STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 06/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	**616 WADE AVENUE RALEIGH, NC 27605**

(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 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		6/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/21/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a sanitary and orderly interior as evidenced by a hole in a door, peeling paint, brown matter on walls, peeling wallpaper, scraped walls, and a scuffed floor in five of eleven rooms reviewed for environmental concerns and all the floor hallways. Findings included: On 6/6/19 at 4:50 PM all the hallway handrails were observed on every floor with the Director of Maintenance. Every handrail between residents' rooms on the 4th floor had multiple areas of peeling, chipped paint. Some of the areas were approximately 8 inches in length where the paint had been chipped away. Every hand rail between residents' rooms on the third floor had peeling, chipped paint. Over fifty percent of the second-floor handrails between residents' rooms had peeling, chipped paint. An observation was made of Room 403 on 6/7/19 at 2:16 PM. Room 403 was observed to have a hole in the bathroom door. Observations were made of resident rooms on 6/8/19 beginning at 10:31 AM with the Director of Maintenance and the Administrator. Room number 435 was observed to have splatters of brown matter on doorway frame, scrapes/gauges extending the length on the entire length of the wall, broken baseboards, black scrapes on the tile floor, peeling paint on the wall, and brown build up on the tile floor. Room number 403 was observed to have splatters of matter on the wall, black scrapes on the wall across from the bathroom, splatters of matter on the walls on	F 584	F584 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State Laws. 1. The hallway handrails on the 2nd, 3rd, and 4th floors were repainted by the Maintenance Director on 6/6/19 and have been put on a touch up maintenance plan. The hole in the bathroom door was repaired, the wall splatter was cleaned, the walls were repaired and repainted of room 403 by the Maintenance Department on 6/21/2019. The wall splatter on the door frame of room 435 was cleaned, the door frame was repainted, the scrapes/gauges were repaired, the base boards were replaced, the black scrapes on the floor were removed, the walls were repainted and the floor was refinished by the Maintenance Department on 6/21/2019. The wall splatter was cleaned, the walls were repaired and repainted of room 431 by the Maintenance Department on 6/21/2019 . The walls were repaired and repainted of room 324 by the Maintenance Department on 6/17/2019.	

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F 584	Continued From page 2 either side of the bed, and peeling wallpaper border near the ceiling. Room number 431 was observed to have peeling wallpaper and splatters of matter on the walls. Room number 324 was observed to have gauged/scraped walls and peeling wallpaper. An interview was conducted with the Maintenance Director on 6/8/19 at 10:45 AM. The Maintenance Director stated that he had been employed at the facility for 2 weeks. He also stated on 6/11/19 five people were coming to the facility to assist with needed repairs to all rooms. An interview was conducted with the Administrator on 6/8/19 at 12:34 PM. The Administrator revealed the facility had been without a maintenance person for a few weeks and the administrative staff was working on maintenance issues until the recent hiring of the current Maintenance Director. The Administrator stated that the current system of making repairs was to put maintenance needs in the maintenance book and then a work order was created. The Administrator revealed there was no formal written plan for repairs such as peeling paint and peeling wallpaper. The Administrator confirmed that five maintenance personnel were coming to the facility to make repairs on 6/11/19.	F 584	2. All residents have the potential to be affected. The Administrator and the Maintenance Director completed rounds on all floors and 100% of all rooms on 6/8/2019 to develop a list of areas needing attention by the Maintenance Department. A schedule was developed for completion of identified areas by the maintenance workers from the other facilities until the maintenance issues are caught up. 3. A maintenance log was developed by the Administrator to transcribe the maintenance requests for better tracking of completion of the maintenance requests. The Maintenance Director will make rounds weekly to identify maintenance issues that need to be addressed and place on the maintenance log. The Maintenance Director was in-serviced by the Administrator regarding usage of the log. 4. The Administrator or designee will review the Maintenance Log to ensure preventative maintenance is being completed as scheduled weekly until 100% compliance is maintained for 2 consecutive months. Outcomes of those reviews will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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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 observation, record review, resident interviews, and staff interviews for two (Residents # 5 and # 8) of three residents sampled for assistance with incontinence and hygiene needs, the facility failed to assure needs were met. The facility failed to assure staff were helping Resident # 8 with specialized hygiene care for a scalp condition. The findings included: 1. Record review revealed Resident # 8 was admitted to the facility on 2/23/15 with a diagnosis of chronic pain, and osteoarthritis. Review of Resident # 8's quarterly MDS (Minimum Data Set) assessment, dated 3/13/19, revealed Resident # 8 had a BIMS (Brief Interview for Mental Status) score of 15. This indicated she was cognitively intact. The resident was assessed to be frequently incontinent of bladder and required extensive assistance with her hygiene needs and total assistance from staff with her bathing needs. The resident was also totally dependent on staff for transfers. Review of Resident # 8's care plan, last revised on 5/8/19, revealed staff identified Resident # 8 had an ADL (activity of daily living) deficit.) The care plan noted Resident # 8 was a functional quadriplegic (the inability to move secondary to frailty and severe disability). Staff were directed to provide frequent and as needed incontinent	F 677	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Activities of Daily Living (ADL) care was provided for Resident #8 by NAs #5 and #6 during the survey when it was noted that care was needed. NAs #1, #2, and #3 were placed on the Do Not Return list for the agency and will no longer work at the facility. Staff nurses #1 and #2 were in-serviced by the Director of Nursing on 6/21/2019 regarding the importance and their responsibility in ensuring care is provided in a timely manner to a resident asking for assistance regardless of the nursing assistant assigned to the resident. The in-service also included the nurses role in completing the assignment sheets, ensuring the staff is working their assignments within fifteen minutes of the beginning of the shift and the responsibility of notifying/involving the Director of Nursing when there are staffing issues for further direction.	6/25/19

