STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	10/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00241249. This visit was in conjunction with the Investigation of Complaint IN00243838. Complaint IN00241249 - Substantiated. Federal/State deficiencies related to the allegations are cited at F312 and F353. Complaint IN00243838 - Substantiated. Federal/State deficiencies related to the allegations are cited at F353. Survey dates: October 11, 12, 13, 16, 17, 18, 19, and 20, 2017 Facility number: 000383 Provider number: 155721 AIM number: 100289610 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 4 Medicaid:33	F 0000	Preparation and or execution of this plan does not constitute admission 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 and or executed solely as required.	

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

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	Other: 2 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 30, 2017			
F 0159 SS=D Bldg. 00	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account,			

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	interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in			

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	addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on observation, interview, and record review, the facility failed to provide quarterly statements for 3 of 7 residents reviewed for personal funds. (Residents M, Y, and Z) Findings include: 1. The clinical record for Resident Z was reviewed on 10/12/17 at 1:45 p.m. The diagnoses for Resident Z included, but were not limited to, dementia and schizophrenia. The 7/17/17 Annual MDS (minimum data set) assessment indicated a BIMS (brief interview for mental status) was not completed, as Resident Z was rarely/never understood. A telephone interview was conducted with Family Member #17 on 10/12/17 at 2:07 p.m. Family Member #17 indicated she was Resident Z's representative for financial decisions and was her POA (power of attorney.) She reported the facility managed Resident Z's personal funds. She indicated the facility used to give her statements of how much money was in Resident Z's account, but hadn't received one "in some time." She referenced a statement from February, 2017. An interview was conducted with the BOM (Business Office Manager) on 10/13/17 at 1:21 p.m. She indicated she provided statements monthly to residents' POAs and guardians, but did not keep a log. She indicated Resident Z had an account, and Family Member #17 should receive statements.	F 0159	F159 1.The quarterly personal funds statement was provided to Residents M and Y, and to Resident Z's representative for financial decisions (POA). Resident Z's current address and contact information were updated. 2.Current personal funds statements were provided to all residents and or their representatives and copies retained in the business office for external review. The addresses and contact information for resident representatives was audited for accuracy and updates made as needed. 3.The regional director of operations inserviced the business office manager on 11-3-17 regarding personal funds management including the dissemination of quarterly statements to residents and or resident representatives. Between quarterly statements, residents and resident representatives may inquire about personal fund transactions and balances any time during posted business office hours. 4.The business office manager will provide a monthly accounting of resident personal funds to the administrator for review for the next six months. The results of	11/19/2017

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	The BOM provided Resident Z's August, September, and October, 2017 personal fund statements on 10/13/17 at 1:36 p.m. The three statements were addressed to Resident Z at an address other than Family Member #17's current address. The BOM indicated she was finding that a lot of information, as far as addresses, was not accurate, and she was currently in the process of updating that. She indicated Resident Z's statements should be going to Family Member #17's current address, but it didn't appear they had been. 2. The clinical record for Resident M was reviewed on 10/11/17 at 1:00 p.m. The diagnoses for Resident M included, but were not limited to, schizophrenia and hypertension. The 9/14/17 Quarterly MDS (minimum data set) assessment indicated Resident M had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An interview was conducted with Resident M on 10/11/17 at 1:59 p.m. She indicated she had a personal funds account with the facility, but the facility did not provide her statements. The last 3 statements for Resident M were requested from the BOM (Business Office Manager) on 10/13/17 at 1:57 p.m. She was sitting in front of her computer, and stated, "I can't pull anything up." She indicated Resident M was probably correct, in regards to not receiving statements, because she (BOM) was unable to pull any statements up on the computer for her. 3. The clinical record for Resident Y was reviewed on 10/12/17 at 11:00 a.m. The diagnoses for Resident Y included, but were not limited to, spinal stenosis. She was admitted to		these reviews will be on the agenda at the monthly QAPI committee meeting with oversight by the administrator and minutes forwarded to Corporate Compliance. If a threshold of 100% compliance is not achieved, action plans will be revised to ensure compliance.	

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	the facility on 3/1/17. The 9/14/17 Quarterly MDS (minimum data set) assessment indicated she had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An interview was conducted with Resident Y on 10/12/17 at 11:28 a.m. She indicated she had a personal funds account with the facility, but the facility did not let her know how much money she had in her account. An interview was conducted with the BOM (Business Office Manager) on 10/13/17 at 1:59 p.m., who provided the September and October, 2017 statements for Resident Y at this time. The BOM indicated Resident Y should be getting statements, but only 2 generated. She stated, "There's only 2 months for her. It's not pulling up anything prior to the September 1st (statement.)" The Resident Facility Trust Fund Policy and Procedure was provided by Administrator #2 on 10/13/17 at 3:00 p.m. It read, "The accounting department will issue a statement, on a quarterly basis, of all transactions to each resident or his/her Responsible Party Designee or Legal Guardian." 3.1-6(g)			
F 0223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY			

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Bldg. 00	SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 7 residents reviewed for abuse (Resident 26). Findings include: 1. The clinical record for Resident 26 was reviewed on 10/19/17 at 2:45 p.m. The diagnoses for Resident 26 included, but were not limited to, cerebral infarct, hemiplegia, diabetes and personality disorder. The 7/3/17 MDS (minimum data set) assessment indicated Resident 26 had a BIMS (brief interview of mental status) of 13, which was indicative of no cognitive impairment. During an interview with Resident 26, on 10/19/17 at 12:55 p.m., Resident 26 indicated CNA #4 called her "fat,"	F 0223	F223 1. The incident regarding C.N.A. #4 and resident 26 was identified during a QIS abuse interview conducted by the social worker during the survey. The allegation was brought to the attention of the administrator immediately and reported to the surveyor and ISDH via the Gateway portal. C.N.A. #4 was suspended pending an investigation which commenced immediately, including resident and staff interviews relevant to the investigation. C.N.A. #4 was subsequently terminated for failure to follow abuse policies and procedures. Social services has continued to follow Resident 26's psychosocial well-being with no concerns reported 2. All residents have the potential to be affected by this deficient practice. In the days immediately following the allegation, all interviewable residents were interviewed by the	11/19/2017

