RA 9/30/14

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WY Dept of Health
SEP 22 2014
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse CAA-Care Area Assessment ADL- Activities of Daily Living CDM- Certified Dietary manager PRN- As needed Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction does not constitute admission and/or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared as required by regulation. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 207 SS=E	483.12(c) EQUAL PRACTICES REGARDLESS OF PAYMENT SOURCE A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and the State is not required to offer additional services on behalf of a resident other than services provided in the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of menus, the facility failed	F 207	**F207** **483.12 Equal Practices Regardless of Payment Source** A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment. **CORRECTIVE ACTION** Facility residents who reside on separate units are treated equally including dietary offerings, newspaper availability, and activities. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION**	10/7/14

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

Accepted with Charges per Jill Hutt NHA on 9/30/14 at 3:20PM [illegible] 9/30/14

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.

[illegible], Administrator 9.19.14

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F 207	Continued From page 1 to treat residents who resided on separate units equally regarding dietary offerings and activities. The facility provided 1 of 5 units with additional menu choices and a daily newspaper. The findings were: Observation of the evening meal preparation on 8/26/14 at 3:20 PM showed the CDM came to the food preparation area of the kitchen and started preparing items that did not appear on the menu for that evening. Review of the facility menu for the evening meal showed the following items: Low Fat Milk, Yogurt, Fruit of the day, Spaghetti, Choice of Meat Sandwich, Soup Minestrone, Bread Stick & Butter, Cold Water, and Yellow Wax Beans. The following concerns were identified: a. Interview with resident #61 on 8/25/14 at 8:40 PM revealed s/he received better care by staff when s/he resided on the rehabilitation unit. When asked for specifics, the resident stated, "Just check it out." b. Interview on 8/26/14 at 3:20 PM confirmed the CDM was preparing food listed on a separate menu (not provided to the surveyor when menus were requested) for the Rapid Recovery Unit residents (rehabilitation unit). c. Review of the menus provided to facility residents, and an additional menu provided only to residents on the Rapid Recovery Unit, showed separate items were available for the residents on the Rapid Recovery Unit which included: "All Entree's are served with choice of one side dish and Dessert, Chefs Menu of the Day-Made fresh, ask your server for today's special, Crab Melt Sandwich-Crab meat and Swiss cheese between two pieces of wheat or white toast grilled to a golden brown, Rapid Recovery Burger-Fresh all beef patty topped with American cheese. Served	F 207	No further residents have been affected by this practice. **MEASURES TO PREVENT RECURRENCE** Activities will provide a newspaper daily to all units in the facility. Dietary offerings will be consistent throughout the facility regardless of unit. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The Activities Director and Dietary Manager will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice.	

BQ 9/8'14

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F 207	Continued From page 2 on a bun with lettuce, tomato, pickle, Rapid Recovery Sausage-Polish Sausage on a bun and or topped with sauerkraut, Grilled Cheese-Grilled with or without turkey ham or roast beef, BLT-Bacon Lettuce and Tomato on white or wheat bread, Fried Egg Sandwich-Fried Egg with Mayo on white or wheat bread grilled to a golden brown, Turkey Salad-Turkey Salad with onion and celery on a bed of fresh lettuce or white or wheat bread, Sides-Side Salad w/Dressing-Potato or Corn Chips-Cottage cheese, Beverages-Milk, Chocolate Milk, Orange Juice, Cranberry Juice, Apple Juice, Hot Tea, Ice Tea, Coffee-regular or decaf, Hot Chocolate, Sugar Free Hot Chocolate, V-8 or Tomato Juice." d. Interview with the CDM after menu review on 8/26/14 at 3:20 PM revealed all residents could request food not on the standard menu. However, she confirmed the additional menu was only provided to residents who resided on the Rapid Recovery Unit. e. Interview with a group of 6 residents on 8/25/14 at 2 PM revealed they did not regularly have newspapers to read if they didn't pay for a subscription. Interview with the activity director on 8/27/14 at 7:15 PM confirmed residents on the East unit did not receive a daily newspaper unless they paid for it; however, residents on the Rapid Recovery unit normally received a daily newspaper provided by the facility.	F 207		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	**F241** **483.15(a) Dignity and Respect of Individuality** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **CORRECTIVE ACTION** All residents are being treated with dignity and respect, including residents #62, #84, #102 and non-sampled resident #~~185~~ #158 Change with permission from Jill Hult NHA 9/9/14 3:20 PM BQ Resident #102 is receiving incontinence care to keep him clean and dry. Resident #7 is receiving assistance with clothing changes and incontinence care as needed. Resident #84's nails have been cleaned and she is receiving care with ADL'S as needed. Resident #158 is assisted to wear the clothes of his choice. Care plans for residents #62, #84, #102 & non-sampled Resident #158 have been updated to reflect current interventions.	10/7/14

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F 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure effective measures to maintain resident dignity were consistently implemented for 3 of 21 sample residents (#62, #84, #102) and 1 non-sample residents (#158). The findings were: 1. Review of the 8/20/14 quarterly MDS assessment showed resident #102 required the extensive assistance of one person with both dressing and toilet use. Review of the resident's care plan, initiated on 6/9/13, showed the resident was at risk for impaired skin integrity related to urine incontinence. Interventions included "Staff will monitor my incontinence and keep me clean and dry..." Continuous observation of the resident on 8/24/14 from 5:15 PM until 9:50 PM showed s/he was wearing pants that were visibly wet across the buttocks and down the left leg as s/he left the dining room after dinner. The resident went to his/her room and laid down on the bed. Observation at 5:45 PM showed the DON entered the resident's room, asked the resident if s/he needed help, but left without checking for incontinence. Observation at 9:10 PM showed CNA #7 entered the resident's room and asked if the resident would like helping changing his/her clothing. The resident expressed his/her hunger to the CNA, who then left to get the resident a snack. The CNA returned with a snack at 9:15 PM, then left without helping the resident to change clothing. The resident continued to sit/lay on his/her bed with soiled clothing. Observation at 9:40 PM showed RN #2 entered the resident's room and closed the door to provide cares, however, the resident was still in the same	F 241	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No further residents identified as affected by this practice. **MEASURES TO PREVENT RECURRENCE** Staff will been re-educated by the SDC/designee on or before 10/07/2014 regarding the consistent treatment of residents with dignity and respect. The DNS has met with CNAs to review any concerns related to job duties and to determine resolution to such concerns if applicable. The DNS/designee will conduct random observations during walking rounds to ensure staff is consistently treating residents with dignity and respect and to ensure residents are receiving the necessary assistance with their ADL's. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The DNS shall report compliance trends identified during the monthly quality assurance meeting for the purpose of process improvement.	

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F 241	Continued From page 4 clothing and incontinent condition when the RN left the resident's room at 9:50 PM. 2. Observation of 8/25/14 at 10:34 AM showed CNA #1 and CNA #2 assisted resident #62 to his/her room to check the incontinence brief. While transferring the resident from the wheelchair to the bed, observation showed s/he was wearing pants that were visibly wet across the buttocks where urine had soaked through. Interview with CNA #2, at that time, verified the incontinence brief was saturated with urine. Further interview with CNA #2 revealed the resident was last toileted at 7:30 AM. CNA #2 also stated the resident required checking and changing every 2 to 2 1/2 hours. Review of the care plan updated on 4/28/14 showed the resident should be toileted before and after meals, every night at bedtime, every 2 hours during the night and PRN. During the interview with CNA #2, it was determined and she verified, the resident was not toileted after breakfast and the time span between being toileted was three hours. Review of the 7/11/14 annual MDS assessment showed the resident had severe cognitive impairment and was unable to be interviewed. 3. Review of the 1/27/14 initial MDS assessment showed resident #84 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan updated 1/14/14 showed the resident was dependent on staff for all care with interventions to include anticipating all his/her needs on a daily basis. An additional intervention included staff should clean and trim the nails after each bath. According to the resident bath list, s/he last had a bath on 8/14/14. Observation on 8/24/14 at 6 PM	F 241	The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 241	Continued From page 5 showed the resident was observed to have uncombed hair and his/her fingernails were encrusted with thick, brown matter. Observations on 8/25/14 from 8:45 AM to 12:26 PM and again from 6:45 PM to 9:03 PM, and at 10:30 AM on 8/27/14 showed the resident's fingernails remained encrusted with thick, brown matter. Interview with RN #1 on 8/27/14 at 10:30 AM verified she had noticed the resident's fingernails were dirty and needed to be cleaned. 4. Observation on 8/25/14 at 9:03 PM revealed CNA #3 and CNA #4 assisted non-sample resident #158 to bed. After transferring the resident from the wheelchair to bed, they removed his/her clothing and placed the resident in a hospital gown. The resident immediately took the hospital gown off and asked for his/her own pajamas. CNA #3 placed the hospital gown back on the resident despite the resident's request to wear his/her own pajamas. The CNA then said the reason the resident had to wear a hospital gown, instead of his/her own sleepwear, was because "it's too hard" to put pajamas on the resident. Interview with the CNA at that time verified it was easier for staff to dress the resident in a hospital gown than it was to place the resident in pajamas. 5. Observation on 8/25/14 during the noon meal showed CNAs #6 and #1 were discussing resident #158 in the dining room where other residents were eating their meal. CNA #6 stated "[s/he] never does" stay at the table during the meal. The intonation the CNA used was derogatory. The two CNAs were complaining about the resident self-propelling in and out of the dining room during the meal creating more work for staff.	F 241	**F248** **483.15(f)(1) Activities Meet Interest/Needs of Each Resident** The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. **CORRECTIVE ACTION** Individualized activities that include meaningful rhythm of life are provided for Residents #19, #60, #62, #84, #102, #112 and #118. Resident #102 is walking outside with staff during appropriate weather. Resident #112 is walking outside with staff during appropriate weather and is offered an opportunity to play board games during her waking hours. Resident #118 is offered books, magazines, newspapers and activities of his/her choice daily by staff. Staff is reminding resident #60 of facility activities and ensuring resident has a copy of activity calendar(s) readily accessible. The activity calendar has been revised to include outings scheduled outside during appropriate weather, board games during	

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F 241	Continued From page 6 6. During an interview with the DON and RN #5 on 8/27/14 at 10:20 AM, RN #5 said all staff should treat all residents with respect and dignity regardless of the diagnosis or condition.	F 241	the daylight hours, and offering residents activity items of choice. The Activity Director is working on obtaining pet visits for the residents.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, review of the activity calendar, and medical record review, the facility failed to ensure individualized activities were provided that included meaningful rhythm of life for 7 (#19, #60, #62, #84, #102, #112, #118) of 21 sample residents. The findings were: 1. Review of the 5/21/14 annual MDS assessment showed resident #102 had severely impaired vision, and rated "go outside to get fresh air when the weather is good" as "very important." Review of the activity schedule for the East station for the month of August 2014 showed the only activity that involved going outside was "Rose Garden," which was scheduled for Saturdays at 1:30 PM and Sundays at 10 AM. There were no outdoor activities scheduled for weekdays. Interview with the resident on 8/27/14 at 10:20 AM revealed "There isn't much to do when you can't see, so it's mostly sit and twiddle	F 248	The activities CAA has been completed for Resident #62. She has been provided with a baby for her enjoyment and is encouraged to attend activities of choice and preference. The activities CAA has been completed for Resident #84 and is encouraged by staff to join in scheduled activities programming of preference and choice. The activities CAA for Resident #19 has been completed and resident is being encouraged to participate in activities of choice and preference. Activities staff is scheduled and present on the West unit to perform scheduled activities and to encourage resident participation with activities of choice and preference which are individualized and include meaningful rhythm of life. Activities care plans for Residents #19, #60, #62, #84, #102, #112 and #118 have been reviewed and revised to reflect current interventions. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION**	10/7/14