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F 677	Continued From page 4 checks and assist the resident with care. On 6/6/19 at 3:35 PM Resident # 8 was observed in her wheelchair in the hallway on her floor. Resident #8 stated she had asked to go to bed at 3:00 PM, and she was wet. Resident # 8 stated she was told there was not enough staff to place her back in bed. NA (Nurse Aide) # 4 was interviewed on 6/6/19 at 3:38 PM. NA # 4 stated she was a 3:00 PM to 11:00 PM agency Nurse Aide on Resident # 8's hall. NA # 4 stated she knew Resident # 8 had requested to go back to bed at 3:00 PM, but she needed a second person to transfer her and there was none at that time to assist her. NA # 4 was not sure who was to be assigned to care for Resident # 8 on the 3:00 to 11:00 PM shift for 6/6/19. On 6/6/19 at 3:50 PM, Resident #8 was observed alone in her room. She was seated in her wheelchair with the mechanical lift in front of her wheelchair. Resident # 8 was continuously observed from 3:50 PM to 4:05 PM in this position without staff entering her room. During this time, Resident # 8 shared the following. Day shift staff had assisted her up to the wheelchair around 10:00 AM that morning, and that was the last time she had received incontinent care. It was difficult for her to always tell exactly when she initially became soiled with urine, but sometime between 10:00 AM and 3:00 PM she became soiled with urine. She was aware she was soiled at 3:00 PM and had asked for assistance to go to bed at 3:00 PM and stated when she was placed back to bed the NAs would then change her. She had been told that there were not enough people to help at 3:00 PM.	F 677	Care was provided to Resident #5 on 5/31/19 as soon as NA #7 was able to provide care. Review of the skin check documentation for Resident #5 determined there was no skin issues identified for this resident. The staffing issue that occurred on 5/31/19 cannot be corrected due to it occurring in the past. The licensed nurses were in-serviced regarding the nurses role in completing the assignment sheets, ensuring the staff is working their assignments within fifteen minutes of the beginning of the shift and the responsibility of notifying/involving the Director of Nursing when there are staffing issues within fifteen minutes of identifying a staffing issue for further direction. The Ketoconazole 2% shampoo for resident #5 was ordered, obtained, and applied on 6/21/2019, and is now being applied per physician orders. Nurse #5 was in-serviced by the Director of Nursing regarding the storage of medicated treatments for residents and a nurse s responsibility to apply/validate application of ordered treatments for residents. 2. Any resident requiring assistance with ADLs has the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team 6/21-24/2019 regarding the importance of ensuring care is provided in a timely manner to a resident asking for	

