STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	R 05/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MOCKSVILLE	1007 HOWARD STREET MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 241} SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to maintain the dignity of 1 of 3 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72). The Findings Included: Resident #72 was admitted to the facility on 03/24/15 with diagnoses that included non-traumatic intracranial hemorrhage, hemiplegia, hemiparesis, major depressive disorder, anxiety, seizures, and chronic pain. Review of the most recent quarterly minimum data set (MDS) dated 03/05/17 revealed that Resident #72 was cognitively intact, understood what was being said to her and was able to make herself understood and had no behaviors. The MDS also revealed that Resident #72 required extensive to total assistance with activities of daily living (ADLs). An interview and observation was conducted with Resident #72 on 05/18/17 at 11:42 AM. Resident #72 stated that yesterday on 05/17/17 on second shift the 2 Nursing Assistants (NAs) "made fun of me" they were talking to each other and said "she	{F 241}	F241 Steps Taken in regards to those residents found to be affected: On 5/19/2017 a surveyor notified the Administrator, DON, Regional Director of Clinical and Regional Vice President of Operations of the resident concern previously voiced to her on 5/18/2017. Upon learning the resident concern, a 24 hour report was completed and faxed to DHHS and the two nursing assistants were suspended pending investigation. The abuse allegation concluded on 5/19/2017. The allegation was determined to be unsubstantiated and a 5 day report was completed and faxed to DHHS on 5/19/2017. Steps Taken in regard to those Residents having the potential to be affected: On 5/22/17 the Admissions Coordinator interviewed the alert and oriented residents in the assignment of the two nursing assistants related to potential dignity concerns. No additional concerns were voiced. Measures put in place to ensure the deficient practice does not recur: All staff were re-educated beginning 5/19/2017 on abuse, dignity and HIPAA.	6/15/17

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

Electronically Signed | 06/14/2017

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{F 241}	Continued From page 1 is never going to get to go home and she used to exercise all the time and now it is hard to move her." Resident #72 was crying and stated that when she heard this from the NAs it made "me feel sad and discouraged." She also stated that she did not say anything to the 2 NAs because "they have smart mouths and I did not want to get into an altercation." Resident #72 was able to spell the names of the staff that took care of her yesterday on second shift. An interview with NA #1 was conducted on 05/18/17 at 3:48 PM. NA #1 confirmed that she had provided care to Resident #72 on 05/17/17 on second shift. She stated that Resident #72 did not talk much and while providing care to her yesterday I did ask her if she was going home and she replied "yes". She stated that there was no conversation between her and NA #2 about Resident #72 exercising more or less. NA #1 stated that NA #2 had stated "oh my God she is getting harder to turn" and made a grunting sound while turning Resident #72 on her side." NA #1 stated that generally we did not talk to each other in front of the resident we try to do that outside the room. An interview with NA #2 was conducted on 05/18/17 at 4:37 PM. She confirmed that she provided care to Resident #72 on 05/17/17 on second shift. NA #2 explained that she used to be able to provide care to Resident #72 by herself but she could no longer do that. She stated Resident #72 used to use red bands to stretch her arms out and that gave her the strength to help me turn her but when she quite using the red bands she could not help me turn her and now it takes 2 staff members to provide care to her. NA #2 stated that while she and NA #1 were	{F 241}	Re-education was completed on 5/31/2017. The Administrator and/or Social Worker will interview 3 residents weekly and will continue on an ongoing basis. Any concerns will be addressed at that time. Monitoring effectiveness of corrective action: The interviews will be brought by the Administrator and/or Social Worker to the Quality Assurance Committee for monthly review. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action plan.	

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{F 241}	Continued From page 2	{F 241}		

providing care to Resident #72 yesterday I did make a straining noise while turning her and I stated to the resident "remember when you used to do your exercise? What happened with that?" NA #2 stated that initially Resident #72 did not respond to those questions but then stated "well there is no point."

In a follow up interview with Resident #72 on 05/19/17 at 10:17 AM she stated that when NA #1 and NA#2 were leaving her room on 05/17/17 on second shift that NA #1 stated "I hate this room" and NA#2 stated "yes" and motioned to the whole room.

An interview was conducted with Nurse #1 on 05/19/17 at 10:23 AM. Nurse #1 confirmed she routinely took care of Resident #72. Nurse #1 stated that all of her staff knew that they were to treat the residents with respect and dignity and they should not be talking about anything personal in front of the residents. Nurse #1 stated that "the staff should not be talking to each other about a resident that is just rude to do to anyone." She added that if there is conversation during care the resident should be included.

An interview was conducted with the Director of Nursing (DON) on 05/19/17 at 11:50 AM. The DON stated that they had recently reeducated all the staff on dignity and treating the residents with respect. She added that on 05/08/17 Resident #72 was asked about staff treating her with respect and dignity and no issues were identified. The DON stated she expected the staff to interact with the resident during care and that interaction should include small talk and be pleasant. She expected the NAs to explain what they were doing to the resident and not talk about the

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{F 241}	Continued From page 3 resident without including the resident in the conversation.	{F 241}		
{F 253} SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration. The facility failed to repair 1 of 1 smoke prevention doors on the 200 hall and 1 of 1 on the 300 hall, failed to repair the double doors of the main dining room on the 200 hall on 1 of 3 residents' hallways, failed to repair 1 of 18 resident bathroom doors on the 200 hall (Room #214) and failed to repair resident room doors in 1 of 18 resident rooms on the 200 hall (Room #217) and 1 of 13 resident room doors on the 300 hall (Room #302). The doors were observed with broken and splintered laminate and wood that were rough to touch. Findings included: 1. Observations on 05/18/17 at 5:46 PM revealed a set of fire doors on the 200 hall. Further observations revealed the corner at the bottom of the door on the right side was broken off on the hinge side of the door which created an open space when the fire doors were closed. Observations on 05/19/17 at 10:03 AM revealed a set of fire doors on the 200 hall. Further observations revealed the corner at the bottom of	{F 253}	F253 Steps Taken in regards to those residents found to be affected: The fire door on the 200 hall was replaced. The smoke prevention door on 200 hall and 300 hall were also replaced. The double doors of the main dining room on 200 hall were replaced. A door guard was placed on 214 hall door and the bathroom door on 6/14/2017. 217 resident door was sanded on 6/14/2017. 302 resident room door was replaced on 6/15/2017. Door edge protectors were ordered on 6/1/2017 for 214 resident bathroom door, 217 resident room door and 302 resident room doors. Once received, the door edge protectors will be installed. Steps taken in regard to those Residents having the potential to be affected: Until the door protectors are received, doors will be audited Monday □- Friday for splintered wood and rough edges. Doors will be sanded as appropriate. Measures put in place to ensure the deficient practice does to not recur:	7/3/17

