| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345191 | A. BUILDING _____ B. WING _____ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

| (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 |
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| F 167 SS=C | RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br>CFR(s): 483.10(g)(10)(i)(11)<br><br>(g)(10) The resident has the right to-<br><br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br><br>(g)(11) The facility must--<br><br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br><br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br><br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br><br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and resident, family and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results.<br><br>Findings included:<br>1. During a tour of the facility on 10/23/17 at 4:28 | F 167 | Please accept this Plan of Correction (POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of noncompliance. | 11/24/17 |

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

Electronically Signed | 11/23/2017

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|---|---|---|---|---|
| F 167 | Continued From page 1<br>PM an observation was made that survey results were located in a notebook binder in a plastic container attached to the wall in the front lobby of the facility.<br><br>An observation on 10/23/17 at 4:45 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results.<br><br>An observation on 10/24/17 at 2:48 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results.<br><br>An interview was completed with a family member on 10/24/17 at 3:00 PM. The family member stated she did not know how to access the state survey results in the facility and said she had no knowledge of any signage that directed residents or families to the location of facility survey results.<br><br>An interview was completed with the Resident Council President on 10/26/17 at 10:45 AM. She stated she thought the survey results were posted on the bulletin board in the front hall. She said she had not seen a sign posted that directed residents to the location of the facility survey results.<br><br>An observation on 10/26/17 at 11:11 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results.<br><br>An interview was completed with the Administrator on 10/27/17 at 8:29 AM. She stated there was a sign posted on the bulletin | F 167 | The POC is being provided pursuant to Federal and State requirements which require an acceptable Plan of Correction as a condition of continued certification. Date of alleged compliance is 11/24/2017.<br><br>F167 – 483.10 Right to Survey Results, Readily Accessible<br><br>1. On 10/27/17 Administrator posted signage on bulletin board, outside new social services office, and on new family council board, advising location of recent survey results. The sign advising location of survey results was taken down when bulletin board was updated.<br><br>2. Resident Council President made aware of location of survey results book and that there should be signage throughout facility as to the location of survey results. Administrator e-mailed Kathy Sutphin, Family Council Representative to ensure awareness of location of survey results book and that there should be signage throughout facility as to the location of survey results. Education provided to staff to ensure they know where recent state survey results are located so they can direct residents or families to them.<br><br>3. Activities Director will complete audit to ensure all signage is in place noting location of survey results weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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|---|---|---|---|---|
| F 167 | Continued From page 2<br>board in the front hallway and that the sign must have been taken down when the bulletin board was updated. She further said that a sign was also posted in the café but upon observation the notice was not posted and the Administrator thought it was taken down when they completed some patching of the wall in the café. The Administrator stated she expected that a notice be posted in the facility that directed residents and families to the location of the survey results. | F 167 | | |
| F 241 SS=D | DIGNITY AND RESPECT OF INDIVIDUALITY<br>CFR(s): 483.10(a)(1)<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to prevent the exposure of 1 of 3 sampled residents wearing adult briefs reviewed for dignity and respect (Resident #114).<br><br>Findings included:<br><br>Resident #114 was admitted to the facility on 11/16/15 with diagnoses which included: intellectual disabilities, bilateral above knee amputation, psychosis, and diabetes mellitus.<br><br>Review of the quarterly MDS (Minimum Data Set) dated 7/18/17 indicated Resident #114 had no short or long term memory problems, but had | F 241 | F241 □ 483.10 Dignity and Respect of Individuality<br><br>1. Resident #114 was immediately covered with sheet. Offered to pull resident□s curtain, but he did not want curtain pulled. Offered to close resident□s door to provide privacy and dignity, resident stated he did not want door closed. Nurse entered note in PCC with resident□s wishes, care plan updated to reflect resident preferences. Staff had walked passed resident # 114□s room and had not offered to cover him. Encourage resident to wear shorts during the day and pajamas at night to ensure he is not left exposed to other residents, staff | 11/24/17 |

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| F 241 | Continued From page 3<br>moderately impaired decision-making skills.<br><br>During a continuous observation on 10/24/17 from 2:08pm through 2:21pm in the hallway of 100 unit, Resident #114 was observed lying flat on his back in the low bed closest to the door of his room. The resident had a top bedsheet over his head and chest leaving the lower half of the resident's body exposed in an adult brief. Staff, visitors, and other residents were observed ambulating and/or propelling wheelchairs up and down hallway, past the resident's room. Thirteen minutes after the initial observation time, a nurse knocked on the resident's door, entered and approached the resident with medication. Before administering the medication, the nurse covered the resident's exposed body with the top bed linen.<br><br>During a second continuous observation in the hallway of the 100 unit, on 10/24/17 from 3:23pm through 3:33pm, the door to Resident #114's room was open and the resident way lying in his bed in the same exposed position. A female resident in a wheelchair was observed in the hallway talking with a surveyor, in full view of the resident in his room. The female resident did not comment or acknowledge observance of the resident in the bed. Also during this ten minute time period, two nursing assistants were observed exiting the room directly across from Resident #114's room, then entering the room next to the exposed resident's room. Neither of the two nursing assistants checked on Resident #114.<br><br>During an interview on 10/25/17 at 3:35pm, NA#1 (Nursing Assistant) revealed that she and NA#2 were responsible for the residents on the 100 | F 241 | or visitors.<br><br>2. 100% audit will be completed by ADON, AIT, Activities Manager and Transitions Coordinator, of all residents to ensure no one has been left exposed in view of other residents, staff, or visitors and will be completed by 11/24/2017. Education will be provided to all staff by the Staff Development Coordinator on dignity and respect specifically related to residents being exposed in view of other residents or visitors and will be completed on 11/24/2017.<br><br>3. Department managers will complete audit on 10 random residents to ensure no residents have been left exposed weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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|---|---|---|---|---|
| F 241 | Continued From page 4 | F 241 | | |

