STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING ______ B. WING ______	C 09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 312 SS=E	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 review, resident, and staff interviews the facility failed to provide bathing/showers as scheduled for residents that required assistance with bathing for 3 of 5 residents sampled for Activities of Daily Living (ADLs) (Resident #1, Resident #4, and Resident #5). The Findings included: 1. Resident #1 readmitted to the facility on 08/27/17 with diagnoses that included hypertension, peripheral vascular disease, Parkinson's disease, anxiety, depression, urinary tract infection, psychotic disorder, and others. Review of the most recent quarterly minimum data set (MDS) dated 08/08/17 revealed that Resident #1 was mildly cognitively impaired for daily decision making. The MDS further revealed that Resident #1 required total assistance of 2 staff members for bathing. No behaviors or rejection of care was identified on the MDS. Review of a progress note dated 09/06/17 revealed that a Brief Interview for Mental Status (BIMS) was conducted and revealed that Resident #1 was cognitively intact for daily decision making. Review of the facility's shower/bathing schedule	F 312	Preparation,submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. On 9/19/17 The Director of Nursing validated that resident#1 received a shower. On 9/20/17 the Director of Nursing validated that resident #4 and resident #5 received showers. On 9/29/17, the Director of Nursing completed a teachable moment with Resident Care Specialist, Licensed Nurses and Certified Medication Aides on documenting completion and/or refusal of bath/shower. The Director of Nursing will report the results of the audits in the facility's weekly and monthly Performance Improvement meeting until compliance is met with subsequent Plan of Correction as indicated. On 9/25/17 an audit was completed, all resident's shower/bath schedules were reviewed and updated per	10/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/06/2017

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

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F 312	Continued From page 1 on 09/19/17 revealed that Resident #1 was scheduled to have a shower on Tuesday and Friday on 1st shift. Review of Resident #1's medical record on 09/19/17 revealed no rejection of care or refusal of care including showers. Review of the facility's shower/bathing sheets on 09/19/17 from 08/15/17 to 09/19/17 revealed no documentation that Resident #1 had received any type of bath or shower. An interview was conducted with Nursing Assistant (NA) #1 on 09/19/17 at 10:00 AM. NA #1 stated that she was pulled to the 300 hall where Resident #1 resided because of staffing issues and she was the only NA on the hall and had been since the start of her shift at 7:00 AM. NA #1 stated she currently was responsible for 24 residents and had 5 showers to complete including Resident #1. NA #1 stated that she would do her best to complete all of her scheduled showers but that it would be very hard being the only NA on the hall. NA #1 stated that she had never bathed or showered Resident #1 because she believed her showers were scheduled for 2nd shift. A follow up interview was conducted with NA #1 on 09/19/17 at 10:45 AM. NA #1 stated that the facility had gotten NA #2 to help her on the hall and they would work together to get everything completed including the scheduled showers for that day/shift. An interview was conducted with Resident #1 on 09/19/17 at 10:48 AM. Resident #1 stated that today was her scheduled shower day and she	F 312	resident preference. No other issues were identified at that time. On 9/29/17 the Director of Nursing and Staff Development Coordinator provided re-education to Resident Care Specialist (CNA), Certified Medication Aides (CMA) and Licensed Nurses (LPN/RN) with emphasis on documenting completion and/or refusal of bath/shower and encouraging good personal hygiene. On 9/29/17 resident shower/bath schedules were entered into Point Click Care as a custom care task and the task is set up to require a response as well as allow for electronic monitoring. Licensed Nurses, Resident Care Specialists and Certification Medication Aides were educated on the new process and expectations. The Director of Nursing, Assistant Director of Nursing and/or Designee will monitor this corrective action plan to ensure its effectiveness by reviewing the Point-Click -Care shower task documentation five (5) times a week times four(4) weeks, then three (3) weeks times four(4) weeks then monthly times two (2) months or until compliance has been determined. Findings will be reported at the monthly QA Risk Management meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director	

