STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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
E 000	Initial Comments An unannounced Recertification survey was conducted from 5/13/19 through 5/16/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness . Event ID S99J11.	E 000		
F 656 SS=E	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	F 656		6/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/10/2019

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

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F 656	Continued From page 1 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 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 record review and staff interview, the facility failed to ensure three (3) of 3 cognitively impaired residents (Resident #51, Resident #81 and Resident # 92) had a care plan developed with measurable goals and objectives to address activities. The findings include: 1. Resident #51 was readmitted to the facility on 12/7/17 with diagnoses that included quadriplegia, cerebrovascular disease and nontraumatic intracranial hemorrhage. Review of the resident ' s activity assessment revealed, the resident was last assessed for activities during admission and assessment was dated 12/7/17. No revised or updated activity assessment. A review of the most recent Minimum Data Set (MDS) assessment dated 4/1/19 marked as a quarterly assessment, revealed the resident was admitted on 5/26/11. Resident was assessed as cognitively impaired, with no speech and adequate hearing. Assessment indicated	F 656	F 656 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a) The facility IDT Team have reassessed resident #51, #81, and #92 to identify their preferences for a meaningful activity program. A care plan has been developed and implemented for resident #51, #81, and #92, that includes measurable goals and objectives to ensure they have a meaningful activities program 6/6/19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a) A care plan audit of current residents was conducted by IDT (SW, MDS, Activity's dept.) to ensure all residents have an activity's care plan congruent with their preferences. This audit was completed on 6/6/19. b) A care plan was developed by the IDT	

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F 656 Continued From page 2

resident was total dependence with one-person assistance for activities of daily living (ADL).

Review of the care plan which was revised on 4/5/19 revealed Resident # 51 was not care planned for activities and did not have any measurable goals or appropriate interventions related to activities.

During an observation on 5/13/19 at 1:28 PM, Resident #51 was observed in her room. Observation also revealed there was no music playing nor was the television in resident ' s room was switched on.

During an interview on 05/15/19 at 8:35 AM, Nurse # 2 was unable to stated if Resident # 51 went to group activity or if activity staff conducting any one on one activities for the resident.

During an observation and interview on 5/16/19 at 10:43 AM, Resident # 51 was observed in her room, sitting in her wheelchair. During an interview, Resident #51 ' s family member stated the resident was not appropriate for group activities as the resident made moaning sounds and drooled. Family member stated he visited the resident daily and he had not seen any staff come in to do any one to one activities with the resident.

During an interview on 5/16/19 at 1:25 PM, the activity assistant #1 was unable to provide any documentation of resident preferences related to activities. She stated she was unsure who was responsible for developing a patient centered care plan which measurable goals and appropriate interventions related to activities.

During an interview on 5/16/19 at 2:49 PM, the

F 656

for any resident identified as not having a care plan reflective of a meaningful activity's program, their resident preferences, and/or measurable goals. 6/6/19

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

a) The Activities Director will complete the Activities Initial Assessment at the time of admission for new residents. The Activities Director will complete an admission assessment at least quarterly to identify activity preferences and update any changes in activity preferences. A Plan of Care will be developed by the facility Care Plan Team (IDT) that reflects the resident's preferences from these completed assessments. Resident and/or RP will receive invitation to care plan meetings held quarterly or at request to discuss any changes or desired additions to the comprehensive care plans

b) Inservice was completed by Executive Director on with the facility IDT Team on 6/6/19, and activity staff (including director). on the intent of 656 including the development of a meaningful activities program at time of admission and within 21 days of admission, to be updated at least quarterly to identify meaningful goals and objectives to ensure resident preferences are honored.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