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F 677	Continued From page 5 Around 3:45 PM, two staff members rolled the mechanical lift into her room, left it, and told her NA # 3 would be there to help her. She did not know who the staff members were. Resident # 8 stated she thought NA # 3 was her assigned NA, but she did not understand why NA # 3 had never been in to help her. The resident stated there were a lot of agency nurse aides, and there had been other days on which she had trouble obtaining assistance, but she did not know the names of all the aides. She was just aware it was difficult to obtain assistance. On 6/6/19 at 4:05 PM NA # 5 and NA # 6 were observed to walk into the room of Resident #8. NA # 5 explained to Resident # 8 that she (NA # 5) did not know what was going on, she was working on another hall, and had been sent from the other hallway to place Resident #8 back in bed and change her. According to NA # 6, she was a dayshift NA, and she was not the resident's nurse aide either, but had been sent to help. The NAs used the lift, which was in the room, and transferred the resident to bed. Resident # 8 was observed as she was then checked for incontinence needs. Resident # 8's brief was soiled with a heavy amount of urine; to the point that there was a urine spot that had gone through her brief and soiled her clothing. NA # 3 was interviewed on 6/6/19 at 5:10 PM. At the time of the interview, NA # 3 was on a different floor than the one on which Resident # 8 resided. NA # 3 stated she was not assigned to care for Resident # 8. NA # 3 stated she was an agency NA who had reported to work at 3:00 PM. She was initially sent to second floor, then to fourth floor, then to third floor, then to fourth floor,	F 677	assistance regardless of the nursing assistant assigned to the resident. The CNA that is informed of the need for assistance is ultimately responsible for ensuring the resident receives the care requested. Any resident with ordered treatments have the potential to be affected. The Administrative Nursing Team completed a Treatment Record to cart audit to ensure all treatments are available for application and treatments were reordered as necessary. The licensed nurses were in-serviced by the Administrative Nursing Team regarding the storage of medicated treatments for residents and a nurse□s responsibility to apply/validate application of ordered treatments for residents. The in-service also included the process for reordering medicated treatment supplies prior to the supply running out to ensure availability at all times 3. The assignment sheet was modified by the Director of Nursing for signature of the verification by a nursing supervisor. The assignment sheets will be verified by a nursing supervisor daily to ensure all staff assigned are present and care is being provided. The licensed nurses will review the treatment carts each Wednesday to ensure ordered treatment are available and order refills as necessary. This process will be added to the orientation of licensed nurses.	

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F 677	Continued From page 6 and then back to third floor. NA # 3 confirmed during all of the reassignments to other floors, she had been on Resident # 8's floor twice, but she had never taken an assignment and actually started working because of all the confusion. She did not know that Resident # 8 needed assistance until she had been sent to Resident # 8's floor the second time, and by that time she thought someone was helping her. Then she was sent away from Resident # 8's floor and had never rendered any care to her on the shift. NA #1 was an agency nurse aide assigned to Resident # 8's floor on 6/6/19 for the 3:00 PM to 11:00 PM shift. NA #1 was interviewed on 6/8/19 at 2:30 PM. NA #1 stated she was given her assignment for the 6/6/19 shift at 3:00 PM and working to orient another agency nurse aide (NA #2), who was new to the facility. NA #1 stated that at approximately 3:15 PM, NA #3 requested NA #1 and NA #2 assist her in laying Resident #8 down in her bed. NA #1 stated that NA #3 explained to them that she (NA # 3) was busy and Resident #8 needed help being put back to bed. NA #1 revealed NA #2 brought a mechanical lift to the room of Resident #8, who was waiting for assistance. NA #1 stated Resident #8 revealed to her that the she hadn't received incontinent care since 10:30 AM that morning and that she needed to be have her incontinence brief changed at that time. NA #1 stated she noted the mechanical lift was making noise like the battery was dying, so she and NA #2 went to the nurse's station to get another battery. NA #1 stated that when she arrived at the nurse's station, NA #3 was sitting there. NA #1 stated she asked NA #3 if she could take care of Resident #8 if she was no longer busy. NA #1 stated NA #3 replied to her that she was not going to do the assignment for	F 677	4. The Administrative Nursing Team will interview ten interviewable residents per week for 4 weeks then 5 interviewable residents per week until 100% compliance is met for 2 consecutive months to determine if ADL assistance was requested and determine if assistance was provided timely as requested. The assignment sheets will be audited every shift daily for the next 4 weeks to ensure all staff noted on the assignment sheets are present, ADL care is being provided to the residents, and the Director of Nursing is notified of any staffing issues. The assignment sheets will be audited every shift two times weekly until 100% compliance is maintained for 2 consecutive months. Three residents from each floor will be audited weekly until 100% compliance is maintained for 2 consecutive months to ensure treatments are being completed as ordered. The DON will report the results of those audits to the QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 677	Continued From page 7	F 677		

