STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 - (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 (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). (iii) Any specialized services or specialized 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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care	F 656		10/4/18

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

Electronically Signed | 10/03/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to implement care planned interventions to provide incontinent care to keep a resident clean and dry for 1 of 2 dependent residents (Resident # 11) reviewed for activities of daily living (ADL). The findings included: Resident #11 was admitted to the facility on 02/16/18 with hemiplegia and hemiparesis following a cerebral vascular accident (CVA), flaccid hemiplegia of the right side, dysphagia, traumatic brain injury (TBI), dementia and others. A review of Resident #11's most recent quarterly Minimum Data Set (MDS) dated 07/20/18 revealed the resident was severely cognitively impaired for daily decision making. The MDS also revealed the resident required extensive assistance of two persons for toileting and was always incontinent of bowel and bladder. A review of Resident #11's care plan dated 09/05/18 revealed the resident had a care plan for being at risk for self-care deficit related to his CVA, dementia and pain. The goal was for the resident to maintain his current level of function through the next review. The interventions read in part, bathing and hygiene with assistance of 2, dressing and grooming with assistance of 2, , provide incontinent care as necessary, provide needed assistance with self-care daily and as needed, report to nursing if resident declines	F 656	F656 Develop/Implement Comprehensive Care Plan CRF(s): 483.21(b) (1) The facility must develop and implement a comprehensive care plan for each resident, consistent with the resident's rights set for at 483.10 (c)(2) and 483.10 (c)(3) that includes measureable objectives and timeframes in which to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment Criteria 1 Based on observations, record reviews, and staff interviews, the facility failed to implement care planned interventions to provide incontinent care to keep a resident clean and dry for 1 of 2 dependent residents reviewed for activities of daily living (ADL) Criteria 2- The procedure for implementing the plan of correction for F656 A list of residents who require total assistance in ADL will be compiled from the most recent MDS quarterly data by September 28, 2018. An audit of care plans will be conducted	

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F 656	Continued From page 2 care, and toileting with assistance of 2. An observation on 09/10/18 at 1:58 PM was made of Nurse #1 instructing the scheduler and NA #1 to put Resident #11 to bed. Resident #11's transfer to bed and incontinence care was observed in his room. As the resident was lifted out of his Geri chair there was a strong odor of urine coming from the resident and the cushion in the resident's chair was noted to be wet. The resident's sweatpants were removed, and Nursing Assistant (NA) #1 held them up and there was a large oval wet spot on the left side back of the pants where urine had seeped through his pants. NA #1 opened the brief and it was saturated with urine from front to back and the lining was completely wet and balled up in the middle from the saturation of urine. The resident had also had a small soft bowel movement in the brief. NA #1 cleaned Resident #11 on the front using aseptic technique, turned him and cleaned him on the back side using aseptic technique. NA #1 removed the dirty brief, wrapped it, and threw it in the trash can. The resident's bottom was slightly red, so she applied cream to it and secured the new brief around him. An interview on 09/10/18 at 2:25 PM revealed NA #1 was not assigned to Resident #11 that day but was helping with the resident. NA #1 stated the resident was on the early riser list and stated he had been up since she reported to work at 7:00 AM. An interview on 09/10/18 at 2:35 PM with NA #2 revealed she had been assigned to Resident #11 for the day. She stated he had been up when she reported to work at 7:00 AM. NA #2 stated she had checked the resident's line on his brief at	F 656	on those residents who require total assistance in ADL to ensure the care plans accurately reflect the resident's care needs by October 4, 2018 All staff will be educated on providing care for the ADL dependent resident as outline in the plan of care by October 4, 2018 Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; The DON or designee will complete a care plan audit of two ADL dependent residents twice a week for 4 weeks, then once a week for 4 weeks then monthly times 3 months. The DON or designee will complete a rounding audit on two ADL dependent residents twice a week for 4 weeks, then once a week for 4 weeks then monthly times 3 months. Results will be reported to monthly QAPI meeting Date of Completion 10/4/18	

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F 656	Continued From page 3	F 656		

7:45 AM and it was yellow, so she had taken him out of the room and placed him in front of the dining room in preparation for breakfast. NA #2 stated she had checked him again at 11:00 AM by taking him into the shower room and looking at the strip on his brief and stated it was still yellow at that time as well. NA #2 stated she had not changed the resident all shift because his brief strip was still yellow and stated he had not been changed since 3rd shift got him up in his chair for the day.