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F 248	Continued From page 7 your thumbs...I like to go outside if I get the chance. They won't let me go by myself and they don't come to take me anymore. There used to be a person who worked with people like me, but she's gone now. I spend a lot of time in my room just being bored." Review of July 2014 activity records for the resident provided by the activity director on 8/27/14 showed the resident's activities consisted primarily of indoor walks, watching her roommate's television, listening to books on tape, "talking/conversing," visits with other residents, and "walks to cantina." 2. Review of the 3/7/14 admission MDS assessment showed resident #112 had rated "going outside to get fresh air when the weather is good" as "very important." Review of the activity schedule for the East station for the month of August 2014 showed the only activity that involved going outside was "Rose Garden," which was scheduled for Saturdays at 1:30 PM and Sundays at 10 AM. There were no outdoor activities scheduled for weekdays. Interview with the resident on 8/27/14 at 10:15 AM revealed s/he liked to go out into the rose garden, but the door to the garden was secured, and s/he was unable to reach the keypad to unlock the door from his/her wheelchair. The resident further indicated s/he would sometimes like to play board games, but that these games were only offered in the evening after s/he had already retired for the night. Further review of the activity schedule for August 2014 confirmed "Table/Card Games" was only offered on Wednesdays at 5:30 PM. Review of August 2014 activity records provided by the activity director on 8/27/14 showed the resident's activities primarily consisted of independent activities such as going to the cantina, reading, watching television, visiting with other residents,	F 248	All residents are potentially affected by this practice. The MDS Coordinator will audit each comprehensive MDS's to ensure compliance with all triggered CAA completion. **MEASURES TO PREVENT RECURRENCE** An activity assessment has been completed for every resident and their individualized care plans in accordance with each resident's comprehensive assessment, interests, physical, mental and psychosocial well-being. Activities and nursing staff have been re-educated regarding activities programming and the importance of providing each resident with individualized activities which include a meaningful rhythm of life and which may effectively assist with the prevention of boredom. The Activities Director/designee will request the input of the residents monthly during the Resident Council meeting. Resident comments and suggestions for activity programming will be implemented into the activity programming to the extent possible. Residents not represented at Resident	

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F 248	Continued From page 8 and "Watches: goings on." 3. Medical record review showed resident #118 was hard of hearing and had impaired vision. Review of the care plan for the resident showed the following: "I have little or no activity involvement r/t [related to] Depression." The goal included, "I will express satisfaction with type of activities and level of activity involvement when asked through the review date." The interventions included, "Explain to me the importance of social interaction, leisure activity time. Encourage my participation by asking me to join, I may still decline but I know what is going on..." The following concerns were identified: a. Review of the 1/27/14 annual MDS assessment showed resident #118 found the following activities very important: To have books, newspapers, and magazines to read, to listen to music, and to do favorite activities. The following activities were somewhat important: Keeping up with the news and to go outside to get fresh air when the weather was good. b. Review of the requested activity assessment and documentation showed the following: The activity assessment was a copy of the 1/27/14 annual MDS assessment with no additional information. Documentation review for July and August of 2014 showed the following: All 4's [independent] were written in on all days for Indoor and Outdoor Walks W/C [wheelchair], Reads/Newspapers/Magazines, Views Television, Talking/Conversing, and Visits-Other Residents. The documentation failed to indicate specifics such as time involved in these activities, if staff and/or other residents were involved, or if any encouragement by staff was provided. c. Interview on 8/25/14 at 7:45 PM with resident #118 revealed, "I wish I could do	F 248	Council or unable to attend the Resident Council meeting will be visited at their bedside for suggestions and comments related to the facility activity programming. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The Activities Director/designee shall report any trends identified during the quarterly quality assurance meeting for the purpose of process improvement. The results interviews and council meetings shall be presented to the QA committee members for the effectiveness of this plan of correction, trends, recommendations for further corrective actions if necessary, and/or termination of monitoring if the intervention is successful.	

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F 248	Continued From page 9 activities." 4. Medical record review showed resident #60 had diagnoses which included multiple sclerosis. Review of the care plan for the resident showed the following: "I'm still able to make independent choice to my involvement, but would like staff to remind me. At times I can be forgetful. I continue to complete independent activities and these include: Family, computer, movies and volunteering." The goals included, "I would like to attend facility activities on my own with min [minimum] verbal reminders weekly." The interventions included, "Coordinate with nursing staff to ensure that I am up in my chair and ready PRN. At times I may need reminder of these special activities/occasion celebrations. Please provide a monthly activity calendar PRN. Often I like South and East station calendars." The following concerns were identified: a. Review of the 4/15/14 annual MDS assessment showed resident #60 found the following activities very important: To have books, newspapers, and magazines to read, to listen to music, to be around animals such as pets, to keep up with the news, to do favorite activities, to go outside and get fresh air when the weather was good, and to participate in religious services or practices. The following activity was somewhat important: To do things with groups of people. b. Review of the requested activity assessment and documentation showed the following: The activity assessment was a copy of the 4/15/14 annual MDS assessment with no additional information. Documentation review for July and August of 2014 showed the following: All 4's [independent] were written in on all days for Indoor and Outdoor Walks W/C [wheelchair], Computers/IPADS/Readers,	F 248		

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(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 248	Continued From page 10 Reads/Newspapers/Magazines, Views Television, Talking/Conversing, Special Interests/Friends/Family, and Visits-Other Residents. The documentation for July 2014 also had a "4" for out of facility for 2 days, and none for August 2014. c. Interview on 8/27/14 at 4:15 PM with resident # 60 revealed, "We have bingo and an occasional outing for shopping, and that is all. I am bored." 5. Group interview with 6 residents on 8/25/14 at 2 PM revealed all residents in attendance felt more activities were needed, stating, "Bingo is good, but we need more than that" and we "hunt for something to do." Additionally, the residents felt the facility did not ask residents for input on planned activities. Four of the six residents attending wanted to go outside more often. 6. Interview with the activities director on 8/27/14 at 7:15 PM revealed she felt there were not enough activity staff at the facility to meet all of the residents' needs for activities. The following concerns were identified in regard to the Secure Unit: 1. Observation on the locked secure unit from 8/25/14 from 8:45 AM to 12:26 PM and again from 6:45 PM through 9:03 PM showed no activities were provided for residents. Periodic observations throughout the day and evening on 8/26/14 again revealed residents were either self propelling up and down the hallway or sitting in the day room without any formal activities being available. Finally, periodic observations throughout the day on 8/27/14 showed there was no formal activity available and no staff were	F 248		

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	535042	A. BUILDING _____ B. WING _____	C 08/27/2014

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F 248	Continued From page 11 assisting residents in an activity. According to the August activity calendar, kick ball, walking club, and trivia was scheduled for 8/25/14. On 8/26/14 these activities were scheduled: ice ream social, nail care, baking club board games and music. However, based on periodic observations, none of these activities were provided for, or offered to residents. On 8/27/14 the scheduled activities included meet and greet, reminiscence, noodle ball, martha goodies, town hall meeting and sing-and-swing. Again, based on observation and record review, none of these activities were provided for, or offered to the residents on the locked secure unit (west). 2. Review of the medical record showed resident #62 had diagnoses including Alzheimer's disease, dementia with behavioral disturbances, senile dementia with delirium, and anxiety. Review of the 7/11/14 annual MDS assessment showed activities triggered for the resident as needing a comprehensive assessment (CAA). The following concerns were identified: a. Review of the medical record showed no evidence the CAA was performed. Interview with the interim DON on 8/27/14 at 5:40 PM verified she was unable to find the activities CAA. b. Review of the care plan, last revised on 4/10/13 (16 months ago), showed the resident liked simple, structured activities such as socializing, reading (likes to be read to), and babies. Review of the 7/11/14 annual MDS assessment showed the resident enjoyed snacks, music, animals, outdoors, and religion. Interview with a family member on 8/26/14 at 6:50 PM revealed the resident had served as the church organist prior to his/her admission to the facility and loved music. However, observations on 8/25/14 from 8:46 AM through 12:26 PM and	F 248		

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F 248	Continued From page 12	F 248		

again from 6:45 PM to 9:03 PM (at least 6 waking hours) showed no attempt to involve the resident in an activity other than at 9:50 AM the resident was given a stuffed animal. The resident immediately placed the stuffed animal on a nearby chair and left the dining area. Periodic observations throughout the day on 8/26/14, and on 8/27/14 from 10 AM through 1 PM, again showed no activity was provided, and no staff assisted or attempted to involve the resident in an activity. Observation showed instead, the resident sat in the wheelchair and repeatedly yelled out "golly, golly, golly, golly."

c. Review of the individual resident activities flow sheet for 8/25/14 through 8/27/14 showed on 8/25/14 the resident "actively" participated in indoor walks, meaning s/he self propelled in an out of his/her room and the dining area. In addition, review of this document showed the resident "passively" participated in "intellectual" and "talking." However, observations showed no interaction with staff or other residents. The resident remained primarily alone, away from other residents and staff, yelling out "golly, golly, golly, golly repeatedly." There was no evidence the resident was offered any type of formalized activity.

3. Review of the medical record showed resident #84 had diagnoses including Alzheimer's disease, dementia without behavioral disturbances, depression, and anxiety. Review of the 1/27/14 initial MDS assessment showed activities triggered for the resident as needing a comprehensive assessment (CAA). The following concerns were identified:

a. Review of the medical record showed no evidence the CAA was performed. Interview with the Interim DON on 8/27/14 at 5:40 PM verified

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F 248	Continued From page 13 she was unable to find the activities CAA. b. Review of the 1/15/14 initial activity assessment showed the resident enjoyed snacks, music, animals, and fresh air. Review of the care plan dated 1/9/14 showed the resident wanted to be included in activities for sensory stimulation such as being read to or listening to music. Observations on 8/25/14 from 8:45 AM through 12:26 PM and again from 6:45 PM to 9:03 PM, periodically throughout the day on 8/26/14, and on 8/27/14 from from 10 AM through 1 PM showed no activity was provided and no staff assisted or attempted to involve the resident in an activity. c. Review of the individual resident activities flow sheet for 8/25/14 through 8/27/14 showed on 8/25/14 the resident passively participated in "intellectual" and "talking." In addition, review showed there was music on in the unit and the resident listened. However, observation showed the resident sat in the wheelchair or in the recliner in the day room in a corner area and slept much of the time. 4. Review of the medical record showed resident #19 had diagnoses including dementia without behavioral disturbances, depression, and anxiety. Review of the 7/10/14 significant change MDS assessment showed activities triggered for comprehensive review: The following concerns were identified: a. Review of the medical record showed no evidence the CAA was performed. Interview with the interim DON on 8/27/14 at 5:40 PM verified she was unable to find the activities CAA. b. Review of the 7/10/14 section "F" of the MDS assessment showed the resident enjoyed a tub bath, family, listening to music, doing things with groups of people, and participating in favorite	F 248		

