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	345384	A. BUILDING _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, and observations, the facility failed to maintain an environment free of physical restraints for 1 of 1 resident (Resident #4) by using a reclined chair which prevented the	F 604	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not	8/27/18

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

Electronically Signed | 08/25/2018

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F 604	Continued From page 1 resident from rising. Findings included: Record review revealed resident #4 was admitted to the facility on 4/7/2016 with diagnoses which included Alzheimer's disease and a history of falls. Review of the annual Minimum Data Set (MDS) dated 2/9/2018 revealed Resident #4 was rarely/never understood, was severely impaired for decision making, and inattention and disorganized thinking were present and fluctuated in severity. The MDS indicated the resident required extensive to total assist with all activities of daily living (ADLs). The MDS indicated the resident had no impairments of upper and lower extremities and was not steady moving from a seated to standing position. The MDS indicated the resident used no restraints. Review of the most recent quarterly MDS assessment dated 5/1/2018 revealed no changes in the previous referenced areas. Review of Resident #4's care plan with the most recent revision dated 2/9/2018 included a focus on falls. The goal was the resident would not experience any falls through the next review. Interventions included to monitor for changes in condition that warranted increased supervision/assistance and notify the physician of changes, and to encourage the resident to get out of bed. Review of a Physical Device Form dated 4/27/2018 indicated Resident #4 used no devices. The devices listed on the form included a reclined chair. The Physical Device Form was	F 604	constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. "The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The Assistive device assessment was completed for Resident # 4 on 8/6/2018. A Physician order was written on 8/6/2018 for recliner Geri-chair for fall prevention safety, and the fall care plan was updated and the restraint reduction form was completed by the Director of Heath Service. Due to resident active mobility in the Geri-chair, including placing foot rest down at his choice and inability to ambulate, the facility did not identify the Geri-chair as a restraint. The facility did not document the resident□s activity to support the decision in the medical record to explain their decision to not identify the Geri-chair as a restraint. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

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F 604	Continued From page 2 signed by Nurse #9. A continual observation of Resident #4 was conducted on 7/31/2018 from 2:15 PM to 3:00 PM. The resident was observed at the nurse's station in a reclining geriatric chair. The chair was reclined and the resident was positioned with his feet on the foot rest which was positioned above the resident's trunk. The resident attempted to push the footrest down several times and would sit up in the chair. The resident attempted to scoot toward the end of the chair several times but the reclined position of the chair prohibited. The facility administrator spoke to the resident twice and tried to convince him to lean back in the chair and rest but the resident continued to attempt to lean up and get the footrest down. An observation was made of Resident #4 on 8/1/2018 at 1:37 PM. The resident was in the same chair as the previous day and was sitting at the nurse's station. The chair was reclined and the resident was positioned with his feet on the foot rest which was positioned above the resident's trunk. The resident made several attempts to sit up and push the footrest down but was unable to. A telephone interview was conducted with Resident #4's responsible party (RP) on 8/2/2018 at 8:48 AM. The RP indicated she visited the resident daily. She stated the resident had been in a reclining chair for a long time and reported she was sure it was over a year. The RP indicated the resident would attempt to stand up and would fall if the chair was not reclined. The RP stated the resident had a history of falling and the staff leaned him way back in the chair so he would not fall.	F 604	On 8/7/2018 the Director of Nursing, Assistant Director of Nursing and Case Mix Coordinator reviewed the MDS RAI Version 3.0 Manual, section P0100: Physical Restraint coding requirements. On 8/7/2018 The Director of Health Services, Assistant Director of Health Services and Charge Nurses began completing the Initial/Annual Observation for a Physical Device Form on 100% of the resident population to ensure physical devices are identified and documented appropriately. All resident including new/readmissions will be completed by 8/15/2018 and new admissions after 8/15/2018 will be completed within 24 hours of admission. The Director of Nursing, Assistant Director of Nursing and/or Nurse Management began education the Licensed Nurses on 8/13/2018 regarding the Initial/Annual restraint observation form and what constitutes and restraint. Nurses that have not been educated by 8/20/2018 will be removed from the schedule until education is completed. This education has been added to the general orientation for newly Licensed Nurses. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or the Assistant Director of Nursing will present	

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F 604	Continued From page 3 An interview was conducted with Nurse #1 on 8/2/18 at 9:14 AM. Nurse #1 stated she worked with Resident #4 daily. Nurse #1 indicated the resident was placed in a reclining chair when he returned from the hospital in January of 2017. Nurse #1 revealed the resident sustained a fractured hip and was unable to sit up in the wheelchair upon readmission to the facility in January of 2017. Nurse #1 stated the resident had a history of falls and the chair was for his safety as well as comfort. Nurse #1 reported the reclining chair prevented the resident from rising. An interview was conducted with the Director of Nursing (DON) on 8/2/18 9:29 AM. The DON indicated Resident #4 was in a reclining chair to enhance safety and prevent the resident from falling. The DON indicated the reclining chair prevented the resident from rising when it was in the reclined position. The DON stated she was unaware the chair was considered a restraint. The DON stated there was not a less restrictive device attempted prior to the resident utilizing the reclining chair. The DON stated the expectation was restraints would be identified and assessed to ensure necessity and to ensure they were the least restrictive. The DON confirmed the expectation was not met with Resident #4. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/2/18 at 2:00 PM. The ADON stated Nurse #9 (who completed the Physical Device Form) was no longer employed with the facility. The ADON reported Resident #4 should have been assessed on the form as having a reclining chair. The ADON indicated the reclining chair prevented the resident from rising when it was in the reclined position. The ADON	F 604	their findings of their findings of the Initial/Annual Observation for a Physical Device Form of current residents to the Quality Assurance and Performance Improvement Committee monthly for recommendations. The Director of Nursing will present the findings of the new/readmission review Physical Devise Audit Tool to the Quality Assurance and Performance Improvement Committee monthly until 6 months of continued compliance is maintained then quarterly thereafter. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. Date of compliance: 8/27/18	