hall. NA#1 stated that she began working at the facility on 9/6/17. She indicated the facility's orientation training included treating residents with dignity and respect; such as, knocking on residents' doors before entering, when providing care, ensure residents were covered and had privacy (pulling privacy curtain closed between residents' beds and pulling the curtain closed between bed and door, even when door is closed. NA#1 stated that she had worked with Resident#114 since the third week of September. She indicated the resident was alert and able to make his needs known, at times; but, never used the call light, would yell out when he wanted anything. NA#1 stated the resident requested the door to his room remain open and he always covered his face with his top bed sheet. NA#1 acknowledged that she should have asked resident to cover himself with the bed sheet or she should have closed/pulled the privacy curtain between the resident's bed and room door. She had no explanation why she did not do either.

During an interview on 10/25/17 at 3:55pm, NA#2 revealed she worked at the facility for almost three months and had worked with Resident #114 since her orientation. She stated the facility's orientation training included providing dignity and respect of residents such as providing privacy, respecting residents' cultures, beliefs, and choices. She also stated that the privacy curtain between two beds and doors should be closed when providing care to a resident. NA#2 indicated Resident #114 was sometimes alert and oriented and frequently liked to sleep. She stated the resident would yell out when he wanted anything and would not use the call light. NA#2 indicated the resident was totally incontinent of bowel and bladder and preferred to lie flat on his back with

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|---|---|---|---|---|
| F 241 | Continued From page 5 | F 241 | | |

the bedsheet over his head. She stated the resident did not care if his room door was left open or closed; but the nursing assistants kept the resident's room door open so they could hear when he called out. NA#2 stated when/if the resident pulled the top sheet over his head and it exposed his lower body, the staff were to either pull both privacy curtains to cover the length of the resident in the bed and/or closed the resident's room door to provide privacy for the resident from people walking by his door (staff, visitors, other residents). NA#2 acknowledged she or NA#1 should have either covered the resident's lower body with the bed covering, pulled the resident's privacy curtain or closed his room door when he pulled the top sheet over his head exposing the lower half of his body to anyone in the hallway.

During an observation in the hallway of the 100 unit on 10/26/17 at 11:34am, the door to Resident #114 was open, the resident was lying on his back in the low bed closest to the room door with a top bedsheet covering his face. The lower half of the resident's body, wearing only an adult brief could be easily viewed by anyone in the hallway. Two female visitors were observed entering a room directly across the hall from Resident #114's room. At 11:38am, Resident #114 began yelling out. NA#3 entered the resident's room, spoke with him, then exited the room two minutes later. NA#3 did not cover the resident's exposed lower body, or pull the privacy curtain around the resident's bed, or close the resident's room door.

During an interview on 10/26/17 at 11:43am, NA#3 revealed she began working at the facility in June 2017. She revealed the facility's orientation training included treating residents

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| F 241 | Continued From page 6<br>with dignity and respect such as, speaking respectfully, knocking on doors before entering residents' rooms, and closing privacy curtains during care. NA#3 revealed she had been working with the Resident #114 for approximately one month. She stated that the resident never used his call light, but would yell out for assistance. NA#3 also stated that the staff would leave the resident's room door open so they could hear when the resident yelled out and staff were able to visually check on the resident. She revealed that when she responded to the resident's yelling out prior to this interview, he complained of something stinging his feet (resident is a bilateral amputee); but she checked the areas around his legs to comfort the resident then left the resident's room and reported the resident's complaint to the nurse. NA#3 acknowledged that she did not, but should have asked the resident if he would allow her to cover the lower half of his body with the bed linen or pull the privacy curtain to prevent exposure of his adult briefs to anyone in the hallway passing by his room.<br><br>During an interview on 10/26/1 at 12:20 pm, the DON (Director of Nursing) revealed her expectation of the staff when Resident #114 has pulled the bedcovers over his head, eposing his adult briefs, was for the staff to enter the resident's room and request permission to pull the bedcovers down, pull the privacy curtain around the resident's bed, or close the door to the resident's room, then report the incident to her (DON). | F 241 | | |
| F 242 SS=D | SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br>CFR(s): 483.10(f)(1)-(3) | F 242 | | 11/24/17 |