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F 248	Continued From page 14 activities. Review of the care plan last revised on 6/9/14 showed the resident preferred activities which did not involve overly demanding cognitive tasks such as being read to, music, massages, television, movies, and nail care. Observations on 8/25/14 from 8:45 AM through 12:26 PM and again from 6:45 PM to 9:03 PM, periodically throughout the day on 8/26/14, and on 8/27/14 from from 10 AM through 1 PM showed no activity was provided and no staff assisted or attempted to involve the resident in an activity. c. Review of the individual resident activities flow sheet for 8/25/14 through 8/27/14 showed on 8/25/14 the resident passively participated in an "intellectual" activity and independently participated in a "talking" activity. In addition, review showed the resident actively went on indoor and outdoor walks. However, observation showed the resident sat in the wheelchair and self-propelled up and down the hallway on his/her own without interaction with activity or nursing staff during the above noted times of observation. 5. Interview with the activities coordinator on 8/27/14 at 5:36 PM revealed there were supposed to be two activity staff on the west unit to provide activities. However observations as noted earlier showed no activities were provided or offered on the unit during observations on 8/25/14 from 8:45 AM through 12:26 PM and again from 6:45 PM to 9:03 PM, periodically throughout the day on 8/26/14, and on 8/27/14 from from 10 AM through 1 PM.	F 248	**F253** **483.15(h)(2) Housekeeping and Maintenance Services** The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. **CORRECTIVE ACTION** Carpets throughout the building have been cleaned including the secured unit, south unit, east unit, Ellbogen unit and the rapid recovery unit. On the B hallway of the rapid recovery unit, the following issues in resident areas have been corrected: The edge of the front of the door to room #206 #211, #203 including the bathroom door, #200 including the bathroom door, #202, #201 chips have been repaired, The wallpaper on the back wall of the bathroom # 212 has been repaired. On the B hallway: rapid recovery unit, the following issues in resident areas have been corrected: The front door to room #218 with a chunk missing from the bottom right, missing chips on the edge of door #220, bathroom door chips in room #217 and #216, front door chips of room #222 and the left side of the kick plate for room #215.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		10/7/14

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F 253	Continued From page 15 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a variety of items in 5 of 5 resident areas, including the locked secure unit (west unit), south unit, east unit, Ellbogen unit, and the rapid recovery unit, were clean and well maintained. The findings were: 1. Interview with the housekeeping supervisor on 8/27/14 at 11:15 AM confirmed the carpets throughout the building, including the secure unit, south unit, east unit, elboken unit, and the rapid recovery unit were dirty with multiple whitish and blackish/brownish stains. She acknowledged the electrical carpet cleaner had been out of operation for a month, and the carpet was old and needed replacement. She further acknowledged that many damaged surfaces in the building, especially the flooring of the shower room next to room #112, were too damaged to be adequately cleaned. The carpet issue was observed by the survey team from entrance to the facility on 8/24/14 at 1:05 PM until exiting the facility on 8/27/14 at 10 PM. 2. Interview with the maintenance supervisor on 8/27/14 at 12:45 PM verified multiple areas of the facility were in need of repair, and the facility failed to have a plan with a specific timeframe to address those concerns. Areas in need of repair/cleaning included the following: a. Observation of the A hallway of the rapid recovery unit on 8/25/14 at 8:25 AM revealed the following issues in resident areas: The edge of the front door to room #206 had multiple chips	F 253	The following issues have been corrected on the secure unit: The back exit door kick plate has been secured and the spider web removed, the holes in the four walls of the dining area have been repaired, the damage on both sides of the door from the dining to the main hallway have been repaired and the baseboard to the right of the dining area replaced. The half wall in the smaller dining area has been secured. The paint on the exit door by the piano and the wall on either side of the piano have been repaired. The piano room door scuffs and jelly located on the piano lid have been removed. The top drawer of the four drawer chest in room #39 has been repaired. The three darkened stained tiles to the left of the front door of room #39 have been cleaned to the extent possible and the kick plate chips have been repaired. The door for room #41 has been replaced and the marking reading the room number has been replaced with appropriate signage. The back wall baseboards and bathroom left wall of room #41 have been cleaned and repaired. Also the wall to the left of the commode and the front door kick plate has been repaired. The rusty heat vent in room #37 has been repaired. The carpet tear at room #43 has been repaired and the divider	

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F 253	Continued From page 16 missing on the outer edge from the floor to 29 inches in height. The edge of the front door to room #205 had multiple chips missing on the outer edge from the floor to 26 inches in height. The edge of the front door to room #211 had multiple chips missing on the outer edge from the floor to 36 inches in height. The back wall of the bathroom in room #212 had wallpaper pulled loose in 2 areas, from the baseboard to 8 inches in height and from the baseboard to 10 inches in height. The edge of the front door to room #203 had multiple chips missing on the outer edge from the floor to 36 inches in height. The bathroom door also had multiple chips missing on the outer edge from the floor to 36 inches in height. The edge of the front door to room #202 had multiple chips missing on the outer edge from the floor to 38 inches in height. The edge of the front door to room #201 had multiple chips missing on the outer edge from the floor to 42 inches in height. The edge of the front door to room #200 had multiple chips missing on the outer edge from the floor to 30 inches in height. The bathroom door had multiple chips missing on the outer edge from the floor to 42 inches in height. b. Observation of the B hallway of the rapid recovery unit on 8/25/14 at 9:35 AM revealed the following issues in resident areas: The front door to room #218 had a 3 inch by 2.5 inch chunk missing on the bottom right. The edge of the front door to room #220 had multiple chips missing on the outer edge from the floor to 32 inches in height. The bathroom door of room #217 had multiple chips missing from the floor to 24 inches in height, and was scraped across the 36 inch door on the inside at 22 inches in height from the floor. The bathroom door of room #216 had multiple scrapes from the floor to 32 inches in	F 253	board along the back wall has been repaired and or replaced. Room #43 transition strip has been replaced. The heat vent in room #35 has been repaired. The front door kick plate chips of room #36 and the torn carpet have been repaired. The back wall heat vent and the bathroom het vent of room #42 has been repaired. The front door kick plate of room #34 and all four walls have been repaired. The shower handle of room #34 has been secured, the inside of the front door and floor have been replaced. The shower room by #112 with two chipped broken floor tiles by the front door and 17 loose floor tiles will be repaired or replaced. The south unit shower room partial divider between two shower stalls has been repaired. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** The Maintenance Director/designee will complete an audit of each room and common areas, by 10/07/2014, to identify any rooms in need of repair(s) which may fail to ensure a safe, comfortable and homelike living environment. Items identified will be logged on the work/repair log for safety prioritization and repairs/replacement in an on-going effort.	

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F 253	Continued From page 17 height. The edge of the front door to room #222 was chipped on the outer edge from the floor to 42 inches in height, which exposed the inner wood in an area 3 inches long by 0.5 inches wide. The left side of the front door kick plate of room #215 was pulled loose from the floor to 34 inches in height. Also, the inner bathroom door had multiple chips in the door from the floor to 32 inches in height. c. Observation of the secure unit on 8/25/14 at 10:55 AM revealed the following issues in resident areas: The back exit door kick plate in the dining area was loose from the door from the top to 11 inches downward. Also, the door handle had a spider web below it. All 4 walls in that dining area had multiple small holes at 1 foot in height from the floor. The door from the dining to the main hallway had damaged areas on both sides from the floor to 32 inches in height that exposed metal underneath, and the baseboard to the right of the door was missing. The smaller dining area had a half wall in front of the servery with the wall pulled loose from the floor to 17 inches in height. The exit door by the piano in the small room across from the dining area had the paint scraped off in a 16 inch by 25 inch rectangle at 26 inches in height from the floor. The wall on each side of the piano had multiple scrapes of varying height which exposed the wall under the paint. The piano room door had scuffs across the entire 36 inches that were located 24 inches in height from the floor. The piano had jelly on the lid for the keyboard. In room #39 the top drawer in a 4 drawer chest of drawers was broken. The floor had 3 darkened stained 1 foot by 1 foot tiles to the left of the front door. Also, the bottom left front door kick plate had multiple chips from the floor to 36 inches in height. The room #41 door number was missing and the number was	F 253	**MEASURES TO PREVENT RECURRENCE** Housekeepers and Department Managers will be re-trained by the Maintenance Director/designee on or before 10/07/2014 re: entering identified items needing repair into the TELS system for timely repair and follow-up to ensure compliance with this measure. The Maintenance Director will re-educate the staff, including Department Managers on or before 10/07/2014 re: the process for communication to the maintenance department of any identified repair concerns, to ensure items identified during rounds, in need of repair, are entered documented for timely repair and follow-up. The Maintenance Director/designee will review the work/repair log five days weekly to ensure items in need of repair are corrected in a timely manner. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The maintenance director will monitor the work/repair log orders and corrections to ensure timely completion and compliance with this plan of correction.	

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F 253	Continued From page 18 marked on the hallway wall with a magic marker. The bathroom left wall and back wall baseboards were scuffed across 52 inches by 52 inches. Also, the wall to the left of the commode had damage 12 inches above the floor to 26 inches above the floor and a second area 36 inches above the floor that measured 33 inches across. The front door kick plate for room #41 had multiple chips on the left from the floor to 36 inches in height. The back wall heat vent in room #37 had multiple rust areas across 110 inches. The front door and kick plate in room #36 had multiple chips on the left from the floor to 36 inches in height. Room #42 had the door number missing. The heat vent along the back wall had multiple rust areas 70 inches across. The carpet between the hallway and room #43 was torn at the left of the door from the floor to 8 inches across. The back wall had a divider board that was damaged at 35 inches in height and 44 inches across that showed the board underneath. A board above the heat vent had stain damage across the entire front wall. The front door transition strip (divides room floor from hallway floor) was damaged all 36 inches across and was not a cleanable surface. Tape had been placed over the area, and was partially off and collected dirt and debris. The back wall heat vent of room #35 was scraped and the entire vent had missing paint. The front door kick plate of room #36 on the left had multiple chips from the floor to 36 inches in height. The carpet in the hallway by the front door had 3 inch tears on each side of the door. The back wall heat vent of room #42 had scraped paint and multiple rusted areas along the entire length of the wall. The bathroom heat vent along the left wall was scuffed 53 inches across. The front door kick plate of room #34 had multiple chips on the left from the floor to 36	F 253	The maintenance director shall report any trends identified during the quarterly quality assurance meeting for the purpose of process improvement. The results of these audits shall be presented to the QA committee for analyzing this quality improvement measure for the effectiveness of the intervention, trends, recommendations for further corrective actions if necessary, and/or termination of monitoring if the intervention is successful.	