An interview on 09/11/18 at 1:18 PM revealed NA #1 had not been assigned to Resident #11 but had assisted in his care. She stated the resident was not a heavy wetter and stated by the looks of his pants yesterday, it had been a while since he had been changed. NA #1 stated she usually changed residents about every 2 hours if they were incontinent.

An interview on 09/11/18 at 1:28 PM revealed NA #2 had been assigned to Resident #11 on 09/10/18 but did not have him on her assignment today. NA #2 stated Resident #11 was not a heavy wetter but was incontinent and should be checked every 2 hours and changed when wet. She stated she checked the resident yesterday at 11:00 AM in the shower room and the briefs' lining was yellow so he was not changed. NA #2 stated Resident #11 was not changed while NA #2 was on duty from 7:00 AM until NA #1 and the scheduler changed him at around 2:00 PM.

An observation was made on 09/11/18 at 1:46 PM of Resident #11's transfer to bed and incontinence care. As the resident was lifted out of the Geri chair there was not an odor of urine and the cushion in the resident's chair was dry.

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F 656	Continued From page 4 The resident's pants were removed and were dry. NA #3 opened his brief and there was urine in the front part of the brief and the back of the brief was dry. NA #3 cleaned the resident and applied a new brief and secured it. The resident was positioned for comfort and his call light was placed within his reach. An interview on 09/11/18 at 2:02 PM with the scheduler revealed Resident #11 was not a heavy wetter and stated he was usually taken to his room every 2 hours and checked and changed. She stated he should have been checked and changed at 10:00 AM yesterday and stated he was not very wet today at 1:46 PM because he had been changed at 10:00 AM before lunch. An interview on 09/11/18 at 2:22 PM with Nurse #1 revealed she was not aware of how much Resident #11 was checked and changed yesterday but stated he typically did not drink a lot and was not a heavy wetter. The nurse stated incontinent residents are typically checked and changed every 2 hours. An interview on 09/11/18 at 4:11 PM with the Charge Nurse revealed she expected all dependent residents to be checked every 2 hours and if wet, to be changed according to their care plan. An interview on 09/11/18 at 5:15 PM with the Administrator revealed it was his understanding the residents were checked and changed every 2 hours whether they were wet or dry.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/4/18

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F 677	Continued From page 5 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide incontinence care to keep a resident clean and dry for 1 of 2 residents (Resident #11) reviewed for activities of daily living (ADL) care provided for dependent residents. The findings included: Resident #11 was admitted to the facility on 02/16/18 with hemiplegia and hemiparesis following a cerebral vascular accident (CVA), flaccid hemiplegia of right side, dysphagia, traumatic brain injury (TBI), dementia and others. A review of Resident #11's most recent quarterly Minimum Data Set (MDS) dated 07/20/18 revealed the resident was severely cognitively impaired for daily decision making. The MDS also revealed the resident required extensive assistance of two persons for toileting and was always incontinent of bowel and bladder. A review of Resident #11's care plan dated 09/05/18 revealed the resident had a care plan for being at risk for self-care deficit related to his CVA, dementia and pain. The goal was for the resident to maintain his current level of function through the next review. The interventions included allow for rest breaks, ambulate/transfer with assistance of 2 with total lift using green sling, assist with shower/bath per schedule per resident's preference, bathing and hygiene with	F 677	F677 ADL Care Provided to Dependent residents CFR(s): 483.24(a) (2) A resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene Criteria 1 The plan of correcting cited deficiency of F677 and the processes that lead to the citation; Based on observations, record reviews, and staff interviews, the facility failed to provide incontinence care to keep a resident clean and dry for 1 of 2 residents reviewed for activities of (ADL) care provided for dependent residents. Criteria 2- The procedure for implementing the plan of correction for F677 A list of residents who require total assistance in ADL will be compiled from the most recent MDS quarterly data by September 28, 2018. All staff will be educated on care for the ADL dependent resident by October 4, 2018 The DON will develop a process and audit	