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F 604	Continued From page 4 indicated the chair was in the reclined position for safety and to attempt to keep the resident from falling.	F 604		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident had a significant weight loss and acquired a Stage 2 pressure ulcer, for 1 of 5 sampled residents (Resident #49). Findings included: Resident #49 was admitted to the facility on 03/27/18 with diagnoses that included coronary artery disease and rhabdomyolosis (the rapid destruction of skeletal muscle). The admission comprehensive Minimum Data Set (MDS) dated 04/03/18, revealed Resident #49's weight was 175 pounds at admission and	F 637	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The comprehensive assessment was completed for resident #49 on 8/7/18. The MDS coordinator did not identify the significant weight change "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; 100% audit of current resident□s status changes completed by 8/27/18 to identify	8/27/18

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F 637	Continued From page 5 he did not have any pressure ulcers. Record review revealed on 06/01/18, Resident #49 was discovered to have developed a Stage 2 pressure ulcer. Physician orders were obtained and treatment began the same day. Resident #49's weights were available in his clinical record and in the Weight Book kept in the nursing station. Both sources revealed the following weights: 175.8 pounds on 04/02/18 148.2 pounds on 05/01/18 143.6 pounds on 06/05/18 which was a weight loss of 18.32%. The MDS Coordinator was interviewed on 08/01/18 at 05:13 PM, about why a comprehensive assessment had not been completed within 14 days of the two significant areas where this resident had changed. The MDS Coordinator reviewed Resident #49's medical record and stated that a Significant Change in Status Assessment should have been completed in June because of the weight loss and development of a pressure ulcer. During an interview on 08/03/18 at 11:35 AM, the Director of Nursing (DON) stated a significant change in status assessment should have been done for Resident #49.	F 637	significant changes and complete assessments as needed. MDS Coordinator completed online training in significant changes. The MDS Coordinator will review the RUGs Analysis for changes that may warrant a significant change in status assessment with the completion of each new assessment and bring forward to the interdisciplinary team to make the determination if significant change assessment is needed and document on significant change audit tool until substantial compliance determined through QAPI. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The administrator will review and trend the findings from the significant change audit tool. The administrator will bring the findings from the audit to the quality assurance performance improvement committee meetings x 3 months or until substantial compliance is achieved. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for	

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F 637	Continued From page 6	F 637	implementing the plan of correction. Date of compliance: 8/27/18	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of restraints (Resident #4), wander/elopement alarms (Resident #5), and a change in weight (Resident #49), for 3 of 11 sampled residents. Findings included: 1. Resident #49 was admitted to the facility on 03/27/18 with diagnoses that included coronary artery disease and rhabdomyolosis (the rapid destruction of skeletal muscle). The admission comprehensive Minimum Data Set (MDS) dated 04/03/18, revealed Resident #49's weight was 175 pounds at admission. Resident #49's weights were available in his clinical record and in the Weight Book kept in the nursing station. Both sources revealed the following weights: 175.8 pounds on 04/02/18 148.2 pounds on 05/01/18 143.6 pounds on 06/05/18 154.0 pounds on 07/02/18 which was a difference of 7.24% in the last 30 days.	F 641	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Assessment with ARD 7/31/18 was reopened and the reclining chair was coded as a restraint for patient #4. Assessment with ARD 5/2/18 was reopened and the wander/elopement alarm was coded for patient #5 Change of status for resident #49 due to weight change was completed on 8/7/18. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All Interdisciplinary Team (IDT) members are completing Assessment and Intelligence System online training to assist in their knowledge of MDS accuracy and assessment. Any newly hired IDT members will complete the AIS training within six months of employment. Prior to closing the MDS, the MDS	8/27/18

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F 641	Continued From page 7 The quarterly MDS dated 07/02/18, revealed Resident #49's weight was 154 pounds, but for a question on the MDS that asked if the resident had a gain of 5% or more in the last month, the response was "No or unknown." During an interview on 08/03/18 at 09:36 AM, the MDS Coordinator was asked why the 7.24% change in weight had not been captured on Resident #49's 07/02/18 assessment. The MDS Coordinator indicated that she probably compared it to the May weight because when she was coding the MDS on 7/2/18, the June weight probably wasn't available. The MDS Coordinator said, "Sometimes the Weight Book isn't available." During an interview on 08/03/18 at 11:35 AM, the DON said it was her expectation that a more thorough assessment be done to ensure accuracy of the MDS. 2. Resident #5 was admitted to the facility on 11/09/17 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 01/31/18, revealed Resident #5 was severely cognitively impaired, only required limited assistance with ambulation on and off the unit. The MDS specified the resident did not exhibit any wandering behavior during the assessment period and did not have a wander/elopement alarm. Record review revealed a document titled Behavioral Symptom Screening Form that was completed by Social Worker #1 and dated 04/24/18. The Behavioral Symptom Screening Form specified the behavior concern was	F 641	coordinator will visually observe the resident and document observations on the printed MDS Coordinator observation tool to ensure that each IDT member□s assessment matches what the MDS Coordinator observes. The MDS Coordinator tool and noted observations will be reviewed with the Interdisciplinary Team daily in the standup meeting to facilitate an IDT discussion to ensure the accuracy of the assessment for each resident. Any discrepancies between what was documented by the IDT member and what the MDS Coordinator observes will be noted on the printed MDS Coordinator tool by the MDS coordinator during observation and discussed with the IDT and follow-up observation will be completed prior to completion of the assessment to ensure accuracy. The Director of Nursing / nursing management and the MDS coordinator will complete daily clinical startup meetings that includes review of the 24-hour reports, staff interviews and visual observations of residents. The MDS Coordinator□s participation in clinical startup will ensure that the MDS coordinator is consistently visually observing the residents and staying knowledgeable on the status of residents and the care provided. The knowledge obtained from daily observations and involvement with clinical staff will support the MDS Coordinator in verifying the accuracy of coding. "The monitoring procedure to ensure that the plan of correction is effective, and that	

