 2 sampled residents (Resident #130 and #205), failed to thoroughly investigate a resident to resident incident and to identify and implement intervention strategies to prevent future similar incidents for 2 of 2 residents (Resident #130 and #205) and on 1 of 1 behavioral health units (300 Hall). Interview with the Administrator on 11/18/16 at 11:00 AM revealed the facility had monitored accidents and incidents but did not have a QA plan in place for resident to resident altercations.	F 520	Services on Quality Assurance and Performance Improvement process with focus on establishing and maintain corrective actions to ensure consistent delivery of care and services. Measures put in place of systemic changes made to ensure that the deficient practice will not occur: QAPI meetings to be held monthly, with minimal attendance of Administrator, DON, Social Service and a nurses' aid, with Medical Record input into identified concerns and Performance Improvement Plan. Monitoring Process: District Director of Clinical Services to randomly review Quality Assurance and Performance Improvement minutes and to attend meetings when possible.	