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{F 253}	Continued From page 4 door on the right side was broken off on the hinge side of the door which created an open space when the fire doors were closed. 2. a. Observations on 05/18/17 at 6:05 PM of smoke prevention doors on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 05/19/17 at 10:03 AM of smoke prevention doors on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. b. Observation on 05/18/17 at 5:56 PM of smoke prevention doors on the 300 hall had broken and splintered laminate and wood on the lower edges of the doors that were jagged and rough to touch. Observation on 05/19/17 at 9:59 AM of smoke prevention doors on the 300 hall had broken and splintered laminate and wood on the lower edges of the doors that were jagged and rough to touch. 3. Observation on 05/18/17 at 6:00 PM revealed double doors at the main dining room had broken and splintered laminate and wood on the lower edges of the doors which contained small pieces of fabric strings that had been caught in the rough edges. Observation on 05/19/17 at 10:00 AM revealed double doors at the main dining room had broken and splintered laminate and wood on the lower edges of the doors which contained small pieces of fabric strings that had been caught in the rough edges. 4. Observations on 05/18/17 at 6:11 PM revealed the bathroom door in resident room #214 had broken and splintered wood at the corner edge of the door on the door handle side of the door that	{F 253}	Door edge protectors were ordered on 6/1/2017 for the remainder of the facility. Audits will be conducted daily Monday - Friday for splintered wood and rough edges. Doors will be sanded as needed. Once door edge protectors are installed, doors will be audited weekly and ongoing. Monitoring effectiveness of corrective action: Door audits will be brought by the Administrator and/or Maintenance Director to the Quality Assurance Committee for ongoing review. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action plan.	

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{F 253}	Continued From page 5	{F 253}		

was rough to the touch.
Observations on 05/19/17 at 9:30 AM revealed the bathroom door in resident room #214 had broken and splintered wood at the corner edge of the door on the door handle side of the door that was rough to the touch.

5. a. Observation on 05/18/17 at 6:04 PM revealed the door of resident room #217 had broken and splintered laminate and wood that was jagged and rough to the touch.
Observations on 05/19/17 at 9:43 AM revealed the door of resident room #217 had broken and splintered laminate and wood that was jagged and rough to the touch.

b. Observation on 05/18/17 at 6:19 PM revealed the door of resident room #302 had broken and splintered laminate with splinters visible on the hinge side of the door.
Observation on 05/19/17 at 9:56 AM revealed the door of resident room #302 had broken and splintered laminate with splinters visible on the hinge side of the door.

An environmental tour and interviews were conducted on 05/19/17 at 3:40 PM with the Maintenance Director, Administrator, and a Corporate Representative. The Maintenance Director stated the repair of doors with broken and splintered laminate and wood was a work in progress. He explained he and his Maintenance Assistant had been sanding doors and had placed corner guards on some doors and they had additional corner guards on order. The Administrator stated it was a daily chore to observe doors because every time staff bumped into a door it chipped them or chipped out the putty or epoxy that had been used to fill holes.

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{F 253}	Continued From page 6 During the tour the Maintenance Director closed the fire door on the 200 hall with the corner that had broken off and confirmed wood was missing from one edge of the door to the other. The Maintenance Director and Administrator stated they were not aware of the damage to the fire door and the Corporate Representative stated since there was missing wood on the door it could not be repaired and the doors would need to be replaced because the fire doors would not provide the protection the doors were designed to provide. The Maintenance Director confirmed the double doors at the dining room had splintered and broken edges of laminate and wood. He also confirmed the smoke prevention doors on the 200 hall had a gouged area with rough edges on the lower edge of the door. He verified the bathroom door in resident room #214 had a broken area at the bottom corner of the door on the door handle side because the laminate had split. He confirmed the door to resident room #217 had broken laminate and wood on the lower edges of the door. He also acknowledged the smoke prevention doors on the 300 hall had rough edges on the lower edges of the door. The Maintenance Director explained the door of resident room #302 had been sanded and patched but someone had already hit the edges of the door with equipment and broke out the wood putty he had put in.	{F 253}		
{F 282} SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	{F 282}		6/15/17

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{F 282}	Continued From page 7 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents (Resident #72). The findings included: Resident #72 was admitted to the facility on 03/24/15 with diagnoses that included non-traumatic intracranial hemorrhage, hemiplegia, hemiparesis, major depressive disorder, anxiety, seizures, and chronic pain. Review of a care plan dated 12/25/16 read in part, at risk for falls related to: decreased mobility, weakness, seizure disorder and hypertension. The goal of stated care plan was Resident #72 would have no preventable injury from falls through the next review. Interventions included: bed in lowest position. Review of Nursing Assistant (NA) kardex report contained the following intervention: Bed in lowest position. Review of the most recent quarterly minimum data set (MDS) dated 03/05/17 revealed that Resident #72 was cognitively intact. The MDS also revealed that Resident #72 required extensive to total assistance with activities of daily living. An observation of Resident #72's room was made on 05/18/17 at 11:47 AM. The observation	{F 282}	F282 Steps Taken in regards to those residents found to be affected: On 5/19/2017 resident #72 was re-evaluated by the MDS Registered nurse related to the need to have a bed in lowest position. It was determined that resident #72 has an electric bed and she can use the bed control and adjust height as desired. Care plan was updated on 5/19/2017 by the MDS nurse. Steps taken in regard to those Residents having the potential to be affected: All current resident care plans and resident kardex were reviewed by the DON, ADON, Administrator, MDS nurses and/or designees to identify potential areas of concern and corrections made as indicated. This was completed on 5/26/2017. Measures put in place to ensure the deficient practice does not recur: The DON and/or Administrator will review five care plans/kardex weekly for three months using the Device/Intervention tool to ensure interventions listed are being followed. Re-education was provided by the DON on 5/26/2017 to the interdisciplinary team related to ensuring appropriate interventions are reflected on the care plan. Re-education was provided by the DON and/or ADON to nurses, nursing assistants, and dietary on 5/23/2017 and	