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| F 242 | Continued From page 7<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review the facility failed to honor one of two residents ' choice for baths (Resident # 175).<br><br>The findings included:<br><br>Review of the medical record revealed Resident #175 was admitted to the facility on 9/19/17 with diagnoses including end stage renal disease and fracture of the femur.<br><br>The Minimum Data Set (MDS) dated 9/26/17 indicated she had no impairment with memory, no behaviors, and required total assistance with transfers, bed mobility, toileting and personal hygiene and bathing.<br><br>Review of the care plan dated 10/9/17 included a problem for resident deficits with activities of daily living (ADL). The approaches for this problem included staff were to encourage the resident to | F 242 | F242 – 483.10 Self-Determination – Right to Make Choices<br><br>1. 10/26/2017 DON validated Resident #175 was given a bath. Nurses had failed to check behind CNA to validate showers were completed.<br><br>2. 100% audit will be completed by ADON, AIT, Activity Director and Transitions Coordinator to ensure residents get a bath per their choice will be completed by 11/24/2017. Staff will be re-educated by the Staff Development Coordinator on resident rights to make choices about care specifically related to baths and will be completed by 11/24/2017.<br><br>3. Department managers will complete audit on 10 random residents to ensure | |

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| F 242 | Continued From page 8<br>do as much for herself as possible, provide cueing and pain management with ADLs.<br><br>Review of the medical record revealed Resident #175 was out of the facility during the first shift for hemodialysis.<br><br>Review of the shower book which contained the shower schedules with residents listed according to their room numbers, which day of the week a shower was to be given and which shift would provide the shower/bath. The nurse aides (NA) would sign shower sheets, and include if a shower/bath was given. Resident #175 was supposed to have baths on Monday, Wednesday and Friday according to her room number. Review of the shower sheets for the past week revealed Resident #175 had not received a bath/shower and was not listed on the shower sheets until 10/25/17.<br><br>Review of the NA ' s documentation in the electronic record revealed Resident #175 had not had a shower/bath during the past two weeks.<br><br>Interview with Resident #175 on 10/24/17 at 3:30 PM revealed she had received one bath since her admission on 9/19/17.<br>Interview with Resident #175 on 10/26/2017 at 11:17 AM revealed she had dialysis yesterday. She did not receive a shower yesterday. The staff had told her she would have one today. She did not receive any personal hygiene before going out to dialysis for treatments. They just got me up, dressed and I went to the dining room for breakfast. When asked if she was provided a partial bath, or wash cloth to wash her face and hands, she stated "no." She said she thought that was just what they did here. | F 242 | residents are receiving a bath per their choice weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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|---|---|---|---|---|
| F 242 | Continued From page 9<br><br>Interview with NA #1 on 10/26/2017 at 3:11 PM revealed Resident #175 was not on the schedule for bath. She explained she had glanced at the shower schedule, NA#2 was doing baths. After looking at the shower book, NA#1 explained she did not know Resident #175 was due a bath on Wednesday, 10/25/17. NA#1 confirmed the resident did not get a shower. Review of the shower sheet for 10/26/17 revealed a bath was to be given on 2nd shift. This resident was on the list for day shift for a shower.<br><br>Interview with NA#2 on 0/26/2017 at 3:27 PM revealed she would use the book with the shower sheets to know who had showers due each day. She further explained she would look at it (shower book) when she comes on duty. This aide stated she had not looked at it yesterday, may have overlooked Resident #175. It may have been missed due to the yellow highlight of the name indicated she was to be given a bath on first shift.<br><br>Interview with the Assistant Director of Nursing on 10/26/17 at 3:00 PM revealed the resident should have received a bath on her bath days.<br><br>Interview with Resident #17 on 10/27/2017 at 9:57 AM revealed she received a bed bath yesterday. She did not know why she had not had one before then and the staff had not offered an explanation. | F 242 | | |
| F 246 SS=D | REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br>CFR(s): 483.10(e)(3)<br><br>483.10(e) Respect and Dignity. The resident has | F 246 | | 11/24/17 |