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F 253	Continued From page 19 inches in height. The back wall heat vent in room #33 had multiple paint scuffs the entire length of the wall. The hallway wall just to the right of room #44 had a chip that measured 1 inch by 6 inches with paint off and wall damage. The front door kick plate of room #44 had multiple chips out on the left from the floor to 36 inches in height. The heat vent on the left wall had paint scraped entirely across at 53 inches. The front door and kick plate of room #45 had multiple chips on the left from the floor to 36 inches in height. The bathroom baseboard on the left wall had multiple scrapes across the entire wall length. The front door and kick plate of room #31 had multiple chips on the left from the floor to 36 inches in height. The television room across from the nursing desk had 9 walls of varying width, and each wall had multiple areas with paint scrapes. d. Observation on 8/25/14 at 11:45 AM of the rapid recovery unit revealed the following issue in a resident area: The cabinet by the television room across from the nursing station had multiple areas of wood damage throughout the cabinet on the outside at 34 inches in height and 72 inches across. e. Observation on 8/25/14 at 2 PM of the east unit revealed the following issues in resident areas: Room #100 had a 2 inch by 3 inch hole in the floor tile in front of the bathroom sink. Carpet was missing in a 4 inch strip at the front door. The bathroom tile of room #101 just inside the door to the right had multiple cracks with the longest at 8 inches in length. The cracks were blackened with dirt and was not an adequate surface for cleaning. The inside bathroom door of room #103 had 3 separate scrapes near the bottom and 2 small holes on the left side. In the bedroom on the wall to the left of the bathroom door there was wall damage from the floor to 18	F 253		

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F 253	Continued From page 20 inches in height and 3 inches across. The floor tiles by the front door of room #104 were split through a total of 16 tiles with blackened dirt and was not an adequate surface for cleaning. The left wall by the bathroom door was torn from the floor to 58 inches in height and included a tear in the baseboard. The back wall in the bathroom of room #105 had 7 holes past the toilet. The baseboard on the wall beside the left bathroom door of room #106 was torn from the floor to 3 inches in height. Also, at 32 inches in height on the same wall there was a 3 inch area of wall that was missing. The front door to room #107 had multiple chips missing on the left from the floor to 13 inches in height. The bathroom floor of room #109 had a 5 inch by 5 inch area of tile to the left of the toilet that was totally crushed and could not be adequately cleaned. The wall behind the toilet was separated from the floor to 12 inches in height. The bedroom wall to the left of the bathroom door had a corner with 2 walls separated from the floor to the ceiling. Also, a 4 inch by 4 inch area of the baseboard was missing. The right wall by bed B had a 4 inch by 7 inch tear over the center of the bed. The bathroom tile floor of room #111 had a 36 inch tear in front of the door which allowed visualization under the door from the bedroom to the bathroom. The bathroom door of room #112 had a hole 6 inches by 9 inches at the bottom right. The tile floor in room #115 was dirty (darkened) throughout. Also, the bathroom floor was dirty and sticky with brownish film. There was a hole completely through the wall behind the toilet that was 4 inch circular. The inside bathroom door of room #118 had a 3 inch by 4.5 inch hole 42 inches above the floor. The bathroom door of room #119 had 2 holes that measured 3 inches across by 0.5 inches wide at	F 253		

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F 253	Continued From page 21 37 inches in height. The baseboard to the right of the bathroom door was missing at 4 inches by 4 inches. The wall behind the toilet had 5 patched holes that were not smoothed or painted. The bathroom door of room #120 had a 3 inch by 1 inch hole on the outside at 23 inches in height. The bathroom door of room #121 had a 1 inch by 3 inch hole on the inside at 23 inches in height. Also, the left bathroom wall baseboard was pulled away from the wall 37 inches across. The wall to the right of the bathroom door in room #124 had a 2 inch hole at 12 inches in height. In room #125 the baseboard to the left of the bathroom door was loose from the wall at 4 inches by 4 inches. The front door of room #127 was chipped on the left from the floor to 36 inches in height. The bathroom door of room #120 had 2- 4 inch by 4 inch patches that were rough and unpainted. The baseboard to the left of the bathroom door in room #129 was loose from the wall 4 inches by 4 inches. Room #131 had 4- 1 foot by 1 foot tiles beside the bed that were dark stained. Also, a tile by the left side of the front door was chipped 2 inches by 4 inches. The wall to the right of the closet in room #110 had a 2 inch by 4 inch tear near the floor. Also, the 4 inch by 4 inch baseboard was missing. f. Observation on 8/25/14 at 9:35 AM across from the secure unit nursing station revealed a bathroom with a torn kick plate on the door at 4 inches by 4 inches. Also, the heat vent on the left wall was scuffed entirely across. The piano in the back right room across from the dining area continued to have jelly on the lid for the keyboard. g. Observation on 8/27/14 at 11:15 AM of the south unit revealed the following issues in resident areas: The baseboard to the left of the bathroom door in the bedroom of room #117 had a 2 inch by 2 inch missing area. The back wall in	F 253		

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F 253	Continued From page 22 the bathroom of room #7 had a 1 foot by 1 foot tear along the bottom of the wall. The left, bottom, and right edges (border) of a mirror on the bathroom door were missing at 10 inches by 1 foot by 12 inches. The bathroom door of room #3 had a 4 inch by 2 inch hole on the outside at 26 inches in height. Also, the left front door kick plate was torn from the door 2 inches at 12 inches in height. The bathroom light switch in room #9 had a chip in the wall on the right corner. Also, there was a hole in the wall there that measured 2 inches by .75 inches. The front door kick plate of room #27 was torn from the floor to 18 inches in height. The bathroom heat vent against the right wall was scraped with multiple rust areas at 36 inches across. The baseboard made of wood at the right and back bathroom wall of room #26 had the stain missing. The front door kick plate of room #15 had an area from the floor to 26 inches in height that had multiple scrapes and missing areas. The front door left kick plate in room #25 had damage from the floor to 36 inches in height. The front door kick plate in room #24 was damaged from the floor to 32 inches in height. The front door transition strip of room #23 had brownish old glue that accumulated dirt and dust at 36 inches across. The corner of the wall by the bathroom door in the bedroom had a piece of wall missing that exposed the metal underneath from the floor to 1 foot in height. The bathroom door in room #22 had bottom inner door damage and multiple scrapes across 36 inches in height and 14 inches up. h. Observation on 8/27/14 of 11:45 AM at the Ellbogen unit revealed the following issues in resident areas: In room #60 the screen was off on the left side of the back window that measured 18 inches by 42 inches. The screen was propped against the back wall. The front door kick plate of	F 253		

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F 253	Continued From page 23 room #68 was damaged from the floor to 26 inches on the right. The bathroom door kick plate was loose from the door at the top 36 inches across. The bathroom heat vent of room #61 against the left wall was scraped 32 inches across. The left bathroom wall of room #62 was damaged at 1 foot in height and 24 inches across. The right wall in the bedroom by the bed was damaged with paint missing by the head 1 foot by 1 foot. I. Observation of the shower/tub rooms on 8/26/14 at 9:10 AM revealed the following issues: The shower room on the rapid recovery unit across from room #215 had 5 floor tiles cut through and were darkened/dirty in the cut. The damaged area could not be adequately cleaned. Paint was scraped off of the right wall from the floor to 42 inches in height. The shower room across from room #201 had the baseboard on the left wall torn at 4 inches by 3.5 inches. The door to the right by the shower had paint scraped off on both sides of the doorframe from the floor to 38 inches in height. The locked secure unit shower had the following issues: to the left of the front door the carpet was torn from the floor to 3 inches across. The flooring at the door was separated between the shower room and hallway with an accumulation of dirt and was not a cleanable surface. The heat vent against the right wall was scraped with multiple areas of rust entirely across. The front door kick plate was chipped at the bottom left corner from the floor to 3.5 inches in height and 2 inches across. The east unit shower room by room #102 had the following issues: The tile transition divider under the front door was chipped in 3 places, the longest was a 2 inch V-shape, was blackened, and was not a cleanable surface. The east unit shower room by room #122 had the following	F 253		

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F 253	Continued From page 24 issues: All 4 walls had paint and wall damage in multiple areas, with the longest damage measured at 10 inches by 8 inches. The shower handle holder was loose from the wall and could not be used to hold the shower handle, which was placed in the sink. The inside of the front door had multiple scrapes to the paint and was not a cleanable surface. The floor was damaged and discolored over the entire surface and was not a cleanable surface. The shower room by room #112 had the following issues: By the front door there were 2 floor tiles that were chipped and broken and could not be adequately cleaned. There were 17 loose tiles at the middle of the under edge of the tub, which created a surface that could not be adequately cleaned. The south unit shower room had the following issues: The partial wall divider between the 2 shower stalls had significant damage throughout on both sides. The end facing the front had a 61 inch by 6 inch damaged area, and the divider was not touching the floor at the front due to the extensive damage. The inside wall of the right shower stall from the floor to 3 inches in height and 8 inches across was torn and could not be adequately cleaned.	F 253	**F282** **483.20(k)(3)(ii) Services by Qualified Persons/Per Care Plan** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **CORRECTIVE ACTION** The facility personnel have reviewed and updated the care plan for Residents #19 and #62. Resident #62 was changed out of wet clothes at the time of staff observation during the survey and is consistently being checked and assisted with incontinence needs as necessary per his care plan. Resident #19 is receiving assistance with oral care, and ADL's per the plan of care.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record interview, staff interview, and review of facility policy and	F 282	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No further residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** Nursing staff will be re-educated by the SDC/designee on or before 10/07/2014 regarding following the plan of care and ensuring residents receive appropriate assistance with their ADL's.	10/7/14

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F 282	Continued From page 25 procedure, the facility failed to ensure staff followed the care plan for 2 of 21 sample residents (#19, #62). The findings were: 1. Observation of 8/25/14 at 10:34 AM showed CNA #1 and CNA #2 assisted resident #62 to his/her room to check the incontinence brief. While transferring the resident from the wheelchair to the bed, observation showed s/he was wearing pants that were visibly wet across the buttocks where urine had soaked through. Interview with CNA #2, at that time, verified the incontinence brief was saturated with urine. Further interview with CNA #2 revealed the resident was last toileted at 7:30 AM. CNA #2 also stated the resident required checking and changing every 2 to 2 1/2 hours. Review of the care plan updated on 4/28/14 showed the resident should be toileted before and after meals, every night at bedtime, every 2 hours during the night and PRN. During the interview with CNA #2, it was determined and she verified, the resident was not toileted after breakfast and the time span between being toileted was three hours. 2. Review of the 7/10/14 significant change MDS assessment showed resident #19 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan last updated on 4/28/14 showed the resident had a deficit in self care performance and required staff assistance with ADLs. Interventions included on the care plan were: resident was edentulous (no teeth) and needs toothettes to clean the mouth and gums. In addition, the resident required assistance in combing his/her hair and washing and drying his/her face. Observation on 8/25/14 at 7:10 PM	F 282	**MONITORING AND INCORPORATION INTO THE QA SYSTEM** The MDS Coordinator/designee will ensure resident care plans are updated quarterly with individualized interventions. The DNS/designee will conduct random observations during walking rounds to ensure staff is consistently providing assistance to the residents with their ADL's. The DNS shall report compliance trends identified during the monthly quality assurance meeting for the purpose of process improvement. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 282	Continued From page 26 revealed staff did not offer to assist or provide oral care or washing of the resident's face and hands during bedtime care. Review of the facility policy and procedure on nursing care standards, reviewed in August 2011, showed "Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean, no less than AM/PM with care which consists of ...PM: washing face, hands, back, peri-area and apply lotion to back/legs." 3. Interview with the DON and RN #5 on 8/27/14 at 10:20 AM revealed staff should follow the care plans as written.	F 282	**F311** **483.25(a)(2) Treatment/Services to Improve/Maintain ADLS** A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. **CORRECTIVE ACTION** Restorative Nursing is being completed as recommended for resident #142. Restorative aides are not being pulled to the floor to cover a shift assignment.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure restorative nursing exercises were consistently utilized to maintain and/or restore ADL function for 1 of 5 sample residents (#142) who were referred for restorative services. The findings were: Review of the 7/2/14 quarterly MDS assessment showed resident #142 suffered from chronic pain. Review of the resident's care plan revealed the resident was "constantly in pain." Care plan interventions included "[resident name] receives massage therapy from RNA [restorative nurse aide] for shoulder pain." Review of the restorative	F 311	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** Residents receiving restorative nursing programs have the potential to be affected. Restorative aides are not being utilized to cover a direct care shift assignment. The DNS/designee will audit Restorative Nursing Services. **MEASURES TO PREVENT RECURRENCE** Nursing staff will be educated by the DNS/designee, on or before 10/07/2014, re: no-tolerance policy regarding restorative aides working a shift assignment. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The DNS/designee will audit Restorative Nursing monthly to ensure that residents are receiving restorative services as recommended, until such time as the QA committee deems compliance has been met.	10/7/14