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{F 282}	Continued From page 8 revealed Resident #72 lying in bed with bilateral side rails up and padded. The bed's height was approximately 3 foot high. An observation of Resident #72's room was made on 05/18/17 at 6:17 PM. The observation revealed Resident #72 lying in bed with bilateral side rails up and padded. The bed's height was approximately 3 foot high. An observation of Resident #72's room was made on 05/19/17 at 10:17 AM. The observation revealed Resident #72 lying in bed with bilateral side rails up and padded. The bed's height was approximately 3 foot high. An interview with Nurse #1 was conducted on 05/19/17 at 10:23 AM. Nurse #1 confirmed that she routinely took care of Resident #72 on first shift. She explained that the nursing staff had recently been educated on the kardex which essentially was the care plan and all nursing staff had access to it. Nurse #1 explained that each NA was expected to read it every shift and sign off that they accept responsibility for making sure the kardex/care plan was followed. She added that she relied on the NAs to make sure all interventions were in place and then she verified them by walking the halls as much as possible. Nurse #1 was not aware that Resident #72's bed was supposed to be in low position and that it had not been in that positron when observed. An interview was conducted with the Director of Nursing (DON) on 05/19/17 at 11:50 AM. The DON stated that they had recently re-educated the nursing staff on the kardex/care plan. They were instructed on where the kardex/care plan was located and what information was on it. The	{F 282}	ongoing regarding review of resident kardex/care plans to ensure interventions listed are followed and accurate and, if not, then to report to supervisor. Monitoring effectiveness of corrective action: Care plan/kardex audits (Device/Intervention List) will be brought by the Administrator/DON to the Quality Assurance Committee for three months to review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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{F 282}	Continued From page 9 staff was told that the kardex/care plan was where they should go to find important information specific to their residents including interventions such as low bed. The NAs were required to sign off on that they had reviewed each kardex for their residents each shift that they work and that all interventions listed on the kardex/care plan were expected to be in place. The DON added that after the education they had completed an audit of every resident's kardex/care plan and made all necessary changes and updated both the kardex/care plan at that time.	{F 282}		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		6/15/17

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F 431	Continued From page 10 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews the facility failed to remove a medication left at bedside for 1 of 1 residents sampled (Resident #55). The findings included: Review of a facility policy titled "Self Administration of Medication" dated January 2014	F 431	F431 Steps Taken in regards to those residents found to be affected: Licensed nurse notified physician on 5/19/2017 and received an order for resident #55 to self-administer Gas X tablets. Interdisciplinary team also evaluated on 5/19/2017 and determined resident #55 was capable/safe to	

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F 431	Continued From page 11 and revised May 2016 read in part, criteria must be met to determine if the resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of administering the medication. The procedure included: verify the physician's order for self-administration and complete the self-administration of Medication Assessment form with the resident. Resident #55 was admitted to the facility on 08/08/14 and most recently readmitted to the facility on 08/15/16 with diagnoses that included depression, macular degeneration, hypertension, anxiety, anemia, and dysphagia. Review of Resident #55's most recent comprehensive minimum data set dated 04/09/17 revealed that Resident #55 was cognitively intact for daily decision making and required extensive assistance with activities of daily living. An observation and interview with Resident #55 was made on 05/18/17 at 11:49 AM and revealed 2 white round pills in a clear medication cup sitting on the bedside table on the right side of the bed. Resident #55 stated that the 2 round white pills on his bedside table were for gas and indicated that the nurse had brought them to him about a month ago but he had not needed them so he just left them there in case he did need them. Resident #55 was not sure which nurse had brought them to him. A review of Resident #55's medical record on 05/18/17 at 12:00 PM revealed no order for anti-flatulence (gas) medication, no physician order to self-medicate, no physician order to keep	F 431	self-administer Gas X. The care plan was updated on 5/19/2017 by the MDS Coordinator. Steps taken in regard to those Residents having the potential to be affected: Resident rooms were audited by the DON on 5/22/2017 for medications at bedside without orders for self-administration of medications. Any areas identified were addressed at the time. Measures put in place to ensure the deficient practice does to not recur: Licensed nurses were re-educated by the DON and/or ADON on self-administration of medication completed on 5/25/2017. Resident rooms were audited by the DON for five days completed on 5/30/2017 for any medications at bedside without physician order. The DON and/or designee will then audit resident rooms weekly times 3 weeks, followed by monthly times three months for any medications at bedside without physician order. Monitoring effectiveness of corrective action: The Self- Administration audits will be brought by the DON to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality assurance Committee for further action plan.	

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F 431	Continued From page 12 medication at bedside, and no self-administration assessment. An interview was conducted with Nurse #1 on 05/18/17 at 12:01 PM. Nurse #1 confirmed that she routinely took care of Resident #55 on first shift. She indicated that she currently had no one that was assessed to self-medicate and if they did we would have to obtain a physician order first. Nurse #1 was not aware of the 2 round white tablets that were at Resident #55's bedside, she stated "they did not come from me, another nurse must have given them to him." Nurse #1 reviewed Resident #55's current physician orders and stated "I see no order for him to have them." An interview was conducted with the Director of Nursing (DON) on 05/19/17 at 11:50 AM. The DON stated that the MDS coordinator would complete a self-administration assessment and deem the resident safe to administer medications, and if the resident was deemed safe to self-administer the medication then a physician order would be obtained and the hall nurse would be made aware. The DON stated "if the resident had not been deemed appropriate to self-medicate then no medication should be kept at bedside."	F 431		
{F 490} SS=E	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	{F 490}		7/3/17