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| F 246 | Continued From page 10<br>a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews the facility failed to keep the resident ' s water in reach to allow for drinking fluids independently for one (Resident #86) of one sampled resident.<br>The findings included:<br>Resident #86 was admitted to the facility on 9/20/17 with diagnoses including DVT, diabetes and dementia.<br><br>The admission Minimum Data Set (MDS) dated 9/27/17 indicated Resident #86 had moderate problems with long term memory. He required supervision of one person for eating.<br><br>Review of the documentation by the aides in the electronic record revealed Resident #86 ate independently with set up assistance by staff.<br><br>A care plan for a problem of activities of daily living had not been completed.<br><br>On 10/25/2017 at 11:10AM observations revealed the resident ' s water was on a tray table, located at the wall by the window, and Resident #86 was on other side of the bed in his wheelchair. His water was out of his of reach.<br><br>Observation on 10/26/2017 at 11:19 AM revealed | F 246 | F246 – 483.10 Reasonable Accommodation of Needs/Preferences<br><br>1. Water was immediately placed within reach of resident #86. Staff failed to place water within residents reach after providing care.<br><br>2. 100% audit completed by ADON, AIT, Activity Director and Transitions Coordinator will be completed to ensure water is within reach for all residents by 11/24/2017. All staff will be re-educated on resident needs specifically related to having water within reach by the Staff Development Coordinator and completed by 11/24/2017.<br><br>3. Department managers will complete audit on 10 random residents to ensure water is within reach weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345191 | A. BUILDING _____ B. WING _____ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 246 | Continued From page 11<br>his water pitcher was out of reach, and was on his tray table on the other side of the bed from where he was sitting.<br><br>On 10/26/2017 at 2:35 PM an interview was conducted with nurse aide (NA)#3. The aide revealed the resident would drink his water, he would ask for it, and request it. NA#3 explained the water should be placed on the table near him.<br><br>Interview with the Assistant director of Nursing on10/26/2017 at 3:40 PM revealed the water should be kept in his reach on the table next to the bed. She explained she was not aware it had not been in his reach.<br><br>Interview with Resident #86 on 10/27/2017 at 8:49 AM revealed he liked to drink his water and wanted it kept in reach. He further stated he could not get to it when it was on the other side of the room. | F 246 | | |
| F 278 SS=D | ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>CFR(s): 483.20(g)-(j)<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the | F 278 | | 11/24/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 278 | Continued From page 12<br>assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to accurately code on the comprehensive admission Minimum Data Set (MDS) assessment a level II PASRR (Preadmission Screening and Resident Review) for 1 of 1 resident (Resident #27) reviewed for PASRR.<br><br>Findings included:<br>1. Resident #27 was admitted to the facility on 4/26/16 with diagnoses that included schizophrenia, anxiety disorder, major depressive disorder and psychosis.<br><br>A review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) revealed that Resident #27 was determined to be a PASRR | F 278 | F278 – Assessment Accuracy/Coordination/Certified<br><br>1. DON validated the Modification of MDS assessment for 02/17/17 to correctly code Level II PASRR was completed and submitted to CMS for resident #27. MDS nurse simply missed the coding for this PASRR.<br><br>2. 100% audit will be completed by Resident Care Management Director on most recent MDS for all residents who have a Level II PASRR to ensure correct coding by 11/24/2017. Education will be provided to MDS nurses on correct coding of Level II PASRR by 11/24/2017. | |

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| F 278 | Continued From page 13<br>level II (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services).<br><br>A review of a significant change comprehensive MDS assessment dated 2/17/17 indicated Resident #27 was not coded as a level II PASRR.<br><br>An interview was completed with the MDS Nurse on 10/26/17 at 10:05 AM. She stated the coding on the MDS "probably got missed." She said that typically the receptionist notified her when there was a level II PASRR and sent her a copy of the PASRR. The MDS Nurse stated she would correct the MDS to reflect the resident's level II status.<br><br>An interview was completed with the Receptionist on 10/26/17 at 10:10 AM. She said when a resident was admitted with a level II PASRR she printed out the notice and notified the MDS Nurse.<br><br>An interview was completed with the Admissions Coordinator on 10/26/17 at 10:14 AM. She stated for new admissions she obtained PASRR information from the hospital paperwork and then verified the PASRR number in the NC MUST system. She reported she then placed that information on a communication form and gave it to the MDS Nurse, therapy, dietary and medical records.<br><br>An interview with the Administrator on 10/27/17 at 10:14 AM revealed her expectation that the level II PASRR information be correctly coded on the MDS assessment. She stated the missed coding | F 278 | 3. District Director of Care Management will complete an audit to ensure all residents with a Level II PASRR are coded correctly on most recent MDS weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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| F 278 | Continued From page 14<br>on the MDS was a data entry error. | F 278 | | |
| F 279 SS=D | DEVELOP COMPREHENSIVE CARE PLANS<br>CFR(s): 483.20(d);483.21(b)(1)<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized | F 279 | | 11/24/17 |