which Resident #8 was on and she was going to a different floor. NA #1 stated she suggested to NA #3 that they switch assignments if NA #3 no longer wanted to care for Resident #8. NA #1 stated that she felt like she was being ignored so she left the floor and went to the third floor to find the Director of Nursing (DON) to fix the problem with the assignments. NA #1 stated she found the DON, explained the problem, and he went to the fourth floor to take care of her concerns. NA #1 stated she returned to the fourth floor a few minutes later and resumed her assignment. NA #1 stated she did not assist Resident #8 to bed or provide her with incontinence care on the 3:00 PM to 11:00 PM shift on 6/6/19. NA #1 stated she thought Resident #8 might be confused as to what was happening when both she and NA #2 left her room without providing care, but she did not have time to go back to the resident and explain.

NA #2, an agency NA assigned to Resident # 8's floor on 6/6/19 on the 3:00 PM to 11:00 PM shift, was interviewed on 6/8/19 at 2:47 PM. NA #2 stated that 6/6/19 was her first day working at the facility so she was unfamiliar with the residents and procedures at the facility. NA #2 stated she went with NA #1 to the room of Resident #8 to help the resident get in bed and assist with incontinent care. NA #2 stated she and NA #1 brought the mechanical lift into the room, but the battery needed to be charged on the lift. NA #2 stated she went with NA #1 to the nurse's station to get a new battery. NA #2 stated NA #3 was sitting laughing and talking to another nurse aide at the nursing station. NA #2 stated she heard NA #1 asking NA #3 why she was not taking care of her resident, indicating Resident #8. NA #2 stated she heard NA #3 reply to NA #1 that she was

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F 677	Continued From page 8	F 677		

working on the schedule and did not have time to assist Resident #8. NA #2 stated that NA #3 said she was not going to do the assignment Resident #8 was on and she was removing herself from the schedule. NA #2 stated that NA #1 got on the elevator and left the floor stating she was going to get out of the building. NA #2 stated she did not know what she was supposed to do when NA #1 was arguing with NA #3. It was confirmed with NA # 2 that at the time that NA # 3 and NA # 1 were arguing, Resident # 8 was still waiting on help that had never been rendered. NA #2 stated the nurses just sat there. According to NA # 2, she did not assist with Resident #8's care.

According to the schedule there were two hall nurses for Resident # 8's floor on 6/6/19 from 3:00 to 11:00 PM. One was Nurse # 1 and one was Nurse # 2.

Nurse #1 was interviewed on 6/8/19 at 1:15 PM. Nurse #1 stated she was aware of NA #1 leaving the floor and not providing care to Resident #8. Nurse #1 stated the start of the 3:00 to 11:00 PM shift of 6/6/19 had been a very frustrating situation because NA #3 was sent to another floor to help, NA #4 switched assignments, NA #1 left the floor but then later came back, and the nurse aide assignments had to be redone three times. Nurse #1 stated that the Director of Nursing was aware of the situation as well as the staff member who takes care of the nursing schedule.