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F 677	Continued From page 6 assistance of 2, bed mobility with assistance of 2, dressing and grooming with assistance of 2, eating with assistance of 1, encourage activity during daily care, encourage to attend activities and assist if necessary, explain all procedures in advance, keep personal items in same location, pain meds as ordered, praise all efforts/accomplishments resident make to assist self and continue to encourage, provide incontinent care as necessary, provide needed assistance with self-care daily and as needed, report to nursing if resident declines care, and toileting with assistance of 2. An observation on 09/10/18 at 11:00 AM of Resident #11 revealed him sitting in his Geri chair outside the dining room. The resident smiled and attempted to talk but was not understood. The resident was dressed in tee shirt and gray sweatpants with bunny boots on both feet. An observation on 09/10/18 at 1:58 PM was made of Nurse #1 instructing the scheduler and NA #1 to put Resident #11 to bed. Resident #11's transfer to bed and incontinence care was observed in his room. As the resident was lifted out of his Geri chair there was a strong odor of urine coming from the resident and the cushion in the resident's chair was noted to be wet. The resident's sweatpants were removed, and Nursing Assistant (NA) #1 held them up and there was a large oval wet spot on the left side back of the pants where urine had seeped through his pants. NA #1 opened the brief and it was saturated with urine from front to back and the lining was completely wet and balled up in the middle from the saturation of urine. The resident had also had a small soft bowel movement in the brief. NA #1 cleaned Resident #11 on the front	F 677	tools to be utilized in the monitoring process to ensure the ADL care for dependent residents is being provided by October 1, 2018 The DON will identify and educate staff members that will be part of the monitoring process by October 4, 2018 The DON will begin the monitoring process effective October 1, 2018 Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; The DON or designee will complete a daily documentation audit of ADL care provided for 2 ADL dependent residents 5 times a week for 4 weeks, then three times a week for 4 weeks then monthly times 3 months. The DON or designee will complete a daily rounding audit on 2 ADL dependent residents 5 times a week for 4 weeks, then three times a week for 4 weeks then monthly times 3 months. Results will be reported to monthly QAPI meeting Criteria 4- The person responsible for implementing the plan of correction.	

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F 677	Continued From page 7 using aseptic technique, turned him and cleaned him on the back side using aseptic technique. NA #1 removed the dirty brief, wrapped it, and threw it in the trash can. The resident's bottom was slightly red, so she applied cream to it and secured the new brief around him. An interview on 09/10/18 at 2:25 PM revealed NA #1 was not assigned to Resident #11 that day but was helping with the resident. The scheduler assisted NA #1 with getting the resident to bed using the lift and assisted with discarding the dirty trash and linen. NA #1 stated the resident was on the early riser list and had been up since early morning when 3rd shift had gotten him up and put him in his Geri chair. She stated he had been up since she reported to work at 7:00 AM. An interview on 09/10/18 at 2:35 PM with NA #2 revealed she had been assigned to Resident #11 for the day. She stated he had been up when she reported to work at 7:00 AM. NA #2 stated she had checked the resident's line on his brief at 7:45 AM and it was yellow, so she had taken him out of the room and placed him in front of the dining room in preparation for breakfast. NA #2 stated she had checked him again at 11:00 AM by taking him into the shower room and looking at the strip on his brief and stated it was still yellow at that time as well. NA #2 stated she had not changed the resident all shift because his brief strip was still yellow and stated he had not been changed since 3rd shift got him up in his chair for the day. An interview on 09/11/18 at 1:18 PM revealed NA #1 had not been assigned to Resident #11 but had assisted in his care. She stated the resident was not a heavy wetter and stated by the looks of	F 677	The DON is responsible for implementing and monitoring the corrective action. Date of compliance is October 4, 2018	

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F 677	Continued From page 8	F 677		

his pants yesterday, it had been a while since he had been changed. NA #1 stated she usually changed residents about every 2 hours if they were incontinent.

