| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment | F 157 | | 4/21/17 |

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

Electronically Signed | 04/14/2017

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| F 157 | Continued From page 1<br>as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, nurse practitioner and physician interviews, and record review, the facility failed to notify the physician of a cancelled gastroenterology appointment to evaluate a possible abscess of a gastrostomy tube site for 1 of 3 sampled residents with appointments out of the facility (Resident #3).<br><br>The findings included:<br><br>Resident #3 was readmitted to the facility on 01/07/17 with diagnoses which included placement of a gastrostomy tube for severe malnutrition.<br><br>Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/31/17 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others.<br><br>Review of Resident #3's care plan revealed interventions for the gastrostomy tube site included provision of local care to the tube site as ordered and observe for sign of infection.<br><br>Review of a nurse practitioner's (NP) note dated 03/08/17 revealed a description of Resident #3's | F 157 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F157<br><br>On 4/7/17, Resident #3□s physician/NP was notified of the cancelled appointment.<br><br>All residents with appointments have the potential to be affected.<br><br>On 4/18/17,Health Information manager reviewed all appointments for the previous 30 days for any missed/cancelled appointments and the residents physician was notified as indicated.<br><br>Clinical staff will be re-educated by DON/ADON/Unit manager on notifying | |

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| F 157 | Continued From page 2<br>feeding tube site. The NP documented a small amount of yellow/tan colored drainage with blood noted to the tube insertion site.<br><br>Review of the NP's order dated 03/08/17 revealed directions to follow up with a Gastroenterologist "ASAP" (as soon as possible) to rule out abdominal abscess at the gastrostomy tube insertion site.<br><br>Review of a NP note dated 03/09/17 revealed documentation Resident #3 went to a Gastroenterologist on 03/09/17 who refused to evaluate Resident #3 due to lack of a decision maker presence. The NP documented the facility rescheduled the appointment for the following week when Resident #3's family member could attend. The NP described the tube site as with redness and no pus drainage.<br><br>Review of the facility's appointment calendar revealed Resident #3's Gastroenterologist appointment on 03/16/17 was cancelled. "Insurance pending" was hand written over Resident #3's name.<br><br>Interview with Nurse #2 on 03/20/17 at 11:35 AM revealed Resident #3 did not have another Gastroenterologist appointment scheduled. Nurse #2 reported she did not notify the NP or physician of the cancelled appointment on 03/16/17.<br><br>Interview with the NP on 03/21/17 at 8:18 AM revealed she was not aware of Resident #3's cancelled second appointment. The NP reported she wanted to be notified if the Gastroenterologist appointment did not occur. The NP explained the missed second appointment would not hurt | F 157 | physician, family, and resident of accidents, significant change in the resident, any changes in treatment/orders, and transfer to the hospital. Education will be completed by 4/21/17.<br><br>Resident documentation for notification of physician will be reviewed during clinical start up 5x/week. The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 157 | Continued From page 3<br>Resident #3 since Resident #3 was already receiving antibiotic therapy.<br><br>Interview with the Director of Nursing (DON) on 03/21/17 at 8:30 AM revealed she expected the nurse to notify the NP or physician when Resident #3 did not receive the gastroenterology consultation. The DON explained she was aware of the second appointment cancellation but thought it had been rescheduled.<br><br>Telephone interview with Resident #3's physician on 03/21/17 at 8:40 AM revealed she was aware of the inability for Resident #3 to be seen on 03/09/17 but was not aware of the cancelled second appointment on 03/16/17. The physician reported she expected the facility to notify either herself or the NP when Resident #3 could not be seen by the Gastroenterologist.<br><br>Interview with the Assistant Director of Nursing on 03/21/17 at 9:17 AM revealed she thought the physician received notification of Resident #3's cancelled appointment on 03/16/17. The ADON explained she orally informed the physician that day (03/16/17). | F 157 | | |
| F 241 SS=E | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff | F 241 | This plan of correction is the centers | 4/21/17 |

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| F 241 | Continued From page 4<br>interviews, and record review, the facility failed to assist a resident with dressing (Resident #4), await permission to enter a bathroom after knocking (Resident #9), provide means of calling for staff assistance without shouting (Resident #7), provide non-disposable items during 4 meal observations and assistance with eating at eye level for a dignified dining experience (Resident #10) for 4 of 12 sampled residents for dignity (Residents #4, #7, #9 and #10).<br><br>The findings included:<br><br>1. Resident #4 was admitted to the facility on 01/30/17.<br><br>Review of Resident #4's admission Minimum Data Set (MDS) dated 02/06/17 revealed the resident had moderately impaired cognition and required the limited assistance of one person with dressing. The MDS indicated that it was very important for the resident to choose his clothes.<br><br>Observation on 03/19/17 at 1:53 PM revealed Resident #4 dressed in a hospital gown. Resident #4's three family members were in the room.<br><br>Interview with Resident #4 on 03/19/17 at 1:54 PM revealed he wanted to get dressed. Resident #4 pointed to a shirt and pants folded on top of the dresser. Resident #4 explained it "disturbed and embarrassed him" to visit with family members dressed in a hospital gown. Resident #4 reported he could not go out of his room or leave the facility with family until he received assistance with dressing. Resident #4 explained he preferred to get dressed before lunch when he had visitors. | F 241 | credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F241<br><br>Resident # 4 was dressed by 3:21pm on 3/19/17.<br><br>On 3/22/17, Resident #9□s Resident Care Specialist was provided re-education on knocking and waiting for a response before entering a resident□s room.<br><br>Resident # 7 was provided with a hand bell on 3/19/17 until her call light was repaired. The call light was repaired on 3/19/17.<br>Resident care specialist caring for Resident # 10 was provided education on correct way to assist a resident with eating on 3/22/17.<br>Resident # 10 is provided non-disposable tableware with each meal as of4/5/17.<br><br>All residents have the potential to be affected. On 3/19/17,<br>maintenance director did a 100% audit on all call lights and all call lights were functioning correctly. On 4/14/17, The business office manager and activity director interviewed all interviewable residents for their preference of time of | |

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| F 241 | Continued From page 5<br><br>Interview with Nurse #4 on 03/19/17 at 1:58 PM revealed Resident #4's assigned Nurse Aide (NA), NA #1, was off the nursing unit for a lunch break. Nurse #4 explained NA #1 would assist Resident #4 upon her return from lunch at 2:30 PM.<br><br>Interview with NA #1 on 03/19/17 at 2:35 PM revealed Resident #4 required assistance with dressing. NA #1 reported Resident #4 refused her assistance after breakfast at approximately 9:00 AM. NA #1 explained she could not force Resident #4 to get dressed at that time and did not have the time to return due to other assigned residents. NA #1 reported Resident #4 would receive assistance before the shift ended at 3:00 PM.<br><br>Observation on 03/19/17 at 3:21 PM revealed Resident #4 fully dressed. Resident #4 left the facility accompanied by two family members.<br><br>Interview with the Director of Nursing (DON) on 03/21/17 at 10:02 AM revealed Resident #4 should receive assistance with dressing before the lunch meal. The DON explained she expected staff to re-approach in the morning and not wait until the end of the shift.<br>2. Resident #9 was admitted to the facility on 1/31/15.<br><br>Review of a quarterly MDS dated 12/22/16 assessed Resident #9 with clear speech, understood/understands, intact cognition, and required limited staff assistance with toileting.<br><br>An observation on 3/19/17 at 2:16 PM revealed NA #6 knocked on the opened room door of | F 241 | day for being dressed and care plans will updated if needed, based on residents answer.<br><br>The business office manager and activity director interviewed all interviewable residents about staff knocking on door and waiting for response before entering on 4/14/17.<br><br>All staff will be re-educated by Social services/DON/ADON/ Department managers, on dressing residents at the time of their choosing , knocking and waiting for a response before entering a residents room, on procedure for reporting equipment that needs repairing, location of extra call lights, on timely call bell response, on the correct way to assist a resident with meals and the use of non-disposable tableware at all meals. . Education will be completed by 4/21/17.<br><br>Department managers will observe residents during rounds for : being dressed timely;, staff sitting at residents level during assisting with meals, Use of non-disposable tableware during meals, staff members for knocking on doors 5x/weekly x2 weeks, then 3x weekly x 2, then 1xweekly x4.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented | |

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Resident #9. After knocking, NA #6 entered the resident's room without awaiting permission to enter. Resident #9 was in his room conversing with visitors and the roommate was observed in bed with severe cognitive impairment.

An interview with Resident #9 on 3/19/17 at 2:18 PM revealed NA #6 just entered his room without his permission, but this was not the first time this occurred. Resident #9 stated staff entering resident rooms without permission was previously discussed during Resident Council meetings, but that staff still entered his room without permission "all the time" and so he stopped bringing it up. Resident #9 further stated it was especially annoying when staff entered his bathroom without his permission, particularly while the bathroom was in use. Resident #9 further stated that staff did not leave the bathroom, when they realized it was in use, but rather proceeded to complete the task they came for. Resident #9 stated this just happened recently, but he could not recall the name of the staff member.

An interview on 3/20/17 at 3:20 PM with NA #6 revealed she provided nursing care to Resident #9 at times. NA #6 stated that "I have walked in on him in the bathroom once or twice, but I walk out, I didn't realize he was in there, I may have forgotten to knock, I apologized. I knocked when I came in his room yesterday, but I did not wait to be invited in because I was going to assist his roommate." NA #6 stated that she was trained to knock, give her name, state the care she would provide and allow the resident to invite her in.

An interview on 3/22/17 at 12:31 PM with housekeeper #1 revealed that she observed Resident #9 in the bathroom a few times in the

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past. She stated that the bathroom door was closed, she knocked, stated who she was, but when she did not hear anything, she walked in and Resident #9 was seated on the toilet. Housekeeper #1 stated she apologized and then came out, but that she was trained that she should knock on the door and await a response before entering.

An interview on 3/22/17 at 3:00 PM with the DON revealed she expected staff to await resident permission before entering their room/bathroom.

3. Resident #7 was admitted to the facility 7/3/15.

Review of Resident #7's quarterly MDS dated 2/2/17, revealed an assessment of clear speech, understood/understands, intact cognition, required extensive staff assistance with activities of daily living, upper extremity impairment on one side, and bilateral lower extremity impairment.

A care plan updated 3/20/17 identified Resident #7 required staff to anticipate her needs, should have her call light accessible, be encouraged to use her call light to request staff assistance and receive prompt response when assistance was requested.

Resident #7 was observed in bed in her room on 3/19/17 at 1:55 PM. Her call light was on and visible outside her door to the hallway.

Resident #7 was observed in bed in her room on 3/19/17 at 2:35 PM. Her call light was on and visible outside her door to the hallway. Resident #7 stated in interview that her call light was broken since Saturday (3/18/17) and that she had already informed staff, but staff did not provide a

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means for her to contact the nurse's station. Resident #7 stated "I holler out when I need help and I don't like that, I would like a bell."

Medication Aide (MA) #1 was observed on 3/19/17 at 2:39 PM to enter Resident #7's room with a call light cord, removed the current call light cord that was attached to the wall and replaced it with a new cord; Resident #7's call light remained on/lit. MA #1 stated she was just made aware that Resident #7's call light was broken and she would try to get it fixed. On 3/19/17 at 2:47 PM MA #1 returned to Resident #7's room with a hand bell, asked Resident #7 to demonstrate the ability to use and the resident did.

An interview on 3/19/17 at 3:09 PM with Nurse #1 revealed the call light for Resident #7 was broken since 3/18/17, 3P - 11P shift. Nurse #1 stated Resident #7 reported the problem to staff on Saturday, 3/18/17 and Nurse #1 tried to change out the call light cord, but the call light still did not work. Nurse #1 stated that she did not document the repair on the maintenance log because she thought the maintenance director would be in the facility over the weekend and she planned to tell him when she saw him or when he came to work on Monday (3/20/17). Nurse #1 stated she had not seen the maintenance director yet, but that staff were monitoring Resident #7 frequently. Nurse #1 confirmed that Resident #7 normally used her call light to request staff assistance, but since her call light was broken, Resident #7 called out to staff to get assistance.