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| F 279 | Continued From page 15<br>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete comprehensive care plans for two of fifteen sampled residents with comprehensive assessments and care plans. Residents # 86, and 63.<br><br>The findings included:<br><br>1. a. Resident # 86 was admitted to the facility on 9/20/17 with diagnoses including DVT, diabetes and dementia. | F 279 | F279 – 483.20 Develop Comprehensive Care Plans<br><br>1. a. Resident #86 discharged from facility.<br>b. Care plan for resident #63 updated to include use of a suprapubic urinary catheter immediately. MDS would have normally care planned the suprapubic catheter and this time it was overlooked.<br><br>2. a. 100% audit of any OBRA assessments requiring CAAS completion in the last 30 days will be reviewed to | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 279 | Continued From page 16<br>The Admission Minimum Data Set (MDS) dated 9/27/17 indicated he had a fall prior to admission, required extensive assistance with bed mobility, transfers and toileting. The MDS indicated Resident #86 had moderate problems with memory.<br><br>Review of the Care Area Assessments (CAAS) revealed a problem of falls and ADLs were initiated. The care plan team identified the following on the CAAS: "He is alert and verbal with STM/LTM (short and long term memory) problems with BIMS score of 7. He does have bilateral hearing aids in place in which he denies problems with hearing. Noted with recent hospitalizations with "difficulty getting out of bed, getting out of chairs and sliding out of chairs and being unable to get off floor." He is followed at current SNF with Deep venous thrombosis tolerating Xarelto, Weakness, Dementia and Diabetes mellitus. He has a stage II pressure ulcer to his sacrum. Staff reports he is incontinent of bladder and bowel and requires extensive assist with bed mobility, transfers, dressing locomotion, personal hygiene and toilet use. He is at risk for decline in ADL status related to his right leg DVT and weakness. He participates with OT/PT services with goals to discharge home with family as support." A decision was made to proceed to care planning for this identified problem.<br><br>Review of the care plan revealed no care plan was completed for a problem of falls or decline in ADLs. There were no interventions or goals for these two areas.<br><br>Interview on 10/26/2017 at 3:57 PM with the MDS nurse revealed she would complete the care plan | F 279 | ensure identified problems have a care plan in place by Resident Care Management Director and will be completed by 11/24/2017. Education will be provided to MDS nurses on developing comprehensive care plans specifically related to ensuring any OBRA assessments requiring CAAS that identify problems have a care plan in place and will be completed by 11/24/2017.<br>b. 100% audit of all residents with suprapubic catheters to ensure care plan includes use of suprapubic catheter by the Resident Care Management Director and will be completed by 11/24/2017. Education will be provided to MDS nurses on comprehensive care plans specifically relate to suprapubic catheters and will be completed by 11/24/2017.<br><br>3. a. District Director of Care Management will complete an audit on 5 random residents to ensure those with OBRA assessments requiring CAAS have a care plan in place that includes any identified problems weekly x 12.<br>b. District Director of Care Management will complete and audit on all residents with suprapubic catheters to ensure care plan reflects use of suprapubic urinary catheter weekly x 12<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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| F 279 | Continued From page 17<br>if the areas triggered and a decision was made to include the area on the care plan. The MDS nurse explained her workload had been high and she care plan the problem of falls.<br><br>2. Resident #63 was admitted to the facility on 9/21/17 with diagnosis including BPH (enlarged prostate) with lower urinary tract symptoms.<br><br>Review of the Minimum Data Set (MDS), an admission, dated 9/28/17, indicated he had no short or long term memory impairment, required limited assistance with all activities of daily living and had an indwelling urinary catheter and was frequently incontinent of urine.<br><br>Review of the care plan did not include the use of a suprapubic urinary catheter.<br><br>Interview with the MDS nurse on10/26/2017at 12:16 PM revealed she did not include the goal and approaches for the use of the suprapubic catheter. She had only care planned the urinary infection. Further interview revealed she would normally have a care plan for the use of the suprapubic catheter. The explanation given indicated she was the only MDS nurse and her workload was high. | F 279 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: | F 280 | | 11/24/17 |

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|---|---|---|---|
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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 280 | Continued From page 18<br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be- | F 280 | | |

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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 280 | Continued From page 19<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to update the Care Plan for 1 of 1 sampled resident with fragile skin who was being administered an anticoagulant medication. (Resident #13). | F 280 | F280 – 483.10 Right to Participate Planning Care-Revise CP<br><br>1. DON validated Care plan for resident #13 was immediately updated to include | |