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F 641	Continued From page 8 "Wandering" and included the statement, "Wanderguard in place. Wanders into others rooms." The quarterly MDS dated 05/2/18 indicated the resident was severely cognitively impaired, ambulatory and had wandering behavior. The MDS did not indicate the resident had a wander/elopement alarm in place. Observations on 07/31/18 at 04:31 PM, revealed Resident #5 was wearing a wandering/elopement alarm on her left ankle and walking down the hallway in stocking feet. Resident #5 was still wearing the wander/elopement alarm on 08/02/18 when Nursing Assistant (NA) #1 was interviewed at 02:31 PM. NA #1 indicated Resident #5 had been wearing the wander alarm bracelet, "for some months now" but was unsure when it was first applied. NA #1 said the resident wandered into other residents' rooms and might lay on the bed because she was unable to identify her own room. The Social Worker (SW #1) was interviewed on 08/02/18 at 02:39 PM, about when Resident #5 had begun wearing the wander/elopement alarm and why the alarm had not been coded on the 05/02/18 MDS. SW #1 stated she thought the resident had begun wearing the wander alarm at the end of May. The SW confirmed she had documented on the Behavior Symptom Screening Form dated 04/24/18, that the wander alarm was in place. SW#1 said, "I can't explain why I would have documented on 4/24 that she had a wanderguard in place at that time but this (documentation) was done in a meeting so I was	F 641	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The MDS coordinator will maintain MDS Coordinator tools with IDT signatures verifying review for accuracy. The MDS Coordinator tool will be signed by the IDT member after discussion concerning the accuracy of the resident assessment has occurred. Analysis of errors identified, and changes made based on the IDT member□s assessment compared to the MDS Coordinator□s assessment will be reviewed by the quality assessment performance improvement committee monthly or until six months of compliance is achieved. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. Date of compliance: 8/27/18	

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F 641	Continued From page 9	F 641		

not the only one in the meeting (on 04/24/18)."

The Director of Nursing (DON) was interviewed on 08/02/18 at 03:37 PM. The DON reviewed the Behavioral Symptom Screening Form that was completed by Social Worker #1 and dated 04/24/18. The DON confirmed 04/24/18 was the date of a Behavioral meeting where she and SW #1 had discussed the increase in Resident #5's wandering behavior in the building. The DON said, "The reason we put the wanderguard on is because she has a tendency to follow people and we were scared she might follow a visitor or someone outside. She has never gotten outside."

The MDS Coordinator was interviewed on 08/02/18 at 04:04 PM about the wander/elopement alarm that was in place at the time of the 05/02/18 assessment but was not coded on the MDS. The MDS Coordinator confirmed she had coded the alarm portion of Resident #5's assessment and said, "If it is not coded, then I didn't see it." When asked if Resident #5 was currently wearing a wandering alarm, the MDS Coordinator said, "I don't know."

During a follow-up interview on 08/03/18 at 11:35 AM, the DON said it was her expectation that a more thorough assessment be done to ensure accuracy of the MDS.

3-Record review revealed resident #4 was admitted to the facility on 4/7/2016 with diagnoses which included Alzheimer 's disease and a history of falls.

Review of the annual Minimum Data Set (MDS) dated 2/9/2018 revealed Resident #4 was

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F 641	Continued From page 10	F 641		

rarely/never understood, was severely impaired for decision making, and inattention and disorganized thinking were present and fluctuated in severity. The MDS indicated the resident required extensive to total assist with all activities of daily living (ADLs). The MDS indicated the resident had no impairments of upper and lower extremities and was not steady moving from a seated to standing position. The MDS indicated the resident used no restraints. Review of the most recent quarterly MDS assessment dated 5/1/2018 revealed no changes in the previous referenced areas.

Review of Resident #4's care plan with the most recent revision dated 2/9/2018 included a focus on falls. The goal was the resident would not experience any falls through the next review. Interventions included to monitor for changes in condition that warranted increased supervision/assistance and notify the physician of changes, and to encourage the resident to get out of bed.

Review of a Physical Device Form dated 4/27/2018 indicated Resident #4 used no devices. The devices listed on the form included a reclined chair. The Physical Device Form was signed by Nurse #9.

A continual observation of Resident #4 was conducted on 7/31/2018 from 2:15 PM to 3:00 PM. The resident was observed at the nurse's station in a reclining geriatric chair. The chair was reclined and the resident was positioned with his feet on the foot rest which was positioned above the resident's trunk. The resident attempted to

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PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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F 641	Continued From page 11	F 641		

push the footrest down several times and would sit up in the chair. The resident attempted to scoot toward the end of the chair several times but the reclined position of the chair prohibited. The facility administrator spoke to the resident twice and tried to convince him to lean back in the chair and rest but the resident continued to attempt to lean up and get the footrest down.

An observation was made of Resident #4 on 8/1/2018 at 1:37 PM. The resident was in the same chair as the previous day and was sitting at the nurse's station. The chair was reclined and the resident was positioned with his feet on the foot rest which was positioned above the resident's trunk. The resident made several attempts to sit up and push the footrest down but was unable to.
A telephone interview was conducted with Resident #4's responsible party (RP) on 8/2/2018 at 8:48 AM. The RP indicated she visited the resident daily. She stated the resident had been in a reclining chair for a long time and reported she was sure it was over a year. The RP indicated the resident would attempt to stand up and would fall if the chair was not reclined. The RP stated the resident had a history of falling and the staff leaned him way back in the chair so he would not fall.