An interview on 3/19/17 at 3:38 PM with NA #5 revealed she was the assigned NA for Resident #7 on Saturday, 3/18/17 for the 3P - 11P shift. NA

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#5 stated that Resident #7 did not have a working call light on Saturday, 3/18/17, her call light was still broken and so Resident #7 called out to staff when she needed something. NA #5 stated Resident #7 would normally use her call light to request staff assistance.

An interview on 3/21/17 at 10:25 AM with NA #2 revealed she was the assigned NA for Resident #7 on Saturday, 3/18/17, 7A - 3P shift and was aware that the resident's call light was broken. NA #2 stated that she informed Nurse #1 of the broken call light and checked on Resident #7 frequently throughout the shift. She stated Resident #7 was capable of using her call light and would typically do so, but on Saturday, 3/18/17 and Sunday, 3/19/17, Resident #7 called out to staff when she needed assistance.

An interview on 3/22/17 at 3:00 PM with the DON revealed she was made aware on Sunday, 3/19/17 when she arrived at the facility that the call light for Resident #7 was broken. The DON stated she expected staff to provide residents with a means to contact the nurses station so that a resident did not have to yell to get staff's attention.

4a. Resident #10 was re-admitted to the facility on 12/20/11.

Review of Resident #10's quarterly MDS dated 2/16/17 revealed an assessment of clear speech, able to be understood, usually understands, moderately impaired cognition and required set up help with supervision during meals.

Observation of Resident #10's lunch meal on 3/19/17 at 1:57 PM revealed the lunch meal tray

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contained a disposable container of cranberry juice and a disposable carton of milk. There was no available glass or straw on the meal tray. Resident #10 drank the juice and milk from the disposable containers without a straw.

Observation of Resident #10's dinner meal on 3/19/17 at 5:51 PM revealed the dinner meal tray included a disposable carton of milk. There was no available glass or straw on the meal tray. Resident #10 drank the milk from the disposable carton without a straw.

Interview with Resident #10 on 3/19/17 at 5:55 PM revealed he drank beverages from disposable containers because he did not have a glass to pour the items into and he did not have a straw. Resident #10 stated he would prefer to receive his foods in non-disposable tableware, but no one offered that. Resident #10 stated "I should at least be offered a straw. Shouldn't a person have that?"

An interview on 3/19/17 at 6:21 PM with nurse aide (NA) #9 revealed she assisted Resident #10 to set up his dinner meal that evening, but she did not offer him a glass for his milk or a straw because these items were not available on his meal tray.

An interview on 3/20/17 at 3:15 PM with NA #2 revealed she assisted Resident #10 during his lunch meal on 3/19/17 to set up his tray, but that she did not offer him a glass/straw for the milk/juice because these items were not available on his meal tray.

An interview on 3/22/17 at 3:00 PM with the director of nursing (DON) revealed she expected

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residents to be offered non-disposable tableware and straws per their preference for a dignified dining experience.

4b. Resident #10 was re-admitted to the facility on 12/20/11.

Review of Resident #10's quarterly MDS dated 2/16/17 revealed an assessment of clear speech, understood/usually understands, moderately impaired cognition and required set up help with supervision during meals. Resident #10's February 2017 care plan indicated that due to cognitive impairment, staff should face the resident and make eye contact when providing care.

Observation of Resident #10's lunch meal on 3/19/17 from 1:57 PM to 2:07 PM revealed NA #2 stood in front of the resident while the resident sat in his wheelchair and NA #2 fed him lunch. Resident #10 was observed to hyper-extend his head/neck and looked up to receive his food. A chair was observed available in the room next to the resident.

An interview with Resident #10 on 3/19/17 at 2:07 PM revealed he would prefer for staff to sit down when assisting him with his meals. He stated "I should see their faces, there is a chair right there."

An interview on 3/20/17 at 3:15 PM with NA #2 revealed she assisted Resident #10 on 3/19/17 with his lunch meal at his request. She stated that at times he fed himself, but lately he had uncontrollable behaviors/outbursts that caused him to throw items. NA #2 stated that she was trained to sit or stand when assisting residents

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with their meals; she knew there was an available chair in the room, but that she chose to stand.

An interview on 3/22/17 at 3:00 PM with the DON revealed she expected staff to sit and assist residents with meals at eye level or per the resident's preference.

5. Resident #4 was admitted to the facility on 01/30/17.

Review of Resident #4's admission MDS dated 02/06/17 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #4 required set up and supervision with eating.

Observation of Resident #4's breakfast meal on 03/20/17 at 8:05 AM revealed the meal tray contained a disposable carton of milk. There was no straw or empty glass on the breakfast meal tray. Resident #4 poured milk from the carton into a bowl of cold cereal. Resident #4 drank orange juice from a non-disposable glass.

Interview with Resident #4 on 03/20/17 at 8:06 AM revealed he did not drink milk from the carton since it "poured down the sides of my mouth and it is sloppy" without a straw or glass.

An interview on 3/22/17 at 3:00 PM with the director of nursing (DON) revealed she expected residents to be offered non-disposable tableware and straws per their preference for a dignified dining experience.

6. An observation of a breakfast meal cart for the 100 hall occurred on 3/20/17 at 8:52 AM. Breakfast meal trays for 3 residents were observed on the cart with milk cartons and no

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glassware or straws available for resident use.

An observation of the lunch meal tray line occurred on 3/20/17 from 11:51 AM to 12:10 PM. A total of 70 glasses were observed stored in storage racks, clean and available for use, but not in use. The lunch tray line was observed with the following disposable items available and placed on resident's lunch meal trays without glassware or straws provided for resident use:
·21 disposable cartons of milk
·3 disposable cartons of a high calorie nutritional shake
·42 disposable containers of thickened beverages
·66 disposable containers of juice

An interview with the certified dietary manager (CDM) on 3/20/17 at 11:55 AM revealed the dietary staff prepared lunch on 3/20/17 for a resident census of 91. An additional interview with the CDM on 3/20/17 at 12:50 PM revealed the following non-disposable tableware items were available for use:
·Ceramic dessert bowls, 150
·Clear dessert bowls 115
·Glasses, 328

A follow-up interview with the CDM occurred on 3/20/17 at 3:25 PM and revealed that she attended a staff meeting and discussed a plan to provide glassware to residents per their preference for beverages/supplements purchased in disposable containers. The CDM stated that the plan was for dietary staff to provide glassware on each resident's meal tray and allow nursing staff to pour the beverages into glassware per resident preference. The CDM stated this was to be implemented on Sunday, 3/19/17, but she failed to advise dietary staff to

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| F 241 | Continued From page 14<br>implement the plan. The CDM stated that beverages were provided to residents in disposable containers for the past year and that dietary staff had not offered residents the option to receive juice, milk, nutritional supplements, frozen supplements/ice cream and yogurt in non-disposable tableware. The CDM further stated that a plan had not been developed regarding offering non-disposable tableware for frozen items or yogurt and that if a resident requested a straw, nursing staff should provide it.<br><br>An interview on 3/21/17 at 6:00 PM with the administrator revealed the facility discussed moving towards a plan for "fine dining" in the previous week, but that the plan for implementation was not final. He stated that the facility had sufficient non-disposable tableware and he expected dietary staff to use the non-disposable tableware items that were available.<br><br>An interview on 3/22/17 at 3:00 PM with the director of nursing (DON) revealed she expected residents to be offered non-disposable tableware and straws per their preference for a dignified dining experience. | F 241 | | |
| F 244 SS=E | 483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br><br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. | F 244 | | 4/21/17 |

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| F 244 | Continued From page 15<br><br>(A) The facility must be able to demonstrate their response and rationale for such response.<br><br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br>This REQUIREMENT is not met as evidenced by:<br>Based on a resident interview (Resident #9), staff interviews and review of Resident Council minutes for 3 months (January 2017, February 2017 and March 2017), the facility failed to resolve and respond to Resident Council concerns related to timely call bell response.<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 1/31/15. Review of a quarterly minimum data set (MDS) assessment dated 12/22/16 assessed Resident #9 with clear speech, understood/understands, adequate vision and intact cognition.<br><br>An interview on 3/19/17 at 2:18 PM with Resident #9 revealed that he no longer used his call bell now because "it takes hours for a response." Resident #9 stated that a grievance related to the length of time residents wait for staff to respond to call bells was discussed during the last 3 Resident Council (RC) meetings (January - March 2017) and nothing was being done. Resident #9 stated that last night (Saturday, 3/18/17) he turned on his call light twice to request staff's help turning off the heat in his room, but both times he waited at least 30 minutes and fell asleep, when he awoke, his call light had been turned off. He stated that he was | F 244 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F244<br><br>The concerns voiced during the resident council meeting on 4/3/17 were documented and addressed.<br>Resident #9□s concern regarding timely call bell response was resolved on 4/17/17.<br>The activity director was educated by the administrator on 3/27/17 regarding addressing all concerns voiced during resident council on a concern form.<br><br>All residents have the potential to be affected<br><br>The Administrator/DON/ADON will re-educate managers on addressing concerns and following through with the | |

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| F 244 | Continued From page 16<br>not sure how long it took for someone to respond, but it was more than 30 minutes and he did not get the assistance he wanted to turn off the heat. Resident #9 was observed with a clock at his bedside and stated he used his clock to monitor the time.<br><br>A review of Resident Council (RC) minutes for January - March 2017 revealed a repeated resident grievance recorded for nursing discussion as "call bell response time depending on staff member/shift" and "call bell response time, person, not shift."<br><br>An interview on 3/21/17 at 11:00 AM with the activity director (AD) revealed she facilitated RC meetings and currently there were no officers assigned. The AD stated that when a grievance was voiced during RC, she completed a concern form and provided it to the manager of the department related to the grievance for follow up. The AD stated she did not address the follow up to RC grievances with the manager once she gave them the grievance and that she did not know how RC grievances were resolved. The AD stated that untimely call bell response had been an ongoing grievance voiced during RC for different residents and that she did not document, nor could she recall the residents who voiced this grievance. The AD stated she did not know which supervisor/manager she provided the grievance to for follow up. The AD stated that she did not discuss the resolution for call bell response during the next RC meeting, but rather expected the supervisor/manager to address it with residents individually and she did not know how the RC grievance related to untimely call bell response was resolved. | F 244 | concern process. Education will be completed by 4/21/17<br><br>Concerns voiced in resident council meetings will be addressed on a concern form and provided to the manager of the appropriate department. The manager of the department will address the concern within 5 days. Social services/designee will interview the resident voicing the concern within 2 weeks after concern has been addressed x 3 months.<br><br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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An interview on 3/21/17 at 5:53 PM with the administrator revealed that when he first arrived, a couple years ago, call bell response time was a problem, but he met with RC and encouraged residents not to wait until RC meetings to express their concerns. The administrator stated that call bell response time had improved, but that residents still voiced concerns. The administrator stated that when a resident filed a grievance about call bell response during RC, the grievance was addressed for that individual resident, but a follow up to RC was not provided. The administrator stated that recently 2 residents filed grievances related to call bell response. The grievances were investigated, staff were in-serviced and staff continued to follow up with the individual residents. The administrator stated that he rounded in the facility at night unannounced to monitor call bell response time, provided several "re-education huddles", but that he did not document/track this monitoring.