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{F 490}	Continued From page 13 by: Based on observations, record review and staff interviews the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction for deficiencies the Quality Assessment and Assurance Committee had put into place in May 2017. The deficiencies were originally cited during the Recertification survey in April 2017 and subsequently re-cited on the current Revisit/Follow-up survey. These deficiencies were in the areas to maintain dignity and respect of 1 of 3 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72), repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration. The facility failed to repair 1 of 1 smoke prevention doors on the 200 hall and 1 of 1 on the 300 hall, failed to repair the double doors of the main dining room on the 200 hall on 1 of 3 residents' hallways, failed to repair 1 of 18 resident bathroom doors on the 200 hall (Room #214) and failed to repair resident room doors in 1 of 18 resident rooms on the 200 hall (Room #217) and 1 of 13 resident room doors on the 300 hall (Room #302). The doors were observed with broken and splintered laminate and wood that were rough to touch. The facility also failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents (Resident #72) during 2 federal surveys of record. Findings included: Cross refer to F 241: Based on observation, record review, resident and staff interviews the facility failed to maintain the dignity of 1 of 3	{F 490}	F490 Steps Taken in regards to those residents found to be affected: On 5/19/2017 a surveyor notified the Administrator, DON, Regional Director of Clinical and Regional Vice President of Operations of the resident concern previously voiced to her on 5/18/2017. Upon learning the resident concern, a 24 hour report was completed and faxed to DHHS and the two nursing assistants were suspended pending investigation. The abuse allegation concluded on 5/19/2017. The allegation was determined to be unsubstantiated and a 5 day report was completed and faxed to DHHS on 5/19/2017. The fire door on the 200 hall was replaced. The smoke prevention door on 200 hall and 300 hall were also replaced. The double doors of the main dining room on 200 hall were replaced. A door guard was placed on 214 hall door and the bathroom door on 6/14/2017. 217 resident door was sanded on 6/14/2017. 302 resident room door was replaced on 6/15/2017. Door edge protectors were ordered on 6/1/2017 for 214 resident bathroom door, 217 resident room door and 302 resident room doors. Once received, the door edge protectors will be installed. On 5/19/2017 resident #72 was re-evaluated by the MDS Registered nurse related to the need to have a bed in lowest position. It was determined that resident #72 has an electric bed and she can use the bed control and adjust height	

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{F 490}	Continued From page 14 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72). F 241 was originally cited on the annual recertification survey on 04/13/17 for failure to maintain the dignity of 1 of 3 residents by allowing the resident to remain in visibly soiled pants with a hole in them for 34 minutes (Resident #103). Cross refer to F 253: Based on observations and staff interviews the facility failed to repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration. The facility failed to repair 1 of 1 smoke prevention doors on the 200 hall and 1 of 1 on the 300 hall, failed to repair the double doors of the main dining room on the 200 hall on 1 of 3 residents' hallways, failed to repair 1 of 18 resident bathroom doors on the 200 hall (Room #214) and failed to repair resident room doors in 1 of 18 resident rooms on the 200 hall (Room #217) and 1 of 13 resident room doors on the 300 hall (Room #302). The doors were observed with broken and splintered laminate and wood that were rough to touch. F 253 was originally cited on the annual recertification survey on 04/13/17 for failure to repair resident room and bathroom doors with broken and splintered laminate and wood in 8 of 40 rooms on the 200 and 300 halls (resident room #206, #210, #216, #300, #303, #304, #308 and #309), failed to repair smoke prevention doors with broken and splintered laminate and wood on the 200 hall, failed to repair a fire door with broken and splintered laminate and wood at the entrance of the 200 hall, failed to repair the shower/bath door on the 400 hall with broken and	{F 490}	as desired. Care plan was updated on 5/19/2017 by the MDS nurse. Steps taken in regard to those Residents having the potential to be affected: On 5/22/17 the Admissions Coordinator interviewed the alert and oriented residents in the assignment of the two nursing assistants related to potential dignity concerns. No additional concerns were voiced. Door edge protectors were ordered on 6/1/2017 for the remainder of the facility. Audits will be conducted daily Monday - Friday for splintered wood and rough edges. Doors will be sanded as needed. Once door edge protectors are installed, doors will be audited weekly and ongoing. All Current resident care plans and resident kardex were reviewed by the DON, ADON, Administrator, MDS nurses and/or designees to identify potential areas of concern and corrections made as indicated. This was completed on 5/26/2017. Measures put in place to ensure the deficient practice does to not recur: All staff were re-educated beginning 5/19/2017 on abuse, dignity and HIPAA. Re-education was completed on 5/31/2017. The Administrator and/or Social Worker will interview 3 residents weekly for 3 months related to dignity and then monthly on an ongoing basis. Any concerns will be addressed at that time. The DON and/or Administrator will review five care plans/kardex weekly for three months and then ongoing monthly using	

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{F 490}	Continued From page 15 splintered laminate and wood on the lower edges of the door and failed to remove brown stains from around the base of toilets and bathroom floors in 3 of 13 rooms on the 300 hall (resident room #304, #308 and #309). Cross refer to F 282: Based on observations, record reviews, and staff interviews the facility failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents (Resident #72). F 282 was originally cited on the annual recertification survey on 04/13/17 for failure to implement care plan interventions by not applying a concave mattress as instructed by the care plan for 1 of 3 residents (Resident #7). During an interview on 05/20/17 at 1:26 PM with the Administrator and Director of Nursing they explained the plans of correction for the repeat deficiencies would have to be revised and monitored. The Administrator acknowledged more work could have been done to correct the deficiencies if there had been more time. He stated they had done audits and staff education regarding the deficiencies but more resources, audits and staff education and training would have to be provided.	{F 490}	the Device/Intervention tool to ensure interventions listed are being followed. Re-education was provided by the DON on 5/26/2017 to the interdisciplinary team related to ensuring appropriate interventions are reflected on the care plan. Re-education was provided by the DON and/or ADON to nursing assistants on 5/23/2017 regarding review of resident kardex/care plans to ensure interventions listed are followed. Monitoring effectiveness of corrective action: The interviews will be brought by the Administrator and/or Social Worker to the Quality Assurance Committee for 3 months for review and then monthly ongoing. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action. Door audits will be brought by the Administrator and/or Maintenance Director to the Quality Assurance Committee for ongoing review. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action plan. Care plan/kardex audits (Device/Intervention List) will be brought by the Administrator/DON to the Quality Assurance Committee for three months and then monthly ongoing for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action.	