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	several times. She indicated she did not know what verbal abuse was until someone explained it to her. She now feels that she was verbally abused. The remarks upset her at the time. An Incident Report, dated 10/13/17, indicated, "Description added--10/13/17 During a social services interview with [name of Resident #47], she stated that [name of CNA #4] has a hateful attitude toward her roommate...Follow Up added--10/17/17 During a follow up interview conducted by the social worked with [name of Resident 26], the resident stated [name of CNA #4] has made remarks about the resident's weight and eating habits which the resident considered hurtful. During an interview conducted by the administrator with [name of Resident 26's] roommate, the roommate corroborated. [Name of CNA #4] denied making remarks that were hurtful. [Name of CNA #4] was terminated for failure to follow facility policies...." A MDS assessment, dated 8/23/17, indicated Resident 47's BIMS was 15, which was indicative of no cognitive impairment. Several documents were provided by Administrator #2, on 10/19/17 at 2:51 p.m. and included the following:		administrator and social services using QIS abuse questions to ensure residents have not experienced any inappropriate verbal communication with no further findings. 3. All staff were educated on verbal abuse and prevention by the administrator and regional director of operations during inservices conducted 10-11-17 through 10-17-17; and 10-30 and 10-31, 2017. Administrator will attend the Residents' Council meeting on 11-10-17 with permission, to encourage residents to report concerns immediately, and to discuss residents' rights regarding abuse, including verbal abuse. 4. To ensure the corrective action is monitored for compliance, a continuous sample of residents will be interviewed using QIS abuse questions tool by the social worker weekly for four weeks and monthly for six months to determine if residents had experienced any inappropriate verbal communication. If any concerns are identified, facility staff will ensure the resident is protected, the allegation is reported, and the allegation is thoroughly investigated by the administrator. The results of these audits will be reviewed by the QAPI committee overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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	-A Resident Interview and Resident Observation, for Resident #47, dated 10/13/17 at 9:30 a.m. It indicated, "Have you seen any resident here being abused-Yes...stated she has seen [name of CNA #4] be verbally abusive towards her Roommate [name of Resident #26]...." -An undated document that indicated, "...Res [Resident] states [name of CNA #4] told [name of Resident #26] to stop ordering [name of pizza restaurant]. Res states [name of CNA #4] has [sic] hateful [sic] attitude towards her roommate...." -An Interview with Resident #47, dated 10/16/17 and performed by Administrator #2. It indicated, "...5. Anything at all you want to tell me about?...[name of CNA #4] says mean things to [name of Resident #26]. Uncalled for. I told [name of Social Services Director] about it the other day. (referring to abuse protocol interview)...." -A document related to a telephone interview with CNA #4, dated 10/18/17. It indicated, "...[CNA #4] she stated she couldn't remember saying anything jokingly or otherwise. She stated she doesn't joke about anything. She stated 'This is a behavior place and your [sic] going to terminate me?' [name of CNA #4] could not think of a resident she may have offended; or anything she may have said that was offensive...."			

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	During an interview with Administrator #2, on 10/19/17 at 2:24 p.m., he indicated several investigations overlapped and new allegations surfaced during other investigations. Social Services interviewed Resident 26 and asked if anyone abused her. Resident 26 initially denied allegations of verbal abuse when she was asked. Social Services went back to reinterview Resident 26 with a different approach. During the interview, the SSD explained what verbal abuse was and Resident #26 confirmed the allegation about CNA #4 saying hurtful things. On 10/19/17, at 2:40 p.m., Resident 47 indicated CNA #4 told Resident 26 that she needed to quit ordering [name of a pizza restaurant], so that she could get up and move better. At 2:51 p.m., on 10/19/17, Administrator #2 indicated CNA #4 was terminated for verbal abuse towards Resident 26. During a telephone interview with CNA #4, on 10/19/17 at 2:58 p.m., she indicated the facility called her to ask her about allegations that surfaced during an abuse investigation. She indicated the facility told her that she was fired for talking about "somebody's attributes." She further indicated she never talked			

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	about the way someone looks. A policy titled Abuse & Neglect Policy, dated 8/5/16, was received from Administrator #2 on 10/12/17 at 1:42 p.m. It indicated, "...Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated...verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families or within their hearing distance, regardless of their age, ability to comprehend or disability...Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc, to assist in preventing resident abuse...." 3.1-27(4)(b)			
F 0226 SS=E Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:			

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	(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.			
	Based on interview and record review, the facility failed to implement its' abuse policy regarding timely reporting to the State Agency for 1 of 7 residents reviewed for abuse and 4 of 10 employees whose personnel files were reviewed for annual abuse training. Findings include: The clinical record for Resident V was reviewed on 10/13/17 at 11:45 a.m. The	F 0226	F226 1.The incident regarding Resident V, (previously investigated on 5/19-5/21, 2017, but not found on the ISDH Gateway as reported to ISDH), was reported to ISDH at the time of survey. QMA #5, C.N.A. #6, C.N.A. #30, and C.N.A. #31 received Abuse training during all staff inservices conducted 10-11-17 through 10-17-17; and 10-30 and 10-31, 2017. 2.All residents have the	11/19/2017

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	diagnoses for Resident V included, but were not limited to, chronic obstructive pulmonary disease and diabetes mellitus. A MDS (minimum data set) assessment, dated 8/9/17, indicated Resident V had a BIMS (brief interview of mental status) of 15, which was indicative of no cognitive impairment. During an interview with Resident V, on 10/12/17 at 3:06 p.m., he indicated he was abused when a CNA called his mom a derogatory term. The incident happened 5 months ago and he filed a grievance about the abuse. On 10/13/17 at 8:25 a.m., Administrator #2 indicated the verbal abuse allegation from Resident V was not reported to the State Agency. At 9:16 a.m., on 10/13/17, Administrator #2 indicated he located the grievance from Resident V and he will report the allegation to the State Agency. During an interview with Administrator #2, on 10/16/17 at 9:53 a.m., he provided an Incident Report to the State Agency and IDT notes. He indicated the facility reported the allegation to the State Agency and he considered it an allegation of abuse. The resident started calling the staff member a derogatory term and then		potential to be affected by this deficient practice. Grievances and incident reports for the past 30 days, potentially reportable, were reviewed by the administrator to ensure they were submitted to ISDH per policy with no findings to the contrary. Employee inservice records were audited and all employees received Abuse training during all staff inservices conducted 10-11-17 through 10-17-17; and 10-30 and 10-31, 2017. 3.All allegations of abuse will be reviewed by the administrator to ensure all components of the abuse policy are followed including timely reporting to the State Agency (using the "Abuse Prevention I/R/I Audit"), and staff training. Human resources will establish a log to track employee attendance at required inservice training, including Resident Abuse and Prevention. 4.To ensure compliance, the Administrator/Designee is responsible for the completion of the QAPI tool, "Abuse Prevention I/R/I" weekly times 4 weeks, monthly times 6 months, until continued compliance is maintained. The administrator will review required inservice attendance monthly for six months, including abuse training. The results of these audits will be reviewed by the QAPI committee overseen by the administrator and forwarded to corporate compliance. If threshold of 100%	