An interview was conducted with Nurse #1 on 8/2/18 at 9:14 AM. Nurse #1 stated she worked with Resident #4 daily. Nurse #1 indicated the resident was placed in a reclining chair when he returned from the hospital in January of 2017. Nurse #1 revealed the resident sustained a fractured hip and was unable to sit up in the wheelchair upon readmission to the facility in

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F 641	Continued From page 12 January of 2017. Nurse #1 stated the resident had a history of falls and the chair was for his safety as well as comfort. Nurse #1 reported the reclining chair prevented the resident from rising. An interview was conducted with the Director of Nursing (DON) on 8/2/18 9:29 AM. The DON indicated Resident #4 was in a reclining chair to enhance safety and prevent the resident from falling. The DON indicated the reclining chair prevented the resident from rising when it was in the reclined position. The DON stated she was unaware the chair was considered a restraint. The DON stated the expectation was restraints would be identified, accurately assessed and care planned. An interview was conducted with the Minimum Date Set (MDS) Nurse on 8/2/2018 at 9:34 AM. The MDS nurse stated she was aware Resident #4 was in a reclining chair. The MDS Nurse indicated the resident used the chair daily and had for a long time. The MDS Nurse stated the chair was for his safety and to try to prevent falls. The MDS Nurse stated the chair prevented the resident from rising when it was in the reclined position. The MDS Nurse also stated the chair was in the reclined position most of the time. The MDS Nurse reported she did not code the chair as a restraint although it did prevent him from rising when it was reclined because she didn't know that was the regulation and the regulation must have changed.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		8/27/18

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F 657	Continued From page 13 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to review and revise the Plan of Care related to a wander alarm (Resident #5), and actual weight loss (Resident #49), for 2 of 7 sampled who had a change in care. Findings included: 1. Resident #49 was admitted to the facility on 03/27/18 with diagnoses that included coronary artery disease and rhabdomyolosis (the rapid destruction of skeletal muscle).	F 657	Failure to review and revise the plan of care related to a wander alarm and actual weight loss. "The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The plan of care resident #5 was revised on 8/3/18 to identify elopement risk and placement of wander/elopement alarm.	

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F 657	Continued From page 14 The admission comprehensive Minimum Data Set (MDS) dated 04/03/18, revealed Resident #49's weight was 175 pounds at admission. The Care Plan, dated 04/03/18, had the problem onset that stated, "(Resident #49) has the potential for alteration in nutrition r/t (related to) new admit, muscle weakness." Resident #49's weights were available in his clinical record and in the Weight Book kept in the nursing station. Both sources revealed the following weights: 175.8 pounds on 04/02/18 148.2 pounds on 05/01/18 143.6 pounds on 06/05/18 which was a weight loss of 18.32% in 2 months. 154.0 pounds on 07/02/18 which was a difference of 7.24% in the last 30 days. The quarterly MDS dated 07/02/18, revealed Resident #49's weight was 154 pounds, but for a question on the MDS that asked if the resident had a gain of 5% or more in the last month, the response was "No or unknown." Documentation on the Care Plan under the problem of "potential alteration in nutrition" revealed the problem had been reviewed on 7/25/18. There were no new interventions and the problem had not been changed to reflect the actual weight loss of 18.32% in 2 months or the 7.24 % weight that he had re-gained in 30 days at the time of the quarterly assessment. During an interview on 08/03/18 at 09:36 AM, the MDS Coordinator was asked why the Care Plan had not been updated to reflect the change in weight and any new interventions in place when	F 657	The plan of care for resident #49 was revised on 8/3/18 to identify actual weight loss. Lack of training for licensed nurses on completing and updating care plans to reflect status changes is identified as the root cause. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 8/24/18 the Director of Nursing, Assistant Director of Nursing, and MDS Coordinator where educated on updating/revising the residents plans of care. Education relating to review and revision of care plans has been added to the new hire Licensed Nurse orientation. The Director of Nursing and/or nurse management will review 24-hour reports for resident changes and ensure the plan of care is updated to accurately reflect resident status. The MDS Coordinator will visually observe the resident prior to completing MDS assessments to ensure the resident plan of care matches the resident status. The MDS Coordinator, DHS/nurse management, and Dietary manager will attend weight meetings weekly to identify changes and review/revise the plan of care as needed. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	

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F 657	Continued From page 15 the resident lost 18.32% of his weight in 2 months. The MDS Coordinator stated that sometimes the weight book was not available when she was doing her assessment and updating the plan of care. During an interview on 08/03/18 at 11:35 AM, the Director of Nursing (DON) said the MDS Coordinator was responsible for updating the Care Plan. The DON said it was her expectation that a more thorough assessment be done to ensure accuracy of the MDS and she expected the care plan to be reviewed and revised to reflect the resident's current status. 2. Resident #5 was admitted to the facility on 11/09/17 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 01/31/18, revealed Resident #5 was severely cognitively impaired, only required limited assistance with ambulation on and off the unit. The MDS specified the resident did not exhibit any wandering behavior during the assessment period and did not have a wander/elopement alarm. Record review revealed a document titled Behavioral Symptom Screening Form that was completed by Social Worker #1 and dated 04/24/18. The Behavioral Symptom Screening Form specified the behavior concern was "Wandering" and included the statement, "Wanderguard in place. Wanders into others rooms." The quarterly MDS dated 05/2/18 indicated the resident was severely cognitively impaired, ambulatory and had wandering behavior. The	F 657	The Director of Nursing / Nurse Management will review all residents with changes during clinical meeting and/or stand up meeting and ensure that the plans of care are completed and updated as necessary. The review will be conducted weekly for 2 weeks then monthly until six months of substantial compliance is maintained then quarterly thereafter. Any areas of non-compliance will be reported by the Administrator and/or Director of Health Services to the Quality Assurance / Performance Improvement Committee quarterly for recommendations as needed. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. Date of Compliance: 8/27/18	

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MDS did not indicate the resident had a wander/elopement alarm in place.

The Care Plan problem list, most recently updated 6/16/18, included a risk for falls, and impaired decision making related to her diagnosis of dementia but did not include any problem or interventions regarding wandering behavior.

Observations on 07/31/18 at 04:31 PM, revealed Resident #5 was wearing a wandering/elopement alarm on her left ankle and walking down the hallway in stocking feet.

Resident #5 was still wearing the wander/elopement alarm on 08/02/18 when Nursing Assistant (NA) #1 was interviewed at 02:31 PM. NA #1 indicated Resident #5 had been wearing the wander alarm bracelet, "for some months now" but was unsure when it was first applied. NA #1 said the resident wandered into other residents' rooms and might lay on the bed because she was unable to identify her own room.

The Director of Nursing (DON) was interviewed on 08/02/18 at 03:37 PM. The DON confirmed 04/24/18 was the date of a Behavioral meeting where she and SW #1 had discussed the increase in Resident #5's wandering behavior in the building. The DON said, "The reason we put the wanderguard on is because she has a tendency to follow people and we were scared she might follow a visitor or someone outside. She has never gotten outside."