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F 311	Continued From page 27 aide documentation for the month of August 2014 showed the resident was to receive "Massage neck and left shoulder at resident's request 15 min [minutes] 2 X [times] weekly." Further review showed the resident had received the massage only 4 times between 8/1/14 and 8/26/14, instead of the 7 times s/he should have. On 8/19/14 a note was written that indicated "RNA not done pulled to the floor." Interview with RN #3 on 8/26/14 at 4:10 PM revealed restorative aides had been been pulled from doing restorative work to working the floor "quite a bit" during the summer due to staffing issues.	F 311	The DNS shall report compliance trends identified during the monthly quality assurance meeting for the purpose of process improvement. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, medical record review, staff interview, and review of policy and procedure, the facility failed to ensure residents who required extensive or total assistance performing ADLs received assistance with hygiene for 5 of 21 sample residents (#19, #22, #62, #84, #102) and 1 non-sample resident (#168) identified as requiring or extensive or total assistance. The findings were: 1. Review of the 8/20/14 quarterly MDS assessment for resident #102 showed s/he required the extensive assistance of one person	F 312	**F312** **483.25(a)(3) ADL care provided for dependent residents** 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. **CORRECTIVE ACTION** Residents who require extensive or total assistance performing ADL's receive assistance with hygiene; including residents #19, #22, #62, #84, #102, and #158. Resident #19 is receiving assistance with oral care, and ADL's per his care plan. Resident #22 is receiving assistance with incontinence care per the care plan.	10/7/14

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F 312	Continued From page 28 with both dressing and toilet use. Review of the resident's care plan, initiated on 6/9/13, showed the resident was at risk for impaired skin integrity related to urine incontinence. Interventions included "Staff will monitor my incontinence and keep me clean and dry..." Continuous observation of the resident on 8/24/14 from 5:15 PM until 9:50 PM showed s/he was wearing pants that were visibly wet across the buttocks and down the left leg as s/he left the dining room after dinner. The resident walked down the hall to his/her room and laid down on the bed. Observation at 5:45 PM showed the DON entered the resident's room, asked the resident if s/he needed help, but left without checking for incontinence. Observation at 9:10 PM showed CNA #7 entered the resident's room and asked if the resident would like help changing his/her clothing. The resident expressed his/her hunger to the CNA, who then left to get the resident a snack. The CNA returned with a snack at 9:15 PM, then left without helping the resident to change clothing. The resident continued to sit/lay on his/her bed with soiled clothing. Observation at 9:40 PM showed RN #2 entered the resident's room and closed the door to provide cares, however, the resident was still in the same clothing and incontinent condition when the RN left the resident's room at 9:50 PM. 2. Review of the 5/14/14 quarterly MDS assessment showed resident #22 was always incontinent of urine. Review of the resident's care plan for bowel and bladder function, last revised on 2/27/13, showed the resident was unable to recognize toileting urges and was incontinent. Care plan interventions included "Staff of 2 anticipate [resident name] needs: check [him/her] for incontinence Q AM [every morning], before/after meals, Q HS [every bedtime], and Q	F 312	Resident #62 is receiving assistance with washing her hands before and after meals per the care plan. Resident #84 nails have been cleaned and she is receiving care with ADL'S as needed. Resident #102 is receiving incontinence care to keep him clean and dry. Non-sampled Resident #158 is receiving assistance with grooming prior to meal times. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No further residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** Nursing staff will be re-educated by the DNS/designee on or before 10/07/2014 regarding following the plan of care and ensuring residents receive appropriate assistance with their ADL's. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The DNS/designee will conduct random observations during walking rounds to ensure staff is consistently providing assistance to the residents with their ADL's.	

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F 312	Continued From page 29 2-3h [every 2 to 3 hours during the night], and PRN, change incontinence product/clothing when soiled, and provide peri care and additional barrier cream application as warranted...[s/he] is changed in bed." Continuous observation of the resident on 8/25/14 from 8:55 AM until 12:50 PM showed the resident was not checked for incontinence. At 12:50 PM, the resident was transferred from wheelchair to bed, but was not checked at that time (almost 4 hours). 3. Review of the 1/27/14 initial MDS assessment showed resident #84 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan updated 1/14/14 showed the resident was dependent on staff for all care with interventions to include anticipating all his/her needs on a daily basis. An additional intervention included staff should clean and trim the nails after each bath. According to the resident bath list, s/he last had a bath on 8/14/14. Observation on 8/24/14 at 6 PM showed the resident had uncombed hair and his/her fingernails were encrusted with thick, brown matter. Observations on 8/25/14 from 8:45 AM to 12:26 PM and again from 6:45 PM to 9:03 PM, and at 10:30 AM on 8/27/14 showed the resident's fingernails remained encrusted with thick, brown matter. Interview with RN #1 on 8/27/14 at 10:30 AM verified she had noticed the resident's fingernails were dirty and needed to be cleaned. 4. Review of the initial and the 4/17/14 quarterly and the 7/11/14 annual MDS assessment showed resident #62 required extensive assistance with personal hygiene. Observations from 8/24/14 through 8/27/14 showed the resident never used silverware but always ate with his/her hands.	F 312	The DNS shall report compliance trends identified during the monthly quality assurance meeting for the purpose of process improvement. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 312	Continued From page 30 Review of the physician's order dated 4/25/14 showed the resident should have his/her hands washed frequently. At no time during the observation of 3 meals, the evening meal on 8/24/14, breakfast on 8/25/14 and lunch on 8/27/14, did staff offer or assist the resident to wash his/her hands prior to or after eating. 5. Review of the 7/10/14 significant change MDS assessment showed resident #19 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan last updated on 4/28/14 showed the resident had an deficit in self care performance and required staff assistance with ADLs. Interventions included on the care plan were: resident was edentulous (no teeth) and needs toothettes to clean the mouth and gums. In addition, the resident required assistance in combing his/her hair and washing and drying his/her face. Observation on 8/25/14 at 7:10 PM revealed staff did not offer to assist or provide oral care or washing of the resident's face and hands during bedtime care. Review of the facility policy and procedure on nursing care standards, reviewed August 2011, showed "Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean, no less than AM/PM with care which consists of ...PM: washing face, hands, back, peri-area and apply lotion to back/legs." 6. Review of the 8/12/14 annual MDS assessment showed non-sample resident #158 required total assistance with personal hygiene and grooming. Observation on 8/24/14 at 6:55 PM showed the resident's hair was uncombed while at the dining table during the evening meal.	F 312	**F315** **483.25(d) No catheter, prevent UTI, restore bladder** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **CORRECTIVE ACTION** Resident #62 is being assisted with timely toileting and incontinence care per care plan. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No further residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** Nursing staff will be re-educated by the DNS/designee on or before 10/07/2014 regarding following the plan of care and ensuring residents receive appropriate assistance with their ADL's. **MONITORING AND INCORPORATION INTO THE QA SYSTEM**	

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	535042	A. BUILDING _____ B. WING _____	C 08/27/2014

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F 315 F 315 SS=D	Continued From page 31 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide appropriate and timely toileting for 1 of 12 sample residents (#62) with incontinence. The findings were: Observation of 8/25/14 at 10:34 AM showed CNA #1 and CNA #2 assisted resident #62 to his/her room to check the incontinence brief. While transferring the resident from the wheelchair to the bed, observation showed s/he was wearing pants that were visibly wet across the buttocks where urine had soaked through. Interview with CNA #2, at that time, verified the incontinence brief was saturated with urine. Further interview with CNA #2 revealed the resident was last toileted at 7:30 AM. CNA #2 also stated the resident required checking and changing every 2 to 2 1/2 hours. Review of the care plan updated on 4/28/14 showed the resident should be toileted before and after meals, every night at bedtime, every 2 hours during the night and PRN. During	F 315 F 315	The DNS/designee will conduct random observations during walking rounds to ensure staff is consistently providing assistance to the residents with their ADL's. The DNS shall report compliance trends identified during the monthly quality assurance meeting for the purpose of process improvement. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful **F323** **483.25 (h) Free of Accident Hazards/Supervision/Devices** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **CORRECTIVE ACTION** Electrical outlets in resident rooms #43, #36, #34, #33, and #44 have been replaced. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION**	10/7/14

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F 315	Continued From page 32 the interview with CNA #2, it was determined and she verified, the resident was not toileted after breakfast and the time span between being toileted was three hours.	F 315	The Maintenance Director/designee completed an audit of each resident room to identify any rooms in need of electrical outlet replacement which may fail to ensure a safe living environment.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility was free from accident hazards in 1 of 5 resident areas (locked secure unit). The findings were: Observation on 8/25/14 at 10:55 AM revealed the following electrical outlets in resident rooms that were in an unsafe proximity to where dementia residents would lay on their beds: a. Room #43 had an electric outlet on the back wall that jutted out over the bed 2 inches by the head of the bed . b. Room #36 had an electric outlet on the back wall by that bed that was by the head of the bed. c. Room #34 had an electric outlet on the back wall by that bed that was by the head of the bed. d. Room #33 had an electric outlet on the back wall that jutted out over the bed 2 inches by	F 323	**MEASURES TO PREVENT RECURRENCE** Housekeepers and Department Managers will be re-trained by the Maintenance Director/designee on or before 10/07/2014, re: entering identified items needing repair or replacement into the TELS system for timely repair and follow-up to ensure compliance with this measure. The Maintenance Director/designee will re-educate the staff, including Department Managers on or before 10/07/2014 re: the process for communication to the maintenance department of any identified repair/replacement concerns, to ensure items identified during rounds, in need of repair, are entered and documented for timely repair and follow-up. The Maintenance Director/designee will review the work/repair log five days weekly to ensure items in need of repair are corrected in a timely manner. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The maintenance director will monitor the work/repair log orders and corrections to ensure timely completion and compliance with this plan of correction.	10/7/14

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F 323	Continued From page 33 the head of the bed . e. Room 44 had an electric outlet on the back wall that jutted out over the bed 2 inches by the head of the bed . Interview with the maintenance director on 8/27/14 at 12:45 PM revealed he never thought of the electrical outlets in the resident rooms in the secure unit as a safety issue, but would re-evaluate them.	F 323	The maintenance director shall report any trends identified during the quarterly quality assurance meeting for the purpose of process improvement. The results of these audits shall be presented to the QA committee for analyzing this quality improvement measure for the effectiveness of the intervention, trends, recommendations for further corrective actions if necessary, and/or termination of monitoring if the intervention is successful.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 353	**F353** **483.30(a) Sufficient 24-hr Nursing Staffing per care plans** The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. **CORRECTIVE ACTION** Adequate staff are assigned to provide for the physical, psychosocial, and quality of life needs for residents #19, #22, #60, #62, #84, #102, #142, and two non-sampled residents #30, and #158.	10/7/14