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{F 520}	Continued From page 16	{F 520}		
{F 520} SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (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 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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.	{F 520}		7/3/17

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{F 520}	Continued From page 17 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2017. This was for four recited deficiencies which were originally cited in April of 2017 on a Recertification survey and subsequently recited in May of 2017 on the current Revisit/Follow-up survey. These deficiencies were in the areas to maintain dignity and respect of 1 of 3 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72), failed to repair doors with broken and splintered laminate and wood (fire door on the 200 hall, smoke prevention doors on the 200 and 300 halls, the main dining room doors on the 200 hall, a resident's bathroom door (Room #214) and resident doors (Room #217 and #302) on 2 of 3 resident hallways and failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents (Resident #72). The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to:	{F 520}	F520 Steps Taken in regards to those residents found to be affected: On 5/19/2017 a surveyor notified the Administrator, DON, Regional Director of Clinical and Regional Vice President of Operations of the resident concern previously voiced to her on 5/18/2017. Upon learning the resident concern, a 24 hour report was completed and faxed to DHHS and the two nursing assistants were suspended pending investigation. The abuse allegation concluded on 5/19/2017. The allegation was determined to be unsubstantiated and a 5 day report was completed and faxed to DHHS on 5/19/2017. The fire door on the 200 hall was replaced. The smoke prevention door on 200 hall and 300 hall were also replaced. The double doors of the main dining room on 200 hall were replaced. A door guard was placed on 214 hall door and the bathroom door on 6/14/2017. 217 resident door was sanded on 6/14/2017. 302 resident room door was replaced on 6/15/2017. Door edge protectors were ordered on 6/1/2017 for 214 resident bathroom door, 217 resident room door and 302 resident room doors. Once received, the door edge protectors will be installed. On 5/19/2017 resident #72 was	

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{F 520}	Continued From page 18 1. a. F 241 Dignity and Respect: Based on observation, record review, resident and staff interviews the facility failed to maintain the dignity of 1 of 3 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72). During the recertification survey of 04/13/17 the facility was cited for failure to maintain the dignity of 1 of 3 residents by allowing the resident to remain in visibly soiled pants with a hole in them for 34 minutes (Resident #103). b. F 253 Housekeeping and Maintenance Services: Based on observations and staff interviews the facility failed to repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration, failed to repair the smoke prevention doors on the 200 and 300 halls with broken and splintered laminate and wood on the lower edges of the door that were rough to touch, failed to repair the double doors at the main dining room with broken and splintered laminate and wood on the edges on the lower half of the doors which were rough to touch, failed to repair a resident's bathroom door with broken and splintered laminate and wood on the lower edges of the door which was rough to touch (room #214) and failed to repair resident room doors with broken and splintered laminate and wood with splinters that were rough to touch in 2 of 40 resident rooms on the 200 and 300 halls rooms (#217 and #302). During the recertification survey of 04/13/17 the facility failed to repair resident room and bathroom doors with broken and splintered laminate and wood in 8 of 40 rooms on the 200	{F 520}	re-evaluated by the MDS Registered nurse related to the need to have a bed in lowest position. It was determined that resident #72 has an electric bed and she can use the bed control and adjust height as desired. Care plan was updated on 5/19/2017 by the MDS nurse. Steps taken in regard to those Residents having the potential to be affected: On 5/22/17 the Admissions Coordinator interviewed the alert and oriented residents in the assignment of the two nursing assistants related to potential dignity concerns. No additional concerns were voiced. Door edge protectors were ordered on 6/1/2017 for the remainder of the facility. Audits will be conducted daily Monday - Friday for splintered wood and rough edges. Doors will be sanded as needed. Once door edge protectors are installed, doors will be audited weekly and ongoing. All Current resident care plans and resident kardex were reviewed by the DON, ADON, Administrator, MDS nurses and/or designees to identify potential areas of concern and corrections made as indicated. This was completed on 5/26/2017. Measures put in place to ensure the deficient practice does to not recur: All staff were re-educated beginning 5/19/2017 on abuse, dignity and HIPAA. Re-education was completed on 5/31/2017. The Administrator and/or Social Worker will interview 3 residents weekly for 3 months related to dignity and	

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{F 520}	Continued From page 19 and 300 halls (resident room #206, #210, #216, #300, #303, #304, #308 and #309), failed to repair smoke prevention doors with broken and splintered laminate and wood on the 200 hall, failed to repair a fire door with broken and splintered laminate and wood at the entrance of the 200 hall, failed to repair the shower/bath door on the 400 hall with broken and splintered laminate and wood on the lower edges of the door and failed to remove brown stains from around the base of toilets and bathroom floors in 3 of 13 rooms on the 300 hall (resident room #304, #308 and #309). c. F 282 Services by qualified persons per Care Plan: Based on observations, record reviews, and staff interviews the facility failed to implement care plan interventions by not applying a concave mattress as instructed by the care plan for 1 of 3 residents (Resident #7). During the recertification survey of 04/13/17 the facility failed to implement care plan interventions by not applying a concave mattress as instructed by the care plan for 1 of 3 residents (Resident #7). d. F 490 Administration: Based on observations, record review and staff interviews the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction for deficiencies the Quality Assessment and Assurance Committee had put into place in May 2017. The deficiencies were originally cited during the Recertification survey in April 2017 and subsequently re-cited on the current Revisit/Follow-up survey. These deficiencies were in the areas to maintain dignity and respect of 1 of 3 residents by allowing staff to	{F 520}	then monthly on an ongoing basis. Any concerns will be addressed at that time. The DON and/or Administrator will review five care plans/kardex weekly for three months and then ongoing monthly using the Device/Intervention tool to ensure interventions listed are being followed. Re-education was provided by the DON on 5/26/2017 to the interdisciplinary team related to ensuring appropriate interventions are reflected on the care plan. Re-education was provided by the DON and/or ADON to nursing assistants on 5/23/2017 regarding review of resident kardex/care plans to ensure interventions listed are followed. Monitoring effectiveness of corrective action: The interviews will be brought by the Administrator and/or Social Worker to the Quality Assurance Committee for 3 months for review and then monthly ongoing. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action. Door audits will be brought by the Administrator and/or Maintenance Director to the Quality Assurance Committee for ongoing review. Any areas of continued concerns will be brought back to the Quality Assurance Committee for further action plan. Care plan/kardex audits (Device/Intervention List) will be brought by the Administrator/DON to the Quality Assurance Committee for three months	