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F 656	Continued From page 3 Administrator stated it was her expectation that the activity staff include the resident ' s preferences in the activity assessments and the assessments were completed timely. Administrator further stated the care plan should include measurable goals, clarify the frequency of the one on one activities and include resident ' s preferences. The administrator added the staff should document resident ' s involvement in the activities at least quarterly and care plan should be updated accordingly. 2. Resident # 81 was admitted to the facility on 1/17/19 with diagnoses that included dementia, schizophrenia, congestive heart failure and sever protein calorie malnutrition. Review of the activity assessment dated 1/21/19 revealed, Resident # 81 preferred music stimulation, men ' s group, friendly visits and needed assistance to and from activities. A review of the most recent Minimum Data Set (MDS) assessment dated 1/25/19 marked as an admission assessment, revealed Resident #81 was assessed as cognitively impaired with unclear speech. Assessment indicated resident was extensive to total dependence with one-person assistance for activities of daily living (ADL). A review of Resident # 81 care plan revealed, the resident did not have any activities care plan that included resident ' s preferences and measurable goals or interventions. Review of the recreation participation record revealed, Resident# 81 participated in group activity only once in March 2019 and twice in April	F 656	a) IDT will conduct random audits of 5 resident care plans during morning clinical review, weekly x4 weeks, monthly x3 months and quarterly thereafter to ensure that resident care plan is accurate, complete, and synonymous with resident preferences related to the residents meaningful activities program. b) A Summary of monitoring efforts will be completed by Executive Director and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance.	

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F 656	Continued From page 4 2019. Multiple observations on 5/13/19 at 9:30 AM ,11:17 AM and 2:30 PM revealed Resident# 81 lying in his bed and observing people in the hallway. There was no TV or music playing in his room. Observation on 5/14/19 at 9:27 AM revealed, Resident#81 lying on his bed in his room. There was no TV or music playing in his room. Observation on 5/15/19 at 12:10 PM revealed, Resident#81 lying in his bed. The TV was switched on but was not within visible level of the resident. The TV was positioned to the right side, near the head of the bed. During an interview on 5/16/19 at 1:25 PM, the activity assistant # 1 stated the resident previously would participate in group activities, but recently had stopped participation in group. She indicated resident # 18 was provided friendly visits. She stated she could not provide any documentation of friendly visit and one to one activities provided to the resident. The activity assistant# 1 was unsure who was responsible for developing a patient centered care plan which measurable goals and appropriate interventions related to activities. During an interview on 5/16/19 at 2:49 PM, the administrator stated it was her expectation that the activity staff include the resident ' s preferences in the activity assessments and the assessments were completed timely. The administrator further stated the care plan should include measurable goals, clarify the frequency of the one on one activities and include resident ' s preferences. The administrator added the staff	F 656		

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F 656	Continued From page 5 should document resident ' s involvement in the activities at least quarterly and care plan should be updated accordingly. 3. Resident #92 was admitted to the facility on 10/27/18 with diagnoses that included dementia, cognitive impairment and communication deficits. The quarterly Minimum Data Set (MDS) dated 4/23/19, was left blank for activities, there was no current assessment or activities care plan available. Review of the activities evaluation dated 11/3/18, indicated Resident 92 ' s activities of interest were movies, music and television. Observation on 05/14/19 at 12:20 PM, Resident #92 had not been observed in any activities or offered. The facility television was not working 5/10/19-5/13/19. Observation on 5/15/19 at 9:26 AM, Resident #92 lying in bed with pillow covering his head. Current activities were trivia in the activity room. Staff did not ask resident if he wanted to get up for the day or offer activities. During an interview on 5/16/19 at 10:29 AM, the Administrator confirmed based on the 1 note on 11/3/18 there was nothing specific to resident interest, response or 1:1 being done. The Administrator indicated the expectation was for the AD to do quarterly notes on resident participation, response of interest, what was being done and when activities were being done. The notes should explain what the specific 1:1 activity that would be done and the care plan to be person centered to the resident's needs and interest.	F 656		