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F 353	Continued From page 34 Based on observation, staff and resident interview, and medical record review, the facility failed to ensure adequate staff were assigned to provide for the physical, psychosocial, and quality of life needs for 7 of 21 sample residents (#19, #22, #60, #62, #84, #102, #142,) and 2 non-sample residents (#30, #158). The findings were: 1. Review of the 8/20/14 quarterly MDS assessment for resident #102 showed s/he required the extensive assistance of one person with both dressing and toilet use. Review of the resident's care plan, initiated on 6/9/13, showed the resident was at risk for impaired skin integrity related to urine incontinence. Interventions included "Staff will monitor my incontinence and keep me clean and dry..." Continuous observation of the resident on 8/24/14 from 5:15 PM until 9:50 PM showed s/he was wearing pants that were visibly wet across the buttocks and down the left leg as s/he left the dining room after dinner. The resident walked down the hall to his/her room and lay down on the bed. Observation at 5:45 PM showed the DON entered the resident's room, asked the resident if s/he needed help, but left without checking for incontinence. Observation at 9:10 PM showed CNA #7 entered the resident's room and asked if the resident would like helping changing his/her clothing. The resident expressed his/her hunger to the CNA, who then left to get the resident a snack. The CNA returned with a snack at 9:15 PM, then left without helping the resident to change clothing. The resident continued to sit/lay on his/her bed with soiled clothing. Observation at 9:40 PM showed RN #2 entered the resident's room and closed the door to provide cares, however, the resident was still in the same clothing and incontinent condition when	F 353	Resident #102 receives snacks when hungry. Resident #102 is receiving incontinence care to keep him clean and dry. Resident #22 is receiving assistance with incontinence care per the care plan. Resident #84 nails have been cleaned and she is receiving care with ADL'S as needed. Resident #19 is receiving assistance with oral care, and ADL's per his care plan. Non-sampled Resident #158 is receiving assistance with grooming prior to meal times. Resident #62 is receiving assistance with washing her hands before and after meals, toileting and incontinence care per the plan of care. Restorative Nursing is being completed as recommended for resident #142, including massage therapy for chronic neck and left shoulder pain, per plan of care. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents have the potential to be affected by this practice. Daily direct care staffing will be overseen by the DON/designee.	

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F 353	Continued From page 35 the RN left the resident's room at 9:50 PM. 2. Review of the 5/14/14 quarterly MDS assessment showed resident #22 was always incontinent of urine. Review of the resident's care plan for bowel and bladder function, last revised on 2/27/13,showed the resident was unable to recognize toileting urges and was incontinent. Care plan interventions included "Staff of 2 anticipate [resident name] needs: check her for incontinence Q AM [every morning], before/after meals, Q HS [every bedtime], and Q 2-3h [every 2 to 3 hours during the night], and PRN, change incontinence product/clothing when soiled, and provide peri care and additional barrier cream application as warranted...[s/he] is changed in bed." Continuous observation of the resident on 8/25/14 from 8:55 AM until 12:50 PM showed the resident was not checked for incontinence. At 12:50 PM, the resident was transferred from wheelchair to bed, but was not changed at that time (almost 4 hours). 3. Review of the 1/27/14 initial MDS assessment showed resident #84 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan updated 1/14/14 showed the resident was dependent on staff for all care with interventions to include anticipating all his/her needs on a daily basis. An additional intervention included staff should clean and trim the nails after each bath. According to the resident bath list, s/he last had a bath on 8/14/14. Observation on 8/24/14 at 6 PM was observed to have uncombed hair and his/her fingernails were encrusted with thick, brown matter. Observations on 8/25/14 from 8:45 AM to 12:26 PM and again from 6:45 PM to 9:03 PM, and at 10:30 AM on 8/27/14 showed the	F 353	**MEASURES TO PREVENT RECURRENCE** Nursing department has received benefit of in-service/training to deficient practice. The DON/designee will monitor staffing daily Monday through Friday, with the Nurse Manager On-Call for Saturday and Sunday providing oversight of the clinical staffing. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The DON/designee will monitor staffing daily Monday through Friday, with the Nurse Manager On-Call for Saturday and Sunday providing oversight of the clinical staffing. Direct reporting of staffing trends will be made to the Administrator. The DNS shall report compliance trends identified during the quarterly quality assurance meeting for the purpose of process improvement. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful	

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F 353	Continued From page 36 resident's fingernails remained encrusted with thick, brown matter. Interview with RN #1 on 8/27/14 at 10:30 AM verified she had noticed the resident's fingernails were dirty and needed to be cleaned. 4. Review of the 7/10/14 significant change MDS assessment showed resident #19 had severe cognitive impairment and required total assistance with personal hygiene. Review of the care plan last updated on 4/28/14 showed the resident had a deficit in self care performance and required staff assistance with ADLs. Interventions included on the care plan were: resident was edentulous (no teeth) and needs toothettes to clean the mouth and gums. In addition, the resident required assistance in combing his/her hair and washing and drying his/her face. Observation on 8/25/14 at 7:10 PM revealed staff did not offer to assist or provide oral care or washing of the resident's face and hands during bedtime care. Review of the facility policy and procedure on nursing care standards, reviewed in August 2011, showed "Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean, no less than AM/PM with care which consists of ...PM: washing face, hands, back, peri-area and apply lotion to back/legs." 5. Review of the 8/12/14 annual MDS assessment showed non-sample resident #158 required total assistance with personal hygiene and grooming. Observation on 8/24/14 at 6:55 PM showed the resident's hair was uncombed while at the dining table during the evening meal. 6. Observation of 8/25/14 at 10:34 AM showed CNA #1 and CNA #2 assisted resident #62 to	F 353		

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F 353	Continued From page 37 his/her room to check the incontinence brief. While transferring the resident from the wheelchair to the bed, observation showed s/he was wearing pants that were visibly wet across the buttocks where urine had soaked through. Interview with CNA #2, at that time, verified the incontinence brief was saturated with urine. Further interview with CNA #2 revealed the resident was last toileted at 7:30 AM. CNA #2 also stated the resident required checking and changing every 2 to 2 1/2 hours. Review of the care plan updated on 4/28/14 showed the resident should be toileted before and after meals, every night at bedtime, every 2 hours during the night and PRN. During the interview with CNA #2, it was determined and she verified, the resident was not toileted after breakfast and the time span between being toileted was three hours. Review of the initial and the 4/17/14 quarterly and the 7/11/14 annual MDS assessment showed resident #62 required extensive assistance with personal hygiene. Observations from 8/24/14 through 8/27/14 showed the resident never used silverware but always ate with his/her hands. Review of the physician's order dated 4/25/14 showed the resident should have his/her hands washed frequently. At no time during the observation of 3 meals, the evening meal on 8/24/14, breakfast on 8/25/14 and lunch on 8/27/14, did staff offer or assist the resident to wash his/her hands prior to or after eating. 7. Review of the 7/2/14 quarterly MDS assessment showed resident #142 suffered from chronic pain. Review of the resident's care plan revealed the resident was "constantly in pain." Care plan interventions included "[resident name] receives massage therapy from RNA [restorative	F 353		

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F 353	Continued From page 38 nurse aide] for shoulder pain." Review of restorative aide documentation for the month of August 2014 showed the resident was to receive "Massage neck and left shoulder at resident's request 15 min [minutes] 2 X [times] weekly." Further review showed the resident had received the massage only 4 times between 8/1/14 and 8/26/14, instead of the 7 times s/he should have. On 8/19/14 a notation indicated "RNA not done pulled to the floor." Interview with RN #3 on 8/26/14 at 4:10 PM revealed restorative aides had been been pulled from doing restorative work to working the floor "quite a bit" during the summer due to staffing issues. 8. Interview on 8/24/14 at 1:30 PM with resident #30 revealed 'sometimes they [the staff] don't answer the call light because they [the facility] don't have enough help." 9. Interview on 8/24/14 at 6:30 PM with resident #60 revealed "only 2 CNAs on the South Unit...not enough help for 50 odd residents...and when they [the facility] is short the bath aides get pulled...at least once a week." 10. Interview with CNA #11 on 8/26/14 at 4 PM revealed "sometimes the bath aide gets pulled [to work the floor] at least once a week...sometimes as much as three times a week."+ 11. On 8/27/14 at 10:40 AM, staffing concerns were discussed with RN #5 and the DON. RN #5 stated the facility was having a problem with hiring CNAs. He said they had been hiring NAs (nurse aides in training for CNA) as potential CNA staff, however, the RN said the NAs were not passing their CNA tests. Consequently, these employees were not qualified by training to	F 353		

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F 353	Continued From page 39 function as an independent CNA caring for residents.	F 353	**F356** **483.30(e) Posted Nurse Staffing Information**	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356	The facility must post the following information on a daily basis: • Facility name • The current date • The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: ➢ Registered Nurses ➢ Licensed Practical Nurses ➢ Certified nurse aides • Resident census **CORRECTIVE ACTION** The facility is posting the total number of nursing staff and their actual hours at the beginning of each shift worked. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** The NHA/designee has re-educated the SDC to post the total number of nursing staff and their actual hours at the beginning of each shift, including changes related to staffing changes. **MONITORING AND INCORPORATION INTO THE QA SYSTEM**	10/1/14

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F 356	Continued From page 40 Based on observation and staff interview, the facility failed to post the total number of nursing staff and their actual hours at the beginning of each shift worked for 4 of 4 days of observation. The findings were: Observation of the nurse staffing board on 8/24/14, 8/25/14, 8/26/14, and 8/27/14 showed it was posted for a 24-hour period instead of at the beginning of each shift as required. Interview with the staff development coordinator and staff coordinator on 8/27/14 at 4:45 PM verified the hours were posted for an entire day rather than at the beginning of each shift. Further, they said changes to the schedule based upon call-ins or changes in acuity or need were not noted on the postings until the following day prior to being filed.	F 356	The Director of Staff Development will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure finger foods were provided for 1 of 1 sample resident (#62) and 1 non-sample resident (#6) who were identified as needing finger foods. The findings were: Observation on 8/27/14 of the noon meal showed residents #62 and #6 received the regular menu served to other residents. The meal included rice as the starch portion of the meal. Both of these residents were to receive all finger foods. When	F 365	**F365** **483.35(d)(3) Food in Form to Meet Individual Needs** Each resident receives and the facility provides food prepared in a form designed to meet individual needs. **CORRECTIVE ACTION** Resident #62 and non-sampled Resident #6 are receiving finger foods. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No further residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** The registered dietitian/designee has re-educated the dietary staff regarding menu alternates for residents with orders to receive finger foods. The dietary manager in collaboration with the dietitian will ensure the menus contain appropriate finger food alternatives.	10/7/14