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{F 520}	Continued From page 20 talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72), repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration. The facility failed to repair 1 of 1 smoke prevention doors on the 200 hall and 1 of 1 on the 300 hall, failed to repair the double doors of the main dining room on the 200 hall on 1 of 3 residents' hallways, failed to repair 1 of 18 resident bathroom doors on the 200 hall (Room #214) and failed to repair resident room doors in 1 of 18 resident rooms on the 200 hall (Room #217) and 1 of 13 resident room doors on the 300 hall (Room #302). The doors were observed with broken and splintered laminate and wood that were rough to touch. The facility also failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents (Resident #72) during 2 federal surveys of record. During the recertification survey of 04/13/17 the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have a medication error rate of 5 percent or greater and resulted in observations during medication pass of a medication error rate of 6.66 percent. The facility also failed to ensure communication occurred from staff to administration to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls. During an interview on 05/20/17 at 1:26 PM with the Administrator and Director of Nursing they explained the Quality Assurance and Assessment	{F 520}	and then monthly ongoing for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action.	

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{F 520}	Continued From page 21 Committee used plans of correction to monitor for a certain period of time to prevent repeat deficiencies. The Administrator stated the plans of correction for F 241 Dignity, F 253 Environment, F 282 Care plans and F 490 Administration would all have to be revised and new plans developed. The Director of Nursing stated all resident care plans would be revised and more staff education and monitoring would need to be done to ensure the deficiencies were corrected. The Administrator explained they had gotten new work order forms and had provided staff education but more staff education would have to be done. He further explained they had started a process of replacement of damaged doors and had purchased door guards for some resident doors to protect the edges of doors from damage but work would have to continue. The Administrator stated they always considered staff education to be part of the plan of correction process but they could have done more work to correct the deficiencies and it was his expectation for the plan of correction to correct the deficiencies.	{F 520}		

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (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. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility to accurately code the minimum data set	F 278	F278 Steps Taken in regards to those residents	6/15/17

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

Electronically Signed | 06/15/2017

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F 278	Continued From page 1 to reflect a resident's height for 1 of 9 residents sampled (Resident #115). The findings included: Resident #115 was admitted to the facility on 04/12/17 and discharged on 04/30/17. Resident #115's diagnoses included osteoarthritis, weakness, dementia, and bilateral below knee amputations. Review of Resident #115's most recent comprehensive minimum data set (MDS) dated 04/19/17 revealed that Resident #115 was moderately impaired for daily decision making and required extensive assistance to total assistance with activities of daily living (ADLs). The MDS also revealed that Resident #115 had impairments to bilateral upper and lower extremities and had Resident #115's height as 65 inches. An interview with the Dietary Manger (DM) was conducted on 05/18/17 at 5:42 PM. The DM stated she had completed the comprehensive MDS dated 04/19/17 for Resident #115. The DM stated she used the medical record to gain most of the information that she coded on the MDS. She stated that she would ask the resident how tall they were and if they did not know then should would measure the resident with them lying flat on the bed. The DM stated that the 65 inches that she coded on the MDS was her mistake and when she had visited with Resident #115 she did not realize the resident was a double amputee. Resident #115 had told her 65 inches and that was what she recorded without verifying the information.	F 278	found to be affected: Resident #115 MDS was modified for height accuracy on 5/20/2017 and transmitted on 5/23/2017 by the MDS Coordinator. Steps Taken in regard to those Residents having the potential to be affected: All otherCurrent residents were audited by the Dietary Manager for accuracy of height that were entered on the MDS since 10/1/2016 on 5/23/2017. No other issues were identified. Measures put in place to ensure the deficient practice does not recur: The DON/Administrator provided re-education on MDS height accuracy to the Dietary Manager, MDS nurses, Social Worker, and Activities Director on 5/26/2017. New admissions and re-entry MDS assessments will be audited for height accuracy by the DON and/or designee times eight weeks. Monitoring effectiveness of corrective action: The MDS (height accuracy) audits will be brought by the DON to the Quality Assurance Committee for two months for review. Any areas of concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 278	Continued From page 2 An interview with the MDS Coordinator was conducted on 05/19/17 at 11:39 AM. The MDS coordinator stated that each department was responsible for completing their assigned sections of the MDS and making sure that it was coded accurately. She stated that she did briefly review the MDS for accuracy but did not review each and every question for accuracy that would be up to the individual that was completing the section. The MDS Coordinator stated she would speak the DM and take care of correcting the MDS for Resident #115. An interview with Director of Nursing (DON) was conducted on 05/19/17 at 11:50 AM. The DON stated she expected all MDS's to be coded accurately and to verify the information given to the staff by the residents before coding it on the MDS.	F 278		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to thoroughly clean a female resident's perineal area during incontinence care to prevent the potential for skin breakdown or infection for 1 of 3 residents sampled for activities of daily living (Resident #72). Findings included:	F 312	F312 Steps Taken in regards to those residents found to be affected: Upon notification by surveyor to DON, two RNs were directed to provide adequate peri-care to the resident #72. Resident #72 was evaluated by a licensed nurse for any signs and symptoms of infection. None were identified. Steps Taken in regard to those Residents	6/15/17