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F 658	Continued From page 6	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to label the tube feeding formula to record the date and time the formula was open and hung, for 1 of 2 residents reviewed for tube feeding (Resident #44). Findings included: Review of the American Society of Parenteral and Enteral Nutrition, "Nursing Care of patients with an Enteral Feeding tube" dated December 2014, revealed the formula container and tubing should be labelled, dated and timed. Review of the manufacturer recommendations "Best practices for managing tube feeding - a Nurse's manual "revised in 2012 revealed the following: 1) to maintain proper handling of formula, the date and time the formula was opened should be recorded. 2) to maintain a safe hangtime, the date and time the formula was hung should be recorded. Resident # 44 was admitted to the facility on 1/15/19 with diagnoses which included Adult failure to thrive, dysphagia and gastrostomy status (tube placement in the abdomen for feeding nutrition). Review of the physician orders dated 2/22/19	F 658	F658 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a) Resident #44 has been discharged from this facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No other residents currently have order for continuous enteral feeding since this incident. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; a) Currently, there are no residents in house receiving continuous enteral feedings. However, an audit tool will be put in place to monitor the following components to insure compliance with future residents receiving continuous enteral feedings: Current Date, Room	6/12/19

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F 658

Continued From page 7

revealed Osmolite 1.50 Cal (nutrition supplement) via pump at 55 milliliters (ml)/ hour (hr.) continuously via gastrostomy-jejunostomy (G/ J) Port tube.

Review of the recent quarterly Minimum Data Set (MDS) assessment dated 4/14/19 revealed Resident #44 was assessed as cognitively impaired with adequate hearing and unclear speech. Resident was assessed as needing extensive to total with one to two-person assistance with activities of daily living (ADL). The resident received tube feeding (TF) for nutrition.

Review of Resident # 44 's plan of care, dated 5/10/19, revealed the resident received continuous GJ tube feeding. The goals were to provide adequate nutrition via enteral nutrition regimen, with no side effects of tube feeding. The interventions included were providing tube feeding formula/ water flushes as ordered, the stoma site to be inspected for any signs of infection, observations for any leakage and notify the physician of any finding.

Record review of the multiple nurses' notes for January through May 2019 revealed that Resident #44 received enteral feedings every day and tolerated it well.

During the observation on 5/13/19 at 10:00 AM, Resident # 44 was sitting in her wheel chair in her room. The tube feeding system was connected to resident's gastric tube (surgically inserted tube to the stomach) via working infusion pump. The pump was running at 55 ml/hr., and flush at 70 ml/ 2 hr. Observation also revealed two enteral feeding bags hanging from the stand and connected to the pump. One enteral feeding bag

F 658

Number, Name present, Formula Type, Rate & Frequency, Date & Time started, Nurse's initials, Issues, Comments, and Auditor's initials. The audit sheet will be reviewed in Clinical Morning Meeting by DON and/or designee for compliance.
b) All current licensed nurses will receive in-servicing by 6/10/19, related to labeling, dating of tube feedings for future residents. Newly hired licensed nurses will receive education upon hire during orientation.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
a) At the time of a new resident admission with continuous feeding the following process with be utilized to ensure continued compliance. Audits to ensure proper labeling will be conducted by DON or designee during daily clinical review, daily x4 weeks, weekly X4, monthly x3, and quarterly thereafter Findings will be documented on the Tube Feeding Audit Tool. The person responsible for ensuring compliance is the Director or Nursing.
b) Results/outcomes of the above plan will be brought to the monthly QA meeting for review by committee members for compliance. Any revisions to the plan will require re-in servicing of appropriate personnel. Executive Director will be responsible for ensuring the above plans are monitored appropriately.