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LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

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	another resident stepped in defending the CNA. The real altercation was more between the 2 residents. The Incident Report, was dated 10/15/17. It indicated, "...Incident Date: 5/19/17...Description added--10/15/17... [name of Resident V] stated he filed a grievance that a C.N.A. called his mother a derogatory term. An Interdisciplinary Team Note, dated 10/21/17, indicated, "...CNA...told this writer that she informed resident that he had 1 cigarette. CNA stated that resident became verbally aggressive towards her calling her [derogatory terms]. CNA stated that she went to let resident back into building when resident tried to hit her after standing up from his wheelchair. CNA stated another resident tried to step between them. Resident was stated [sic] to then become verbally aggressive towards the other resident. CNA also stated resident grabbed another residents [sic] walker as if he was going to throw it.... A Grievance Form, dated 5/19/17, was received from the Social Services Director (SSD) on 10/18/17 at 9:35 a.m. It indicated, "...verbal assault by [name of CNA #4]. Using profanity and putting hands on myself. She called me [explicit		is not achieved an action plan will be developed to ensure compliance.	

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	terms] and my mother a derogatory term!!!...Grievance resolved in 5 day No...Admin et social services continues to speak [symbol for with] resident regarding matter voiced...." During an interview with the SSD on 10/18/17 at 11:48 a.m., she indicated she was not present during the actual event noted above, but was notified when she came in later that day and spoke with Resident V for a lengthy amount of time in regards to the event. She documented the event and conversations with Resident V, Resident 29 and Resident 13, whom was a witness. The SSD indicated the previous Administrator spoke with the CNA involved. Resident 29 no longer resides in the facility. The following interviews were provided by the SSD, on 10/18/17 at 12:16 p.m.: -An interview from CNA #4 dated, 5/21/17, indicated "...he then grabs...walker & starts swinging it, I tell him he better not hit me [symbol for with] that walker, [name of Resident 29] steps up & tells him the same thing [sic] he then directs his anger towards [name of Resident 29] stating he'd [explicit term] up [name of Resident 29][sic] he stood up out of his [symbol for wheelchair, symbol for 2 times] and approached [name of Resident 29], [sic] I			

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	stepped between the two...once insid [sic] he continues to call [name of Resident 29] & myself [derogatory terms]...he..stated..'I ain't thorough [symbol for with] you or you either [name of Resident 29].... -An interview with Resident 13, no date, indicated Resident V called Resident 29's mother a "derogatory term"...Resident 29 indicated his mother was not a "derogatory term" and then called Resident V's daughter a "derogatory term." During an interview with Administrator #2, on 10/18/17 at 12:26 p.m., Administrator #2 indicated the allegation/event should've been reported to the State Agency timely. He further indicated he needed to review the paperwork again to determine if these allegations/events were one in the same. The IDT notes were dated 5/21/17 and the SSD indicated she documented the event on the same day of resident to resident/CNA event and the grievance was dated 5/19/17 At 2:20 p.m., on 10/18/17, Administrator #2 indicated the handwriting on the grievance was the previous administrator's and he must've wrote the wrong date when he was filling it out.			

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	A policy titled Abuse & Neglect Policy, dated 8/5/16, was received from Administrator #2 on 10/12/17 at 1:42 p.m. It indicated, "...Purpose: To assure all unusual occurrences and allegations of abuse are reported to ISDH immediately by telephone and with written notice within 24 hours...Unusual occurrences are defined by ISDH as:...Verbal abuse-is defined as the use of oral, written and/or gestured language that willfully includes disparaging and derogatory terms to resident or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to:...Resident to resident verbal threats of harm.... 2. The Employee Records for QMA #5, CNA #6, CNA #30 & CNA #31 were reviewed on 10/20/17 at 11:00 a.m. The Employee Records form indicated the following staff and start dates: QMA #5-5/9/00 CNA #6-2/22/02 CNA #30-7/29/15 CNA #31-8/25/16. The employee personnel files included the following abuse inservice dates: QMA #5-8/26/16 CNA #6-8/26/16 CNA #30-3/28/16			

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	CNA #31-8/26/16 During an interview with the Business Office Manager, on 10/20/17 at 11:53 a.m., she indicated the facility was unable to determine if the above staff members had any abuse inservice training after the above dates. Individual Employee Time Cards for QMA #5, CNA #6, CNA #30 and CNA #31 were provided by the Business Office Manager on 10/20/17 at 12:03 p.m. They indicated all 4 staff members had worked over 15 hours per week since September 1, 2017. A policy titled Abuse & Neglect Policy, dated 8/5/16, was received from Administrator #2 on 10/12/17 at 1:42 p.m. It indicated, "...Annual resident rights and abuse prevention in-service training programs are conducted and it is mandatory that all personnel attend such training programs...." 3.1-28(a)			
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES			

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	(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on interview and record review, the facility failed to bathe a resident as he preferred for 1 of 4 residents reviewed for bathing (Resident K) Findings include: The clinical record for Resident K was reviewed on 10/18/17 at 2:45 p.m. The diagnoses for Resident K included, but were not limited to, diabetes mellitus and advanced degenerative joint disease. During an interview with Resident K, on 10/12/17 at 11:00 a.m., he indicated he had only received 3-4 showers since he was admitted to the facility in August of 2017. A MDS (minimum data set) assessment, dated 8/15/17, indicated it was somewhat important to Resident K to choose	F 0242	F242 1.Resident K was interviewed by the social worker utilizing the revised Resident Preferences Form and his bathing preferences were noted and will be honored. 2.All residents (and resident representatives as appropriate) were interviewed to determine bathing preferences, utilizing the revised Resident Preference Form. These preferences were updated in point of care EMR, the C.N.A. assignment sheet, and resident care plan. 3.As noted above, the Resident Preferences Form was revised to include mode of bathing. All nursing staff was inserviced on honoring bathing preferences and ADL bathing documentation week of 11-5-17. 4.Charge nurses will monitor the completion of bathing tasks, including whether preferences were honored, at each shift by	11/19/2017