Nurse #2 was interviewed on 6/8/19 at 1:22 PM. Nurse #2 stated she was unaware of any issues with the assignments or that one of the nurse aides left the floor on 6/6/19 but she heard about it the next day.

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F 677	Continued From page 9	F 677		

The facility nurse consultant was interviewed on 6/7/19 at 10:20 AM. The nurse consultant stated she had been on Resident # 8's floor on 6/6/19 around 3:30 PM and knew Resident # 8 needed assistance. She sent two NAs to help her and did not know why they did not help her. According to the consultant nurse, the floor nurses should be handling staffing assignments to make sure their residents' needs are met. The nurse consultant stated she was aware there had been some agency nurse aides who had been refusing assignments when they reported to work. It was her understanding that three of the four nurse aides, who had been assigned to work on Resident # 8's floor on the 3:00 to 11:00 shift of 6/6/19, were agency nurse aides. These were NA # 1, NA # 2, and NA # 4. It was also her understanding that two of the three agency nurse aides (NA # 1 and NA # 2) had walked off Resident # 8's floor after they reported to work, and after assignments were given to them on 6/6/19 at 3:00 PM. This was at a time in which Resident # 8 was needing assistance.

Interview with the Director of Nursing on 6/7/19 at 4:35 PM revealed it was his expectation that nurse aides would be able to provide incontinent care to an alert resident, who was requesting assistance, within the hour the request was made.

2a. Record review revealed Resident # 5 was admitted to the facility on 11/2/18 with a diagnosis of ankylosing spondylitis (a form of arthritis that can affect multiple joints and can lead to severe and chronic pain). Additionally, the resident had a diagnosis of generalized muscle weakness.

Review of Resident # 5's quarterly MDS

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	345049	A. BUILDING _____ B. WING _____	C 06/08/2019

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F 677	Continued From page 10	F 677		

(Minimum Data Set) assessment, dated 4/16/19 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15; indicating he was cognitively intact. The resident was assessed to be frequently incontinent of bladder and as needing extensive assistance with his hygiene and toileting needs.

Review of Resident # 5's care plan, last revised on 6/4/19, revealed the care plan directed staff to assist the resident with bathing, showers, incontinent care, and hygiene.

Resident # 5 was interviewed on 6/6/19 at 10:31 AM. Resident # 5 stated that there was a week-end night in the past two week-ends in which he needed assistance for two hours and no one came. This had happened on the third shift. The resident stated he was wet with urine, and he rang his call bell to obtain assistance. NA # 7 came after two hours and helped him. Resident # 5 stated NA # 7 was a very good NA, and it was not her fault. The resident stated the problem occurred because there was supposed to have been another NA at work that night, and this other NA was not in the building working when he needed help.

NA # 7 was interviewed on 6/7/19 at 3:45 PM. NA # 7 stated the week-end night to which Resident # 5 referred was the shift which began at 11:00 PM on 5/31/19. NA # 7 stated there was supposed to be three NAs on Resident # 5's floor that night, and one of the NAs did not show up for work. That left only her and NA # 8. She validated that she saw Resident # 5's call bell on during that night, but she was busy and could not get to him. There was a resident trying to get out of bed, and other things which needed to be done before

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	345049	A. BUILDING _____ B. WING _____	C 06/08/2019

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F 677	Continued From page 11	F 677		

she could attend to his needs. NA # 7 could not recall the exact time frame but did validate that it "was at least an hour; maybe even longer" before she could change Resident # 5 when he called for help.

The facility Administrator and the facility nursing consultant provided a copy of the nursing schedule for 5/31/19 11:00 PM to 7:00 AM shift and were interviewed on 6/8/19 at 2:36 PM. The facility consultant stated that the facility had two nurses and two nurse aides working on Resident # 5's floor on the shift which began at 11:00 PM on 5/31/19 and ended at 7:00 AM on 6/1/19. There had been three scheduled nurse aides for the shift. One of the nurse aides on the schedule did not come in to work at 11:00 PM as scheduled.