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F 658	Continued From page 8 (TF bag) had approximately 200 ml of creamy off-white nutrition formula like substance remaining in it. The bag did not have a label on it. No date and time; time initiated, no name of the formula, no nursing initials. The other flush bag was not labelled and dated. During the observation on 05/13/19 01:23 PM, Resident# 44 was observed lying in bed. The tube feeding system was connected to resident's gastric tube via working infusion pump. The pump was running at 55 ml/hr., and flush at 70 ml/ 2 hr. Observation of the TF stand revealed two enteral feeding bags hanging from the stand and connected to the pump. One enteral feeding bag (TF bag) had approximately 900 ml of creamy off-white nutrition formula like substance remaining with "5/13/19" written on it. There was no label indicating time the bag was hung, name of the resident or the name of the formula. The flush bag was not labelled and dated. During the observation on 05/14/19 at 08:27 AM, Resident# 44 was observed sitting in her wheelchair. The infusion pump was running at 55 ml/hr., and flush at 70 ml/ 2 hr. An approximately half-empty flush bag was hanging that was not labeled with date or time. During an observation on 5/15/19 at 10:30 AM, Resident #44 was observed sitting in her room in her wheelchair. The TF system was connected to resident's gastric tube via working infusion pump. Observation also revealed an approximately half full, 1 L (liter) bottle of Osmolite 1.5 Cal formula (nutrition formula) that was was not labeled with the time the bottle was hung or with nursing staff initials. The bottle was labeled with a date "5/15/19" on it.	F 658		

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F 658	Continued From page 9 During an interview on 5/15/19 at 11:01 AM, Nurse #1 indicated Resident # 44 was on continuous TF, Osmolite 1.5 Cal via pump at 55 ml/hr. and 70 ml every 2 hr. of flushes that was infused by the infusion pump. Nurse #1 indicated she was unsure of the time the formula was hung. She stated she did not recall if the bottle was labeled by the previous nurse. She stated she checked on the resident's TF site, gastric residuals and offered flushes as ordered before medication during medication administration and did not observe if the bottle was labelled. During an interview on 5/15/19 at 11:30 AM, the Director of Nursing, was unsure why the read to feed container was not used and instead the TF formula was filled in a enteral feeding bag. She stated it was her expectation that nurses label the TF formula and flush bags with resident's name, nurse initials, date and time of infusion. She further stated it was the responsibility of all nurses to administer the correct nutritional formula at the correct rate as ordered by the physician. During an interview on 5/16/19 at 3:09 PM, the administrator stated her expectation was for all staff to follow the facility policies and procedures related to medication administration including TF.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		6/12/19

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F 679	Continued From page 10 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, family interview, staff interview and record review, the facility failed to provide an on-going activity program as scheduled and that met the individual interest and needs to enhance the quality of life for 3 of 3 cognitively impaired residents reviewed for activities (Residents #92, #51 and #81). The findings included: Review of the facility ' s planned activity calendar revealed the following activities were scheduled for 05/13/19 and 05/16/19: The activities included: 05/13/19:10:00 AM, Dress like Twin ' s Day, Balloon Release at 2:00 PM and 7:00 PM, Movie night. 05/14/19: 10:15 AM, body stretch at 10:30 AM, Ice cream social 2:00 PM, Bingo with friends 3:00 PM and Movie Night 6:30 PM. 05/15/19 at 10:15 AM, Body Stretch, Noodle Ball at 10:30 AM, Music & Manic at 2:00 PM, Table Puzzle at 2:30 PM and Planting Group at 3:30 PM. 05/16/19 at 10:15AM Body Stretch, Cup of Coffee at 10:30AM, Big Bingo 2:00 PM, WII Games 2:30 PM, Book Mobile 3:00 PM and Resident Choice at 7:00 PM. 1.Resident #92 was admitted to the facility on 10/27/18. The diagnoses included dementia, cognitive impairment and communication deficit. The quarterly Minimum Data Set (MDS) dated 4/23/19, coded Resident #92 ' s cognition was impaired and needed assistance with activities.	F 679	F679 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #51, #81, and #92 have been re-assessed by the facilities Activities Director for their preferences related to a meaningful activities program. Resident Representatives for #51, #81 and #92 were included in this assessment to ensure each resident's preferences were identified. An Activities Initial Assessment was utilized for this assessment. The activities director and facility Care Plan Team (IDT) held an ad hoc meeting on 6/5/19. A Plan of Care was developed and implemented on 6/6/19 for #51, #81 and #92 that includes resident preferences and set measurable goals. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a) An audit was completed by IDT on 6/6/19 to ensure that all current residents, have a Plan of Care that addresses their activities preferences. b) An updated activity's preference list was conducted for 100% of current	