The MDS Coordinator was interviewed on 08/02/18 at 04:04 PM about the increase in wandering behavior and the wander/elopement

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F 657	Continued From page 17 alarm in place at the time of the 05/02/18 assessment that was not reflected in the Care Plan. The MDS Coordinator indicated that wandering and placement of a wander alarm would be something that should be on the Care Plan. When asked if Resident #5 was currently wearing a wandering alarm, the MDS Coordinator said, "I don't know." During a follow-up interview on 08/03/18 at 11:35 AM, the Director of Nursing (DON) said the MDS Coordinator was responsible for updating the Care Plan. The DON said it was her expectation that a more thorough assessment be done to ensure accuracy of the MDS and she expected the care plan to be reviewed and revised to reflect the resident's current status.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide adequate supervision and implement interventions to prevent a cognitively impaired resident (Resident #5) from wandering into the rooms of other residents, for 1 of 3 residents sampled for supervision to prevent accidents. Findings included:	F 689	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Staff unable to redirect resident #5 from going into other resident□s space. Resident #5 was assigned 1 on 1 supervision from 8/3/18 to 8/6/18.	8/27/18

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F 689	Continued From page 18 Resident #5 was admitted to the facility on 11/09/17 with diagnoses that included dementia. The comprehensive Minimum Data Set (MDS) dated 11/16/17, indicated the resident was severely cognitively impaired and ambulatory. Resident #5's MDS specified that verbal behavioral symptoms directed at others (e.g. threatening others, screaming at others, cursing at others) were present 1-3 days during last 7 days. Other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging) were also present during the assessment period. Also in the Behavior section of the MDS there were questions titled "Impact on Resident" that asked, "Did any of the identified symptoms: A. Put the resident at significant risk for physical illness or injury? B. Significantly interfere with resident's care? C. Significantly interfere with the resident's participation in activities or social interaction?" The response to those questions were all coded "Yes." More questions in the Behavior section titled, "Impact on Others" asked, "Did any of the identified symptoms: A. Put others at significant risk for physical injury? B. Significantly intrude on the privacy of others? C. Significantly disrupt care or living environment?" The response to those questions were all coded "Yes." The Care Area Assessment summaries dated 11/16/17 were reviewed. The summaries did not include any discussion of wandering behavior but did state that Resident #5, "displays impaired memory/thought process." and "She has also attempted to pull another resident out of their bed. She requires constant supervision by staff."	F 689	Resident # 5 was discharged to memory care unit on 8/6/18. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Staff educated that if a resident is unable to be redirected, notification of the charge nurse and/or the Director of Nursing is required. Nursing management and social services director reviewed current residents in facility on 8/24/18 to identify any residents that wander into other□s rooms. New residents will be screened on admission using the behavior screening tool and with each comprehensive assessment or if change in behavior is identified. The facility will assist residents that are unable to be redirected in finding appropriate placement. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The behavior screening tools will be presented to the IDT weekly x 4 weeks and monthly thereafter until 6 months of compliance is achieved. Findings of the analysis of the behavior monitoring tool will be reviewed by the quality assessment performance improvement committee. "The title of the person responsible for implementing the acceptable plan of	

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F 689	Continued From page 19 Record review revealed a document titled Behavioral Symptom Screening Form that was completed by Social Worker #1 and dated 04/24/18. The Behavioral Symptom Screening Form specified the behavior concern was "Wandering" and included the statement, "Wanderguard in place. Wanders into others rooms." The quarterly MDS dated 05/2/18 indicated the resident was severely cognitively impaired, ambulatory and had wandering behavior. The quarterly MDS is a shorter form than the comprehensive assessment and does not include the questions about "Impact on Resident" or "Impact on Others." The Care Plan problem list, most recently updated 6/16/18, included a risk for falls, and impaired decision making related to her diagnosis of dementia but did not include any problem or interventions regarding wandering behavior. Observations on 07/31/18 at 04:31 PM, revealed Resident #5 was wearing a wandering/elopement alarm on her left ankle and walking down the hallway in stocking feet. During the Resident Council group interview on 08/01/18 at 3:00PM, four residents were identified by the facility, as alert and oriented and regularly attended meetings. During the meeting the residents revealed an issue that had not previously been discussed in a Resident Council Meeting. Residents #13, #23, #50 and #53 all cited incidents when Resident #5 wandered into rooms of other residents to lie down on the first bed in the room. Resident #53 further reported that last weekend the identified resident had	F 689	correction. The Administrator is responsible for implementing the plan of correction. Date of Compliance: 8/27/18	

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come into Resident #53's room, took the water pitcher and poured it out onto the over-bed table. Resident #53 specified that water was all over the table, wall, floor and had gotten on her Bible, and on her hearing aid box. Resident #53 also believed Resident #5 had taken personal items like shoes and glasses because she found them in odd places and scattered in the dayroom. Resident #53 stated that she had to send her Bible home with a family member to dry out the pages.

Nursing Assistant #2 (NA #2) was interviewed on 08/01/18 at 05:40 PM, regarding Resident #5's wandering behavior. NA #2 confirmed that Resident #5 would go into other residents' rooms. When asked if other residents complain, NA #2 said "Yes and we let the nurse know and we get her out of the room and try to occupy her." The NA added that most often it was because the bed was empty and Resident #5 thought it was her bed. NA #2 also confirmed that the water incident described by Resident #53 had occurred and said, "Yes that was last weekend. I had to go in and clean it up. I told the nurse. It had spilled by door, on the wall and on some prayer pamphlets." The NA didn't think it had gotten Resident #53's Bible wet.

Nurse #1 was interviewed on 08/01/18 at 05:50 PM. Nurse #1 stated she had worked the night of the water incident but had never known Resident #5 to be aggressive. "I think she was patting around on the table and knocked it (the water pitcher) over. I went and got her. She stood with me for a minute and then took right off again. She is easily redirected but that doesn't mean she won't get right back into it again." When asked what interventions were in place to prevent

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Resident #5 from going into other resident rooms, Nurse #1 said, "There is no way to prevent it. We just redirect her when it happens."