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	between a tub bath, shower, bed bath or sponge bath. A Resident Preferences sheet for Resident K, no date, indicated, "When do you prefer to take a shower? Evening Wed/Sat...We offer two showers per week, is that sufficient for you? Yes...." A Bathing Report was provided by Nurse Consultant #1, on 10/19/17 at 10:20 a.m. It indicated CNA #6 provided some form of bathing on the following days: 10/1/17, 10/10/17, 10/11/17, 10/12/17, 10/14/17. During an interview with CNA #6, on 10/19/17 at 10:29 a.m., she indicated on the above days listed she gave him a bed bath, instead of a shower. She did not recall giving Resident K a shower since he was admitted. The Bathing Report also indicated CNA #13 provided some form of bathing on the following days: 10/2/17 & 10/3/17. During an interview with CNA #13, on 10/19/17 at 10:48 a.m., she indicated she had given him a complete bed bath on the		reviewing the point of care EMR and the shower sheets. The director of nursing will conduct point of care EMR audits weekly; and shower sheets weekly for six months and ongoing. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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	above days and had not given him a shower since he was admitted. During an interview with Resident K, on 10/19/17 at 11:48 a.m., he indicated he preferred showers but he has mostly been getting bed baths. No one had ever asked him specifically if he prefers to get a bed bath or a shower. At 3:14 p.m., on 10/19/17, during an interview with Nurse Consultant #1, she indicated the the Resident Preference form does not capture the Resident's preference for showers or bed baths. She further indicated the facility did not have a method to capture how the resident was bathed, whether it was a bed bath or shower. On 10/19/17 at 3:14 p.m., the Social Services Director indicated the Resident Preference form does not capture the Resident's preference for showers or bed bath, but she will ask follow up questions to see what the Resident prefers. She did not interview Resident K about his bathing preference so she was not sure if follow up questions were asked to ensure Resident K was being bathed per his preference. 3.1-3(v)(1)			

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F 0244 SS=E Bldg. 00	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. Based on observation, interview, and record review, the facility failed to ensure residents concerns were addressed timely for 5 of 39 residents that are alert and attend monthly resident council meetings. (Residents 6, 13, 20, 26, 31, 33, 40, 46) Findings include: An interview was conducted with the	F 0244	F244 1.The administrator called a Residents' Council meeting, with the approval of the Council president, on 11-10-17, at which time he renewed the facility's commitment to reviewing and acting promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the facility. 2.At the meeting, the	11/19/2017

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	Resident Council President on 10/11/17 at 11:40 a.m. She reported the residents discuss their concerns, but the concerns are not being addressed. The staff write on the paper resolutions, but nothing changes. 1a. The July, August, September 2017, Resident Council minutes were provided by the Activities Director on 10/18/17 at 10:41 a.m. The July Resident Council minutes indicated, "...Resident Council Action Form... Department Assigned: Administration (checked marked)...Complaints/Concerns: Who is responsible for putting out gloves in the residents rooms?....Concern Response/Resolution: ...Nursing administration is placing the gloves in the room...Date Resolved 8/2/17 Signature of Department Manager: (signed by Administrator)..." The September, Resident Council minutes indicated, "...Resident Council Action Form...Department Assigned..Administration (checked marked)...Complaints/Concerns:...4. Admin (administration) stated Nursing is to pass out gloves. Still not being done....Concern Response/Resolution: (nothing written with no date resolved or signature)..."		administrator elicited a list of concerns both past and present, unresolved or new, from all in attendance (including distribution of gloves and notification of ancillary practitioner visits). 3.The grievance policy and procedure was revised to include the following: All resident suggestions and concerns voiced by the Residents' Council will be recorded by the activity director, who attends by invitation, and brought to the attention of the administrator as soon after the meeting as practical. Those things that can be acted upon immediately will be enacted. Those things requiring an inter/intra-departmental response will be assigned to a department manager responsible for forming a performance improvement plan (PIP). A follow up response will be required within five days. The resolution/action taken will be reported at the next scheduled Residents' Council meeting. Gloves will be stored in the utility room, accessible to staff at all times. The director of nursing or designee will check for availability of gloves during room rounds, Monday/Wednesday/Friday. A notice of the ancillary practitioner visits will be posted by social services in advance on the resident bulletin board outside the MDS office. Social services is responsible for maintaining a list of residents in need of ancillary practitioner services and	

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	An observation was made on 10/16/17 at 11:00 a.m., of Residents 20, 33, 13, 6, 31, and 40's rooms. There was no observation of gloves in the rooms. An observation was made on 10/16/17 at 2:50 p.m., of Residents 20, 33, 46, 26, 13, 6, 31, and 40's rooms. There was no observation of gloves in the rooms. An interview was conducted with the Activities Director on 10/18/17 at 8:52 a.m. She reported Resident Council Meetings are held once a month. She stated concerns on the action forms are gone over with the Administrator prior to the morning meeting, and then they are gone over with the staff in the morning meeting. Activities Director indicated the action forms are given to the staff person assigned, and then he or she gives it back with a resolution and signed. An interview was conducted with Resident 3 on 10/18/17 at 11:55 a.m. He reported there was never enough glove supply in the building. He stated he does not have gloves placed in his room often. An interview was conducted with Resident 26 on 10/18/17 at 11:50 a.m. She stated she had not seen an improvement with the gloves being placed in the rooms. At that time, an		providing the list to the practitioner. 4.To monitor and ensure compliance, all Residents' Council concerns and suggestions, including action plans (PIPs) and resolutions, will be added to the monthly QAPI meeting agenda and remain on the agenda and reviewed for a period of six months or until compliance is maintained.	

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	observation was made of Resident 26's room, and there was no gloves in her room. An interview was conducted with the Administrator 3 on 10/18/17 3:00 p.m. He indicated after reviewing the Resident Council Action forms for July, August, and September he was unaware of gloves not being placed in the residents' rooms. He reported the action forms are suppose to be taken to the department meeting and given to the department staff person by the Activities Director. Then the concern would be addressed, and the resolution would be written on the form. He indicated the staff person that addressed the concerned would signed the action form. Administration 3 stated the concern would have a resolution prior to the next Resident Council Meeting, so the residents would be aware. 1b. The August, resident council minutes indicated, "...Resident Council Action Form..Department Assigned:...Social Services (checked marked)...Complaints/Concerns: When the doctors (eye, foot, dentist) come can it be posted 3 days in advance?..Concerns Response/Resolution: This writer will comply with residents request for ancillary doctor visits to be posted @ least 3 days in advance. Will also ask			

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	residents 1 week prior to ancillary doctors visit in case a resident needs to be added to the list to be seen...Date Resolved 8/30/17...Signature of Department Manager: (signed by the Social Services Director)..." The September, resident council minutes indicated "...Resident Council Action Form...Department Assigned...Social Services (checked marked)...Complaints/Concerns:...The eye Dr and (name of physician) were here and we were not notified...Concern Response/Resolution:..Working on new system to notify residents of upcoming doctor visits which will include posting in @ least 3 areas of building and personally notifying those who are unable to view those notices...Date Resolved: 10/9/17..Signature of Department Manager: (signed by the Social Services Director)..." An interview was conducted with the Social Services Director on 10/18/17 at 10:48 p.m. She reported she was still working on a system to let residents know when the doctors would be in the facility. She stated she did plan to place signs up prior to doctors and ancillary visits, but had not done it yet. Social Services Director provided a form			