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|---|---|---|---|
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|---|---|
| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 280 | Continued From page 20<br><br>Findings included:<br><br>Resident #13 was admitted to the facility on 12/5/16 with diagnoses which included: COPD (chronic obstructive pulmonary disease) and paroxysmal atrial fibrillation.<br><br>Review of the Physician's Order dated 7/5/17 revealed Resident #13 received 2.5mg (milligrams) of Apixaban (anticoagulant medication) twice each day.<br><br>The quarterly MDS (Minimum Data Set) dated 10/11/17 indicated Resident #13 was cognitively intact, received an anticoagulant medication, had no skin problems, and received hospice care.<br><br>The updated Care Plan dated 10/21/17 revealed Resident #13 had potential for skin tears related to fragile skin. Interventions included geri-sleeves (protective sleeves for resident's arms) and padding to the bed's side rails.<br><br>The Care Plan was not updated to include Resident #13 receiving the anticoagulant medication (apixaban).<br><br>A review of the Weekly Head to Toe Skin Check dated 10/25/17 documented Resident #13 had discolorations to his bilateral upper extremities.<br><br>During an observation and interview on 10/26/17 at 12:02 pm, Resident #13 was noted with red and blue discolorations on bilateral arms and foam padding on both quarter sized side rails attached to his bed. The resident stated that the staff were never rough when providing his care. | F 280 | the use of anticoagulant medication. MDS nurse failed to update care plan to reflect use of anticoagulant medications.<br><br>2. 100% audit of all residents taking anticoagulants to ensure anticoagulant use is noted on care plan will be completed by Resident Care Management Director by 11/24/2017. Education will be provided to MDS nurses on revising care plans, specifically related to ensuring anticoagulants are care planned by 11/24/2017.<br><br>3. District Director of Care Management will complete an audit on 10 random residents taking anticoagulants to ensure each has a care plan that reflects anticoagulant use weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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| F 280 | Continued From page 21<br>The resident revealed the bruise-like areas on both of his arms were due to the blood thinner medication he received which causes the discolorations to his arms.<br><br>During an interview on 10/27/17 at 9:05 am, Resident #13 revealed the facility staff had encouraged him to wear geri-sleeves but he refused. The resident stated that he did not even wear long sleeve shirts.<br><br>During an interview on 10/27/17 at 11:20 am, the MDS Coordinator confirmed the medication section of Care Plan should have been updated to include the anticoagulant medication administered to Resident #13, but was not. She stated that the resident's Care Plan would be immediately updated to include the use of anticoagulant medication. | F 280 | | |
| F 281 SS=D | SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>CFR(s): 483.21(b)(3)(i)<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and physician interviews, the facility failed to clarify a medication order for Lactobacillus for 1 of 5 residents (Resident # 136) reviewed for unnecessary meds.<br><br>Findings included: | F 281 | F281 – 483.21 Services Provided Meet Professional Standards<br><br>1. DON validated Lactobacillus order for resident # 136 was updated immediately to reflect correct indication for use. | 11/24/17 |

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| | 345191 | A. BUILDING _____ B. WING _____ | C 10/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SURRY COMMUNITY HEALTH AND REHAB CENTER | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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|---|---|---|---|---|
| F 281 | Continued From page 22<br><br>Resident # 136 was admitted to the facility on 2/17/17 with diagnosis of: Depression, Mood Disorder, Peripheral Vascular Disease, Hallux Valgus, Seborrheic Keratosis, Vitamin D Deficiency, Osteoporosis, Constipation, Chronic Kidney Disease, Osteoarthritis, Hypertension, Gastro-esophageal Reflux Disease, Hypothyroidism and Insomnia and Pneumonia.<br><br>A review of the physician orders for February 2017 revealed an order on 2/24/17 for Ceftin, an antibiotic. Lactobacillus 1 capsule by mouth two times a day was also ordered with "for antibiotic use" as an indication for use. A stop date was not indicated in the order.<br><br>A record review of physician orders for March and April 2017 revealed the resident did receive antibiotic therapy for at least part of the month; Lactobacillus was given daily during both months.<br><br>A further review of the physician orders for May through October 2017 revealed an order present each month for Lactobacillus twice a day, however, the resident did not have any antibiotic therapy ordered during those months.<br><br>Review of the Medication Administration Record (MAR) for May through October 2017 revealed the resident received Lactobacillus twice daily.<br><br>An interview with the Nurse assigned to take care of the resident, revealed he was unaware whether Resident #136 was on antibiotic or not.<br><br>An interview with the unit coordinator on 10/27/17 at approximately 0930 revealed that when a resident is admitted, the computer requires an | F 281 | Charge nurse failed to change the indication for use after the antibiotic course was completed.<br><br>2. 100% audit of all residents on Lactobacillus will be completed by the Unit Managers to ensure order includes the correct indication for use and will be completed by 11/24/2017. Education will be provided to nurses by the Staff Development Coordinator on professional standards, specifically related to orders including correct indication for medication use to be completed by 11/24/2017.<br><br>3. Unit manager will complete audit on all residents taking Lactobacillus to ensure order includes the correct indication for use weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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|---|---|---|---|---|
| F 281 | Continued From page 23<br>indication for each medications use. When Resident #136 was admitted, Kimberly entered antibiotic use for the medication Lactobacillus. She stated she never went back in to change the indication for use.<br><br>An interview with the Discharge Planner, on 10/27/17 revealed she does monthly MAR reviews and only focuses more on whether there's a stop date indicated for a medication, to ensure the medications get stopped and started as ordered. She revealed the nurses giving out the medication would be the ones responsible for making sure medications were ordered correctly.<br><br>An interview with the facility physician on 10/26/17 at approximately 1000 revealed that Resident #136 wasn't on an antibiotic at this time but was at risk for infection and he thought the resident should remain on Lactobacillus. The physician did acknowledge that the order needed clarification to read that the resident was on the medication for prophylaxis rather than for antibiotic use. | F 281 | | |
| F 312 SS=D | ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>CFR(s): 483.24(a)(2)<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and record reviews the facility failed to provide showers for two (Residents # 86 and 175) of four sampled residents dependent on | F 312 | F312 – 483.24 – ADL Care Provided for Dependent Residents<br><br>1.(1a) Resident #86 discharged from | 11/24/17 |