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F 312	Continued From page 2 would love to go to the shower but she doubted that there was enough staff. She added that when there was only 1 NA on the hall she did not get her showers. A follow up interview and observation was conducted with Resident #1 on 09/19/17 at 12:15 PM. Resident #1 was sitting in a shower chair outside her room. Her hair was visibly wet and she was covered with towels and sheets. Resident #1 stated she had just returned from the shower room and "felt so much cleaner." Resident #1 stated that she "had not had a shower since the end of June" and was so glad to finally get a good shower. She added that she did not refuse any showers and she really would just be happy with her 2 scheduled showers per week but "they can't seem to make that happen." An interview was conducted with NA #5 on 09/19/17 at 4:06 PM. NA #5 confirmed that she had been working on the hall where Resident #1 resided on Friday 09/08/17. She added that she had never showered or offered to shower Resident #1. NA #5 stated that the she did not have time to complete her assignment including showers when she worked on the unit by herself which happened a lot. NA #5 stated that Resident #1's hall was very busy and there was no way to complete showers when they were short staffed. An interview was conducted with NA #3 on 09/19/17 at 4:10 PM. NA #3 stated that she believed she had given Resident #1 a shower on Friday 09/15/17 and if she would have showered her she would have documented it in the shower book kept on the hall in the clean linen room and on the kiosk on the hallway.	F 312	of Clinical Services or Designee to maintain compliance.	

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An attempt to interview NA #6 was unsuccessful on 09/19/17 at 4:17 PM. NA #6 was responsible for Resident #1 on Friday 09/01/17.

An interview was conducted with NA #4 on 09/20/17 at 10:29 AM. NA #4 confirmed that she had been working with Resident #1 on Friday 09/08/17 and Tuesday 09/12/17 and stated she had never showered Resident #1. NA #4 stated she "thought maybe she had given her a bed bath once" but could not recall the date when she provided the bed bath.

Review of the facility's ADLs sheet for Resident #1 on 09/20/17 at 11:00 AM revealed that bathing of any type had not occurred anytime between 08/16/17 to 09/19/17 except for 09/05/17 and 09/15/17.

An interview was conducted with Nurse #1 on 09/20/17 at 12:49 PM. Nurse #1 confirmed that she routinely cared for Resident #1 and stated that she expected the NAs to perform their scheduled showers on a daily basis. Nurse #1 stated she expected each resident to receive 2-3 shower a week of course if the resident was willing. She added that it was unaccepted to not complete showers as scheduled. Nurse #1 confirmed that at times there was 1 NA on the hall and she always tried to reach out and obtain additional help from other staff members in the facility to make sure everything got done that needed to get done.

An interview was conducted with the Assistant Director of Nursing (ADON) on 09/20/17 at 3:48 PM. The ADON stated that she expected showers to be offered and given as scheduled. The ADON added that if a resident refused then it should be

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F 312	Continued From page 4 documented on the shower sheets that are kept in the clean linen closet on each of the hallways in the facility. The ADON stated that she did not monitor the shower sheets and was not sure who did. An interview was conducted with the Director of Nursing (DON) on 09/20/17 at 4:10 PM. The DON explained that she created the shower sheets and shower schedule and placed them in a book in the clean linen closet on each hallway. The DON added that the NAs were to check the schedule each shift to see which showers were scheduled on their shift and she expected them to complete the showers as scheduled. She added that they should be documenting it on the shower sheet as well as the kiosk system located in the hallways. The DON stated that some staff were not documenting showers in the kiosks so she relied more heavily on the shower sheets to determine if showers were being given as scheduled. The DON stated that she "needed to monitor them more closely" probably every day to make sure they were being completed. 2. Resident #4 initially admitted to the facility on 01/18/17 and most recently readmitted to the facility on 08/23/17. Resident #4's diagnoses included: sepsis, gastritis, neuromuscular dysfunction of the bladder, malnutrition, hydrocephalus, meningitis, anxiety, blindness, and others. Review of the most recent quarterly minimum data set (MDS) dated 07/21/17 revealed that Resident #4 was cognitively intact and no behaviors or rejection of care was noted during the assessment reference period. The MDS also indicated that bathing for Resident #4 had not	F 312		