An interview on 3/22/17 at 3:00 PM with the director of nursing (DON) revealed that both she and the administrator were aware of resident concerns related to untimely call bell responses. The DON stated that as a result of this concern, the administrator began rounding at different times/shifts, to monitor call bell response times and staff were in-serviced, but the monitoring/in-services was not documented/tracked. The DON stated that staff were encouraged to answer call lights in 10 -15 minutes. The DON stated that when a resident was admitted, the resident/family was informed that call lights were answered in 20 - 25 minutes, and depending on the need, staff would try to meet the need at that time, otherwise, staff would identify the need and give the resident a time that

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| F 244 | Continued From page 18<br>staff would return to provide assistance. The DON stated that she expected that when a call light was answered and the care could not be provided immediately, that staff gave the resident a time that a staff member would return to provide the care. The DON stated that staff may not be able to provide the care when the resident wanted it, but that staff should inform the resident of what time to expect the care to be provided and then return and provide the care at that time. The DON did not provide an expectation regarding when nursing care should be provided. | F 244 | | |
| F 248 SS=D | 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>(c) Activities.<br><br>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident, family member and staff interviews, and record review, the facility failed to provide an ongoing activity program which met the individual interests and needs to enhance the quality of life for 1 of 4 sampled bedfast residents (Resident #3).<br><br>The findings included: | F 248 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by | 4/21/17 |

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| F 248 | Continued From page 19<br>Resident #3 was admitted to the facility on 12/07/16 with diagnoses which included schizophrenia, chronic osteomyelitis, Stage 4 pressure sores, bilateral above the knee amputations and depression.<br><br>Review of Resident #3's admission Minimum Data Set (MDS) dated 12/14/16 revealed cognition and mood were not assessed. The MDS indicated an interview conducted with Resident #3 indicated it was very important to listen to music, keep up with the news and do favorite activities. The MDS indicated Resident #3 required the extensive assistance of two persons with bed mobility, did not walk and did not move between locations in the room or nursing unit. The MDS did not trigger the Activities Care Area Assessment.<br><br>Review of Resident #3's care plan revised 01/09/17 revealed interventions for pain management included diversional activities such as positioning, music and television. The care plan did not contain an activity care plan.<br><br>Observation on 03/19/17 at 3:14 PM revealed Resident #3 in bed next to a window with open blinds. Resident #3 was awake, alert and looked out the window. A privacy drape was drawn between Resident #3 and her roommate. There was no sound in the room.<br><br>Interview with Resident #3 on 03/19/17 at 3:15 PM revealed Resident #3 was oriented to self but disoriented to time, place and situation. Resident #3 began to talk about a car then began to talk to a person not visible in the room.<br><br>Observation on 03/19/17 at 6:14 PM revealed | F 248 | the provisions of federal and state law.<br><br>F248<br><br>Resident #3□s activity care plan was initiated on 4/12/17. A radio was placed in her room on 4/12/17.<br><br>All residents who prefer in room activities have the potential to be affected.<br><br>Residents who prefer in room activities will be audited for activity of choice availability by activity director on 4/18/17. Any resident found lacking, will have the activity of choice made available.<br><br>Department managers will audit residents who choose in room activities 5x/week x2, then 3x weekly x 2, then 1xweekly x4 for activities of choice availability.<br>The results of monthly monitoring will be brought to monthly and to quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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Resident #3 in bed next to a window with open blinds. Resident #3 was awake, alert and looked out the window. A privacy drape was drawn between Resident #3 and her roommate. There was no sound in the room.

Observation on 03/20/17 at 7:37 AM and at 8:37 AM revealed Resident #3 in bed next to a window with open blinds. Resident #3 was awake, alert and looked out the window. A privacy drape was drawn between Resident #3 and her roommate. There was no sound in the room.

Observation on 03/20/17 at 9:54 AM, 11:22 AM, 2:33 PM and at 5:05 PM revealed Resident #3 in bed next to a window with open blinds. Resident #3 was awake, alert and looked out the window. A privacy drape was drawn between Resident #3 and her roommate. There was no sound in the room.

Telephone interview with Resident #3's family member on 03/21/17 at 2:15 PM revealed Resident #3 lived independently until August 2016. Resident #3's family member explained Resident #3 was a very social person who loved all kinds of music. The family member reported Resident #3 experienced many recent deaths of family members in the past several years and coped with grief by listening to music and talking to others.

Interview with Nurse #2 on 03/21/17 at 2:47 PM revealed Resident #3 remained bedfast. Nurse #2 explained Resident #3 received family member visits and talked to direct care staff. Nurse #2 explained Resident #3's cognition varied and visually hallucinated at times. Nurse #2 reported Resident#3 was bedfast and left the

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room only for outside medical appointments. Nurse #2 reported Resident #3 became agitated when the privacy drape was pulled back.

Interview with Nurse Aide (NA) #2 on 03/20/17 at 3:00 PM revealed she cared for Resident #3 full time on the day shift. NA #2 reported Resident #3 responded to conversation during care and was confused. NA #2 reported Resident #3 remained in bed and rejected repositioning at times. NA #2 explained Resident #3 did not like to see her roommate so the privacy drape was always pulled. NA #2 reported she had not received direction to provide Resident #3 with music or television programs.

Interview with NA #4 on 03/21/17 at 3:10 PM revealed Resident #3 enjoyed conversation and was confused. NA #4 explained Resident #3 recognized family members but could not initiate conversation or make requests. NA #4 reported Resident #3 did not get out of bed.

Interview with the Activity Director (AD) on 03/22/17 at 1:11 PM revealed Resident #3 received one to one visits twice weekly from either herself or a volunteer. The AD reported Resident #3 attended one large group music activity approximately 3 weeks ago due to a family member's encouragement. The AD was not aware of the care plan intervention of music and television as diversional activities. The AD reported the facility could provide a radio in Resident #3's room.

Interview with the Director of Nursing (DON) on 03/22/17 at 1:18 PM revealed she was aware that Resident #3 "really loved" music which could easily be provided. The DON reported she was

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| F 248 | Continued From page 22<br>not aware staff did not provide music when Resident #3 was awake. | F 248 | | |
| F 250 SS=D | 483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and palliative care nurse interviews, and record review, the facility failed to schedule a meeting with family members to discuss expectations of palliative care, pain management and prognosis as requested by the palliative care nurse for 1 of 4 sampled residents who required pain management (Resident #3).<br><br>The findings included:<br><br>Resident #3 was admitted to the facility on 12/07/16 with diagnoses which included schizophrenia, chronic osteomyelitis, Stage 4 pressure sores, bilateral above the knee amputation and depression.<br><br>Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/31/17 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others. The MDS indicated Resident #3 received scheduled and as needed pain medication. The MDS indicated Resident #3 occasionally experienced moderate pain and did not receive non-medication intervention for pain.<br><br>Review of Resident #3's care plan initiated on | F 250 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F250<br><br>Resident # 3□s continues on Palliative care services upon readmission on 4/10/17. Her care plan was updated on 4/12/17. Family meeting is scheduled for Friday 4/21/17.<br><br>All residents with orders for Palliative Care have the potential to be affected.<br><br>Residents with ordered Palliative Care were audited by DON on 4/14/17. Care plans will be updated and family notified as indicated by 4/21/17. | 4/21/17 |

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| F 250 | Continued From page 23<br>12/20/16 and reviewed on 01/09/17 revealed interventions for pain management included observe for signs of pain, diversional activities and pain medication administration. There was no documentation regarding the involvement of palliative care.<br><br>Review of an initial palliative care nurse consultation dated 02/03/17 revealed Resident #3 experienced chronic and acute pain. The palliative care nurse documented a recommendation for Resident #3's family members to meet and clarify expectations of care since a poor outcome was anticipated despite maximal medical support. The palliative nurse documented recommendation to change the dosage times of Resident #3's scheduled pain medications.<br><br>Review of a palliative care nurse consultant progress note dated 02/24/17 revealed no recommendations in pain management. The palliative care nurse documented attempts to schedule a meeting with Resident #3's family members.<br><br>Interview with MDS Coordinator #1 on 03/21/17 at 3:43 PM revealed the facility's social worker coordinated communication with hospice but not palliative care. MDS Coordinator #1 explained nursing staff managed Resident #3's pain. MDS Coordinator #1 was unable to provide a staff member assigned to palliative care coordination.<br><br>Interview with the facility's social worker (SW) on 03/21/17 at 4:19 PM revealed she would not contact the palliative care nurse until the next scheduled care plan meeting in April 2017. The SW explained the nursing staff implemented | F 250 | The DON/ADON/Unit manager will provide education to nurses on procedure of notifying social services for palliative care. Education will be completed by 4/21/17<br>The DON/designee will review orders during clinical startup for any palliative referrals and will verify with social services as indicated 5x/week x2, 3x/week x 2, then weekly x 4.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 250 | Continued From page 24<br>interventions for Resident #3's pain without social work involvement.<br><br>A second interview with the facility's SW on 03/22/17 at 9:23 AM revealed Resident #3's family members visited regularly. The SW was not aware of the palliative care nurse's documentation of attempts to schedule a meeting to discuss expectations of pain management and care.<br><br>Interview with the Administrator on 03/22/17 at 4:44 PM revealed he expected the facility's social worker to coordinate Resident #3's palliative care services.<br><br>Telephone interview with Resident #3's palliative care nurse on 03/22/17 at 4:53 PM revealed she communicated with Resident #3's nurse practitioner and medication nurse orally. The palliative care nurse reported the written notes of 02/03/17 and 02/24/17 were provided to the facility. | F 250 | | |
| F 253 SS=D | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, a resident interview (Resident #9), staff interviews and review of facility records, the facility failed to maintain a commode secure to the floor for 7 months and a grab bar to the wall (Room #113) for a resident who used the bathroom independently, for 1 of 10 resident bathrooms observed. | F 253 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. | 4/21/17 |

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| F 253 | Continued From page 25<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 1/31/15. Review of a quarterly minimum data set assessment dated 12/22/16 assessed Resident #9 with clear speech, understood/understands, intact cognition, and required limited staff assistance with toileting.<br><br>Interview with Resident #9 on 3/19/17 at 2:18 PM and observation of the bathroom revealed that the commode in his bathroom was not secure to floor, shifted at the base when he sat on it and had been like that since he was admitted to the facility in 2015. Resident #9 stated he voiced this concern multiple times to staff (previous and current maintenance director and his nurse) and during Resident Council meetings, staff attempted to repair it 3 - 4 times and said it was fixed, but eventually the commode would loosen at the base and begin to shift again when he sat on it. Resident #9 also stated that the right side grab bar in his bathroom became loose about 2 weeks before it eventually broke while he was using it to transfer to the commode and he reported it to the maintenance director when it initially became loose and again when it broke. He stated that the grab bar continued to loosen as he used it over the 2 weeks and eventually broke while he used it to transfer. Resident #9 stated "I almost fell, I don't feel safe to use my bathroom now, so I either use the urinal or the bathroom in the shower room."<br><br>Review on 3/19/17 at 6:00 PM of the 100/200 hall maintenance book revealed there was no documentation of recent repairs to secure the commode or to repair the loosened grab bar for | F 253 | The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F253<br><br>The toilet was immediately replaced and secured to the tile floor with anchoring cement on 3/23/17. The broken grab bar was repaired and reinstalled on 3/20/17 and checked to be secure and stable. The Grab bars will be replaced with a more secure model that will have added bracing on the sides and will be cemented into the concrete floor.<br><br>All residents have the potential to be affected. A 100% audit of toilets and grab bars was performed by the maintenance director on 3/20/17. All were found to be secure and stable.<br><br>All staff will be reeducated by Maintenance director/DON/ADON on the procedure on reporting equipment that is malfunctioning or needing repair. Education will be completed by 4/21/17.<br><br>The maintenance director will note repairs made in the maintenance book at the corresponding nurses station at each occurrence within 72 hours.<br>The Administrator to review maintenance log 3 x weekly during morning meeting.<br>The department managers will look in rooms 5 x weekly during rounds to ensure items used by resident used by resident are safe.<br>Maintenance director will make weekly | |