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	on 10/19/17 at 10:10 a.m., indicating the following dates, the physician and ancillary services were in the facility: dentist: 9/15/17 eye doctor 9/25/17 physician: 9/28/17 A grievance policy was provided by the MDS (Minimum Data Set) Coordinator on 10/19/17 at 9:30 a.m. It indicated "...Policy: It is the policy of this facility to ensure the resident to voice grievances is done without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and prompt efforts by the facility to resolve grievances the residents may have, including those with respect to the behavior of other residents. the intent of the regulation is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to ensure that after receiving a complaint/grievance the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. "voice grievances" is not limited to a formal, written grievances process but may include a resident's verbalized complaint to facility staff. To ensure prompt efforts to a			

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	resolution of grievances process but may include a resident's verbalized complaint to facility staff. Procedure: To ensure prompt efforts to a resolution of grievances, the facility shall initiate the following steps: 1. The facility will not take resident complaints/comments/concerns lightly or pass off as 'The resident ALWAYS complains" 2. The facility will document the following information [contained within the 'Grievance/Complaint Report']...5. Social Service to review resident council meeting minutes to determine if the complaint being addressed has been previously verbalized by residents and subsequently resolved..." 3.1-3(l)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.			

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	(i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			
	Based on interview, and record review, the facility failed to ensure accuracy of a MDS (minimum data set) assessment for 1 of 3 residents reviewed for ADL (Assisted Daily Living). (Resident M) Findings include: The clinical record for Resident M was reviewed on 10/12/17 at 1:30 p.m. The diagnosis for Resident included, but was	F 0278	F278 1.The MDS for Resident M was reviewed and the coding for Resident M's abilities for locomotion on the unit was corrected. 2.All resident MDSs were reviewed to ensure coding reflected the resident's status with locomotion on the unit. 3.The MDS coordinator was inserviced on ADL coding, including locomotion status, by the regional nurse responsible for	11/19/2017

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	not limited to: paraplegia. An annual MDS assessment dated 4/26/17, indicated Resident M was total dependence (staff performs all the activity) and needed 2 person assistance with locomotion on unit (resident moves in room, in wheelchair and on same floor). A quarterly MDS assessment dated 7/27/17, indicated Resident M was extensive assistance (resident assists in activity) and needed 2 person assistance with locomotion on unit (resident moves in room, in wheelchair and on same floor). . An interview was conducted with Qualified Medication Aide (QMA) 5 on 10/18/17 at 11:34 a.m. She stated Resident M has never been extensive assistance in wheelchair. She reported Resident M can not propel self in wheelchair due to her disability. An interview was conducted with MDS Coordinator on 10/19/17 3:22 p.m. She reported the coding on locomotion on the unit for Resident M's July quarterly assessment was coded incorrectly. She stated Resident M was a total dependence on locomotion on the unit.		MDS coding training on 10-31-17. 4.The MDS coordinator is responsible for accurate and timely MDS assessment documentation. The RN certifying the completion of the assessment will review ADL coding for the MDSs generated for three months, and a sample of MDSs for an additional three months. The results of these audits will be reviewed by the QAPI committee overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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	3.1-31(g)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--			

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	(i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals			

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	in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to include a resident to her care plan meetings for 1 of 3 residents reviewed for participation in care planning and the facility also failed to revise a dialysis care plan for 1 of 1 residents reviewed for dialysis. (Resident L and Y). Findings include: 1. The clinical record for Resident Y was reviewed on 10/12/17 at 11:00 a.m. The diagnoses for Resident Y included, but were not limited to, spinal stenosis. She was admitted to the facility on 3/1/17. The 9/14/17 Quarterly MDS (minimum data set) assessment indicated she had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An interview was conducted with Resident Y on 10/12/17 at 11:19 a.m. She indicated staff did not include her in	F 0280	F280 1.Resident Y was invited and attended a care plan meeting on 11-8-17. 2.The social worker, responsible for inviting residents and or their representatives to the care plan meeting, audited all invitations made during the past ninety days and there were no further missed opportunities identified. 3.The social worker was inserviced on the policy and procedure for care plan invitations and documentation by the regional director of operations on 11-3-17. Care plan invitations will be hand delivered to residents who would attend on their own behalf; and mailed or emailed to resident representatives. Evidence of the invitation will be maintained in the social services office. Residents, resident representatives, and staff who attend a care plan meeting will sign an attendance sheet at the time of the meeting. 4.The administrator will review the invitations sent on a weekly basis for one month, and monthly for five months. The results of	11/19/2017

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	decisions about her medicine, therapy, or other treatments, nor was she invited to her care plan meetings. The clinical record for Resident Y did not reference invitation to her care plan meetings. An interview was conducted with the SSD (Social Services Director) on 10/17/17 at 10:44 a.m. She indicated residents are invited to their care plan meetings. She spoke to the residents, invited them verbally, and gave them a care plan letter. She indicated she would make a copy of the letter, and place it in the resident's clinical record. She indicated care plan meetings were held quarterly, and invitations were supposed to be given to the resident quarterly. She indicated care plan sign in sheets were kept in care plan binders at the nurses station, and residents and family members signed it, if they attended. On 10/17/17 at 10:46 a.m., the SSD reviewed Resident Y's clinical record and stated, "I don't see an invitation in here for her." The care plan sign in sheet, located in the care plan binder at the nurses station, was reviewed with the SSD on 10/17/17 at 10:52 a.m. The 3/16/17 meeting did not		these audits will be reviewed by the QAPI committee overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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	include a signature for Resident Y, only staff members. The 6/15/17 meeting did not include a signature for Resident Y, only staff members. There were no signatures at all for September, 2017. An interview was conducted with the SSD on 10/17/17 at 10:53 a.m. She indicated there should have been a care plan meeting in September, 2017 for Resident Y. The Care Plan Meetings and Invitations policy was provided by the SSD on 10/17/17 at 11:42 a.m. It read, "It is the Policy of this Facility to invite the Residents and/or their Responsible Party to their Care Plan meetings....The Social Service Director shall record sent invitations in the Social Service Progress Note or, on the Care Plan Invitation Log each week. Both the Resident and their Responsible Party will be asked to sign an Attendance Sheet during the Care Plan Meeting to prove their attendance." 2. The clinical record for Resident L was reviewed on 10/19/17 at 10:45 a.m. The diagnoses for Resident L included, but were not limited to, end stage renal disease, epilepsy, hypertension and tremor. A Dialysis care plan, dated 1/12/16 and remained current at the time of review,			