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| F 312 | Continued From page 24<br>staff for care and failed to provide complete incontinence care for one of one observations of incontinence care (Resident #86).<br><br>The findings included:<br><br>1.a. Resident #86 was admitted to the facility on 9/20/17 with diagnoses including blood clot in the leg, diabetes and dementia.<br><br>The Admission MDS dated 9/27/17 indicated Resident #86 had moderate problems with long term memory. He required extensive assistance of two staff persons with bed mobility, transfers, toileting, bathing, locomotion and personal hygiene. The MDS indicated he was incontinent of both bowel and bladder frequently or always.<br><br>Review of the Care Area Assessments (CAAs) dated 10/3/17 revealed the area of Activities of Daily Living (ADLs) was reviewed and a decision was made to take it to care plan.<br>Review of the care plan revealed a problem of extensive assistance for ADLs was not on the care plan.<br><br>Review of the shower book with the scheduled showers for the past two weeks (10/12/17 to 10/25/17) revealed Resident #86 received one shower, on Saturday 10/21/17. Review of the shower sheet revealed Resident #86 was to have a shower on Tuesdays, Thursdays and Saturdays. During this time, residents were changed from 100 hall to 200 hall due to renovations. He was not changed on those lists to ensure he had a shower.<br><br>Review of the aides ' documentation for provision of showers in the electronic chart for the past two | F 312 | facility.<br>(1b) Peri-care was immediately provided to resident #86. CNA failed to provide proper peri care.<br>(2) Resident #175 was given a bath on 10/26/2017.<br><br>2.(1a) 100% audit of any OBRA assessments requiring CAAS completion in the last 30 days will be reviewed by Resident Care Management Director to ensure identified problems have a care plan in place and will be completed by 11/24/2017. 100% audit of all residents will be completed by ADON, AIT, Activity Director and Transitions Coordinator to ensure they are receiving the assistance needed for ADLs and will be completed by 11/24/2017. Education will be provided to MDS nurses on developing comprehensive care plans specifically related to ensuring any OBRA assessments requiring CAAS that identify problems have a care plan in place and will be completed by 11/24/2017.<br>(1b) Nursing staff will be re-educated by the Staff Development Coordinator on proper peri-care procedure and will be completed by 11/24/2017.<br>(2) 100% audit of all residents will be completed by ADON, AIT, Activity Director and Transitions Coordinator to ensure they are receiving assistance needed for ADLs and will be completed by 11/24/2017. Education will be provided to nursing staff by Staff Development Coordinator on ADL care for dependent residents, specifically related to ensuring residents get assistance needed for ADLs | |

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|---|---|---|---|---|
| F 312 | Continued From page 25<br>weeks revealed he had four baths (documentation did not include if it was a bed bath or a shower).<br><br>Observations on10/24/2017 at 2:51 PM revealed Resident #86 had a growth of stubble that was long on his face. Interview with the resident at that time revealed he wanted his face shaved and stated staff shaved him.<br><br>Resident observation on 10/25/2017 at 11:11AM revealed the growth of facial hair remained on Resident #86 ' s face.<br><br>Interview with the resident on 10/26/2017 at 11:19 AM revealed he had not received a shower yesterday or today. He explained the staff told him "at first they would do a shower today, then said they had to do something else." He explained he didn't know if he would have a shower or not today. Observations during the interview revealed his face continues to have the beard growth and his clothes have not been changed from the previous day.<br><br>Observations and interview on 10/27/2017 8:00 AM revealed the resident had a clean shaven face. Interview with the resident revealed he had received a shower and a shave. He stated "that got me all fixed up."<br><br>Interview with nurse ' s aide (NA) # 4 on 10/26/17 at 1:35 PM revealed Resident #86 should receive showers on Tuesday, Thursday and Saturday. NA#4 explained shaves would usually be provided during the shower. NA#4 further explained a resident would receive a shave if they looked "scruffy." When asked if she had noticed Resident #86 looked "scruffy" and needed a | F 312 | and will be completed by 11/24/21017.<br><br>3.(1a) District Director of Care Management will complete and audit on 5 random residents to ensure those with OBRA assessments requiring CAAS have a care plan in place that includes any identified problems weekly x 12. Department managers will complete audit on 10 random residents to ensure they are receiving the assistance needed for ADLs weekly x 12.<br>(1b) Staff Development Manager will complete audits on 5 random nursing assistants per week to ensure proper peri-care is provided to residents.<br>(2) Department managers will complete audit on 10 random residents to ensure they are receiving the assistance needed for ADLs weekly x 12.<br><br>4. All results will be brought to QAPI x 3 months, or until no further issues noted. | |

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|---|---|---|---|---|
| F 312 | Continued From page 26 | F 312 | | |

shave, she replied "no." She had not given him a shower. She looked at the shower book for the schedule. His room was scheduled for a shower on second shift.