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F 679	Continued From page 11 Review of the activities evaluation dated 11/3/2018, indicated Resident 92 ' s activities of interest were movies, music and television. Review of January 2019 in room on 1/1/19, 1/8/19, 1/15/19, 1/21/19, 1/29/19(there was no entries of what the in-room activities consisted of in the record), Feb 1, 8, 15 and 22nd 2019(in-room) no entries of what the in-room consisted of regarding the activities of interest), 3/1/19, 3/8/19, 3/15/19 and 3/27/19 friendly visits, no entries of what was done. 4/1/19 in room, 4/7/19, 4/15/19, or 4/22/19. There was documentation of activity progress notes for more than a year that indicated whether Resident #92 was involved in any activities. Observation on 05/14/19 at 12:20 PM, Resident #92 had not been observed in any activities or offered. The facility television was not working 5/10/19-5/13/19. Observation on 5/15/19 at 9:26 AM, Resident #92 lying in bed with pillow covering his head. Current activities were trivia in the activity room. Staff did not ask resident if he wanted to get up for the day or offer activities. During an interview at 9:26 AM, Resident #92 stated he liked music (country, classical, rock n roll) animals, dogs/cats, reading historical books, looking through magazine, western movies. resident stated no one asked him what he liked. There was no radio or other stimulatory activities in the room. During an interview on 5/16/19 at 10:29 AM, the	F 679	residents. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; a) The Activities Director will complete the Activities Initial Assessment at the time of admission for new residents. The Activities Director will complete an admission assessment at least quarterly to identify activity preferences and update any changes in activity preferences. A Plan of Care will be developed by the facility Care Plan Team (IDT) that reflects the resident's preferences from these completed assessments. b) Activity's Director was in-serviced by Executive Director on 6/6/19 on the content of F 679 and importance of developing an activities program that includes a plan of care for all residents, including those residents that trigger for 1:1 activities. c) An Activity Attendance Log will be used by the Activities Staff to ensure there is documentation all resident attendance of activities programs, this includes groups' and 1 to 1 activities. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; a) Random Observation audits will be conducted by IDT during daily rounds to ensure that residents are provided with appropriate meaningful activities. These observations will be weekly x 4weeks, monthly for 3 months, and quarterly	

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F 679	Continued From page 12 Activities Assistance (AA) and the Administrator, stated there was no notes to indicate Resident #92 participation in any activities. Review of the participation records from January 2019 through April 2019 revealed the resident had inconsistent entries, however the record had no information whether the resident participation of activities in-room, one or one of activities of choice. The AA stated she just started and was told by the resident ' s family he did not like group activities, she was uncertain what exactly the resident liked or disliked, the only thing she had done was just talk with the resident in the room. There was no response by the Administrator and the AA of why 1:1 ' s was not being done or why the assessment was incomplete of the resident's interest and preference of activities. Administrator confirmed based on the 1 note on 11/3/18 there was nothing specific to resident interest, response or 1:1 being done. The Administrator indicated the expectation was for the AD to do quarterly notes on resident participation, response of interest, what was being done and when activities were being done. The notes should explain what the specific 1:1 activity that would be done and the care plan to be person centered to the resident's needs and interest. During an interview on 5/16/19 at 12:25 PM, resident was lying in bed watching television. Resident #92 stated he had many interests which included animals, music of all kinds, listening to the radio, reading books/magazines, occasionally like going outside see the bright skies. Resident stated no one ask him about what he likes. Resident #92 was not offered any activities during the week. During a telephone interview on 5/16/19 at 12:51	F 679	thereafter to ensure continued compliance Findings of observation audits will be documented and discussed at the morning team meeting. b) A summary of monitoring efforts will be completed by the facility administrator and brought to the monthly QA meeting for review by committee members for compliance. Executive Director is responsible for ensuring that all monitoring is compliant with plan, and for the implementation of any changes.	