An interview on 09/11/18 at 1:28 PM revealed NA #2 had been assigned to Resident #11 on 09/10/18 but did not have him on her assignment today. She again stated Resident #11 was up in the Geri chair when she had reported to work at 7:00 AM. NA #2 stated Resident #11 was not a heavy wetter but was incontinent and should be checked every 2 hours and changed when wet. She stated she checked the resident yesterday at 11:00 AM in the shower room and the brief 's lining was yellow and if wet it turned a greenish blue color so he was not changed. NA #2 stated Resident #11 was not changed while NA #2 was on duty from 7:00 AM until NA #2 and the scheduler changed him at around 2:00 PM.

An observation was made on 09/11/18 at 1:46 PM of Resident #11's transfer to bed and incontinence care. As the resident was lifted out of the Geri chair there was not an odor of urine and the cushion in the resident's chair was dry. The resident's pants were removed and were dry. NA #3 opened his brief and there was urine in the front part of the brief and the back of the brief was dry. NA #3 cleaned the resident using aseptic technique, and his bottom was noted to be intact with no broken skin. NA #3 applied a new brief and secured it. The resident was positioned for comfort and his call light was placed within his reach.

An interview on 09/11/18 at 2:02 PM with the scheduler revealed she helped on both sides of the building yesterday due to 2 NA call outs for

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F 677	Continued From page 9	F 677		

day shift. She stated it was not possible that Resident #11 had wet his brief that much yesterday in 3 hours. The scheduler stated Resident #11 was not a heavy wetter and stated he was usually taken to his room every 2 hours and checked and changed. She stated he should have been checked and changed at 10:00 AM yesterday and stated he was not very wet today because he had been changed at 10:00 AM before lunch.

An interview on 09/11/18 at 2:22 PM with Nurse #1 revealed she had been training another nurse on 09/10/18 and that had been her focus. Nurse #1 stated she was not aware of how much Resident #11 was checked and changed yesterday but stated he typically did not drink a lot and was not a heavy wetter. The nurse stated yesterday had been a terrible day for the NAs because they had 2 call outs and the NAs were real busy.

An interview on 09/11/18 at 4:11 PM with the Charge Nurse revealed she would not expect Resident #11 to saturate his brief through his clothing onto his chair from 11:00 AM to 2:00 PM. She stated she expected all dependent residents to be checked every 2 hours and if wet, to be changed.

An interview on 09/11/18 at 5:15 PM with the Administrator revealed it was his understanding the residents were checked and changed every 2 hours whether they were wet or dry.

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{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide incontinence care to keep a resident clean and dry for 1 of 2 residents (Resident #11) reviewed for activities of daily living (ADL) care provided for dependent residents. The findings included: Resident #11 was admitted to the facility on 02/16/18 with hemiplegia and hemiparesis following a cerebral vascular accident (CVA), flaccid hemiplegia of right side, dysphagia, traumatic brain injury (TBI), dementia and others. A review of Resident #11's most recent quarterly Minimum Data Set (MDS) dated 07/20/18 revealed the resident was severely cognitively impaired for daily decision making. The MDS also revealed the resident required extensive assistance of two persons for toileting and was always incontinent of bowel and bladder. A review of Resident #11's care plan dated 09/05/18 revealed the resident had a care plan for being at risk for self-care deficit related to his CVA, dementia and pain. The goal was for the resident to maintain his current level of function through the next review. The interventions included allow for rest breaks, ambulate/transfer with assistance of 2 with total lift using green	{F 677}	F677 ADL Care Provided to Dependent residents CFR(s): 483.24(a) (2) A resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene Criteria 1 The plan of correcting cited deficiency of F677 and the processes that lead to the citation; Based on observations, record reviews, and staff interviews, the facility failed to provide incontinence care to keep a resident clean and dry for 1 of 2 residents reviewed for activities of (ADL) care provided for dependent residents. Criteria 2- The procedure for implementing the plan of correction for F677 A list of residents who require total assistance in ADL will be compiled from the most recent MDS quarterly data by September 28, 2018. All staff will be educated on care for the ADL dependent resident by October 24, 2018	10/24/18