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F 312	Continued From page 5 occurred during the reference period. Review of the facility's shower/bathing schedule on 09/19/17 revealed that Resident #4 was scheduled to have a shower on Wednesday and Saturday on 2nd shift. Review of Resident #4's medical record on 09/19/17 revealed no rejection of care or refusal of care including showers. Review of the facility's shower/bathing sheets on 09/19/17 revealed no documentation of a shower on Saturday 09/16/17 for Resident #4. An interview was conducted with Resident #4 on 09/20/17 at 11:30 AM. Resident #4 confirmed that she was scheduled for a shower on Saturday 09/16/17 and also confirmed that she had not received a shower that day or evening. Resident #4 explained that she has not ever refused a shower and would not refuse a shower but she was not going to ask for one either. Resident #4 explained that she was blind and felt very vulnerable in the large shower room, naked, and unable to see. She further explained that she did enjoy the "clean feeling" and it often times would help her relax in the evenings. An interview was conducted with Nursing Assistant (NA) #5 on 09/20/17 at 10:42 AM. NA #5 confirmed that she had been working on the 200 hall where Resident #4 resided on Saturday afternoon. She added that she was the only NA on the 200 hall from 3:00 PM to 7:00 PM and she was unable to complete Resident #4 or any of the scheduled showers that shift. She stated that all she had time to do was provide incontinence care and put the residents to bed. Na #5 stated that	F 312		

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she was not able to complete any of her scheduled showers on Saturday 09/16/17 due to being short staffed.

Review of the facility's ADLs sheet for Resident #4 on 09/20/17 at 11:00 AM revealed that bathing of any type had not occurred anytime between 08/23/17 to 09/19/17 except for 08/23/17 and 09/06/17.

An interview was conducted with the Assistant Director of Nursing (ADON) on 09/20/17 at 3:48 PM. The ADON stated that she expected showers to be offered and given as scheduled. The ADON added that if a resident refused then it should be documented on the shower sheets that are kept in the clean linen closet on each of the hallways in the facility. The ADON stated that she did not monitor the shower sheets and was not sure who did.

An interview was conducted with the Director of Nursing (DON) on 09/20/17 at 4:10 PM. The DON explained that she created the shower sheets and shower schedule and placed them in a book in the clean linen closet on each hallway. The DON added that the NAs were to check the schedule each shift to see which showers were scheduled on their shift and she expected them to complete the showers as scheduled. She added that they should be documenting it on the shower sheet as well as the kiosk system located in the hallways. The DON stated that some staff were not documenting showers in the kiosks so she relied more heavily on the shower sheets to determine if showers were being given as scheduled. The DON stated that she "needed to monitor them more closely" probably every day to make sure they were being completed.

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An interview was conducted with Nurse #2 on 09/20/17 at 4:29 PM. Nurse #2 confirmed that she was working on the 200 hall on Saturday 09/16/17 on 2nd shift. Nurse #2 stated that the NA on the hall did not report to her that the scheduled showers were not completed. Nurse #2 confirmed that NA #5 was on the hall by herself from 3:00 PM to 7:00 PM. Nurse #2 stated that she generally signs the shower sheets but she could not recall if she had signed any on this particular shift or not. Nurse #2 further stated she expected the scheduled showers to be completed and if they are not then she was to be notified.

3. Resident #5 was admitted to the facility on 08/04/17 with diagnoses that included: unspecified open wound to right knee, long term use of anticoagulants, adult failure to thrive, weakness, chronic obstructive pulmonary disease, and heart failure.

Review of the most recent comprehensive minimum data set (MDS) dated 08/11/17 revealed that Resident #5 was cognitively intact for daily decision making and required total assistance of 1 staff member for bathing. No behaviors or rejection of care was noted on the MDS.

Review of the facility's shower/bathing schedule on 09/19/17 revealed that Resident #5 was scheduled to have a shower on Wednesday and Saturday on 2nd shift.

Review of Resident #5's medical record on 09/19/17 revealed no rejection of care or refusal of care including showers.