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| F 253 | Continued From page 26<br>the bathroom of room 113.<br><br>Observations on 3/19/17 at 2:18 PM, 3/19/17 at 6:02 PM, 3/20/17 at 11:15 AM, and 3/21/17 at 4:00 PM revealed the commode in the bathroom of room 113 was positioned to the left, unsecured to the floor and shifted easily at the base when moved. The right grab bar was missing with 3 wholes observed in the wall to the right of the commode.<br><br>An interview on 3/21/17 at 4:00 PM with the maintenance director revealed he kept a maintenance book at each nurses' station for staff to record repairs that were needed and he reviewed the book daily. The maintenance director stated that he tried to make all repairs within 10 days, but that it usually did not take him that long. The maintenance director described the commode in room 113 as requiring repeated repairs to secure it to the floor, he stated "his toilet has always been like that, I have been trying to secure his toilet for a while, I fix it then it gets loose again." He stated "I can only tighten it so much because it is secured to tile, if I try to tighten it too much it will crack the tile." The maintenance director stated he tried to come up with a permanent solution to secure the commode to the floor, and had an idea that he planned to try on 3/22/17. The maintenance director stated that Resident #9 may have mentioned the loosening grab bar to him, but he forgot because he did not record it in the maintenance book. The maintenance director stated Resident #9 told him that the grab bar in his bathroom was loose sometime ago and told him again on Wednesday, 3/15/17 when it broke off the wall. The maintenance director stated that he told Resident #9 that he forgot and apologized | F 253 | rounds to ensure environmental safety. The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 253 | Continued From page 27<br>for not making the repair.<br><br>An interview on 3/21/17 at 5:55 PM with the administrator revealed he expected repairs to be recorded in the maintenance book so that the maintenance director would not forget to make the repairs. He stated the commode in room 113 should be fixed even if that required a replacement commode.<br><br>An interview on 3/22/17 at 12:00 PM with nurse aide (NA) #10 revealed Resident #9 preferred to be independent with toileting, but required and used the grab bars in his bathroom to do so. NA #10 stated he knew that the commode in room 113 had been repaired a few times, once because it was leaking, but he was not aware that the right grab bar was missing.<br><br>An interview on 3/22/17 at 12:31 PM with housekeeper #1 revealed she previously observed the commode in room 113 "crooked" at the base when she cleaned the bathroom, but she did not report/record it in the maintenance book, because she saw it that way so often and thought that was how it was supposed to be. Housekeeper #1 said that then she noticed at times the commode was positioned straight and other times crooked, but "I didn't think anything about it."<br><br>A follow up interview with the maintenance director on 3/23/17 at 3:20 PM revealed he secured the commode in room 113 to the floor using an anchoring cement, a product he used about a year ago to successfully repair another commode, but had not yet tried on the commode in room 113. | F 253 | | |

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| F 272 | Continued From page 28 | F 272 | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>(b) Comprehensive Assessments<br><br>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br><br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the<br>care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct<br>observation and communication with | F 272 | | 4/21/17 |

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| F 272 | Continued From page 29<br>the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br><br>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to cognition and behavior for 1 of 11 sampled residents (Resident #3).<br><br>The findings included:<br><br>Resident #3 was admitted to the facility on 12/07/16 with diagnoses which included schizophrenia, chronic osteomyelitis, multiple Stage 4 pressure sores and depression. Resident #3 was discharged to the hospital on 12/22/16 and readmitted to the facility on 01/07/17.<br><br>Review of Resident #3's admission Minimum Data Set (MDS) dated 12/14/16 revealed cognition was not assessed. The MDS indicated Resident #3 demonstrated physical behaviors directed toward others. The MDS indicated Cognitive Loss and Behavioral Symptoms were among the areas that triggered for further analysis.<br><br>Review of Resident #3's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/22/16 | F 272 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F272<br><br>1) One resident was affected by the alleged deficiency of failing to assess how condition affected function and quality of life related to cognition and behavior. The normal correction for this resident would be to complete a significant correction. However, resident #3 went out to the hospital and was not available for the significant correction assessment to be completed. Resident #3 returned from hospital on 4/10/2017 and a new comprehensive assessment has been scheduled with ARD of 4/18/2017. The | |

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| F 272 | Continued From page 30<br>revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to cognitive loss. The CAA indicated no documentation of a Brief Interview for Mental Status (BIMS) score, description of care rejection or staff assessment of Resident #3's cognition. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.<br><br>Review of Resident #3's Behavioral Symptom Care Area Assessment (CAA) dated 12/22/16 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to behavioral symptoms. The CAA contained no staff assessment, resident or family input regarding past and current behaviors. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.<br><br>Observation on 03/20/17 at 8:37 AM revealed Nurse Aide (NA) #2 informed Resident #3 she would begin to reposition her in bed. Resident #3 began to slap NA #2 on the arm. NA #2 immediately stopped.<br><br>Observation on 03/21/17 at 9:08 AM revealed Resident #3 refused nail care and repositioning.<br><br>Interview with MDS Coordinator #1 on 03/22/17 at 9:17 AM revealed the facility's social worker completed the Cognitive Loss/Dementia and Behavioral Symptoms CAAs. MDS Coordinator #1 was not aware the CAAs contained no documentation. MDS Coordinator #1 explained she thought the CAA was complete. | F 272 | cognition and behavior section will be completed appropriately.<br><br>2) Any resident having a comprehensive assessment completed has the potential to be affected by the alleged deficient practice. All residents receiving a comprehensive assessment during the last 14 days will be audited to verify behavior and cognition sections are completed appropriately on 4/18/17.<br><br>3) All department heads who complete a portion of the MDS will be in serviced by the RCMD on proper assessment and completion of each of their sections of the MDS assessment. Education will be completed by 4/21/17.<br><br>4) Each comprehensive MDS will be reviewed by a Registered Nurse and logged prior to locking to ensure cognition, and behavior for the MDS assessment are completed properly.<br><br>5) The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 272 | Continued From page 31<br>Interview with the facility's social worker (SW) on 03/22/17 at 9:23 AM revealed she did not do the Cognitive Loss or Behavior Care Area Assessments Resident #3. The SW explained she was not able to meet with Resident #3 until the CAA due date. The SW explained Resident #3 was in the hospital when the 12/22/16 due date occurred so an assessment could not be done.<br><br>Interview with the Director of Nursing (DON) on 03/22/17 at 9:36 AM revealed she expected the SW to conduct and document cognitive loss and behavioral symptoms assessments. | F 272 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly- | F 278 | | 4/21/17 |

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| F 278 | Continued From page 32<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and medical record review, the facility failed to accurately assess a resident for a history of falls on an annual and quarterly Minimum Data Set assessment for 1 of 13 sampled residents reviewed (Resident #9).<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 1/31/15. Diagnoses included contracture of muscle and lack of coordination.<br><br>Review of section J1800 (falls since admission or the prior assessment) for an annual Minimum Data Set (MDS) assessment dated 9/23/16 and a quarterly MDS dated 12/22/16, recorded that Resident #9 had not fallen.<br><br>Medical record review of nurse's notes, incident reports and a care plan updated 12/16/16, revealed Resident #9 sustained a fall on the following dates:<br>·9/5/16<br>·9/11/16<br>·11/24/16 | F 278 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F278<br><br>1) A modification for the alleged miscoding for resident #9 assessments dated 9/23/2016 and 12/22/2016 was completed and submitted on 3/30 2017.<br><br>2) All residents have the potential to be affected by the alleged deficient practice. The Resident Case Management Director(RCMD) or designee will complete an audit of all current residents receiving a comprehensive assessment during the | |

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| F 278 | Continued From page 33<br><br>An interview on 3/23/17 at 11:44 AM with MDS Coordinator #2 revealed she completed both the annual (9/23/16) and quarterly (12/22/16) MDS for Resident #9 and reviewed his medical record and care plan, but missed seeing in his medical record that he fell prior to each MDS assessment.<br><br>An interview on 3/23/17 at 2:38 PM with the director of nursing revealed that she expected each MDS to be completed accurately and the MDS Coordinator to identify any falls that have occurred for a resident. | F 278 | last 14 days to verify accurate assessment of those resident's fall status per RAI manual guidelines on 4/18/17.<br><br>3) The District Resident Case Management Director ( RCMD) will re-educate the interdisciplinary team and MDS staff on accurate coding related to fall status. The RCMD or designee will randomly review 5 completed MDS weekly for 12 weeks to verify accurate coding of falls. Opportunities will be corrected as identified as a result of these audits. Education will be completed by 4/21/17.<br><br>4) The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to implement non-medication care plan interventions for pain | F 282 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan | 4/21/17 |

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| F 282 | Continued From page 34<br>management for 1 of 4 sampled residents who received pain management interventions (Resident #3).<br><br>The findings included:<br><br>Resident #3 was admitted to the facility on 12/07/16 with diagnoses which included schizophrenia, chronic osteomyelitis, Stage 4 pressure sores, bilateral above the knee amputation and depression.<br><br>Review of Resident #3's admission Minimum Data Set (MDS) dated 12/14/16 revealed cognition was not assessed. The MDS indicated Resident #3 experienced frequent severe pain and received scheduled and as needed pain medication. The MDS specified Resident #3 did not receive non-medication intervention for pain.<br><br>Review of Resident #3's Pain Care Area Assessment (CAA) dated 12/20/16 revealed Resident #3 complained of pain from sacral pressure sores with pain management by medication. The Pain CAA indicated a decision to proceed to care plan for pain management interventions.<br><br>Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/31/17 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others. The MDS indicated Resident #3 received scheduled and as needed pain medication. The MDS indicated Resident #3 occasionally experienced moderate pain and did not receive non-medication intervention for pain.<br><br>Review of Resident #3's care plan initiated on | F 282 | of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F282<br><br>The care plan for resident #3 was updated by the RCMD on 4/11/17.<br><br>2) All residents with care plans have the potential to be affected by the alleged deficient practice.<br>The RCMD or designee will audit all resident care plans for those residents receiving a comprehensive assessment for the last 14 days to ensure accuracy per RAI Manual guidelines on 4/18/17..<br><br>3)The RCMD will re-educate the MDS Coordinators and any other IDT members that are participating in care plan completion per the RAI Manual guidelines. Education will be completed by 4/21/17<br>The RCMD or designee will audit 10 completed pain care plans each week for 12 weeks to verify accuracy per RAI Manual guidelines. Once completion is achieved, the RCMD or designee will audit 2 completed pain care plans each week for 4 weeks. If no additional issues are identified, the RCMD or designee will then audit 1 pain care plan each month on an ongoing basis. Opportunities will be corrected as identified. | |

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| F 282 | Continued From page 35<br>12/20/16 and reviewed on 01/09/17 revealed interventions for pain management included diversional activities such as positioning, music and television.<br><br>Review of Resident #3's monthly physician's orders dated 03/01/17 revealed Resident #3 received scheduled pain medications before dressing changes and as needed in addition to a narcotic pain patch.<br><br>Observation on 03/19/17 at 3:21 PM revealed Nurse #1 removed a soiled gastrostomy tube dressing from Resident #3. Resident #3 complained of pain during the dressing change. Nurse #1 stopped the dressing change when requested by the surveyor. There was no music, conversation with Resident #3 and the television was not on.<br><br>Interview with Nurse #1 on 03/19/17 at 3:26 PM revealed Resident #3's gastrostomy tube leaked and the skin was irritated. Nurse #1 reported she intended to administer Resident #3 pain medication and perform the dressing change later in the shift.<br><br>Interview with Resident #3 on 03/19/17 at 3:30 PM revealed the skin hurt when touched and did not want the dressing change done "for a-while." The TV at the foot of Resident #3's bed was not on and there was no radio in the room<br><br>Observation on 03/20/17 at 8:37 AM revealed Nurse Aide (NA) #2 informed Resident #3 she would begin to reposition her in bed. Resident #3 began to slap NA #2 on the arm. NA #2 immediately stopped. The TV at the foot of Resident #3's bed was not on and there was no | F 282 | The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 282 | Continued From page 36 | F 282 | | |

radio in the room

Observation on 03/21/17 at 9:08 AM revealed Resident #3 refused nail care and repositioning. The TV at the foot of Resident #3's bed was not on and there was no radio in the room.