Resident #5 was walking in the hall on 08/02/18, when Nursing Assistant (NA) #1 was interviewed at 02:31 PM. NA #1 indicated Resident #5 had been wearing the wander alarm bracelet, "for some months now" but was unsure when it was first applied. NA #1 said the resident wandered into other residents' rooms and might lay on the bed because she was unable to identify her own room.

The Social Worker (SW #1) was interviewed on 08/02/18 at 02:39 PM. SW #1 confirmed she had documented on the Behavior Symptom Screening Form dated 04/24/2018, that the wander alarm was in place because Resident #5, "wanders into others rooms." The Behavior Symptom Screening form asked, "Does the behavior endanger the patient/resident? Others?" The response was, "Yes - invasion of others privacy" and indicated it was not isolated, but was a pattern of behavior for this resident.

The Director of Nursing (DON) was interviewed on 08/02/18 at 03:37 PM. The DON reviewed the Behavioral Symptom Screening Form dated 04/24/18. The DON said, "The reason we put the wanderguard on is because she has a tendency to follow people and we were scared she might follow a visitor or someone outside. She has never gotten outside." The DON was unaware of the water incident described by Resident #53 but said Resident #5 was on a waiting list for a memory care unit.

During a follow-up interview on 08/03/18 at 11:35

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F 689	Continued From page 22 AM, the DON said it was her expectation that staff make her aware of incidents regarding Resident #5. The DON stated, "The challenge with her is her vision so a lot of activities don't work for her." The DON indicated the Administrator had just gotten approval for 1:1 staffing for Resident #5 to begin 08/03/18. The DON said that resident safety was most important, and privacy of other residents should be respected. During an interview on 08/03/18 at 12:06 PM, the Administrator said, "I expect that we protect both the wanderer's safety and other residents' rights."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide respiratory care per the physician's orders by not changing the oxygen tubing weekly for 2 of 2 residents (Resident #3 and Resident #26). Findings included: 1-Record review revealed resident #3 was admitted to the facility on 11/24/2009 with	F 695	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The oxygen tubing and suction canister□s where changed on 8/1/2018 by the Licensed Nurse. The Charge Nurse assigned to change and sign off on the medication	8/27/18

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F 695	Continued From page 23 diagnoses which included Anemia and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) dated 5/1/2018 indicated resident #3 was rarely/never understood and required total assistance with all activities of daily living. The MDS also indicated the resident required oxygen therapy. Review of Resident #3's care plan initiated 8/18/2017 and most recently updated 5/1/2018 included a focus of alterations in oxygen (O2) saturation levels which required continuous O2 therapy. The goal was listed as the resident would exhibit no shortness of breath through the next review. Interventions included to change resident's O2 tubing per protocol. An observation was conducted on 7/31/2018 at 10:46 AM of Resident #3. The resident was observed to be lying in bed and well kempt. The resident was receiving oxygen via nasal cannula from an oxygen concentrator with a humidification bottle attached. There were no dates observed on the tubing or the humidification bottle. Review Resident #3's signed physician's orders for June 1, 2018 through August 30, 2018 revealed an order for oxygen tubing and respiratory supplies to be changed every Thursday on the 11:00 PM to 7:00 AM shift. Review of the Medication Administration Record (MAR) for June 2018 and July 2018 for Resident #3 revealed an order for the oxygen tubing and respiratory supplies to be changed every Thursday on the 11:00 PM to 7:00 AM shift. Thursdays were indicated on the MAR with a box	F 695	administration record that they changed the nasal cannula, suction canister and other respiratory equipment weekly was so aromatic that she just changed everything and did not think about signing it off on the medication administration record. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The Director of Nursing and/or Assistant Director of Nursing began education the Licensed Nurses on 8/10/2018 on weekly oxygen tubing, suction canister and other respiratory equipment, changes with documentation on the Medication Administration Record to confirm completion. Licensed Nurses who have not received the education by 8/20/2018 will be removed from the schedule until they have completed the education. This education has been added to the general oriented for newly hired Licensed Nurses. The Director of Nursing and/or Assistant Director of Nursing will monitor the Medication Administration Record to confirm documentation of weekly changes of the oxygen tubing, suction canister□s, and other respiratory equipment, utilizing the Oxygen and Equipment MAR Audit Form and will correlate the documentation with visualization of the clean equipment. The Director of Health Services and/or Assistant Director of Health Services will complete the Oxygen and Equipment MAR audit weekly for 12 weeks then	

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F 695	Continued From page 24 for signature drawn around the dates for initials when completed. There were no initials in the boxes for verification of the tubing changes. All other orders on the MAR were initialed. An interview was conducted with the Director of Nursing (DON) during an observation of Resident #3 on 8/1/18 at 2:53 PM. The DON looked at the oxygen tubing and the humidification bottle and stated they should be dated to ensure they were changed per physician orders. The DON stated the night nurse was responsible for changing the tubing every Thursday night and the documentation was on the Medication Administration record (MAR) as a reminder for the nurse and to ensure the task was completed. The DON indicated the nurse initialed the MARS when the tubing was changed. The MARS for June 2018 and July 2018 were reviewed by the DON and writer. There were no initials on any of the blocks indicated for the tubing change. The DON stated the expectation was for the all the O2 tubing and respiratory supplies to be changed every Thursday on the night shift and the MAR to reflect the tubing and respiratory supplies were changed. The DON stated there was no way to ensure the tubing was changed as there was no documentation. A telephone interview was conducted on 8/1/2018 at 5:43 PM with Nurse #4. Nurse #4 confirmed she was the nurse who worked on the night shift almost every Thursday with Resident #3. Nurse #4 indicated she was aware it was her responsibility to change the oxygen tubing and supplies every Thursday night. She stated she sometimes used a small piece of tape and attached to the tubing with the date she changed it, but she didn't do that all the time. She stated	F 695	monthly thereafter. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Assistant Director of Nursing will track, trend and analyses the data from the Oxygen and Equipment MAR audit form and present their finding to the Quality Assurance and Performance Improvement Committee monthly until 6 consecutive months of compliance is maintained then quarterly thereafter. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. Date of compliance: 8/27/18	

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F 695	Continued From page 25	F 695		

sometimes she changed it and didn't indicate the date anywhere on the oxygen tubing or the supplies. She stated she knew she changed it and must have forgotten to date it. Nurse #4 indicated she did not know why she did not sign/initial the Medication Administration record when she changed the tubing. Nurse #4 stated she was aware the MAR needed to be signed, but she must have forgotten to sign it every week.