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F 312	Continued From page 8 Review of the facility's shower/bathing sheets on 09/19/17 revealed no documentation of a shower on Saturday 09/16/17 for Resident #5. Review of the facility's ADLs sheet for Resident #5 on 09/20/17 at 11:00 AM revealed that bathing of any type had not occurred anytime between 08/16/17 to 09/19/17 except for 08/28/17, 09/07/17 and 09/14/17. An interview was conducted with Resident #5 on 09/20/17 at 11:26 AM. Resident #5 stated that she had moved to the 200 hall on 09/15/17 and her shower days were Wednesday and Saturday on 2nd shift. Resident #5 confirmed that she did not get a shower on Saturday 09/16/17 as scheduled. Resident #5 stated "actually I have not had a shower since coming to the 200 hall on 09/15/17" and at home I showered 3 times a week in the evening and that helped me relax and feel "like a new woman." Resident #5 stated she had never refused a shower while at the facility. An interview was conducted with Nursing Assistant (NA) #5 on 09/20/17 at 10:42 AM. NA #5 confirmed that she had been working on the 200 hall where Resident #5 resided on Saturday afternoon. She added that she was the only NA on the 200 hall from 3:00 PM to 7:00 PM and she was unable to complete Resident #5 or any of the scheduled showers that shift. She stated that all she had time to do was provide incontinence care and put the residents to bed. Na #5 stated that she was not able to complete any of her scheduled showers on Saturday 09/16/17 due to being short staffed. An interview was conducted with the Assistant Director of Nursing (ADON) on 09/20/17 at 3:48	F 312		

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F 312	Continued From page 9 PM. The ADON stated that she expected showers to be offered and given as scheduled. The ADON added that if a resident refused then it should be documented on the shower sheets that are kept in the clean linen closet on each of the hallways in the facility. The ADON stated that she did not monitor the shower sheets and was not sure who did. An interview was conducted with the Director of Nursing (DON) on 09/20/17 at 4:10 PM. The DON explained that she created the shower sheets and shower schedule and placed them in a book in the clean linen closet on each hallway. The DON added that the NAs were to check the schedule each shift to see which showers were scheduled on their shift and she expected them to complete the showers as scheduled. She added that they should be documenting it on the shower sheet as well as the kiosk system located in the hallways. The DON stated that some staff were not documenting showers in the kiosks so she relied more heavily on the shower sheets to determine if showers were being given as scheduled. The DON stated that she "needed to monitor them more closely" probably every day to make sure they were being completed. An interview was conducted with Nurse #2 on 09/20/17 at 4:29 PM. Nurse #2 confirmed that she was working on the 200 hall on Saturday 09/16/17 on 2nd shift. Nurse #2 stated that the NA on the hall did not report to her that the scheduled showers were not completed. Nurse #2 confirmed that NA #5 was on the hall by herself from 3:00 PM to 7:00 PM. Nurse #2 stated that she generally signs the shower sheets but she could not recall if she had signed any on this particular shift or not. Nurse #2 further stated	F 312		

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F 312	Continued From page 10 she expected the scheduled showers to be completed and if they are not then she was to be notified.	F 312		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed	F 353		10/17/17

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F 353	Continued From page 11 nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to have sufficient quantity of staff to ensure residents that required assistance with bathing/showers received bathing/shower assistance as scheduled for 3 of 5 residents sampled (Resident #1, Resident #4, and Resident #5). The Findings included: Cross reference F- 312: Based on observations, record review, resident, and staff interviews the facility failed to provide bathing/showers as scheduled for residents that required assistance with bathing for 3 of 5 residents sampled for Activities of Daily Living (ADLs) (Resident #1, Resident #4, and Resident #5). An interview was conducted with the Scheduling Coordinator (SC) on 09/19/17 at 11:45 AM. The SC stated that the call in's at the facility were "ridiculous, we had 20 call outs in 19 days" and	F 353	Cross referenced to F312. On 9/19/17 the Director of Nursing validated that resident #1 received a shower. On 9/20/17 the Director of Nursing validated that resident #4 and resident #5 received showers. On 9/20/17 the Director of Nursing completed a teachable moment with Resident Care Specialist, Licensed Nurses and Certified Medication Aides on documenting completion and/or refusal of bath/shower. The Director of Nursing will report the results of the audits in the facility's weekly and monthly Performance Improvement meeting until compliance is met with subsequent Plan of Correction as indicated. On 9/25/17 an audit was completed, all resident's shower/bath schedules were reviewed and updated per resident preference. No other issues were identified at that time.	