Observation on 03/20/17 at 11:03 AM revealed Resident #3 held both leg stumps and expressed pain. The television was not on and there was no radio in the room. Nurse #2 administered pain medication to Resident #3.

Telephone interview with Resident #3's family member on 03/21/17 at 2:15 PM revealed Resident #3 usually hugged both of her leg stumps for comfort from phantom pain and enjoyed music.

Interview with Nurse #2 on 03/21/17 at 2:47 PM revealed she was not aware of non-medication interventions for Resident #3.

Interview with Nurse Aide (NA) #2 on 03/20/17 at 3:00 PM revealed she cared for Resident #3 full time on the day shift. NA #2 reported Resident #3 responded to conversation during care but did not like to be touched. NA #2 explained she reported Resident #3's complaints of pain to the nurse who would administer medication. NA #2 reported she had not received direction to provide Resident #3 with music or television programs.

Interview with NA #4 on 03/21/17 at 3:10 PM revealed Resident #3 complained of pain when repositioned. NA #4 explained she reported complaints of pain to the nurse who administered medication. NA #4 had not received direction to provide Resident #3 with music or television

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| F 282 | Continued From page 37<br>programs.<br><br>Interview with the Activity Director (AD) on 03/22/17 at 1:11 PM revealed Resident #3 received one to one visits twice weekly from either herself or a volunteer. The AD was not aware of the care plan intervention of music and television as diversional activities. The AD reported the facility could provide a radio in Resident #3's room.<br><br>Interview with the wound nurse on 03/22/17 at 1:15 PM revealed Resident #3 received pain medication before dressing changes. The wound nurse was not aware of Resident #3's pain care plan interventions of diversional activities.<br><br>Interview with the Director of Nursing (DON) on 03/22/17 at 4:13 PM revealed Resident #3 should receive the non-medication pain interventions directed by the care plan. The DON explained the nursing unit manager communicated care plan interventions. The DON reported a vacancy in the nursing unit manager position caused lack of communication to direct care staff.<br><br>Interview with MDS Coordinator #2 on 03/23/17 at 2:46 PM revealed she wrote Resident #3's care plan. MDS Coordinator #2 explained she relied on the nurses to communicate the interventions of the care plan. | F 282 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the | F 309 | | 4/21/17 |

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| F 309 | Continued From page 38<br>facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident, staff, and nurse practitioner interviews, and record review, the facility failed to assess pain and stop during a dressing change when Resident #3 cried out in pain for 1 of 4 sampled residents who required dressing changes (Resident #3). | F 309 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. | |

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| F 309 | Continued From page 39<br>The findings included:<br><br>Resident #3 was readmitted to the facility on 01/07/17 with diagnoses which included placement of a gastrostomy tube for severe malnutrition.<br><br>Review of Resident #3's physician's orders dated 01/24/17 revealed the gastrostomy tube site dressing was to be changed daily with a dry dressing on the 7:00 PM to 7:00 AM shift.<br><br>Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/31/17 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others. The MDS indicated Resident #3 received scheduled and as needed pain medication. The MDS indicated Resident #3 occasionally experienced moderate pain.<br><br>Review of Resident #3's care plan revealed interventions for the gastrostomy tube site included provision of local care to the tube site as ordered.<br><br>Review of a nurse practitioner's (NP) note dated 03/08/17 revealed a description of Resident #3's gastrostomy tube site. The NP documented a small amount of yellow/tan colored drainage with blood noted to the tube insertion site<br><br>Review of a NP note dated 03/09/17 revealed Resident #3's gastrostomy tube site was red with no pus drainage.<br><br>Observation on 03/19/17 at 3:21 PM revealed Nurse #1 washed her hands and donned gloves. Resident #3 was supine on an air mattress. | F 309 | The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F309<br><br>Treatment was stopped and Resident # 3 was administered pain medication at 1538 on 3/19/17 and treatment delayed until pain medication took effect. Nurse was educated by DON on 3/19/17 about assessing for pain, before, during and after treatment.<br><br>All residents receiving treatments have the potential to be affected.<br><br>Residents with treatments were interviewed by Treatment nurse on 3/20/17 about pain during treatments and if medication is offered/administered. No other resident was affected.<br><br>The DON/ADON/Unit manager/designee will educate nurses on assessing for pain before during and after performing treatments, to include stopping if resident complains of pain, administering pain med, then completing task after pain medication takes effect.<br>Nurses will be re-educated on cleansing technique, using soap and water or wound cleanser, patting dry and covering site with appropriate dressing. Education will be completed by 4/21/17.<br><br>Random observations of Nurses performing treatments will be done by DON/ADON/Unit manager 5x/weekly x2 | |

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| F 309 | Continued From page 40<br>Nurse #1 removed the 4 by 4 drain sponge around the gastrostomy tube, which was half wet with tan colored liquid. A white, thick paste was on the skin surrounding the gastrostomy tube approximately 2 inches in diameter. Nurse #1 reported the white substance was calazime protectant paste placed to protect Resident #3's red and sensitive skin. Nurse #1 discarded the soiled dressing, washed her hands and donned gloves.<br><br>Continued observation on 03/19/17 at 3:24 PM revealed Nurse #1 began to wipe away the white substance with a dry 4 by 4 gauze pad. Resident #3 yelled out, "that hurts" and cried. Nurse #1 did not stop and did not ask Resident #3 about the complaint of pain. Nurse #1 began to wipe the skin with a new dry 4 by 4 gauze pad and was stopped by the surveyor. Nurse #1 placed a clean drain sponge on the site.<br><br>Interview with Nurse #1 on 03/19/17 at 3:26 PM revealed she did not assess Resident #3 for pain during the dressing change. Nurse #1 reported she should have used soap and water when she began to remove the calazime protectant paste. Nurse #1 reported she should have stopped when Resident #3 began to complain of pain. Nurse #1 explained Resident #3's tube leaked and the skin was irritated. Nurse #1 reported she intended to administer Resident #3 pain medication and perform the dressing change later in the shift. Nurse #1 reported she made a mistake when she tried to remove the paste.<br><br>Interview with Resident #3 on 03/19/17 at 3:30 PM revealed the skin hurt when touched and did not want the dressing change done "for a-while." | F 309 | weeks, then 3x weekly x 2, then 1xweekly x4.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 309 | Continued From page 41<br>Interview with Resident #3 on 03/20/17 at 7:37 AM revealed she did not remember the dressing change which occurred on 03/19/17 and was confused.<br><br>Observation on 03/20/17 at 11:22 AM revealed Nurse #2 used wound cleanser to remove the calazime protectant paste from the skin surrounding the gastrostomy tube. Resident #3 had no complaints of pain.<br><br>Interview with the Nurse Practitioner on 03/21/17 at 8:18 AM revealed Resident #3's feeding tube leaked and the skin around the stoma was very sensitive. The NP explained Resident #3's gastrostomy tube site should be cleansed with soap and water or wound cleanser, rinsed, patted dry and covered with a clean dressing. The NP explained application of the calazime protectant paste should not be done since the zinc oxide in the paste is difficult to remove.<br><br>Interview with the Director of Nursing (DON) on 03/21/17 at 8:29 AM revealed she expected staff to assess for pain before, during and after dressing changes. The DON reported Nurse #1 should have used soap and water and immediately stopped when Resident #3 complained of pain. | F 309 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) 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.<br>This REQUIREMENT is not met as evidenced by: | F 312 | | 4/21/17 |

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| F 312 | Continued From page 42<br>Based on observations, a resident interview and medical record review, the facility failed to provide nail care (Resident #10) and use clean water to wash a resident's back (Resident #7) for 2 of 4 sampled residents dependent on staff for assistance with activities of daily living.<br><br>The findings included:<br><br>1. Resident #10 was re-admitted to the facility on 12/20/11. Diagnoses included intellectual disabilities, stroke, hemiplegia right dominant side, and stiffness left hand/left wrist.<br><br>Review of Resident #10's quarterly MDS dated 2/16/17 revealed an assessment of clear speech, understood/usually understands, moderately impaired cognition, no behaviors and required extensive staff assistance with personal hygiene.<br><br>Review of Resident #10's care plan, updated 2/22/17, revealed he required staff assistance with activities of daily living (ADL) due to his history of a stroke and limited physical mobility. The goal and care plan interventions included to assist Resident #10 with ADL as needed.<br><br>Resident #10 was observed in his room on 3/19/17 at 1:57 PM, 3/19/17 at 5:51 PM, 3/20/17 at 8:48 AM, and 3/20/17 at 11:15 AM with dark colored debris underneath each fingernail of both his right and left hands.<br><br>During an interview on 3/20/17 at 11:15 AM with Resident #10, he was asked if he would like to have his nails cleaned, and he stated "Yes ma'am, that will be alright."<br><br>An interview on 3/20/17 at 3:15 PM with nurse | F 312 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F312<br><br>Resident #10 had his nails cleaned immediately on 3/20/17.<br>Resident Care Specialist of Resident # 7 was provided re-education on 3/21/17<br><br>All residents have the potential to be affected.<br><br>100% audit was performed by nursing on 3/20/17 and nails cleaned and trimmed as indicated.<br><br>The DON/ADON/Unit manager/designee will re-educate nursing staff on correct way to give a bath and performing nail care. Education will be completed by 4/21/17.<br><br>Resident care specialist will clean nails on shower days 2 x weekly with follow up by charge nurse to ensure nail care is completed. Department managers will observe resident□s nails for cleanliness during rounds 5x/week. The charge nurse is to be notified of any resident needing nail care. The results of the audit will be | |

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| F 312 | Continued From page 43<br>aide (NA) #2 revealed she was the assigned NA to care for Resident #10 on 3/19/17 and 3/20/17 for the 7:00 AM - 3:00 PM shift. NA #2 stated that Resident #10 was cooperative with nursing care and required staff assistance to complete his ADL. NA #2 stated she assisted Resident #10 with a bed bath on both days, but that she did not notice the debris underneath his fingernails. She stated "I should have paid attention to that when I gave him a bed bath."<br><br>An interview with Nurse #2 (charge nurse) on 3/21/17 at 4:00 PM revealed she observed Resident #10's fingernails to have dark matter underneath and confirmed that he needed nail care. Nurse #2 further stated that staff should monitor Resident #10's nails and provide nail care with morning care/showers and as needed.<br><br>An interview on 3/22/178 at 3:00 PM with the Director of Nursing revealed she expected staff to monitor Resident #10's fingernails and provide nail care with ADL care and as needed.<br><br>2. Resident #7 was admitted on 07/03/2015. Review of the quarterly Minimum Data Set (MDS) dated 02/02/2017 assessed her as totally dependent for bathing.<br><br>An observation on 03/21/2017 at 10:28 AM of Resident #7 revealed Nurse Aide (NA) #2 removed Resident #7's incontinent brief which had urine on it. She washed the resident's face, and then her chest and abdomen. She then washed the resident's perineal area and cleaned the urine off the area. She put the used wash cloth back into the basin of bath water. She had two used wash cloths in the basin at the same time and did not switch the water before | F 312 | reported to the DON. Further education/training will be provided as indicated.<br><br>The DON/ADON/Unit manager/designee will observe staff performing a bath 5x/week x2, then 3x weekly x 2, then 1xweekly x4. The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 312 | Continued From page 44 | F 312 | | |

continuing with the resident's bath. She had the resident roll to her side and washed her back from the neck to her buttocks with the same water used to wash the perineal area. NA #2 changed the water after washing the resident's back and then continued with the resident's bath.

An interview on 03/21/2017 at 2:13 PM with NA # 2 revealed she switched wash cloths and knew there were "bodily fluids" (urine). "I had extra wash cloths and switch the water whenever it gets dirty like when was I was cleaning her and I saw it got dirty."

An interview on 03/22/2017 at 9:40 AM with the Assistant Director of Nursing (ADON) revealed that the nurse aides when they did perineal care were to wipe from front to back, were to use one wash cloth for the arms and upper body, a separate one for the face, one for the perineal area and wipes for the buttocks. She stated the water was to be changed when doing the upper body and changed when doing the lower body. Staff were to change gloves when they washed the resident's perineal area, wash their hands and put on new gloves.