2-Record review revealed Resident #26 was admitted to the facility on 10/31/2016 with diagnoses which included Acute Respiratory Failure and Coronary Artery Disease.

Review of Resident #26 quarterly Minimum Data Set (MDS) dated 6/13/2018 indicated the resident was cognitively intact and required extensive assistance with all activities of daily living. The MDS also indicated the resident required continual oxygen therapy.

Review of Resident #26's care plan most recently updated 6/13/2018 included a focus of alterations in oxygen (O2) saturation levels which required continuous O2 therapy. The goal was listed as the resident would exhibit no shortness of breath through the next review. Interventions included to change resident's O2 tubing per protocol.

An observation and interview was conducted on 7/31/2018 at 9:17 AM of Resident #26. The resident was observed to be lying in bed and well kempt. The resident was receiving oxygen via nasal cannula from an oxygen concentrator with a humidification bottle attached. There were no dates observed on the tubing or the humidification bottle. The resident was alert,

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F 695	Continued From page 26	F 695		

oriented and pleasant. The resident stated he was unsure when the oxygen tubing was changed as the staff were in and out of his room during the day and he really didn't pay much attention to what they were doing.

Review of the signed physician's orders for Resident #26 for June 1, 2018 through August 30, 2018 revealed an order for oxygen tubing and respiratory supplies to be changed every Thursday on the 11:00 PM to 7:00 AM shift.

Review of the Medication Administration Record (MAR) for June 2018 and July 2018 for Resident #26 revealed an order for the oxygen tubing and respiratory supplies to be changed every Thursday on the 11:00 PM to 7:00 AM shift. Thursdays were indicated on the MAR with a box for signature drawn around the dates for initials when completed. There were no initials in the boxes for verification of the tubing changes. All other orders on the MAR were initialed.

An interview was conducted with the Director of Nursing (DON) on 8/1/18 at 3:15 PM. The DON stated the night nurse was responsible for changing the oxygen tubing every Thursday night and the documentation was on the Medication Administration record (MAR) as a reminder for the nurse and to ensure the task was completed. The DON indicated the nurse initialed the MARS when the tubing was changed. The MARS for Resident #26 for June 2018 and July 2018 were reviewed by the DON and writer. There were no initials on any of the blocks indicated for the tubing change. The DON stated the expectation was for the all the O2 tubing and respiratory supplies to be changed every Thursday on the

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F 695	Continued From page 27 night shift and the MAR to reflect the tubing and respiratory supplies were changed. The DON stated there was no way to ensure the tubing was changed as there was no documentation. A telephone interview was conducted on 8/1/2018 at 5:43 PM with Nurse #4. Nurse #4 confirmed she was the nurse who worked on the night shift almost every Thursday with Resident #26. Nurse #4 indicated she was aware it was her responsibility to change the oxygen tubing and supplies every Thursday night. She stated she sometimes used a small piece of tape and attached to the tubing with the date she changed it, but she didn't do that all the time. She stated sometimes she changed it and didn't indicate the date anywhere on the oxygen tubing or the supplies. She stated she knew she changed it and must have forgotten to date it. Nurse #4 indicated she did not know why she did not sign/initial the Medication Administration record when she changed the tubing. Nurse #4 stated she was aware the MAR needed to be signed, but she must have forgotten to sign it every week.	F 695		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.	F 811		8/27/18

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F 811	Continued From page 28 §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews, the facility failed to ensure that a staff member completed state-approved training prior to feeding 1 of 2 sampled residents (Residents #4) observed being fed. Findings included: During the Entrance Conference on 07/30/18 at 3:15 PM, the Administrator and Director of Nursing (DON) specified the facility did not have a Paid Feeding Assistance Program. Resident #4 was admitted to the facility on 04/07/16. Current diagnoses included Alzheimer's disease, cervical vertebrae 1 and cervical vertebrae 2 neck fracture and seizure disorder. The most recent Minimum Data Set assessment (dated 05/01/18), revealed Resident #4 was	F 811	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The Financial Counselor was educated by the Administrator on 8/2/2018, that until she could provide proof of a feeding assistance class, she would not be allowed to feed the residents. The financial counselor thought that since she went through a feeding class with another company that she would be able to feed residents in this facility also. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

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F 811	Continued From page 29 severely cognitively impaired, required extensive assistance with eating, had no trouble with swallowing, and was receiving hospice services. On 08/02/18 at 12:58 PM, the Business Office Manager was observed feeding lunch to Resident #4. Resident #4 was in a specialty wheelchair, wearing a cervical collar and was in the dining room. Upon interview, the Business Office Manager said she had never been a nurse or nursing assistant, but that she like to help out whenever possible. During an interview on 8/3/18 at 11:35 AM, the Director of Nursing stated it was her expectation that anyone feeding residents would have the proper training to ensure the resident's safety . During an interview on 08/03/18 at 12:06 PM, the Administrator stated the facility did not have a Paid Feeding Assistance program and anyone feeding residents should have the proper training.	F 811	The Administrator, Director of Health Services and/or Assistance Director of Health Services educated all non-nursing staff regarding their inability to feed residents during meals. This education will be completed by 8/20/2018, any non-nursing personnel in feeding who have not received education will be removed from the schedule until their training is complete. This education has been added to new hire orientation for non-nursing personnel. The Administrator and / or Director of Nursing will monitor meal times, to ensure no non-nursing employee is feeding resident□s) daily for 5 days, then twice a week for 4 weeks then monthly until 3 months of continued compliance is maintained then quarterly. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator and / or Director of Nursing will present the analyzes of the data from the Meal Monitoring Form to the Quality Assurance and Performance Committee monthly until 3 months of continued compliance is maintained then quarterly thereafter. "The title of the person responsible for implementing the acceptable plan of correction.	