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	345080	A. BUILDING ______ B. WING ______	C 09/20/2017

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F 353	Continued From page 12 we do not have enough staff to pull from. The SC added that when there was 2-3 call outs per day there was just not enough people to call in to help out. She added that the facility used to have lots of applicants from prospective employees but here lately "we are lucky to get 1 or 2 applications from prospective employees." The SC stated that the facility had no unit managers and no supervisory staff to monitor the schedule throughout the day. She stated the facility expected her to manage the schedule when things come up during the day which really was not a part of her responsibilities. The SC stated that the facility had placed advertisements online and the administrator did not realize that those advertisements expired and had to be redone, so there was a period of time that the advertisement had expired and the Administrator was not aware that he had to renew them. The SC stated that currently she had 1 full time Nursing Assistant (NA) position on 1st shift, 5 full time NA positions and 2 part time NA positions on 2nd shift, 1 full time NA position and 1 part time NA positon on 3rd shift. She added that currently she had no floor nursing positons open but some "as needed" nurses would be wonderful to cover time off and vacations. The SC also stated that they currently had openings for 1 Unit Manager on 1st shift and a Unit Coordinator on 2nd shift. The SC indicated that the facility continued to use agency staff on a daily basis but that the goal was to have enough facility staff to not need the agency staff. An interview was conducted with NA #8 on 09/19/17 at 3:14 PM. Na #8 stated that she generally works on the 500 hall but gets pulled frequently to the 200 hall because the facility was so short staffed. NA #8 stated that most of the staff was agency and they were rarely on time	F 353	On 9/29/17 the Director of Nursing and Staff Development Coordinator provided re-education to Resident Care Specilist, Licensed Nurses and Certified Medication Aides with emphasis on documenting completion and/or refusal of bath/shower and encouraging good personal hygiene. On 9/29/17 resident shower/bath schedules were entered into Point Click Care as a custom care task and the task is set up to require a response as well as allow for electronic monitoring. Licensed Nurses, Resident Care Specialists and Certified Medication Aides were educated on the new process and expectations. The Staffing Clerk will provide the Director of Nursing and Administrator with daily and weekly staffing sheets for review to ensure sufficient staffing levels have been appropriately scheduled to meet the resident's needs. On 10/5/17 the District Director of Clinical Services completed a teachable moment with the Staffing Clerk on accessing and printing weekly and monthly staffing schedules in On-Shift. The Director of Nursing and Assistant Director of Nursing and/or Designee will monitor this corrective action plan to ensure its effectiveness by reviewing the Point-Click Care shower task documentation five (5) times weekly times four(4) weeks, then three(3) times weekly times four(4) weeks then monthly times two (2) months or until compliance has	

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Continued From page 13

and often times called out which made the facility more short staffed and made it difficult to spend the quality time with the residents.

An interview was conducted with Nurse #1 on 09/20/17 at 12:49 PM. Nurse #1 stated that the facility had regular full time employees and those employees repeatedly called out. She added that the facility had staff in the building that were also NAs and when the facility was short staffed due to call outs she would go and ask those employees to come and help out on the hallway and in the dining room. The 3rd shift nurse usually had a list of the call outs and the people that she had called and the agencies that she had contacted to get some help for me when I come into work. If the agency staff showed up then the employees would go back to their other assigned duties.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 09/20/17 at 1:22 PM. The DON stated that when there was a call in the facility staff usually contacted her and she directed them to contact the agency and let them know the need. She added that the Restorative caseload was low and was easily completed by 1 Restorative aide leaving the other Restorative aide available to help out on the hallways. The facility also had other full time employee's that were also NAs and they were always available to help on the hallways and in the dining room if needed. The DON stated that the facility has had no recent terminations and they continued to actively recruit NAs and management staff. The DON stated that bathing/showers had not been brought to her attention and she was not aware that they were not being completed as scheduled. The Administrator stated that the Certified Medication

F 353

been determined.