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	indicated an intervention of "...Resident receives dialysis at [name of dialysis center] on Monday-Wednesday-Friday...." During an interview with QMA #5 , on 10/19/17 at 12:20 p.m., she indicated Resident L received dialysis on Tuesday, Thursday and Saturday. A policy titled, Care Plans-Comprehensive, dated 9/2014, was received from the Director of Nursing on 10/19/17 at 3:40 p.m. It indicated, "...8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change...." 3.1-35(d)(2)(B) 3.1-35(c)(2)(C)			
F 0312 SS=D Bldg. 00	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and	F 0312	F312	11/19/2017

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	record review, the facility failed to provide bathing, as care planned, for 2 of 3 residents reviewed for activities of daily living. (Resident S and Z) Findings include: 1. The clinical record for Resident Z was reviewed on 10/12/17 at 1:45 p.m. The diagnoses for Resident Z included, but were not limited to, dementia and schizophrenia. The 7/17/17 Annual MDS (minimum data set) assessment indicated a BIMS (brief interview for mental status) was not completed, as Resident Z was rarely/never understood. It indicated she was total dependence of one person for bathing. A telephone interview was conducted with Family Member #17 on 10/12/17 at 1:55 p.m. She indicated Resident Z did not receive the same number of baths/showers in a week as she did in the past. She indicated, the last time she saw Resident Z, in August, 2017, her clothes were dirty and her hair was greasy. The 7/25/17 bathing, dressing, and personal hygiene care plan indicated Resident Z was dependent on staff for bathing. The goal was for her to be		1.Personal preference questionnaires were completed for Residents S and Z as to their preferred mode(s) of bathing, time, and frequency. These preferences were updated in point of care EMR, the C.N.A. assignment sheet, and resident's care plan. 2.Personal preference questionnaires were completed for all residents as to their preferred mode(s) of bathing, time, and frequency. These preferences were updated in point of care EMR, the C.N.A. assignment sheets and residents' care plans. 3.All nursing staff were inserviced on honoring resident bathing preferences (mode, time, frequency) the week of 11-5-17. Should a resident refuse or their condition be such that a deviation in preference or schedule is needed, the charge nurse will be informed. 4.Charge nurses will monitor the completion of bathing tasks at each shift by reviewing the point of care EMR and the shower sheets. The director of nursing will conduct point of care EMR audits weekly; and shower sheets weekly for six months and ongoing. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100%	

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	appropriately bathed every day. Interventions were to provide staff assist with a full body sponge bath on her non-shower days, to provide staff assist with a shower and shampoo 2 times weekly, and to chart care provided on her adl (activities of daily living) flow sheet everyday. The Shower List Evening Shift-Front schedule, updated 8/3/17, located in a binder at the nurses station, was reviewed on 10/16/17 at 11:26 a.m. It indicated Resident Z's shower days were Tuesdays and Fridays. There were shower sheets included in the binder, but none for Resident Z. On 10/16/17 at 2:36 p.m., the DON (Director of Nursing) provided September and October, 2017 bathing logs for Resident Z. There was no bathing verification for the following days: 9/5/17, 9/9/17 through 9/12/17, 9/14/17 through 9/20/17, 9/22/17 through 9/24/17, and 10/3/17 through 10/15/17. An interview was conducted with the DON on 10/16/17 at 2:50 p.m. She indicated Resident Z should be provided showers on Tuesdays and Fridays, with bathing in between as needed, but not daily. She indicated she was unaware of Resident Z's care plan to provide a full		is not achieved action plans will be revised to ensure compliance.	

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	body sponge bath on her non-shower days.2. The clinical record for Resident S was reviewed on 10/12/17 at 11:30 a.m. The diagnosis for Resident included, but was not limited to: dementia. A care plan date initiated on 2/18/16, indicated "....Name of resident (Resident S)has an ADL Self Care Performance Deficit r/t (related to) Fatigue and Limited Mobility was loss of balance r/t his left AKA (above knee amputation) and age related debility...Goal. name of resident (Resident S) will be assisted up in his w/c (wheelchair) daily as tolerates desires and be appropriately bathed, dressed and groomed every day through the next review date....Interventions. Assist with a full body sponge bath on his non-shower days..." A shower binder indicated "Shower Sheets are to be filled out daily. Fill out sheets for scheduled, unscheduled and refused showers and bed baths. Sheets are to be turned into the charge nurse. (Do not leave filled out sheets in the book.)..." The shower list indicated Resident S's scheduled shower days were Tuesdays and Fridays. An interview was conducted with Family Member 10 on 10/12/17 at 11:49 a.m. She indicated Resident S did not appear			

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	to be clean. She reported she had seen his head and neck dirty, and at times he had an odor. Family Member 10 stated during a visit, she had turned Resident S over and had seen food particles all over the sheets. The August, September, and October bathing reports for Resident S were provided by the MDS (Minimum Data Set) Coordinator on 10/17/17 at 9:49 a.m. It indicated the following days Resident S had not received bathing: August: 8/2/17 - bathing provided: response on report - not applicable 8/5/17 - bathing provided: response on report - not applicable 8/26/17 - bathing provided: response on report - not applicable 8/28/17 - bathing provided: response on report - not applicable September: 9/2/17- bathing provided: response on report - not applicable 9/3/17 - bathing provided: response on report - not applicable 9/25/17 - date was not on report 9/26/17 - date was not on report 9/29/17 - date was not on report October			

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	10/5/17 - bathing provided: response report - not applicable 10/8/17 - date was not on report 10/10/17 - date was not on report 10/14/17 - bathing provided: response report - not applicable 10/15/17 - bathing provided: response report - not applicable An interview was conducted with the Nurse Consultant 1 on 10/18/17 at 3:25 p.m. She indicated she could not locate shower sheets for the missing dates or the dates the staff documented as not applicable on the bathing report. She also indicated hospice had sent over a report when their staff was in the building to provide bathing care, and the days hospice aides were in the building were not on the days that were either missing or documented not applicable. The Shower/Tub Bath policy was provided by the MDS Coordinator on 10/17/17 at 9:49 a.m. It read, "The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath....5. If the resident refused the shower/tub bath, the reason(s) why and the intervention			