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F 679	Continued From page 13 PM, the family stated Resident #92 had a variety of interest to included auditory books (which he had some things at home) but was afraid to bring to facility in fear they would be stolen from the facility. "I have begged for the facility to provide activities of interest for her brother that he could do in his room. The resident was a famous disc jockey in his youth and loves music, the resident could benefit from pet therapy. I would love for him to do something and he would love to do some activities. I feel like the facility would be mad at me when I suggest things for him to do. I have told the activities or different times to encourage my brother to do things even if it is 1:1 and nothing is being done. "I would really like for my brother to do things and have a radio, so he could listen to his music because he was a disc jockey for many years. If I brought those things in for him, the radio would be stolen as many other things that have been brought to the facility. there was no reason why he could not go to the music stuff, no he doesn't like bingo, but he would certainly like pet therapy, music therapy, books, magazines. "I have not seen any staff come in and do 1:1 activity with him or provide any direct stimulation for him. I was not made aware that the facility could provide auditory books or music for him at the facility. "I have not said to anyone that my brother could not go to any groups, it ' s just the type of activities that they have had my brother doesn't like. I have made suggestions on how to get him to go to activities or things he could do in the room and nothing was done or changed." 2. Resident # 51 was readmitted to the facility on 12/7/17 with diagnoses that included	F 679		

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F 679	Continued From page 14 quadriplegia, cognitive communication deficit, nontraumatic intracranial hemorrhage, cerebrovascular disease and dysphagia. Review of the resident ' s activity assessment revealed, the assessment was completed on 12/7/17. There was no annual assessment available. A review of the most recent Minimum Data Set (MDS) assessment dated 4/1/19 marked as a quarterly assessment, revealed the resident was admitted on 5/26/11. Resident was assessed as cognitively impaired, with no speech and adequate hearing. Assessment indicated resident was total dependence with one-person assistance for activities of daily living (ADL). Review of the care plan which was revised on 4/5/19 revealed Resident # 51 was not care planned for activities and did not have any measurable goals or appropriate interventions related to activities. There was documentation of activity progress notes since 2013 that indicated whether Resident #51 was involved in any activities. Review of individual activity report for March 2019 revealed the resident was provided verbal stimulation on 3/2/19, 3/4/19, 3/7/19, 3/12/19, 3/21/19, and on 3/28/19. There were no details on kind of stimulation or what activity was provided. The report indicated the resident responses were grunting, moaning, husband visiting and resident sleeping. Review of individual activity report for April 2019 revealed the resident was provided verbal	F 679		

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F 679	Continued From page 15 stimulation on 4/1/19, 4/9/19, 4/11/19. 4/16/19, and on 4/21/19. There were no details on kind of stimulation or the activity that was provided. The report indicated the resident responses were grunting, moaning, eyes half open and husband visiting. Review of individual activity report for May 2019 revealed verbal stimulation was provided on 5/9/19 and 5/13/19 with no details on kind of activity provided. The report indicated the resident responses were grunting, eye contact and husband visiting. The report also indicated on 5/15/19 the resident was provided tactile stimulus by rubbing her forehead. The review of the facility ' s activity calendar for May 2019, revealed no specified one to one activities scheduled for the month. During an observation on 5/13/19 at 1:28 PM, Resident #51 was observed sitting in her wheelchair in her room. There was no Television or music playing in her room. During an interview on 05/15/19 at 8:35 AM, Nurse # 2 stated she does not recollect the resident going to group activities or activity staff conducting any one on one activities for the resident. During an observation and interview on 5/16/19 at 10:43 AM, Resident # 51 was observed in her room, sitting in her wheelchair. During an interview, Resident #51 ' s family member stated the resident was not appropriate for group activities as the resident made moaning sounds and drooled. Family member stated he was with the resident most of the day and he had not seen	F 679		

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any staff come in to do any one to one activities with the resident.