The Director of Nursing and Administrator will monitor staffing sheets daily for the following day. On Fridays the weekend and Mondays will be reviewed. Monitoring will be five(5) times weekly times twelve(12) weeks or until compliance has been determined.

Findings will be reported at the monthly QA/ Risk Management meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance.

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F 353	Continued From page 14 Aides (CMA) were instructed to help the NAs on the hallway as much as possible including answer call lights, placing residents on/off the bed pan and etc. He added that they have had no resignations recently and no terminations and they have hired more permanent staff. The Administrator stated that the facility had sign on bonus for newly recruited staff and he had contacted the local community colleges recruiting new NAs. The Administrator stated that they staggered staff lunches so that there was always someone on the hall. The Administrator stated that he felt like the facility had improved and that the residents, staff, and families were happy with the facility.	F 353		
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 by: Based on observations, record reviews resident and staff interviews the facility's Administration failed to manage the care and needs of residents in the building for 3 of 5 sampled residents (Resident #'s 1, 4, and 5). The Findings included: 1. Cross-Reference F-312: Based on observations, record review, resident, and staff interviews the facility failed to provide	F 490	Cross referenced to F312 and F353. On 9/19/17 the Director of Nursing validated that resident #1 received a shower. On 9/20/17, the Director of Nursing validated that resident #4 and resident #5 received showers. On 9/20/17, the Director of Nursing completed a teachable moment with Resident Care Specialist, Licensed Nurses and Certified Medication Aides on documenting completion and/or	10/17/17

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F 490 Continued From page 15

bathing/showers as scheduled for residents that required assistance with bathing for 3 of 5 residents sampled for Activities of Daily Living (ADLs) (Resident #1, Resident #4, and Resident #5).

2. Cross-Reference F-353:

Based on observations, record reviews, resident and staff interviews the facility failed to have sufficient quantity of staff to ensure residents that required assistance with bathing/showers received bathing/shower assistance as scheduled for 3 of 5 residents sampled (Resident #1, Resident #4, and Resident #5).

An interview was conducted with the Administrator on 09/20/17 at 3:02 PM. The Administrator stated that the facility was continuing to complete audits and work through their plan of correction to makes sure the facility remained in compliance. The Administrator added that they continued to have some key nurse management positions open but he believed that the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were doing a great job of circulating through the building and managing the day to day things. He added that nothing of any real concern had been brought to his attention as result of the audits or of the morning stand up meeting. He added that he had not heard of any issues with bathing/showers not being given as scheduled and he believed that the showers were being given. The Administrator stated that the facility continued to actively recruit new employees through various avenues including online advertisements, job fairs, word of mouth, referrals, and reaching out to the community colleges to recruit new Nursing

F 490

refusal of bath/shower.

The Director of Nursing will report the results of the audits in the facility's weekly and monthly Performance Improvement meeting until compliance is met with subsequent Plan of Corrections as indicated. On 9/25/17 an audit was completed, all resident's shower/bath schedules were reviewed and updated per resident preference. No other issues were identified at that time.

On 9/29/17 the Director of Nursing and Staff Development Coordinator provided re-education to Resident Care Specialist, Licensed Nurses and Certified Medication Aides with emphasis on documenting completion and/or refusal of bath/shower and encouraging good personal hygiene.

On 9/29/17 resident shower/bath schedules were entered into Point Click Care as a custom care task and the task is set up to require a response as well as allow for electronic monitoring. Licensed Nurses, Resident Care Specialist and Certified Medication Aides were educated on the new process and expectations. The Staffing Clerk will provide the Director of Nursing and Administrator with daily and weekly staffing sheets for review to ensure sufficient staffing levels have been appropriately scheduled to meet the resident's needs.