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

Electronically Signed | 09/28/2018

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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 677}	Continued From page 1 sling, assist with shower/bath per schedule per resident's preference, bathing and hygiene with assistance of 2, bed mobility with assistance of 2, dressing and grooming with assistance of 2, eating with assistance of 1, encourage activity during daily care, encourage to attend activities and assist if necessary, explain all procedures in advance, keep personal items in same location, pain meds as ordered, praise all efforts/accomplishments resident make to assist self and continue to encourage, provide incontinent care as necessary, provide needed assistance with self-care daily and as needed, report to nursing if resident declines care, and toileting with assistance of 2. An observation on 09/10/18 at 11:00 AM of Resident #11 revealed him sitting in his Geri chair outside the dining room. The resident smiled and attempted to talk but was not understood. The resident was dressed in tee shirt and gray sweatpants with bunny boots on both feet. An observation on 09/10/18 at 1:58 PM was made of Nurse #1 instructing the scheduler and NA #1 to put Resident #11 to bed. Resident #11's transfer to bed and incontinence care was observed in his room. As the resident was lifted out of his Geri chair there was a strong odor of urine coming from the resident and the cushion in the resident's chair was noted to be wet. The resident's sweatpants were removed, and Nursing Assistant (NA) #1 held them up and there was a large oval wet spot on the left side back of the pants where urine had seeped through his pants. NA #1 opened the brief and it was saturated with urine from front to back and the lining was completely wet and balled up in the middle from the saturation of urine. The resident	{F 677}	The DON will develop a process and audit tools to be utilized in the monitoring process to ensure the ADL care for dependent residents is being provided by October 4, 2018 The DON will identify and educate staff members that will be part of the monitoring process by October 24, 2018 The DON will begin the monitoring process effective October 4, 2018 Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; The DON or designee will complete a daily documentation audit of ADL care provided for 2 ADL dependent residents 5 times a week for 4 weeks, then three times a week for 4 weeks then monthly times 3 months. The DON or designee will complete a daily rounding audit on 2 ADL dependent residents 5 times a week for 4 weeks, then three times a week for 4 weeks then monthly times 3 months. Results will be reported to monthly QAPI meeting Criteria 4- The person responsible for implementing the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	R-C 09/11/2018

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{F 677}	Continued From page 2 had also had a small soft bowel movement in the brief. NA #1 cleaned Resident #11 on the front using aseptic technique, turned him and cleaned him on the back side using aseptic technique. NA #1 removed the dirty brief, wrapped it, and threw it in the trash can. The resident's bottom was slightly red, so she applied cream to it and secured the new brief around him. An interview on 09/10/18 at 2:25 PM revealed NA #1 was not assigned to Resident #11 that day but was helping with the resident. The scheduler assisted NA #1 with getting the resident to bed using the lift and assisted with discarding the dirty trash and linen. NA #1 stated the resident was on the early riser list and had been up since early morning when 3rd shift had gotten him up and put him in his Geri chair. She stated he had been up since she reported to work at 7:00 AM. An interview on 09/10/18 at 2:35 PM with NA #2 revealed she had been assigned to Resident #11 for the day. She stated he had been up when she reported to work at 7:00 AM. NA #2 stated she had checked the resident's line on his brief at 7:45 AM and it was yellow, so she had taken him out of the room and placed him in front of the dining room in preparation for breakfast. NA #2 stated she had checked him again at 11:00 AM by taking him into the shower room and looking at the strip on his brief and stated it was still yellow at that time as well. NA #2 stated she had not changed the resident all shift because his brief strip was still yellow and stated he had not been changed since 3rd shift got him up in his chair for the day. An interview on 09/11/18 at 1:18 PM revealed NA #1 had not been assigned to Resident #11 but	{F 677}	The DON is responsible for implementing and monitoring the corrective action. The date of compliance is October 24, 2018 POC Amended F656 Tag 10/1/2018 F656 Develop/Implement Comprehensive Care Plan CRF(s): 483.21(b) (1) The facility must develop and implement a comprehensive care plan for each resident, consistent with the resident's rights set for at 483.10 (c)(2) and 483.10 (c)(3) that includes measureable objectives and timeframes in which to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment Criteria 1 Based on observations, record reviews, and staff interviews, the facility failed to implement care planned interventions to provide incontinent care to keep a resident clean and dry for 1 of 2 dependent residents reviewed for activities of daily living (ADL) Criteria 2- The procedure for implementing the plan of correction for F656 A list of residents who require total assistance in ADL will be compiled from	