The Director of Nursing was interviewed on 6/8/19 at 3:30 PM. The DON stated that he had not known that Resident # 5's floor on 5/31/19 had two nurse aides on the 11:00 PM to 7:00 AM shift when a nurse aide had not reported to work. The DON stated that if one of the nurse aides does not show up as scheduled the nurses are supposed to contact the on-call staff member first and if unable to resolve the staffing issue, then the assistant director of nursing (ADON) was to be contacted. The DON stated that if the on- call staff member and the ADON could not resolve the issue then the DON was to be contacted. The DON stated it was his expectation the nurse on the floor should notify the on-call person within a 15- minute time frame of knowledge of a problem with staffing, but a staffing issue had not been brought to his attention for 5/31/19 prior to being informed by the surveyor.

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F 677	Continued From page 12	F 677		

The Assistant Director of Nursing was interviewed on 6/8/19 at 3:35 PM. The ADON stated she was not aware that a nurse aide had not reported to work on 5/31/19 at 11:00 PM; thereby leaving two nurse aides on Resident # 5's floor on the 11:00 PM to 7:00 AM shift on 5/31/19. She stated she was not called on that evening to assist with the schedule.

Interview with the Director of Nursing on 6/7/19 at 4:35 PM revealed it was his expectation that nurse aides would be able to provide incontinent care to an alert resident, who was requesting assistance, within the hour the request was made.

2b. Review of Resident # 5's record revealed he was ordered a prescription shampoo to be applied to his hair on his shower days; which were noted by the shampoo order and on the MAR (medication administration record) to be Mondays and Thursdays. The prescription shampoo order, which originated on 11/5/18, was for Ketoconazole 2 % and was to be used for tinea versicolor (a condition which can cause itching and scaling of the skin).

During an interview with Resident # 5 on 6/6/19 at 10:31 AM, the resident stated he had been having trouble getting his showers and assistance with shampooing his hair with the correct shampoo. The resident stated he had dandruff. The resident stated he had two showers in the past two weeks, and he would try to tell the NAs that there was a special shampoo he needed but they would just use the regular shampoo in the shower and not help him with the special shampoo.

A review of the MAR revealed Nurse # 5 had

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F 677	Continued From page 13	F 677		

documented the shampoo had been used on the resident's hair on 6/3/19 (Monday) and 6/6/19 (Thursday) at 7:00 AM.

A review of Resident # 5's NA documentation, revealed he had not received showers on 6/3/19 and 6/6/19, which were the days noted the shampoo was applied. According to the NA documentation, the resident had last received a shower on 6/4/19 (Tuesday). There was no documentation the Ketoconazole shampoo was applied on 6/4/19 (Tuesday).

Nurse # 4 was Resident # 5's day shift nurse on 6/7/19. Nurse # 4 was interviewed on 6/7/19 at 1:15 PM. Nurse # 4 was observed to look through the treatment cart and medication cart and could not find Resident # 5's Ketoconazole shampoo. Nurse # 4 stated it was not in the facility at the current time. Nurse # 4 was accompanied to Resident # 5's room where she examined Resident # 5's scalp. The resident's scalp was observed to have multiple areas of dry flaking skin on his scalp. The resident explained that it had been about two weeks since the prescription shampoo had been used on his head, and at that time the staff had borrowed some one else's shampoo. The resident stated there was no special shampoo for his head specifically for him. It was confirmed with Nurse # 4 by looking at the shower schedule that Tuesday and Fridays were Resident # 5's scheduled shower days, and those were the days that the shampoo was to be used on his head; not on Monday and Thursdays as indicated on the MAR.

The facility nurse consultant was interviewed on 6/7/19 at 4:10 PM and stated she had spoken to Nurse # 5. Nurse # 5 was the nurse, who had

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F 677	Continued From page 14 signed that the prescription shampoo had been used to shampoo the resident's head on 6/3/19 and 6/6/19. According to the consultant, Nurse # 5 had assumed the nurse aides had the shampoo in the shower room and had shampooed his head with it on the days she signed that it was done.	F 677		