An interview on 03/23/2017 at 10:51 AM with the Director of Nursing (DON) revealed their procedure manual for care was an online manual which staff had access on facility's computers. She stated they used universal precaution for hand washing and where gloves were concerned. The Wound Nurse (WN) was present at the time of the interview and revealed they had in-services recently provided to staff regarding infection control. She stated they had a staff development person who was responsible for staff training and came to the facility weekly. The WN described

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| F 312 | Continued From page 45<br>the process for bathing a resident. She stated one would sanitize their hands using hand sanitizer, wash the top part of the body, empty the water, then wash the bottom part of the body. She stated staff would wash the face, the top of the body, change the water, wash the resident's "private parts" and wash them front to back. She stated they have videos they watched on how to bath a person.<br><br>An interview on 03/23/2017 at 10:51 AM with the DON revealed it was her expectation that staff would follow proper facility procedures when providing care to the residents. | F 312 | | |
| F 322 SS=D | 483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. | F 322 | | 4/21/17 |

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| F 322 | Continued From page 46<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review the facility failed to provide a tube feeding at the correct flow rate for a resident (Resident #8) for 57 days and failed to provide proper gastrostomy tube site care for a resident (Resident #3). This was for two of four residents reviewed with gastrostomy tubes.<br><br>Findings included:<br><br>1. Resident #8 was admitted 09/20/2016 with diagnoses that included quadriplegia, dysphagia, and gastrostomy.<br><br>A review of the physician's order dated 11/03/2016 revealed the flow rate for Resident #8's tube feeding was 85 milliliters/hour (ml/hr.).<br><br>A quarterly Minimum Data Set (MDS) dated 01/19/2017 specified the resident received greater than 51% of his calories via feeding tube. Review of the physician's order dated 01/24/2017 for Resident #8's tube feeding rate indicated the flow rate was increased to 95ml/hr.<br><br>A review of his care plan dated 03/09/2017 indicated that he was receiving a tube feeding per the physician's orders for his nutrition.<br>An observation on 03/20/2017 at 05:53 AM revealed a tube feeding was infusing at a rate of 85 ml/hr.<br><br>On 3/21/2017 at 11:12 AM Nurse # 2 was observed hanging a new tube feeding, water for flushes and replaced the tube feeding tubing. She started the new bottle of tube feeding at a flow rate of 85ml/hr. | F 322 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F322<br><br>The rate on Resident # 8□s tube feeding was increased to correct rate of 95cc/hr on 3/22/17. The order for Jevity 1.5 at 85cc/hr was d/c□d on 3/21/17. A medication variance was completed on 4/13/17.<br><br>Resident # 3 received a new order for G-tube care on 3/20/17.<br><br>All residents receiving tube feedings have the potential to be affected.<br><br>The orders for residents receiving enteral nutrition were audited for accuracy by DON on 4/14/17. No other resident was found to be affected.<br><br>Nurses will be educated by the DON/ADON/Unit manager on correct procedure for discontinuing orders in the electronic medical record when new orders are received. Nurses will be re-educated on following physician orders | |

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| F 322 | Continued From page 47<br><br>An interview on 03/21/2017 at 11:27 AM with the Dietary Manager (DM) and the Registered Dietician (RD) by phone revealed the dietician had increased Resident #8 tube feeding. She requested the DM to get their weight loss communication book. Review of the note for Resident #8 on 03/10/2017 indicated Resident #8 had triggered for a 14% weight loss for 6 months but his weight had increased 1.7 pounds (lb.) for 1 month, March 2017. His weight was stable at 254-259 lb. since 01/25/2017.<br><br>A review of Resident #8 Medication Administration Records (MAR) for January-March 2017 indicated there were two orders for Resident #8's tube feeding that were current orders, one rate at 85ml/hr. and one rate at 95ml/hr.<br><br>An interview on 03/21/2017 at 03:21 PM with Nurse # 2 revealed she had been setting the pump rate at 85ml/hr. when she worked and the order on the Medication Administration Record (MAR) indicated Resident #8's tube feeding was at a rate of 85ml/hr. She stated when a new order was entered the old order was to be discontinued. She had not seen an order entered on the MAR for the rate at 95cc/hr.<br><br>An interview on 03/21/2017 at 03:45 PM with the Assistant Director of Nursing (ADON) revealed she had entered the order for Resident #8's tube feeding rate to be increased to 95 ml/hr. on 01/24/2017. She stated she had not discontinued the old order of 85ml/hr. which is the facility's procedure when updating and entering a new order. | F 322 | and on cleansing technique, using soap and water or wound cleanser, patting dry and covering site with appropriate dressing. Education will be provided by 4/21/17.<br><br>The DON/ADON/Unit manager will review orders during clinical startup to verify accuracy of orders 5x/weekly x 2, then 3 x weekly x2 then weekly x 4.<br>Clinical administrative staff will observe nurses for correct orders and procedure while performing treatment 5x/weekly x2, then 3 x weekly x 2 then weekly x 4.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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An observation on 03/21/2017 at 03:45 PM with the ADON revealed Resident #8's tube feeding was infusing at 85ml/hr. The ADON changed the rate the infusion rate to the correct rate of 95ml/hr.

An interview on 03/21/2017 at 04:00 PM with the Director of Nursing (DON) revealed she expected physician orders to be entered correctly and orders to be discontinued when required. The unit manager had the responsibility of checking orders but that position had been vacant so there was not the second check on orders being done. She expected tube feedings to run at the correct rate as ordered.

An interview on 03/22/2017 at 09:13 AM with the Nurse Practitioner (NP) revealed Resident #8 had a weight of 252 pounds 02/16/2017 and a weight of 258 pounds on 03/16/2017. The rate of his tube feedings not being changed from January didn't impact his weight since he was on 85ml/hr. and gained weight. His current weight was a good weight for him. He had no infections or wounds, and his blood sugars were in good control.

An interview on 03/22/2017 at 05:45 PM with the Registered Dietician (RD) Resident #8 revealed she was not aware the rate of his tube had not been increased to 95ml/hr. as she had recommended. She stated his weight was stable for the month of March 2017. She stated she considers weekly weights, if a resident had a pressure wound(s), time to provide care to the resident intermittently, and time for flushes in her calculation for tube feedings.

An additional interview on 03/23/2017 at 11:45 AM with the RD revealed that Resident #8 did not

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have any negative outcomes from his tube feeding not being run at the increased rate of 95ml/hr. that was ordered on 01/24/2017. I looked at him on 03/17/2017 and he was a good weight range that was holding, but I thought he was at the 95ml/hr. We weren't able explain if his weight variation was caused by the diuretic he was on since he stabilized his weight and had an increase of 1.7 lb. without the tube feeding rate increase.

2. Resident #3 was readmitted to the facility on 01/07/17 with diagnoses which included placement of a gastrostomy tube for severe malnutrition.

Review of Resident #3's physician's orders dated 01/24/17 revealed the gastrostomy tube site dressing was to be changed daily with a dry dressing.

Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/31/17 revealed an assessment of moderately impaired cognition with the ability to understand and be understood by others.

Review of Resident #3's care plan revealed interventions for the gastrostomy tube site included provision of local care to the tube site as ordered and observe for sign of infection.

Review of a nurse practitioner's (NP) note dated 03/08/17 revealed a description of Resident #3 s gastrostomy tube site. The NP documented a small amount of yellow/tan colored drainage with blood noted to the tube insertion site. The NP ordered a Gastroenterology consultation as soon as possible.

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Review of a NP note dated 03/09/17 revealed documentation Resident #3 went to a Gastroenterologist who refused to evaluate Resident #3 due to lack of a decision maker presence. The NP documented the facility rescheduled the appointment for the following week when Resident #3's family member could attend. The NP described the tube site as with redness and no pus drainage.

Observation on 03/19/17 at 3:21 PM revealed Nurse #1 removed the 4 by 4 drain sponge from the area around Resident #3's gastrostomy tube. A white, thick paste was on the skin surrounding the gastrostomy tube approximately 2 inches in diameter.

Interview with Nurse #1 on 03/19/17 at 3:26 PM revealed staff used the calazime protectant paste to protect skin from irritation. Nurse #1 explained Resident #3's gastrostomy tube leaked and the skin was irritated.

Observation on 03/20/17 at 11:22 AM revealed Nurse #2 washed her hands and donned gloves. Resident #3 was supine on an air mattress. Nurse #2 removed three, stacked 4 by 4 gauze pads, which were half wet with feeding formula like fluid. The dressing was initialed and dated by Nurse #3, the night shift nurse. A white, thick paste was on the skin surrounding the gastrostomy tube approximately 2 inches in diameter. Nurse #2 reported the white substance was a barrier cream placed to protect Resident #3's red and sensitive skin. Nurse #2 discarded the soiled stoma dressing, washed her hands and donned gloves. Nurse #2 used wound cleanser to remove the barrier cream, patted the area dry

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| F 322 | Continued From page 51<br>and placed a clean drain sponge on the site. Resident #3's skin was red around the tube site.<br><br>Interview with Nurse #2 on 03/20/17 at 4:25 PM revealed there was no physician's order for calazime protectant paste application to the gastrostomy tube site. Nurse #2 provided a new physician's order dated 03/20/17 to cleanse the gastrostomy-tube site every shift with wound cleanser, pat dry and apply dry dressing.<br><br>Interview with the NP on 03/21/17 at 8:18 AM revealed Resident #3's gastrostomy tube site should be cleansed with either soap and water or wound cleanser, rinsed, patted dry and covered with a clean dressing. The NP explained application of the calazime protectant paste should not be done since the zinc oxide in the paste is difficult to remove.<br><br>Interview with the Director of Nursing (DON) on 03/21/17 at 8:29 AM revealed nurses should cleanse Resident #3's gastrostomy tube site as directed by the physician and/or NP.<br><br>Telephone interview with Nurse #3 on 03/21/17 at 2:56 PM revealed she initiated application of the calazime protectant paste when Resident #3's skin around the gastrostomy tube became red. Nurse #3 explained she did not obtain a physician's order since the calazime protectant paste was used after incontinence care for skin protection and Resident #3 had a Gastroenterologist appointment scheduled. | F 322 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents. | F 323 | | 4/21/17 |

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| F 323 | Continued From page 52<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, a resident interview (Resident #9), staff interviews, and medical record review the facility failed to maintain a toilet secured to the floor and a grab bar secured to the wall for a resident's safe transfer from a wheelchair to the commode for 1 of 4 sampled residents reviewed for accidents.<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 1/31/15. Diagnoses included multiple sclerosis and paraplegia. | F 323 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F 323 | |

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| F 323 | Continued From page 53<br><br>Review of a quarterly minimum data set assessment dated 12/22/16 assessed Resident #9 with clear speech, understood/understands, intact cognition, supervision with transfers, unsteady when moving from a seated to standing position or on/off toilet and required limited staff assistance with toileting.<br><br>Review of Resident #9's December 2017 care plan revealed he was at risk for falls due to a history of falls, unsteady gait/poor balance and required supervision/limited staff assistance with transfers. The goal included to assist Resident #9 with transfers as needed to maintain the highest level of independent function. Interventions included for staff to encourage Resident #9 to use his call bell to request staff assistance with transfers, offer/assist to toilet as accepted and provide assistive devices as indicated/accepted.<br><br>Medical record review of nurse's notes and incident reports, on the following dates, revealed Resident #9 fell, without injury on:<br>·9/5/16, trying to stand to dress himself, independently<br>·9/11/16, toileting himself in the shower room, independently<br>·11/24/16, toileting himself in his bathroom, independently<br><br>Interview with Resident #9 on 3/19/17 at 2:18 PM and observation of his bathroom revealed that the commode in his bathroom was not secure to floor, shifted at the base when he sat on it and had been like that since he was admitted to the facility in 2015. Resident #9 stated he voiced this concern multiple times to staff (previous and current maintenance director and his nurse) and | F 323 | The toilet was immediately replaced and secured to the tile floor with anchoring cement on 3/23/17. The broken grab bar was repaired and reinstalled on 3/20/17 and checked to be secure and stable. The Grab bars will be replaced with a more secure model that will have added bracing on the sides and will be cemented into the concrete floor.<br><br>All residents have the potential to be affected.<br>A 100% audit of toilets and grab bars was performed by the maintenance director on 3/20/17. All were found to be secure and stable.<br><br>All staff will be reeducated by Maintenance director/DON/ADON on the procedure on reporting equipment that is malfunctioning or needing repair.<br>Education will be completed by 4/21/17.<br><br>The maintenance director will note repairs made in the maintenance book at the corresponding nurses station at each occurrence within 72 hours.<br>The Administrator to review maintenance log 3 x weekly during morning meeting.<br>The department managers will look in rooms 5 x weekly during rounds to ensure items used by resident used by resident are safe.<br>Maintenance director will make weekly rounds to ensure environmental safety.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will | |