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F 365	Continued From page 41 RN #1 asked the dietary staff member to replace the rice with a finger food, the dietary aide said the only other choice was mashed potatoes because the kitchen had prepared no other starch alternative. The RN asked the dietary aide to obtain a finger food to replace the rice for these 2 residents a second time, and was again told by the dietary aide there were no other options available. The RN then told the dietary aide to return to the kitchen and ask them to prepare tater tots or french fries for residents #62 and #6. Interview with the RN at that time revealed she did not know why the residents did not receive their finger foods as usual.	F 365	The dietary manager/designee will ensure each meal prepared is served in accordance with residents' diet orders an in accordance to meet their individual needs. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The Dietary Manager will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice.	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to ensure an alternate meal was offered or provided to 1 of 1 sample resident (#19) who verbalized s/he did not like the meal provided. The findings were: Observation on 8/24/14 at 6:50 PM revealed resident #19 refused to eat the meal s/he was served. The resident kept repeating s/he "didn't like it." The resident further said the food "burned [his/her] mouth." Instead of offering the resident an alternative, staff placed a health shake in front of him/her and told the resident to drink the health shake. The resident received no other food	F 366	**F366** **483.35(d)(4)Substitutes of Similar Nutritive Value** Each resident receives and the facility provides substitutes offered of similar nutritive value to resident who refuse food served. **CORRECTIVE ACTION** Resident #19 is receiving meals in accordance with her/his preferences. The dietary manager completed a meal preference interview with Resident #19. Resident #19's meal card and care plan were reviewed and updated to reflect current preferences and interventions.	10/7/14

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F 366	Continued From page 42 during that meal. The resident was assisted to his/her room by CNA#3 on 8/24/14 at 7 PM. Interview with the CNA at that time revealed the reason she did not offer the resident an alternate meal was because she "didn't think about it."	F 366	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No other residents affected by this practice.	
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, staff and resident interview, the facility failed to offer bedtime snacks to residents on 1 of 5 units (East unit). The findings were: 1. Continuous observation of the East unit on 8/24/14 from 5:15 PM to 9:50 PM showed no bedtime snacks were offered to residents on that unit.	F 368	**MEASURES TO PREVENT RECURRENCE** The SDC/designee will re-educate the nursing staff on or before 10/07/2014, re: offering residents a nutritive equivalent alternate when the resident does not like their meal, requests something different or eats less than 50% of their meal. The facility completes meal preference interviews with residents on admission and quarterly and as needed. Resident tray cards and care plans are reviewed and updated to reflect changes in resident food preferences to ensure compliance with practice and resident preference. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The Dietary Manager will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practices.	10/7/14

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F 368	Continued From page 43 2. Review of the 5/21/14 annual MDS assessment for resident #102 showed that "snacks between meals" was "very important" to him/her. Observation of the resident on 8/24/14 from 5:15 PM to 9:50 PM showed no bedtime snack was offered to the resident. At 8:58 PM, the resident was heard to tell her roommate "I'm about to starve!" The roommate, resident #107 was heard to reply, "I'm hungry, too." At 9:10 PM, CNA #7 approached the resident and asked if s/he wanted help getting ready for bed. The resident and his/her roommate expressed their hunger to the CNA, who said she would "Check the snack box" and see what she could get for them. 3. Interview with resident #112 on 8/25/14 at 10:20 AM revealed s/he was not routinely offered a bedtime snack. 4. Interview with a group of 6 residents on 8/25/14 at 2 PM revealed that bedtime snacks were not offered to them. One resident stated it had been "months" since bedtime snacks were offered, and added "You can ask, but they don't always have anything." 5. Interview with CNA #8 on 8/27/14 at 9 PM verified the residents on the East Unit were not routinely offered bedtime snacks, and have to ask for them.	F 368	**F368** **483.35(f) Frequency of meals/snacks at bedtime** Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal meal times in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except: The facility must offer snacks at bedtime daily. **CORRECTIVE ACTION** Residents are being offered bedtime snacks on all units of the facility. The Dietary Manager will meet with Residents #102, #107 and #112 to ensure their needs related to snacks are being met. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** Residents residing on east unit are potentially affected by this practice. **MEASURES TO PREVENT RECURRENCE**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	The SDC/designee will re-educate the nursing staff on or before 10/07/2014, re: the procedure for passing and documenting bedtime snacks. Dietary staff will prepare and deliver ~~bedtime snack to each unit daily.~~	10/7/14

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F 371	Continued From page 44 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 5 food preparation/storage areas (the main kitchen). In addition, the facility failed to follow proper thawing procedures for liquid nutritional supplements in 2 of 5 food storage areas (rapid recovery dining, locked secure unit dining). The findings were: 1. Observation in the main kitchen on 8/26/14 from 2:20 PM through 4:20 PM revealed cook #1 was preparing the evening meal. The following concerns were identified: a. Observation showed the cook carried a large colander of pasta, the main entree for the evening meal, to a sink. The cook had gloves on, turned on the water, and used the sink hose to rinse the pasta. Without removing the gloves, the cook placed his hands in the pasta, mixed it, and transferred it to another container. Afterward, the cook removed the gloves, washed his hands, and re-gloved. Then he pushed a cart to the walk-in refrigerator, grabbed two large tubes of raw ground beef and placed them on the cart, and took them to the tilt table. He cut open the tubes of raw beef, and without changing gloves, placed his hands in and transferred the beef to the tilt table. b. Observation showed the ceiling above the	F 371	The DNS/designee will audit documentation validating that bedtime snacks have been offered. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** Licensed nurses will ensure residents are offered a bedtime snack and acceptance or refusal of snacks are documented. The Director of Staff Development will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice. **F371** **483.35(i) Food Procure, Store/Prepare/Serve – Sanitary** The facility must store, prepare, distribute and serve food under sanitary conditions. **CORRECTIVE ACTION** The Registered Dietitian/designee has re-educated Dietary Staff regarding kitchen sanitation, including proper glove usage including donning and removal. The ceiling above the main stove has been cleaned, the pipes for the fire suppression above the main stove has been cleaned and the missing chips of have been repaired.	

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F 371	Continued From page 45 main stove was soiled with food debris and grease. There was also grease on the pipes for the fire suppression system above the main stove, and the pipes had chips of paint missing. c. Observation showed 11 (1 foot by 1 foot) tiles in the food preparation area that had various cracks with blackened and dirty lines, with surfaces that were unable to be adequately cleaned. d. Observation showed the cook was wiping the food preparation area with a cloth from a bucket with quat (ammonia) solution. He then replaced the cloth in the bucket. The cook then took a food thermometer and temped the different foods being prepared. The cook washed the thermometer off in the sink, dipped the thermometer in the quat solution which contained the cloth used to sanitize the surface of the food preparation area, and temped the minestrone soup. The cook repeated the same process and temped the pasta. According to Food Code 2013, U.S. Public Health Service 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 8/24/14 at 5:25 PM in the Rapid Recovery dining room showed 12 (4 ounce) cartons of nutritional shakes in the refrigerator that were undated. Additional observation on 8/25/14 at 9:35 AM in the rapid recovery dining room showed 7 (4 ounce) nutritional shakes in the refrigerator undated. Observation on 8/24/14 at 5:45 PM in the locked secure unit dining room showed 23 (4 ounce) cartons of nutritional shakes in the refrigerator	F 371	Eleven tiles in the food preparation area with various cracks and blackened dirty lines, have been repaired and or replaced to allow for proper cleaning of the surface area. Nutritional Shakes are dated prior to dietary staff distributing to the facility units. Nursing staff are dating nutritional shake cartons when opened for use. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No residents affected by this practice. **MEASURES TO PREVENT RECURRENCE** The Registered Dietitian has re-educated dietary staff on 09/12/2014 regarding the process for Equipment-food contact surfaces and utensils; and nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. The Registered Dietitian/designee has re-educated the dietary department regarding kitchen sanitation, including proper glove usage including donning and removal. A cleaning schedule has been developed to ensure kitchen surfaces are clean and sanitary and the dietary staff have been re-educated by the Registered Dietitian/designee. The SDC/designee will re-educate the nursing and dietary staff to date the nutritional shake carton when the cart	

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F 371	Continued From page 46 that were undated. Additional observation on 8/25/14 at 12:05 PM in the locked secure unit dining room showed 17 (4 ounce) nutritional shakes in the refrigerator undated. According to the nutritional shake cartons, the shakes should be frozen, then when brought to the refrigerator for thawing the product is good for up to 14 days. Interview with the CDM on 8/27/14 at 9:44 AM confirmed facility staff should change gloves and re-wash hands properly when handling food. She also acknowledged the ceiling above the stove needed repainting in order to be an adequate surface for cleaning, and floor tiles should be intact for adequate cleaning. In addition, the CDM stated nutritional shakes should be dated when transferred to the refrigerator for thawing in order to determine if the shake is still adequate for consumption.	F 371	leaves the kitchen and again when the carton is opened for use. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The Registered Dietitian will complete kitchen sanitation audits monthly and as needed to ensure continued compliance with this plan of correction and kitchen sanitation protocol. The SDC will complete random audits of unit refrigerators to ensure nutritional shakes are dated when opened and discarded when expired. The Dietary Manager will report any trends not consistent with this plan of	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility satisfaction with meals. **F441** **483.65 Infection Control, Prevent Spread, Linens** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	10/7/14

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F 441	Continued From page 47 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of manufacturer's instructions, the facility failed to ensure infection control practices were practiced by staff on 2 of 5 resident units. The findings were: 1. Observation on 8/25/14 at 10:50 AM showed resident #142 was transferred from a shower gurney to bed after receiving a shower. The resident had a urinary catheter in place, and the urine collection bag was lying at the foot of the gurney, level with the resident's supine body. After the resident was transferred from the gurney to bed, the urine collection bag was laid at the foot of the bed, which was elevated. Urine was noted to be flowing backwards in the tubing	F 441	**CORRECTIVE ACTION** Infection Control is being practiced on resident units for all residents, including residents #142, #112, #62, #75, #129; to include shower and gurney disinfection. Resident #142 and #129 receives a shower on a shower gurney that has been properly disinfected, and in a shower room that has been properly disinfected. Residents #142 & #112's urine collection bag is kept at the proper level (below waist) at all times to prevent potential complications. Resident #62 is receiving assistance with washing her hands before and after meals per the care plan. Resident #75 is receiving medications administered per best practice and the facility's policy on Medication Administration. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No other residents were affected by this practice. **MEASURES TO PREVENT RECURRENCE** Licensed Nurses were re-educated on Medication Administration on 09/15/2014 by Omnicare Pharmacy.	