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F 312	Continued From page 3 Resident #72 was admitted to the facility on 03/24/15 with diagnoses which included muscle weakness and history of a stroke with paralysis. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/05/17 indicated Resident #72 was cognitively intact for daily decision making. The MDS also indicated Resident #72 required extensive staff assistance with toileting but required total care with personal hygiene and bathing and was always incontinent of bladder and bowel. A review of a care plan dated 03/16/17 indicated a focus statement Resident #72 was at risk for self-care deficit due to poor motivation and declined to get out of bed. The goals indicated in part Resident #72 would have activities of daily living met daily and the interventions were listed in part to provide incontinent care as necessary. During an observation of incontinence care on 05/20/17 at 9:30 AM NA #3 and the MDS Coordinator washed their hands and put on gloves. NA #3 removed Resident #72's brief which was wet and soiled with stool and Resident #72 was turned to her right side. NA #3 then took a wet wash cloth and applied soap and wiped Resident #72's buttocks in a circular motion and wiped stool from inside Resident #72's buttocks back and forth. She then took a wet washcloth and wiped inside Resident #72's buttocks again and the MDS Coordinator told NA #3 to dry the resident's skin with a towel. NA #3 placed a clean brief under Resident #72 and she was turned onto her back. NA #3 attempted to spread Resident #72's legs apart but had difficulty so she wiped down inside Resident #72's right and left groin with a wet washcloth and soap and then wiped down the front of Resident #72's vaginal	F 312	having the potential to be affected: Residents dependent on staff to provide/assist with peri-care were identified by RN on 5/22/2017. Licensed nurses completed bi-weekly skin checks on 5/22/2017 to ensure no areas of infection were identified. None were identified with signs and symptoms of infection related to improper peri-care. Measures put in place to ensure the deficient practice does not recur: DON and/or designee re-educated nursing staff on proper peri-care to prevent infection. All nursing assistants were required to complete a return demonstration to an RN which was completed on 5/31/2017. RN/ADON, RN treatment nurse will observe 5 nursing assistants weekly for 6 weeks to ensure adequate/proper peri-care is provided to prevent infection. Monitoring effectiveness of corrective action: The peri-care audits will be brought by the DON and/or designee to the Quality Assurance Committee for two months to ensure continued compliance.	

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area but did not separate the labial folds to clean the resident. She then took a wet washcloth and wiped down inside each groin and the front of Resident #72's vaginal area and wiped her with a towel and fastened her brief. NA #3 placed soiled linens into a clear plastic bag, removed her gloves and washed her hands and carried the soiled linen bag out of the resident's room.

During an interview on 05/20/17 at 9:43 AM with NA #3 she confirmed the incontinence care she had provided to Resident #72 was her usual technique when she provided incontinence care to Resident #72 as well as other residents. NA #3 stated Resident #72 was hard to clean because her legs were tight and were hard to get open. She confirmed it was difficult to clean inside Resident #72's labial folds in front but she thought she had cleaned them some. She further acknowledged she probably could have cleaned Resident #72 more thoroughly but she had cleaned what she could.

During an interview on 05/20/17 at 9:45 AM with the MDS Coordinator she stated she did not think NA #3 had cleaned Resident #72 as thoroughly as she should have. She further stated NA #3 did not separate labial skin folds and clean thoroughly in the front and she had cleaned Resident #72's buttocks in a random fashion. She also stated she probably should have intervened and told NA #3 to clean Resident #72 more thoroughly but didn't because it was not her routine to assist Nurse Aides during incontinence care.

During an interview and observation on 05/20/17 at 10:02 AM with a weekend Nursing Supervisor she stated she was going to repeat the

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incontinence care for Resident #72 because she had been told Resident #72 had not been thoroughly cleaned. The weekend Nursing Supervisor and the MDS Coordinator washed their hands and put on gloves and Resident #72 was positioned on her back and her brief was opened. The weekend Nursing Supervisor and the MDS Coordinator separated Resident #72's legs and the weekend Nursing Supervisor used a wet wash cloth from a bath basin that contained soap and water and wiped inside Resident #72's labial folds and the wash cloth was soiled with black stool. She then used 2 more washcloths with soap and water to clean stool from Resident #72's labial folds, then rinsed her skin with water and dried her skin with a towel. Resident #72 was turned onto her right side and black stool was visible on her buttocks. The MDS Coordinator used wet washcloths with soap and water to clean Resident #72's buttocks, then rinsed and dried her skin. A clean brief was placed on Resident #72 and she was repositioned in bed and was covered in a blanket. The weekend Nursing Supervisor and MDS Coordinator removed their gloves, washed their hands and removed soiled linens from Resident #72's room.

During an interview 05/20/17 at 10:26 AM with the weekend Nursing Supervisor she confirmed Resident #72 had stool in her labial folds that had not been cleaned during the incontinence care that was provided by NA #3. She stated she felt incontinence care should have been done more thoroughly because it increased the risk of urinary tract infections and skin breakdown.

During an interview on 05/20/17 at 12:16 PM with the Director of Nursing she stated it was her

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F 312	Continued From page 6 expectation for a resident to be cleaned and dried during incontinence care. She stated if the NA could not thoroughly clean a resident she expected for them to report to the nurse so it would be done thoroughly. She stated if a resident was not cleaned thoroughly, it was unacceptable because it put the resident at risk for urinary tract infections and skin breakdown.	F 312		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and family interviews and record review the facility failed to provide a two handled drinking cup with spouted lid for 1 of 2 sampled residents reviewed for assistive eating devices. (Resident #44) The findings included: Resident #44 was admitted to the facility on 02/22/16 and had current diagnoses including; muscle weakness, cancer and congestive heart failure. Review of Resident #44's care plan, which was last reviewed and updated on 04/19/17, revealed he was at increased nutrition and hydration risk due to diagnoses of congestive heart failure and cancer. A care plan approach directed staff to	F 369	F369 Steps Taken in regards to those residents found to be affected: Resident #44 was interviewed by the MDS nurse on 5/19/2017 and his preference for a cup with a handle, lid and straw for his coffee was determined. The care plan was updated on 5/19/2017. Steps Taken in regard to those Residents having the potential to be affected: All other current residents' care plans/kardex were reviewed and updated as indicated related to assistive devices by the Dietary Manager MDS nurse. A device list was completed on 5/26/17 for all residents to include any assistive devices. The device list will be updated with changes during morning risk meeting	6/15/17