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| F 323 | Continued From page 54<br>staff attempted to repair it 3 - 4 times and said it was fixed, but eventually the commode would loosen at the base and begin to shift again when he sat on it. Resident #9 also stated that the right side grab bar in his bathroom became loose about 2 weeks before it eventually broke while he was using it to transfer to the commode and he reported it to the maintenance director when it initially became loose and again when it broke. Resident #9 stated "I almost fell, I don't feel safe to use my bathroom now, so I either use the urinal or the bathroom in the shower room."<br><br>Review on 3/19/17 at 6:00 PM of the 100/200 hall maintenance book revealed there was no documentation to repair the loosened grab bar or the unsecured commode for the bathroom of room 113.<br><br>The bathroom of room 113 was observed on 3/19/17 at 2:18 PM, 3/19/17 at 6:02 PM, 3/20/17 at 11:15 AM, and 3/21/17 at 4:00 PM. In each observation, the commode was positioned to the left, unsecured to the floor and shifted easily at the base when moved. The right grab bar was missing from the bathroom wall beside the toilet.<br><br>An interveiw on 3/21/17 at 2:35 PM with Nurse #1 revealed she routinely worked with Resident #9 on the 7AM- 3PM shift, but she was not aware that his commode in his bathroom was not secured to the floor, or that the right grab bar in his bathroom was missing. Nurse #1 stated Resident #9 preferred to transfer independently, but was safer to do so if he used assistive devices like grab bars.<br><br>During an interview on 3/21/17 at 4:00 PM with the Maintenance Director he described the | F 323 | be adjusted according to results and success of the plan implemented | |

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| F 323 | Continued From page 55 | F 323 | | |

commode in room 113 as requiring repeated repairs to secure it to the floor, he stated "his toilet has always been like that, I have been trying to secure his toilet for a while, I fix it then it gets loose again." He stated "I can only tighten it so much because it is secured to tile, if I try to tighten it too much it will crack the tile." The Maintenance Director stated he tried to come up with a permanent solution to secure the commode to the floor, and had an idea that he planned to try on 3/22/17. The Maintenance Director stated that Resident #9 may have mentioned the loosening grab bar to him, but he forgot because he did not record it in the maintenance book. The Maintenance Director stated Resident #9 told him that the grab bar in his bathroom was loose sometime ago and told him again on Wednesday, 3/15/17 when it broke off the wall. The Maintenance Director stated that he told Resident #9 that he forgot and apologized for not making the repair.

An interview on 3/21/17 at 5:55 PM with the Administrator revealed he expected the commode in room 113 should be fixed even if that required a replacement commode.

An interview on 3/22/17 at 11:55 AM with Nurse #5 revealed she routinely worked with Resident #9 on the 7:00 AM - 3:00 PM shift and that he preferred to remain independent as much as possible and used his own bathroom for toileting. Nurse #5 stated she was not aware that the commode in his bathroom was not secured to the floor or that his bathroom was missing a grab bar. Nurse #5 stated Resident #9 used grab bars in his bathroom for transfers to the commode.

An interview on 3/22/17 at 12:00 PM with nurse

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aide (NA) #10 revealed Resident #9 preferred to be independent with toileting, but required and used the grab bars in his bathroom to do so. NA #10 stated he knew that the commode in room 113 had been repaired a few times, once because it was leaking, but he was not aware that the right grab bar was missing.

A follow up interview and observation occurred on 3/22/17 at 12:10 PM with Resident #9. The resident was observed to transfer from his bed to his wheelchair and from his wheelchair to the commode while supervised by NA #10. Resident #9 locked the brakes to his wheelchair and held both wheelchair arm rests to transfer to his wheelchair and held both grab bars in the bathroom to transfer to the commode. Resident #9 was observed unsteady and with involuntary tremors during each transfer.

An interview on 3/22/17 at 12:31 PM with Housekeeper #1 revealed she previously observed the commode in room 113 "crooked" at the base when she cleaned the bathroom, but she did not report it, because she saw it that way so often and thought that was how it was supposed to be. Housekeeper #1 said that then she noticed at times the commode was positioned straight and other times crooked, but "I didn't think anything about it."

An interview on 3/23/17 at 2:10 PM with the Director of Nursing (DON) revealed Resident #9 valued his independence and chose not to ask for staff assistance with transfers. The DON stated that the facility conducted weekly interdisciplinary team meetings to discuss falls, how/why the fall occurred, and how to reduce the risk of reoccurrence. The DON stated that Resident #9's

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| F 323 | Continued From page 57<br>recent falls occurred because he chose not to ask for staff assistance with transfers for continued independence with transfers. The DON stated that follow-up to Resident #9's falls included re-education to encourage him to ask for assistance and that staff should ensure he had the assistive devices necessary, to include a secured commode and grab bars, to maintain his safety during transfers.<br><br>A follow up interview with the Maintenance Director on 3/23/17 at 3:20 PM revealed he secured the commode in room 113 to the floor using an anchoring cement, a product he used about a year ago to successfully repair another commode, but had not yet tried on the commode in room 113. | F 323 | | |
| F 325 SS=D | 483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. | F 325 | | 4/21/17 |

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| F 325 | Continued From page 58<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and medical record review, the facility failed to provide a high calorie frozen nutritional supplement as prescribed by the physician to a resident (Resident #10) with active weight loss for 1 of 3 sampled residents reviewed for weight loss.<br><br>The findings included:<br><br>Resident #10 was re-admitted to the facility on 12/20/11. Diagnoses included adult failure to thrive (FTT), anorexia, dysphagia, anemia, gastroesophageal reflux disease and depression.<br><br>Review of Resident #10's most recent minimum data set, a quarterly, dated 2/16/17, revealed an assessment of clear speech, understood/usually understands, moderately impaired cognition, required set up help with supervision during meals and with recent weight gain due to a physician prescribed weight gain regimen.<br><br>Review of Resident #10's February 2017 care plan revealed a potential for decline in nutritional status regarding FTT and anorexia. The care plan goal included a plan for no significant weight changes, with interventions for staff to provide diet/supplements as ordered by the physician.<br><br>Medical record review revealed Resident #10 had the following physician's order:<br>·11/23/15, regular diet<br>·8/26/16, fortified foods<br>·9/1/16, house supplement, 120 milliliters (ml) 4 times daily (QID) for weight loss<br>·9/2/16, frozen nutritional treat, 3 times daily (TID) | F 325 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F325<br><br>Resident # 10 received his frozen nutritional treat on the evening meal..<br><br>All residents receiving frozen nutritional treats have the potential to be affected. An audit performed by the CDM of all residents receiving frozen nutritional treats will be completed on 4/19/17. Tray cards will be updated as indicated.<br><br>Certified Dietary Manager (CDM) reeducated dining services department on tray accuracy on 3/22 /17. The dietary staff have been re-educated by the Dietary Manager on the importance of tray accuracy, texture, therapeutic restrictions, special requests, cutlery, beverages, adaptive equipment and supplements. Education was 3/22/17.<br><br>Nursing staff will be educated by CDM/DON on importance of ensuring resident receives frozen nutritional treat on tray as ordered. Education will be | |

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| F 325 | Continued From page 59<br>for weight loss<br>·9/15/16, high calorie shake between meals for anorexia<br>·12/12/16, increase Remeron (antidepressant) to 15 milligrams (mg) at bedtime for FTT/depression/appetite stimulant<br><br>A 2/7/17 progress note by the registered dietitian (RD), revealed Resident #10 received a regular fortified foods diet, appetite stimulant (Remeron), frozen nutritional treat TID, house supplement QID, high calorie shake between meals and ate approximately 50% of his meals. His weight was assessed with no significant changes and a plan to continue his diet/supplements as ordered.<br><br>Continued medical record review revealed Resident #10 currently sustained a 3.18% weight loss in 30 days as evidenced by the following weights:<br>·2/1/17, 154.4 pounds (#)<br>·3/13/17, 150#<br>·3/22/17, 149.5#<br><br>Observation of Resident #10's lunch meal on 3/19/17 at 1:57 PM revealed nurse aide (NA) #2 set up his tray. The tray card recorded he should receive a regular, fortified foods diet and a frozen nutritional treat. The frozen nutritional treat was not observed on the lunch tray. An interview on 3/19/17 at 2:07 PM with Resident #10 revealed that he did not always receive all of his supplements. He stated that he did not get his "ice cream" for lunch that day and that he wanted it. NA #2 removed Resident #10's lunch tray on 3/19/17 at 2:08 PM, but did not offer/provide the frozen nutritional treat.<br><br>Observation of Resident #10's dinner meal on | F 325 | completed by 4/21/17.<br><br>The CDM will complete tray accuracy tool 3x/week for 8 weeks, 2x/week x 4 weeks, then once a week for one month. In addition to that, the district manager will monitor for accuracy and compliance weekly during facility visits.<br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |

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| F 325 | Continued From page 60 | F 325 | | |

3/19/17 at 5:51 PM revealed the tray card recorded he should receive a regular, fortified foods diet and a frozen nutritional treat. Resident #10 received/consumed the frozen nutritional treat with his dinner meal.

An interview on 3/19/17 at 6:00 PM with Nurse #1 revealed Resident #10 should receive supplements as ordered to help him with his weight, because he had a history of weight loss. Nurse #1 stated that the supplements should come on the meal tray, but if not, staff should contact the dietary department and get any items that were not provided.

An interview on 3/20/17 at 3:15 PM with NA #2 revealed she assisted Resident #10 with his lunch meal on 3/19/17 and that she should review the tray card and make sure all items were provided. NA #2 stated Resident #10 did not receive his "ice cream" on 3/19/17 with his lunch meal tray and that there were other times he did not receive his "ice cream." NA #2 "We should go to dietary and get it, but sometimes we get busy and forget; I forgot Sunday."

An interview on 3/20/17 at 3:25 PM with the certified dietary manager (CDM) revealed dietary staff should place all items on the resident's meal tray according to the tray card, if nursing staff identified that a food item was missing, the CDM expected nursing staff to inform the dietary department, because the food item could have been missed during the tray line.