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F 441	Continued From page 48 toward the resident. CNA #9 and RN #4 proceeded to place a dressing on the resident's wound. At 10:58 AM, the CNA and RN proceeded to dress and groom the resident, placing soiled linens on top of the urine collection bag. Throughout the observation the urine collection bag remained above the level of the resident's bladder, with backflow noted. Interview with RN #4 at 11 AM confirmed the urine collection bag should be kept below the level of the resident's waist. 2. Observation on 8/25/14 at 12:44 PM showed resident #112 being transferred from the wheelchair to the shower gurney. The resident had a urinary catheter in place, and after being placed onto the shower gurney, the urine collection bag was placed on the gurney at the resident's feet, level with the resident's supine body. Interview with the infection control nurse on 8/27/14 at 6:15 PM confirmed it was the facility's expectation that urine collection bags be kept below the resident's waist level. 3. Review of the initial and the 4/17/14 quarterly and the 7/11/14 annual MDS assessment showed resident #62 required extensive assistance with personal hygiene. Observations from 8/24/14 through 8/27/14 showed the resident never used silverware but always ate with his/her hands. Review of the physician's order dated 4/25/14 showed the resident should have his/her hands washed frequently. At no time during the observation of 3 meals, the evening meal on 8/24/14, breakfast on 8/25/14 and lunch on 8/27/14, did staff offer or assist the resident to wash his/her hands prior to or after eating. 4. Observation on 8/27/14 at 9 AM showed LPN	F 441	SDC/designee re-educated direct care staff on Infection Control practices, on or before 10/07/2014, including: • Shower and shower gurney disinfection • Urine drainage bag positioning and management • Hand hygiene for staff • Cleaning resident's hands before and after meals. • Proper handling of medications when dropped. • Disinfection of Whirlpool type tubs. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** DNS, SDC, and Unit Managers will observe staff during cares for visual confirmation of proper infection control procedures, during daily walking rounds. The Infection Preventionist/designee will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice.	

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F 441	Continued From page 49 #1 administered medications to resident #75. The following concerns were noted: a. The resident dropped all the pills on the floor. The nurse did not know how many pills she was to administer to the resident, but gave him/her 18 pills off the floor, and did not check the Medication Administration Record (MAR) before allowing the resident to swallow the medication. b. The resident stated this happens "all the time," nurses hand the cup to the resident and leave the room, and then return to find the resident has spilled the pills onto the carpeted floor. c. Interview with the Infection Preventionist (IP) on 8/27/14 at 6:15 PM verified the expectation is to throw away the pills after they have been on the floor. 5. Observation on 8/25/14 at 9 AM showed CNA #10 showered resident #129 then transferred him/her to the wheelchair via the Hoyer lift. The following concerns were noted: a. The CNA sprayed VIREX TB product on the shower gurney cushions, and then proceeded to immediately wipe the product off the gurney. b. Instructions on the product stated "Formulated to disinfect hard non-porous environmental surfaces ...spray evenly over surface ...let product remain on surface for 3 minutes." c. Subsequent observations on the same day showed the CNA allowed a contact time of 15 seconds and 6 seconds. d. Observation on the same day at 10 AM revealed CNA #10 poured Classic Whirlpool disinfectant cleaner on the floor and washed the floor 15 seconds later. Review of the product's instructions stated "allow to remain wet for 10	F 441		

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F 441	Continued From page 50 minutes and then let air dry." During an interview with the CNA at the time of observation, she said "I pour some of the product out [an unknown quantity], and I leave the product on for 10 seconds, then I spray it down." e. Interview with the IP on 8/27/14 at 6:15 PM verified the expectation is to leave the product on the floor for a 10 minute wet time, and on the gurney for a 3 minute wet time before wiping the equipment down.	F 441	**F456** **183.70(c)(2) Essential Equipment, Safe Operating Condition** The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. **CORRECTIVE ACTION** The facility put the buffer out of service on 8/24/2014. The facility provides safe equipment for staff use.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure equipment used by staff was in safe operating condition. The findings were: Observation on 8/24/14 at 5:10 PM showed housekeeper #1 took a floor buffer to storage. The buffer had an attached tag that stated, "Danger, do not operate." Interview with the housekeeper at that time confirmed he had just used the buffer, and had used it other times during his employment of 3 months. He confirmed the Danger tag had been attached to the buffer for those 3 months. Interview on 8/27/14 at 11:15 AM confirmed the floor buffer with the Danger tag should not have been used as it was potentially a fire hazard.	F 456	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** No residents were affected by this practice. **MEASURES TO PREVENT RECURRENCE** The Maintenance Director/designee will complete safety checks on resident equipment, on or before 10/07/2014. Any equipment identified as a safety concern will be placed in Lock-Out/Tag-Out, and removed from the patient care area. The Maintenance Director/designee re-educated All Staff on the process of Lock-Out/Tag-Out, removing equipment in need of repair, and the process for reporting maintenance concerns on or before 10/07/2014. **MONITORING AND INCORPORATION INTO THE QA SYSTEM**	10/7/14
F 494	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO -	F 494		10/7/14

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	535042	A. BUILDING _____ B. WING _____	C 08/27/2014

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F 494 SS=D	Continued From page 51 TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the facility failed to provide adequate dementia orientation and training for the CNA staff who worked on the locked secure unit (west) for 2 of 5 CNAs (#3, #5) observed working on 8/24/14 and 8/25/14. The findings were: 1. Observation of CNA #3 during the evening meal on 8/24/14 revealed she used a curt and	F 494	Equipment will be safety-checked quarterly and as indicated during routine Maintenance Rounds. The Maintenance Director/designee will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice. **F494** **483.75(e)(2)-(3) Nurse Aide Work >4 mo – Training/Competency** A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program. **CORRECTIVE ACTION** The CNA Staff working the locked secure unit have received Dementia Training on or before 10/07/2014. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** Residents who reside on the locked secure unit have the potential to be affected by this practice. All nursing assistants assigned to work on the locked secured	

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F 494	Continued From page 52 harsh tone of voice to assist residents during their meals, telling them they must eat or "eat your food." In addition, observation of the CNA while providing care to non-sample resident #158 on 8/25/14 at 9:03 PM showed she laughed when the resident removed the hospital gown she had placed on the resident for bedtime. The CNA placed the hospital gown back on the resident even though the resident had said s/he wanted pajamas. The CNA said "oh these residents behaviors are so funny, they just make me laugh." Interview with the CNA on 8/25/14 at 6:52 PM revealed s/he had been assigned to the unit for approximately two months. She also stated she had received no specialized training on how to care for dementia residents but that she thought they were "funny" to work with. 2. Interview with CNA #5 on 8/24/14 at 6 PM revealed she had been assigned to the dementia care unit for only two days and had not been provided any specialized training on dementia care. The CNA indicated she was unfamiliar with the residents and how to work with them. 3. During an interview with the DON and RN #5 on 8/27/14 at 10:20 AM, RN #5 said all staff should treat all residents with respect and dignity regardless of the diagnosis or condition. Interview with the DON on 8/27/14 at 4:35 PM verified CNA staff had received no specialized training on care of residents with dementia.	F 494	unit will be educated on Dementia Training, on or before 10/07/2014. **MEASURES TO PREVENT RECURRENCE** The Hand-in-Hand Training Program will be utilized to train all nursing assistants on caring for residents who have dementia. The facility will provide Dementia Training upon hire to all new nursing assistant staff. The SDC/designee will re-educate staff on the proper manner in communicating with and about residents who have dementia, on or before 10/07/2014. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The SDC/designee will audit training records to ensure compliance with this dementia training practice, monthly until all nursing assistants have been trained. The SDC/designee will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice.	
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	**F514** 10/7/14 **483.75(l)(1) Res Records-Complete/Accurate/Accessible** The facility must maintain clinical records on each resident in accordance with	

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F 514	Continued From page 53 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to maintain complete and accurate medication administration records for all residents in the facility. The census at the time of the survey was 160. The findings were: 1. Review of medical records for all sample residents (#5, #18, #19, #21, #22, #29, #33, #35, #49, #60, #62, #67, #84, #86, #88, #102, #112, #118, #121, #127, and #142) showed MARs for the month of July 2014 were not available. 2. Interview with the facility administrator on 8/27/14 at 8:20 AM confirmed an issue with the facility's software, and that records of medication administration for the month of July, 2014 could not be viewed, printed or otherwise retrieved for any of the residents in the facility. The facility had communicated with their software vendor, and had been unable to resolve the problem.	F 514	accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **CORRECTIVE ACTION** The July 2014 MARS for residents #5, #18, #19, #21, #22, #29, #33, #35, #49, #60, #62, #67, #84, #86, #88, #102, #112, #118, #121, #127, and #142 have been obtained through PCC and printed. The software problem was remediated by PCC. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** Point Click Care was notified in early August 2014 that the facility was unable to view or print July 2014 MARS, and then contacted frequently up to and through the survey period via the support line to receive updates. PCC worked through the concern until remediated. All residents had the potential to be affected by this practice. **MEASURES TO PREVENT RECURRENCE** Medical Records will perform electronic data access audits twice monthly and report any inability to access data to the NHA and Point Click Care.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	**MONITORING AND INCORPORATION INTO THE QA SYSTEM**	10/7/14

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F 520	Continued From page 54 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, review of medical records, and facility policy and procedure, and review of the activity calendar, the facility failed to ensure the quality assessment and assurance program was effective in maintaining and sustaining improvement in repeating deficient practices identified and cited over the past four surveys. The findings were: The following concerns with the facility's quality assessment and assurance program:	F 520	Medical Records will report any trends not consistent with this plan of correction during the quarterly QA meeting for the purpose of process improvement. The quality assurance committee members will analyze data and make recommendations to improve facility practice. **F520** **483.75(o)(1) QAA Committee-Members/Meet Quarterly/Plans** The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. **CORRECTIVE ACTION** The facility has implemented a QAPI process to address the practices cited in the Annual Survey of 08/27/2014; including: • F241 • F248 • F282 • F312 • F315 • F323 • F371 • F441 • F520	

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F 520	Continued From page 55 1. Examples where resident dignity was not maintained during the 2014 survey is detailed in Federal citation F241. Deficient practice in regard to not maintaining dignity was also written in 2010 and 2011. 2. Examples where activities were not individualized or provided to residents during the 2014 survey is detailed in Federal citation F248. Deficient practice in regard to the activity program was written in 2010 and 2011 as well. 3. Refer to Federal citation F282 for evidence facility staff did not follow the care plan for residents during the 2014 survey as well as the 2010 and 2012 surveys. 4. Federal citation F312, toileting, grooming, and care/assistance with activities of daily living, was cited as a deficiency in 2010, 2011, 2012, and 2013. This personal care tag will again be cited in 2014. 5. Refer to Federal citation F315 for details regarding inadequate incontinence care cited in 2011, 2012, and again in 2014. 6. Federal tag F323 regarding providing supervision to prevent accidents was cited in 2010, 2011, and 2012. This citation will again be cited during this current survey. 7. Federal citation F371 regarding clean and sanitary conditions in the kitchen was cited in 2010, 2011, 2012, and will be cited again in 2014. 8. Federal citation F441 in regard to infection control deficient practice was cited during the	F 520	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents have the potential to be affected by this practice. The QA Committee will continue auditing the above F-Tag concerns until the next annual survey. **MEASURES TO PREVENT RECURRENCE** The QA process has been redeveloped into a new format that encompasses elements of a QAPI program. The QA Team and all staff will be educated on the QAPI process, on or before 10/07/2014. A process improvement will be developed following analysis of the trends, and reviewed for progress in the next QA meeting. **MONITORING AND INCORPORATION INTO THE QA SYSTEM** The QA Committee will gather data and report quarterly at the QA Meeting, analyze data and make recommendations to improve facility practice.	

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F 520	Continued From page 56 past four surveys and will be cited again during this current survey. 9. Finally, the quality assurance and performance improvement Federal citation, F520, is being cited during the 2014 survey and was also cited in 2011 and 2013. 10. Interview with the DON and RN #5 on 8/27/14 at 10:20 AM revealed these were areas being monitored as part of the quality assurance process. However, each of these areas continued to be cited as areas of deficient practice during the most current survey.	F 520		