The Director of Nursing, Assistant Director of Nursing and/or Designee will monitor this corrective action plan to

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F 490	Continued From page 16 Assistants. He added that he had the support of his corporation and the facility staff was a hard working group people and were pulling together to get the job done.	F 490	ensure its effectiveness by reviewing the Point-Click-Care shower task documentation five(5) times weekly times four(4) weeks, then three(3) times weekly times four(4) weeks, then monthly times two(2) months or until compliance has been determined. The Director of Nursing and Administrator will monitor staffing sheets daily for the following day. On Fridays the weekend and Mondays will be reviewed. Monitoring will be five (5) times weekly times twelve (12) weeks or until compliance has been determined. Findings will be reported at the Weekly /Monthly QA/Risk Management meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or Designee to maintain compliance.	
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	F 520		10/17/17

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F 520	Continued From page 17 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. (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 facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place in June 2017 following a recertification and complaint survey and subsequently recited in September 2017 on the current complaint survey. The repeat deficiencies are in the areas of activities of daily living (F312) and sufficient	F 520	The Area Staff Development Coordinator and District Director of Clinical Services re-educated the Administrator and management staff on implementing and maintain an effective Quality Assurance and performance improvement (QAPI) Committee. The committee uses the Plan, DO, Study, Act method for QAPI, including scheduling	

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F 520 Continued From page 18

nursing staff (F353). These deficiencies were recited in the facilities current complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The Findings included:

This tag is cross referred to:

1a). F312: Activities of Daily Living: Based on observations, record review, resident, and staff interviews the facility failed to provide bathing/showers as scheduled for residents that required assistance with bathing for 3 of 5 residents sampled for Activities of Daily Living (ADLs) (Resident #1, Resident #4, and Resident #5).

During the recertification and complaint survey of June 2017, this regulation was cited for failing to keep residents fingernails cleaned and trimmed for 3 of 6 (Resident # 84, #45, and #135).

1b). F353: Sufficient Nursing Staff: Based on observations, record reviews, resident and staff interviews the facility failed to have sufficient quantity of staff to ensure residents that required assistance with bathing/showers received bathing/shower assistance as scheduled for 3 of 5 residents sampled (Resident #1, Resident #4, and Resident #5).

During the recertification and complaint survey of June 2017, this regulation was cited for failing to have sufficient quantity of staff to ensure a dependent resident was provided incontinent care (Resident #47) and dependent residents received

F 520

, identification of trends or patterns, submission of data and initiation of quality improvements plans related to identified areas of opportunity.

The Quality Assurance Committee consists of : Administrator, Director of Nusing, Dietary Manager, Rehabilitation Manager, Maintenance of Environmental, Assistant Director of Nursing. Representative: Activities Director, Social Services Director, Human Resources Designee, Business Office Director, Resident Care Management, Wound Care Nurse. Director: Medical Director, Infection Preventionist.

All repeated citations were reviewed, corrected and monitoring tools implemented to maintain compliance. (F312, F353 and F520).

The Quality Assurance committee will meet weekly for four (4) weeks and then resume monthly meetings. The results from the monitoring tools utilized in the corrective action plans will be reported to the committee until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or Designee to maintain compliance. Any other trends or opportunities will also be identified and reviewed at this time. The Quality Assurance Committee will identify the need for additional interventions, QAPI's and/or subsequent Plan of Corrections.

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F 520	Continued From page 19 nail care (Resident #84, #45, #135) for 4 of 4 sampled residents. An interview was conducted with the Administrator on 09/20/17 at 3:02 PM. He stated that the Quality Assurance (QA) meetings were held the 3rd Thursday of every month and the attendees included: the Administrator, Director of Nursing, Medical Director, and all the Department Heads. The Administrator stated that he was in charge of the agenda. He added that all the audits from the previous recertification and complaint survey were still being completed and to his knowledge nothing of any concern had come to his attention. He further stated that in addition to the audits they also reviewed weights, pressure ulcers, falls, and maintenance issues, resident council concerns, quality measures, new staff, and the 5 star rating. The Administrator added that the facility has improved a lot of systems and making good head way, we have the full support of corporation. The Administrator stated that his biggest obstacle for maintaining compliance was the need for continuous training and in services on customer service and continuing to stay on the floor and educated the staff along the way as things arise to find the root cause. The Administrator confirmed that "it is taking me longer then I would like to fix the issues, it is a challenge to fix these things and we are trying to always improve."	F 520	The Quality Assurance and Improvement Committee will implement additional changes as needs are identified.	