A telephone interview on 3/22/17 at 5:35 PM with the RD revealed she had not assessed Resident #10 for several months because he had not triggered for significant weight loss. The RD

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| F 325 | Continued From page 61<br>stated Resident #10 had a goal for weight gain and that she would like to see him reach his usual weight (165 - 175#), received a physician prescribed weight gain diet and should receive supplements/diet as ordered by the physician.<br><br>An interview on 3/23/17 at 2:38 PM with the director of nursing revealed she expected nutritional supplements to be provided to residents as ordered by the physician. | F 325 | | |
| F 356 SS=C | 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) 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:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census.<br><br>(2) Posting requirements. | F 356 | | 4/21/17 |

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| F 356 | Continued From page 62<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents and visitors.<br><br>(3) Public access to posted nurse staffing data. 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.<br><br>(4) Facility data retention requirements. 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review the facility failed to post accurate nurse staffing information on 5 of 8 days reviewed.<br><br>The findings included:<br><br>Observations on Sunday, 03/19/2017 at 1:45 PM and at 6:30 PM revealed the nursing staff information posted at the front desk was dated Thursday, 03/16/2017.<br><br>An interview on 03/23/2017 at 8:04 AM with the staffing scheduler revealed that she completed the daily nurse staff information and posted it at the front desk. She stated she usually had the staffing information posted by 9:00 AM. She | F 356 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F356<br><br>The daily nurse staffing information is being posted daily since 3/20/17. Re-education was provided to scheduler | |

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| F 356 | Continued From page 63<br>stated the nursing staff posting listed a total census for the both the skilled and independent living sections of the facility. She stated the nurse staff hours included on the posting was only for the skilled nursing beds.<br><br>An interview on 03/23/2017 at 9:30 AM with the Director of Nursing (DON) revealed the supervisors were to post the nurse staffing information on the weekends. There was not a supervisor on duty this past weekend and that is who would have posted the nurse staffing.<br><br>An interview on 03/23/2017 at 11:07 AM with the Administrator revealed that a nurse was to post the nurse staffing on the weekends. If there was no supervisor on duty then the charge nurse or manager on duty was to check that it was posted. He stated the staffing was updated at the nursing stations throughout the day for both the staffing and census. He stated it was his expectation that the census and nurse staffing posted was to be accurate and up to date every day. | F 356 | and manager on duty by the administrator regarding accuracy and<br>Scheduler will be responsible for posting daily staffing Monday through Friday; Manager on duty will be responsible for ensuring daily staffing is posted on Saturday and Sunday; Charge nurses will be responsible for posting during off hours.<br><br>The administrator / designee will verify staffing is posted daily.<br>The results of monthly monitoring will be brought to quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 441 | | 4/21/17 |

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| F 441 | Continued From page 64<br>conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. | F 441 | | |

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| F 441 | Continued From page 65<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review the facility failed to wash hands after providing tracheostomy care and before providing wound care for 1 of 7 residents. (Resident #6).<br><br>The findings included:<br><br>Resident #6 was admitted on 02/01/2017.<br><br>A review of the facility's tracheostomy suctioning procedure dated 08/12/2016 was done. It documented performing hand hygiene after glove removal.<br><br>A review of the facility's hand hygiene procedure dated 04/15/2016 was done. It documented when to use alcohol based sanitizers, washing hands with soap and water and changing gloves.<br><br>An observation on 03/20/2017 at 8:49 AM revealed Nurse #5 was suctioning Resident #6's tracheostomy (trach). Resident #6 uncapped his trach and Nurse #5 had put gloves on. She was using a reusable suction catheter with a sheath | F 441 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.<br><br>F441<br><br>Nurse # 5 was educated on 3/20/17 on following proper infection control practices.<br><br>All residents have the potential to be affected by this alleged deficient practice.<br><br>All staff will be re-educated on proper hand hygiene by the DON/ADON/Unit manager by 4/21/17. Information to include changing of gloves between procedures, wash hands and put on new | |

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| F 441 | Continued From page 66<br>which she pushed back during the intermittent suctioning. She did not change her gloves or wash hands after suctioning and continued to assist the WN with the resident's wound care. She was observed touching the resident's skin and touching some of the material being placed on his wounds during the application of the negative pressure device to Resident #6's sacral and buttocks wounds.<br><br>An interview on 03/23/2017 at 10:51 AM with the DON revealed it was her expectation that staff would follow proper procedures including infection control practices. | F 441 | gloves.<br><br>The DON/ADON/ Unit manager will monitor 5 staff members per week for proper hand hygiene x 2 weeks, then 3 x/week x 2, then weekly x 4.<br><br>The results of monthly monitoring will be brought to monthly and quarterly QAPI meeting to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to results and success of the plan implemented. | |
| F 463 SS=D | 483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>(g) Resident Call System<br><br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -<br><br>(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, a resident interview (Resident #7), staff interviews and medical record review, the facility failed to provide a resident with a means to contact the nurse's station for 24 hours for 1 of 6 sampled residents reviewed with the ability to use their call light.<br><br>The findings included:<br><br>Resident #7 was admitted to the facility 7/3/15. | F 463 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. | 4/21/17 |

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| F 463 | Continued From page 67<br><br>Review of Resident #7's quarterly MDS dated 2/2/17, revealed an assessment of clear speech, understood/understands, intact cognition, and required extensive staff assistance with activities of daily living. Resident #7's March 2017 care plan included interventions for staff to anticipate her needs, keep her call light accessible and encourage its use to request staff assistance.<br><br>Resident #7 was observed in bed in her room on 3/19/17 at 1:55 PM. Her call light was on and visible outside her door to the hallway.<br><br>Resident #7 was observed in bed in her room on 3/19/17 at 2:35 PM. Her call light was on and visible outside her door to the hallway. Resident #7 stated in interview that her call light was broken since Saturday (3/18/17) 7:00 AM - 3:00 PM shift and that she had already informed staff, but staff did not provide a means for her to contact the nurse's station. Resident #7 stated that since her call light was not working that she "hollered out" to get staff assistance, but that she would "like a bell."<br><br>Medication Aide (MA) #1 was observed on 3/19/17 at 2:39 PM to enter Resident #7's room with a call light cord, removed the current call light cord that was attached to the wall and replaced it with a new cord; Resident #7's call light remained on/lit. MA #1 stated she was just made aware that Resident #7's call light was broken and she would try to get it fixed. On 3/19/17 at 2:47 PM MA #1 returned to the resident's room with a hand bell, asked Resident #7 to demonstrate the ability to use and the resident did. | F 463 | F463<br><br>Resident # 7 was provided with a hand bell on 3/19/17 until her call light was repaired. The call light was repaired on 3/19/17.<br><br>All residents have the potential to be affected. On 3/19/17, the maintenance director did a 100% audit on all call lights and all call lights were functioning correctly.<br><br>All staff will be re-educated Maintenance director/DON/ADON/ Department managers on procedure for reporting equipment that needs repairing and location of extra call lights and bells. Education will be completed by 4/21/17<br><br>The maintenance director will note repairs made in the maintenance book at the corresponding nurses station at each occurrence within 72 hours and present all findings and their results to the QAPI (Quality Assurance Performance Improvement) Committee x 3 months for review and discussion. The QAPI Committee will then decide if further necessary steps need to be put in place. | |

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| F 463 | Continued From page 68 | F 463 | | |

An interview on 3/19/17 at 3:09 PM with Nurse #1 revealed the call light for Resident #7 was broken since 3/18/17, 3:00 PM - 11:00 PM shift. Nurse #1 stated Resident #7 reported the problem to staff on Saturday, 3/18/17 and Nurse #1 tried to change out the call light cord, but the call light still did not work. Nurse #1 stated that she thought the Maintenance Director would be in the facility over the weekend and she planned to tell him when she saw him or when he came to work on Monday (3/20/17). Nurse #1 confirmed that Resident #7 normally used her call light to request staff assistance, but since her call light was broken, Resident #7 called out to staff to get assistance with no other means to contact the nurse's station.

An interview on 3/19/17 at 3:38 PM with NA #5 revealed she was the assigned NA for Resident #7 on Saturday, 3/18/17 for the 3:00 PM - 11:00 PM shift. NA #5 stated that Resident #7 did not have a working call light on Saturday, 3/18/17, her call light was still broken and so Resident #7 called out to staff when she needed something. NA #5 stated Resident #7 would normally use her call light to request staff assistance.

An interview on 3/21/17 at 10:25 AM with NA #2 revealed she was the assigned NA for Resident #7 on Saturday, 3/18/17, 7:00 AM - 3:00 PM shift and was aware that the resident's call light was broken. NA #2 stated that she informed Nurse #1 of the broken call light and checked on Resident #7 frequently throughout the shift. She stated Resident #7 was capable of using her call light and would typically do so, but on Saturday, 3/18/17 and Sunday, 3/19/17, Resident #7 called out to staff when she needed assistance.

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| F 463 | Continued From page 69<br>An interview on 3/22/17 at 3:00 PM with the director of nursing (DON) revealed she was made aware on Sunday, 3/19/17 when she arrived at the facility that the call light for Resident #7 was broken. The DON stated she expected staff to provide residents with a means to contact the nurse's station so that a resident did not have to yell to get staff's attention.<br><br>An interview with the Administrator on 3/21/17 at 5:55 PM revealed that the Maintenance Director was in the facility on Saturday, 3/18/17 and had the broken call light for Resident #7 been recorded in the maintenance book, the Maintenance Director could have repaired the broken call light while he was in the facility.<br><br>An interview on 3/22/17 at 11:45 AM with the Maintenance Director revealed he was in the facility on Saturday, 3/18/17 painting, but that he was not made aware that the call light for Resident #7 was broken, otherwise he would have repaired it. | F 463 | | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's | F 520 | | 4/21/17 |

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| F 520 | Continued From page 70<br>staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place June, 2015, October 2015, and July 2016. This was for deficiencies cited during the facility's recertification/complaint investigation surveys conducted on 05/22/15, a complaint survey conducted on 09/29/15 and a recertification | F 520 | This plan of correction is the centers credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. | |

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| F 520 | Continued From page 71<br>survey conducted on 06/30/16. The deficiencies were in the areas of assessment accuracy and provision of assistance with activities of daily living for dependent residents. The continued failure of the facility to sustain compliance during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F278: Based on staff interviews and medical record review, the facility failed to accurately assess a resident for a history of falls on an annual and quarterly Minimum Data Set assessment for 1 of 13 sampled residents reviewed (Resident #9).<br><br>The facility was cited for F278 regarding failure to accurately assess a resident regarding falls. F278 was originally cited during a recertification/complaint investigation survey on 05/22/15 for failure to accurately code hospice services. F278 was recited during a complaint investigation survey on 09/29/15 for failure to accurately code use of pressure relieving mattress, pressure reducing device to chair and a turning/repositioning program. F278 was recited cited during a recertification survey on 06/30/16 for failure to accurately code bowel continence.<br><br>F312: Based on observations, a resident interview, and medical record review, the facility failed to provide nail care (Resident #10) and use clean water to wash a resident's back (Resident #7) for 2 of 4 sampled residents dependent on staff for assistance with activities of daily living. | F 520 | F520<br><br>A QAPI (Quality Assurance Performance Improvement) meeting will be held on 4/20/17 to discuss (F278 MDS accuracy and F312 related to nail care) and develop an immediate plan for improvement and to ensure practices are being maintained.<br><br>The District Director of Clinical Services will provide education to the QAPI (Quality Assurance Performance Improvement) members. Education will be completed by 4/21/17.<br><br>The District Director of Clinical services will randomly review QAPI minutes and attend meetings when possible.<br><br>The QAPI committee will meet more frequently than the required quarterly meeting, meeting at least monthly. The monthly meeting will focus on the requirements of the tags referenced (F278 MDS accuracy and F312 related to nail care) and the committee will develop action plans for process improvements and deficiency correction.<br><br>All results from the action plan steps will be discussed in detail at each QAPI meeting and existing action steps will be revised and/or added to ensure correction.<br><br>The results of the monthly monitoring will be brought to the quarterly QAPI | |

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| F 520 | Continued From page 72<br><br>The facility was cited for F312 regarding failure to provide nail care and clean bath water. F312 was originally cited during a recertification/complaint survey on 05/22/15 for failure to provide nail care. F312 was recited during a recertification survey on 06/30/16 for failure to provide nail care.<br><br>Interview with the Administrator on 03/23/17 at 2:27 PM revealed the facility audited assessment accuracy, identified no problems and stopped monitoring after 12 weeks. The Administrator reported monitoring of provision of assistance with activities of daily living was on-going with no identified problems. | F 520 | committee meeting to ensure quality improvement and to track progress. The medical director will attend the quarterly meeting as required and collaborate with the team for improvements and the QAPI plan will be adjusted according to results and success of the plan implanted. | |