Interview with the ADON, on 10/26/2017 at 1:13 PM revealed the shower sheets were not part of the chart, and were not kept. The showers/baths would be documented in the electronic record. For clarification, she was asked if the surveyor was to use the documentation in the electronic chart and she said "yes."

Interview with NA #1 10/26/2017 at 3:11 PM revealed Resident #86 was not on schedule for a shower that she was aware of. NA#1 explained she had glanced at it,(shower list) but NA#2 was doing the baths.

Interview with NA#2 on 10/26/2017 at 3:27 PM revealed she used the book with the shower sheets. She would look at the list when she came on duty. Resident #86 was on the list for a shower that evening. NA#2 explained male residents would receive a shave on their shower days.

Interview with the ADON on 10/26/17 at 3:00 PM revealed residents should receive their showers according to their schedules. No explanation was provided as to why Resident #86 had not had his scheduled showers.

1b. Observations on 10/25/2017 at 5:12 PM of incontinence care revealed his brief was saturated, with the bed linens with a large wet circle through the draw sheet and bottom sheet. His sweatpants were wet as evidenced by a darker circle at the crotch area. The top sheet

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|---|---|---|---|---|
| F 312 | Continued From page 27 | F 312 | | |

and bath blanket were wet per the aides (NA#1 and 2). During incontinence care the NA#1 cleaned the stool from the buttocks and groin. An open area was noted on right buttock. The aide applied cream to the area. She did not clean the front of the peri area. Next, the disposable brief was tabbed closed at the sides. Interview with the NA#1 immediately after incontinence care was provided revealed she did not clean the front peri area. On interview, she was asked what she would normally do for incontinence care. She explained she would clean the front area. She did not do that, because she was nervous and was concentrating on getting the stool cleaned.

Interview on 10/26/17 at 3:00 PM with the ADON revealed the aide knew she should have cleaned the entire peri area and was nervous.

2. Review of the medical record revealed Resident #175 was admitted to the facility on 9/19/17 with diagnoses including end stage renal disease and fracture of the femur.

The Minimum Data Set (MDS) dated 9/26/17 indicated she had no impairment with memory, no behaviors, and required total assistance with transfers, bed mobility, toileting and personal hygiene and bathing.

Review of the care plan dated 10/9/17 included a problem for resident deficits with activities of daily living (ADL). The approaches for this problem included staff were to encourage the resident to do as much for herself as possible, provide cueing and pain management with ADLs.

Review of the medical record revealed Resident

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|---|---|---|---|---|
| F 312 | Continued From page 28 | F 312 | | |

#175 was out of the facility during the first shift for hemodialysis.

Review of the shower book which contained the shower schedules with residents listed according to their room numbers, which day of the week a shower was to be given and which shift would provide the shower/bath. The nurse aides (NA) would sign shower sheets, and include if a shower/bath was given. Resident #175 was supposed to have baths on Monday, Wednesday and Friday according to her room number. Review of the shower sheets for the past week revealed Resident #175 had not received a bath/shower and was not listed on the shower sheets until 10/25/17.

Review of the NA ' s documentation in the electronic record revealed Resident #175 had not had a shower/bath during the past two weeks.

Interview with Resident #175 on 10/24/17 at 3:30 PM revealed she had received one bath since her admission on 9/19/17.
Interview with Resident #175 on 10/26/2017 at 11:17 AM revealed she had dialysis yesterday. She did not receive a shower yesterday. The staff had told her she would have one today. She did not receive any personal hygiene before going out to dialysis for treatments. They just got me up, dressed and I went to the dining room for breakfast. When asked if she was provided a partial bath, or wash cloth to wash her face and hands, she stated "no." She said she thought that was just what they did here.

Interview with NA #1 on 10/26/2017 at 3:11 PM revealed Resident #175 was not on the schedule for bath. She explained she had glanced at the

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|---|---|---|---|---|
| F 312 | Continued From page 29 | F 312 | | |

shower schedule, NA#2 was doing baths. After looking at the shower book, NA#1 explained she did not know Resident #175 was due a bath on Wednesday, 10/25/17. NA#1 confirmed the resident did not get a shower. Review of the shower sheet for 10/26/17 revealed a bath was to be given on 2nd shift. This resident was on the list for day shift for a shower.

Interview with NA#2 on 0/26/2017 at 3:27 PM revealed she would use the book with the shower sheets to know who had showers due each day. She further explained she would look at it (shower book) when she comes on duty. This aide stated she had not looked at it yesterday, may have overlooked Resident #175. It may have been missed due to the yellow highlight of the name indicated she was to be given a bath on first shift.

Interview with the Assistant Director of Nursing on 10/26/17 at 3:00 PM revealed the resident should have received a bath on her bath days.

Interview with Resident #17 on 10/27/2017 at 9:57 AM revealed she received a bed bath yesterday. She did not know why she had not had one before then and the staff had not offered an explanation.