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	taken." This federal tag relates to Complaint IN00241249. 3.1-38(b)(2)			
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to follow plan of care with catheter care for 1 of 1 residents reviewed for urinary catheter. (Resident M) Findings include: The clinical record for Resident M was reviewed on 10/12/17 at 1:30 p.m. The diagnosis for Resident included, but was not limited to: paraplegia. A physician order dated 3/27/15, indicated staff was to irrigate Resident M's foley catheter as needed with 30 milliliters of normal saline due to low urinary output or urinary leakage. The October 2017, TAR (Treatment Administration Record) indicated there were no staff signatures irrigation of Resident M's foley catheter was provided.	F 0315	F315 1.Resident M was seen by the nurse practitioner on 10-16-17 related to her urine output and possible urinary tract infection. A UA C&S was ordered. The following day nursing staff noted a change in condition, physician notified, and resident was sent to the hospital where nephrostomy tubes were inserted. Resident returned on 10-29-17. Resident M's care plan was updated to reflect her current needs. 2.Two residents receiving catheter care were assessed by the director of nursing to ensure appropriate catheter care was being rendered and no concerns were noted. 3.Licensed nursing staff were inserviced on catheter care including irrigation, recording input/output, and signs and symptoms of related maladies the week of 11-5-17. 4.The director of nursing/designee will review the MARs and TARs for catheter care and I/O documentation weekly for	11/19/2017

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	A October 2017, "Comprehensive Intake and Output Record" indicated the following days and shifts no urine output was recorded for Resident M: 10/10/17 - evening and night shift 10/11/17 - evening and night shift 10/12/17 - evening and night shift 10/13/17 - day, evening, and night shift 10/14/17 - day, evening, and night shift 10/15/17 - evening shift 10/16/17 - evening and night shift An interview was conducted with Qualified Medication Aide (QMA) 5 on 10/19/17 at 11:00 a.m. She indicated she had worked with Resident M on Saturday, Sunday, and Monday on day shift. Resident M's urine output was low, but catheter was leaking. She reported Resident M's bed was wet, so it was hard to determine her urine amount. She indicated Resident M's urine appearance was dark and cloudy from what urine she had seen collected in the catheter bag. QMA 5 had reported to the agency staff nurse Resident M's catheter was leaking. An interview was conducted with Certified Nursing Assistant (CNA) 6 on 10/20/17 at 8:45 a.m. She reported she did take care of Resident M on Saturday and Sunday on days. She stated she did not have to empty Resident M's urine catheter, because there was no urine in		2 months and bi-monthly for four months until continued compliance is maintained. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	the bag. CNA 6 indicated Resident M was wearing a brief, and it was soiled. She stated the agency staff nurse was in the room with her during care, and at that time had not done anything to the catheter. An interview was conducted with License Practical Nurse (LPN) 15 on 10/22/17 at 8:50 a.m. She indicated she had taken care of Resident M on Sunday evening and Monday morning. She reported she had only worked at the facility a couple of times, so she wasn't too familiar with the residents. LPN 15 stated Resident M was alert and oriented. She indicated Resident M had stated to her that the catheter leaking was normal. Resident M wore a brief which was soiled. LPN 6 reported she did not irrigate Resident M's catheter. An interview with the Director of Nursing (DON) on 10/20/17 at 10:52 a.m. The DON reported she had known Resident M was going to have a urinalysis due to possible urinary tract infection, but did not know her catheter was leaking with minimal urine collection in the bag. She stated Resident M's catheter had been changed September 28th. An interview was conducted with the			

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	Nurse Practitioner (NP) 50 on 10/20/17 at 12:13 p.m. She indicated she had went in and seen Resident M on Monday. NP 50 reported Resident M was alert and oriented at that time. NP 50 stated Resident M had indicated she believed she had a UTI (urinary tract infection). NP 50 reported she had discussed with Resident M about a urostomy due the catheter leaking, because Resident M had mentioned the catheters leak. NP 50 indicated Resident M refused the option of an urostomy. She reported during the assessment with Resident M she had lots of covers on, but her skin was not sweaty with touch. NP 50 indicated Resident M's catheter bag was empty and there was sediment observed in tubing. Resident M had stated to her that her catheter had been replaced not too long ago. NP 50 indicated she had ordered a urinalysis. 3.1-41(a)(1)			
F 0318 SS=D Bldg. 00	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services			

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	to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure a plan of care was followed for splinting and range of motion for 1 of 2 residents reviewed for range of motion (Resident C). Findings include: The clinical record for Resident C was reviewed on 10/13/17 at 2:35 p.m. The diagnoses for Resident C included, but were not limited to, hemiplegia, abnormal posture and unspecified lack of coordination. During an interview with the MDS Coordinator, on 10/12/17 at 2:06 p.m., she indicated Resident C had a contracture of his left hand and he does not wear a brace or receive therapy services since he refuses. A Range of Motion care plan, dated 9/14/16 and remained current at the time of review, indicated, "...Provide PROM	F 0318	F318 1.Resident C was assessed by the Occupational Therapist for evaluation and treatment and is currently on therapy case load. 2.There are no other residents currently using splint devices. 3.Nursing staff was inserviced week of 11-5-17 by the rehab department on restorative nursing including splint devices. 4.The MDS coordinator who oversees the restorative program will check splinting devices daily for application and related documentation for one month and monthly for six months and ongoing. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	11/19/2017

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	[passive range of motion] as ordered on his restorative program...Provide skin care to left hand and pat dry prior to applying left hand cone [symbol for each] day...." A Restorative Care Plan and Charting for PROM, indicated the goal: Resident will tolerate 10 reps x 2 sets of passive range of motion exercises as stated on restorative nursing program though next review...." It indicated Resident C refused the following dates: 10/2/17-p.m. 10/3/17-p.m. 10/4/17-p.m. 10/5/17-a.m. 10/5/17-p.m. There was no other documentation on the chart to indicate the PROM was completed or refused for the other unlisted days between 10/1/17-10/17/17. The Restorative Care Plan and Charting for Dressing/Grooming, indicated the goal: Resident will be able to perform the following tasks:"...Wash face with cupping of his hand or with support of his elbow while he is holding a wash cloth after each meal through the next review..." It indicated Resident C refused the following dates: 10/2/17-p.m. 10/3/17-p.m.			