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F 811	Continued From page 30	F 811	The Administrator is responsible for implementing the plan of correction. Date of compliance: 8/27/18	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interviews from both residents and staff, the facility failed to have a safe, functional environment by allowing unused equipment (wheelchairs, reclined specialty chairs, mechanical lifts, vacuum cleaners) to be stored throughout the day, along one of two hallways during 5 of 5 days of the survey. Findings included: During the initial tour on 07/30/18 at 03:15 PM, equipment including unoccupied wheelchairs, mechanical lifts, an emergency cart, medication carts, soiled linen carts, clean linen carts and unoccupied reclined specialty chairs were observed on both sides of the Long and Short hallways. The amount of equipment stored along the hallways allowed little or no room for residents in wheelchairs to pass freely from one area of the facility to another without asking for equipment to be moved or having to wait for staff to step aside. On 07/31/18 at 09:05 AM, observation revealed equipment lined up along the wall space between doorways on both hallways. The left side of the Long Hall contained five unoccupied wheelchairs,	F 921	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Unused equipment was removed from both long and short hallways on 8/3/2018. The increase in wheelchair usage combined with the limited space for storage in the resident rooms contributed to the inappropriate storage of items in the hallways. "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Unused equipment was removed from both long and short hallways on 8/3/2018 and a interior room was reassigned to be utilized for storing equipment. The Staff was educated on maintaining a clutter free hallway and the proper locations to store equipment that is not in use by 8/24/18. Staff that have not	8/27/18

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F 921	Continued From page 31 two unoccupied specialty recliners, one mechanical lift, one linen cart and the emergency cart. The right side of the hall contained one medication cart and one treatment cart. On 08/01/18 at 08:13 AM, left side of the Long Hall contained seven unoccupied wheelchairs, four unoccupied specialty recliners, one mechanical lift, one linen cart and the emergency cart. The right side of the hall contained one medication cart and one meal cart. At 08:15 AM on 08/01/18, Resident #5, who was ambulatory, had to turn sideways to get between the medication cart where the nurse was preparing medications and an open unoccupied bariatric wheelchair on the opposite side of the hall. Another resident in a wheelchair was unable to pass until the nurse stepped away from the front of her cart. On 08/01/18 at 10:45 AM, the left side of the Long Hall contained one medication cart, one treatment cart, one over-bed table, one emergency cart, six empty wheelchairs, three empty specialty recliners, one mechanical lift, one walker that was not in use, and one unplugged/stored vacuum cleaner. On the right side of the hall stood one clean linen cart, one housekeeping cart, one clean laundry delivery cart, one dirty linen cart and one ice delivery cart. At 10:48 AM, an ambulance gurney emerged from a resident room with Resident #21. The ambulance staff had to weave the gurney to the left and to the right as they made their way toward the nursing station and the front doors of the building. On 08/01/18 at 04:53 PM, Resident #29 was in a	F 921	completed training by this date must receive training prior to working their next assigned shift. "The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator and/or management will complete rounding throughout the day including meal times and medication administration times to ensure that the hallway remains clutter free. Findings from the rounds will be reviewed weekly for one month, monthly for 3 months, and quarterly thereafter. The Administrator will present the analysis of the appropriate storage of equipment to the Quality Assurance and Performance Improvement Committee monthly until six months of continued compliance is maintained then quarterly thereafter. "The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. Date of Compliance: 8/27/18	

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F 921	Continued From page 32	F 921		

wheelchair as he attempted to go down the Long Hall. Resident #29 said, "I can't get through but that's okay. I'll come back later."

During a Medication Pass observation and interview on 08/01/18 5:13 PM, Nurse #1 indicated it was often a "tight squeeze" in the hallway, so she would sometimes back into a resident's room and pull the medication cart up to the doorway in an effort to make more room to pass in the hall.

During an interview on 08/02/18 at 08:06 AM, Resident #23 indicated it could be difficult to maneuver the hallway in her wheelchair. Resident #23 said "If I can't get through, I have to ask them to move it so I can get through."

On 08/02/18 at 04:41 PM, the left side of the Long Hall contained one locked, unattended treatment cart, one over-bed table, one emergency cart, seven unoccupied wheelchairs, three unoccupied specialty recliners, two mechanical lifts, two unplugged/stored vacuum cleaners, and one linen cart. On the right side of the hall stood a dirty laundry cart and a medication cart where the nurse was preparing medications. Also observed at that time was a Nursing Assistant pushing a resident in a wheelchair. The nurse had to stop dishing up the medication and step aside so the Nursing Assistant could push the resident in the wheelchair between the equipment and through to the Day room.

On 08/03/18 at 08:35 AM the Long Hall contained one emergency cart, eight unoccupied wheelchairs, four unoccupied specialty recliners, two mechanical lifts, one linen cart, and two

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unplugged/stored vacuum cleaners. On the right side of the hall stood a meal cart, a treatment cart, one unattended walker and a medication cart where the nurse was preparing medications.

Resident #52 was interviewed on 08/03/18 at 08:57 AM, while sitting in a wheelchair in the dining room. Record review revealed Resident #52 was admitted to the facility on 7/3/18 and had a comprehensive Minimum Data Set (dated 7/10/18) that indicated Resident #52 was cognitively intact. When asked if there was any difficulty with maneuvering a wheelchair down the hallway, Resident #52 said, "If there was a fire it would be a disaster." The resident also said, "But they move stuff eventually and you can get through."

On 08/03/18 at 10:12 AM, the Maintenance Director paced off the hallway and indicated the area from the nursing station to the end of Long Hall was approximately 150 feet long and 8 feet wide.

During an interview on 08/03/18 at 11:02 AM, the Director of Nursing indicated she was aware there was a lot of unused equipment and stated they would need to try to find an area to keep the equipment that was currently stored in the hallway.

At 08/03/18 at 12:40 PM, the Administrator stated his expectation would be to maintain a clutter-free hallway.