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F 369	Continued From page 7 provide the resident with adaptive equipment as needed/ordered. Review of Resident #44's quarterly Minimum Data Set assessment of 05/06/17 revealed he was cognitively intact, understood what was being said to him and was able to make himself understood and required supervision and oversight with eating and drinking. Observations of Resident #44 on 05/18/17 at 1:12 PM revealed he was in his room with his lunch meal. Review of the tray slip served with the resident's meal revealed a two handled mug with spouted lid was to be served with his meal. However, observations of the resident's meal tray revealed he was not provided with a two handled mug or the spouted lid. Continued observations of Resident #44 on 05/18/17 from 1:12 PM to 1:27 PM revealed he made attempts to independently drink fluids by placing a straw in beverages and soup that were served, but his hand was very unsteady when he placed the straw in the liquids and he was observed to only be able to consume minimal fluids using the straw. On 5/18/17 at 1:35 PM a staff member was observed to provide the resident with assistance and encouragement to consume foods and fluids provided at this meal which the resident accepted. Observations of Resident #44 on 05/18/17 at 6:17 PM revealed he was in his room with his evening meal tray. Review of the tray slip served with this resident's meal revealed a two handled mug with spouted lid was to be served with his meal. Observations of the resident's meal tray revealed the two handled mug was on his tray, but the mug's spouted lid was not available. A family member was observed assisting the resident with	F 369	Monday - Friday by the interdisciplinary team. Measures put in place to ensure the deficient practice does not recur: 5 residents on the device list will be audited weekly times three months to ensure devices are in place on the care plan and kardex updated as appropriate by the DON and/or designee. All nurses, CNAs, and dietary staff members were inserviced on ensuring that the kardex/care plans matches the adaptive devices listed on the tray. Monitoring effectiveness of corrective action: The device list audit will be brought by the DON and/or designee to the Quality Assurance Committee for three months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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his meal. Interview with the resident's family member at the time of this observation revealed, the two handled cup with lid was beneficial for the resident because he was able to use it to independently drink fluids and it prevented him from spilling fluids onto himself.

Observations of Resident #44 on 05/19/17 at 1:00 PM revealed he was in his room with his lunch meal tray. Review of the tray slip served with this resident's meal revealed a two handled mug with spouted lid was to be served with his meal. Observations of the resident's meal tray revealed the two handled mug was on his tray, but the spouted lid was not available. The resident was observed to use both of his hands to bring the two handled mug to his mouth and consume tea independently. The resident's hands were shaking while drinking from the two handled cup, but he did not spill any fluids onto himself. Interview with the resident at the time of this observation revealed, he liked to use the two handled cup to consume his beverages.

Nursing Assistant (NA) #4, who provided care to Resident #44, was interviewed on 05/19/17 at 1:15 PM. NA #4 stated that when Resident #44 used the two handled cup with spout lid to drink liquids he was more independent and it prevented spills. NA #4 stated the two handled cup and spout lid were usually on the resident's meal trays.

Interview with the Dietary Manager (DM) on 05/19/17 at 1:25 PM revealed Resident #44 should have a two handled cup with spouted lid on his meal trays to allow him to independently drink fluids and prevent spills. The DM stated the resident spilled coffee on himself 6 to 8 months

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F 369	Continued From page 9 ago, so the two handled cup and spouted lid was implemented to prevent further spills. The DM checked the kitchen and stated she was unable to find the spouted lid for the resident's two handled cup, so she would have therapy order another lid.	F 369		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to document a pressure ulcer wound treatment for a resident with a stage 4 pressure ulcer on the sacrum (Resident #115).

Findings included:

Resident #115 was admitted to the facility on 04/12/17 with diagnoses which included diabetes, heart disease, anxiety, depression and Alzheimer's disease. A review of the admission Minimum Data Set dated 04/19/17 indicated Resident #115 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #115 required extensive assistance with bed mobility and had a stage 4 pressure ulcer on her sacrum.

A review of a hospital discharge summary dated 04/12/17 indicated Resident #115 had sepsis (presence of bacteria spread in the blood stream throughout the body) due to an infected sacral pressure ulcer. A section

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

The above isolated deficiencies pose no actual harm to the residents

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labeled plan indicated in part to continue with local wound care and turn every 2 hours.

A review of a Weekly Wound Assessment electronically signed by the Wound nurse dated 04/14/17 indicated Resident #115 had a stage 4 pressure ulcer on her sacrum which was 5.5 centimeters (cm) length by 5 cm width and 0.9 cm depth, had no drainage, no odor and the wound bed was pink, yellow and had necrotic (dead tissue). A section labeled comments indicated a Wound Physician would evaluate the pressure ulcer on his next round at the facility on 04/18/16.

A review of a facility document labeled Physician's Order Sheet dated 04/14/17 indicated to clean sacral wound with wound cleaner, apply Dakin's moist gauze and cover with an absorbent dressing daily.

A review of a Treatment Administration Record (TAR) dated 04/14/17 revealed there were no staff initials to indicate wound treatments had been done.

A review of a care plan dated 04/17/17 indicated Resident #115 had actual skin breakdown to her sacrum. The goals were listed in part the wound to sacrum would show decreased size through next review and would show no signs or symptoms of infection and interventions were listed in part to provide treatment as ordered.

During an interview on 05/20/17 at 11:55, MDS Nurse #1 stated Resident #115 had a pressure ulcer on her sacrum when she was admitted to the facility. After review of the TAR she confirmed the orders for wound treatments for Resident #115's pressure ulcer were not documented on 04/14/17.

During an interview on 05/20/17 at 12:12 PM, the Wound Treatment Nurse stated the nurse who admitted the resident was responsible for putting in the admission treatment orders. She stated she did Resident #115's wound assessment on 04/14/17 and verified she wrote a paper order on 04/14/17 to clean sacral wound with wound cleaner, apply Dakin's moist gauze and cover with an absorbent dressing daily but there was no documentation treatments had been done on 04/14/17.

During an interview on 05/20/17 at 12:53 PM, the weekend Nursing Supervisor confirmed there was no documentation of the treatments on 04/14/17.

During an interview on 05/20/17 at 1:12 PM, the Director of Nursing stated it was her expectation for staff to document wound treatments on the TAR according to physician's orders.

During a telephone call received on 05/20/16 at 2:06 PM, a wound technician stated she remembered Resident #115 had a wound on her sacrum. She further stated she thought someone had told her to put a wet to dry dressing on Resident #115's sacral wound on 04/14/17 but was not sure why it wasn't documented.