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{F 677}	Continued From page 3 had assisted in his care. She stated the resident was not a heavy wetter and stated by the looks of his pants yesterday, it had been a while since he had been changed. NA #1 stated she usually changed residents about every 2 hours if they were incontinent. An interview on 09/11/18 at 1:28 PM revealed NA #2 had been assigned to Resident #11 on 09/10/18 but did not have him on her assignment today. She again stated Resident #11 was up in the Geri chair when she had reported to work at 7:00 AM. NA #2 stated Resident #11 was not a heavy wetter but was incontinent and should be checked every 2 hours and changed when wet. She stated she checked the resident yesterday at 11:00 AM in the shower room and the brief's lining was yellow and if wet it turned a greenish blue color so he was not changed. NA #2 stated Resident #11 was not changed while NA #2 was on duty from 7:00 AM until NA #2 and the scheduler changed him at around 2:00 PM. An observation was made on 09/11/18 at 1:46 PM of Resident #11's transfer to bed and incontinence care. As the resident was lifted out of the Geri chair there was not an odor of urine and the cushion in the resident's chair was dry. The resident's pants were removed and were dry. NA #3 opened his brief and there was urine in the front part of the brief and the back of the brief was dry. NA #3 cleaned the resident using aseptic technique, and his bottom was noted to be intact with no broken skin. NA #3 applied a new brief and secured it. The resident was positioned for comfort and his call light was placed within his reach. An interview on 09/11/18 at 2:02 PM with the	{F 677}	the most recent MDS quarterly data by September 28, 2018. An audit of care plans will be conducted on those residents who require total assistance in ADL to ensure the care plans accurately reflect the resident's care needs by October 24, 2018 All staff will be educated on providing care for the ADL dependent resident as outline in the plan of care by October 24, 2018 Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; The DON or designee will complete a care plan audit of two ADL dependent residents twice a week for 4 weeks, then once a week for 4 weeks then monthly times 3 months. The DON or designee will complete a rounding audit on two ADL dependent residents twice a week for 4 weeks, then once a week for 4 weeks then monthly times 3 months. Results will be reported to monthly QAPI meeting The date of compliance is October 24, 2018	

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{F 677}	Continued From page 4	{F 677}		

scheduler revealed she helped on both sides of the building yesterday due to 2 NA call outs for day shift. She stated it was not possible that Resident #11 had wet his brief that much yesterday in 3 hours. The scheduler stated Resident #11 was not a heavy wetter and stated he was usually taken to his room every 2 hours and checked and changed. She stated he should have been checked and changed at 10:00 AM yesterday and stated he was not very wet today because he had been changed at 10:00 AM before lunch.

An interview on 09/11/18 at 2:22 PM with Nurse #1 revealed she had been training another nurse 09/10/18 and that had been her focus. Nurse #1 stated she was not aware of how much Resident #11 was checked and changed yesterday but stated he typically did not drink a lot and was not a heavy wetter. The nurse stated yesterday had been a terrible day for the NAs because they had 2 call outs and the NAs were real busy.

An interview on 09/11/18 at 4:11 PM with the Charge Nurse revealed she would not expect Resident #11 to saturate his brief through his clothing onto his chair from 11:00 AM to 2:00 PM. She stated she expected all dependent residents to be checked every 2 hours and if wet, to be changed.

An interview on 09/11/18 at 5:15 PM with the Administrator revealed it was his understanding the residents were checked and changed every 2 hours whether they were wet or dry.