During an interview on 5/16/19 at 1:25 PM, the activity assistant #1 stated the resident was provided one to one activity at least twice a week. The activity assistant was unsure why the resident had not received adequate activities . The assisstant was unable to state why the visits were so random during the past 3 months reviewed. Activity assistant # 1 was unable to provide any documentation of resident preferences related to activities.

During an interview on 5/16/19 at 2:49 PM, the Administrator stated it was her expectation that the activity staff include resident preferences in the activity assessment and the assessment was completed and updated accordingly. The Administrator further stated the care plan should clarify the frequency of the one on one activities and staff should document resident ' s involvement in the activities at least quarterly. Administrator stated the activity participation records should be utilized to accurately reflect the resident activity participate and should involve more one on one staff interactions.

3. Resident # 81 was admitted to the facility on 1/17/19 with diagnoses that included dementia, schizophrenia, congestive heart failure and sever protein calorie malnutrition.

Review of the activity assessment dated 1/21/19 revealed, Resident # 81 preferred music stimulation, men ' s group, friendly visits and needed assistance to and from activities.

A review of the most recent Minimum Data Set

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(MDS) assessment dated 1/25/19 marked as an admission assessment, revealed the resident was assessed as cognitively impaired. Assessment indicated resident was extensive to total dependence with one-person assistance for activities of daily living (ADL).

Review of the revised care plan revealed Resident # 81 was not care planned for activities.

Review of the recreation participation record for March 2019 indicated on 3/6/19 the resident was involved in exercise, group games, music appreciation, movie/ theater/ TV.

Review of the recreation participation record for April 2019 indicated resident was involved in religious and current events on 4/10/19 and Sing along and group games on 4/9/19.

Review of the recreation participation record for May 2019 indicated the resident participated in religious activities on 5/1/19 resident attended exercise group and music appreciation, on 5/3/19 and 5/6/19 attended exercise group, on 5/4/19 and 5/7/19 attended religious service and music appreciation, and on 5/10/19 attended music appreciation.

Observations on 5/13/19 at 9:30 AM ,11:17 AM and 2:30 PM, revealed Resident# 81 lying in his bed and observing people in the hallway. There was no TV or music playing in his room.

During an observation on 5/14/19 at 9:27 AM, Resident#81 was observed in his room lying on his bed. There was no TV or music playing in his room.

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F 679	Continued From page 18 During an observation on 5/15/19 at 12:10 PM, Resident#81 was observed lying in his bed. The TV was switched on but was not within visible level of the resident. The TV was positioned to the right side, near the head of the bed. During an interview on 5/16/19 at 11:32 AM, Nurse # 2 stated the resident likes to socialize when awake. She indicated Resident # 81 would go to activities on his good days and was unsure if activity staff conducted any one on one activities for the resident. During an interview on 5/16/19 at 1:25 PM, the activity assistant #1 stated Resident# 81 had recently stopped participation in group activity. She indicated the resident spend time sitting in the hallways in his wheelchair, and was provided friendly visits. She stated she could not provide any documentation of friendly visit and one to one activities conducted with the resident. The activity assistant was unsure why resident did not receive adequate activities and was unable to state why the visits were so random during the 3 months reviewed. During an interview on 5/16/19 at 2:49 PM, the Administrator stated it was the expectation that the activity staff to include resident preferences in the activity assessment and the assessment was completed timely. Administrator further stated the care plan should clarify the frequency of the one on one activities and staff should document resident ' s involvement in the activities at least quarterly. Administrator stated the activity participation records should be utilized to accurately reflect the resident activity participate and should involve more one on one staff interactions.	F 679		

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