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	10/4/17-p.m. 10/5/17-a.m. 10/5/17-p.m. There was no other documentation on the chart to indicate the goal was completed or refused for the other unlisted days between 10/1/17-10/17/17. An ADL/Total Assistance care plan, dated 6/19/17 and remained current at the time of review indicated the intervention, "...Chart refusal of care and/or agitation/delusions on his Behavior Flow Sheet for MD review...." The Behavior Management Record for October 2017, did not indicate any refusals of care. An Occupational Therapy Discharge Summary, dated 7/1/16, indicated, "...To facilitate patient maintaining current level of performance and in order to prevent decline...L [left] hand palm protector and ROM (Passive). PROM to be completed prior to application of L hand palm protector roll. Pt to wear L hand palm protector roll after breakfast for up to 3 hours and after dinner for up to 3 hours. Pt to wear the L hand palm protector roll daily if he allows staff to place it on his L hand...." During the following observations,			

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	Resident C was observed without a splint on: 10/12/17 at 10:15 a.m., 10/12/17 at 2:06 p.m., 10/12/17 at 3:00 p.m., 10/13/17 at 9:28 a.m., 10/18/2017 at 11:04 a.m. 10/18/2017 at 1:10 p.m., 10/18/2017 at 2:03 p.m. During an interview with the Director of Nursing, on 10/18/17 at 11:41 a.m., she indicated if a resident refuses a treatment or an ADL, staff should reapproach or attempt to use another staff member at another time. If the resident continues to refuse, nursing should be notified. At 12:15 p.m., on 10/18/17, CNA #6 indicated she does range of motion daily with her residents and there were only a few residents that refused. If the resident continued to refuse, I will notify nursing of the refusal. On 10/18/17 at 1:07 p.m., CNA #9 indicated Resident C's care was part of her assignment and she did not perform PROM or attempt to apply Resident C's splint that day or any other day. She further indicated she had not notified Nursing that Resident C did not receive his PROM or splinting that day.			

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	During an interview with LPN #7, on 10/18/17 at 2:04 p.m., she indicated she was unaware that PROM or splinting was not completed for Resident C that day. She was not previously notified of any refusals by Resident C for PROM or splinting. Resident C was typically pretty cooperative with care. At 2:19 p.m., on 10/18/17, OTR #8 indicated Resident C was discharged from Occupational Therapy in June 2016 and he should be getting a cone splint applied daily. She further indicated she was unaware that Resident C had not been wearing his cone or had been refusing his splint. Staff should notify therapy if there was refusals of range of motion or splinting. During an observation and interview with OTR #8, on 10/18/17 at 2:39 p.m., she looked through Resident C belongings and room and was unable to locate the soft cone splint for Resident C. She indicated a new splint will need to be ordered. During a telephone interview with the Therapy Manager, on 10/18/17 at 2:45 p.m., she indicated the therapy department was unaware the soft cone splint was missing and/or that Resident C had refused splinting and PROM. She			

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	indicated Therapy will need to screen Resident C to see what type of splinting he was appropriate for since his splint was missing and the cone splint may no longer be the appropriate device for him. On 10/19/17 at 10:11 a.m., CNA #6 indicated there used to be a restorative program with a designated staff person that would ensure PROM, ROM and splinting was done as care planned. That program had been discontinued about year ago. There was no way that all the ROM, PROM and splinting was being completed as care planned due to staffing. A policy titled, Restorative Nursing Policy and Procedures, no date, was received from Administrator #3, on 10/20/17 at 11:00 a.m. It indicated, " Policy: It is the policy of this facility to provide restorative nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible...." 3.1-42(a)(2)			

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F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and	F 0323	F323 1. Resident Z's care plan for fall	11/19/2017

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	record review, the facility failed to implement a resident's fall intervention for 1 of 3 residents reviewed for accidents and also the facility failed to have the interdisciplinary (group of facility staff members from various healthcare fields) team evaluate circumstances and probable causes of a fall for 1 of 3 residents reviewed for accidents (Resident L and Z). Findings include: 1. The clinical record for Resident Z was reviewed on 10/12/17 at 1:45 p.m. The diagnoses for Resident Z included, but were not limited to, dementia and schizophrenia. The 7/17/17 Annual MDS (minimum data set) assessment indicated a BIMS (brief interview for mental status) was not completed, as Resident Z was rarely/never understood. It indicated Resident Z required limited assistance of one person for dressing. It indicated her functional status to walk in room, walk in corridor, locomotion on and off unit were supervision of one person. It indicated her balance during walking and turning around and facing the opposite direction while walking was not steady, but able to stabilize without human assistance.		potential was updated to include current interventions. The C.N.A. assignment sheet was updated to reflect the current plan of care.Resident L's fall within the past thirty days was reviewed by the interdisciplinary team and a root cause analysis completed. The resident's care plan and C.N.A. assignment sheet was reviewed and updated. 2. The care plans for all residents with potential for falls were reviewed and updated as needed, including fall interventions. C.N.A. Assignment sheets were updated accordingly. Incident reports and nurses' notes for the past 30 days were reviewed to determine whether a root cause analysis and IDT review were conducted for any resident falls during the time period. Residents with falls in the last 30 days that did not meet the criteria, were reviewed by the IDT and a root cause analysis completed. Care plans and C.N.A. assignment sheets were reviewed and updated as needed. 3. Falls Policy reviewed and updated to include interventions. Nursing staff were inserviced on the Falls Prevention Program including assessment, interventions, post-fall root cause analysis, reporting, and documentation week of 11-5-17. Director of nursing or designee will conduct rounds daily on all shifts to ensure care planned interventions are in place as a fall prevention measure.	

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	An interview was conducted with DON on 10/11/17 at 1:33 p.m. She indicated Resident Z had no falls in the last 30 days. The 10/1/17 Nurse's Note read, "Resident was found sitting on buttock in dining room (sic) resident alert (sic) ROM (range of motion) to all extremities...faxed doctor, notified family in the a.m., neuro (neurological checks) started (sic) will continue to observe." The 7/25/17 falls care plan for Resident Z read, "Resident is at high risk for falls: tends to bend over & pick up pieces of lint, dirt, or little pieces of anything she may find on the ground with her fingers/hands." The goal was for Resident Z to be free from falling over. An intervention was to make sure she had skid free shoes during waking hours. Another 7/25/17 falls care plan indicated Resident Z had potential for falls related to confusion, wandering, and gait/balance problems. An intervention was to ensure she was wearing appropriate footwear or non-skid socks when ambulating or mobilizing. An observation of Resident Z was made on 10/12/17 at 12:02 p.m. She was in the lobby area. She had on a pair of white		4. The director of nursing/designee will audit the incident/accident reports, 24-hr report, nurses' notes, and physicians' orders daily as a means of monitoring falls during the previous 24-hour period, ongoing. The IDT will review falls, including interventions and root cause analysis, as they occur, and will update the resident care plan and C.N.A. assignment sheet accordingly. A summary of falls and fall activity will be summarized and reviewed monthly. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	socks with no shoes. The socks were not skid free. An observation of Resident Z was made on 10/13/17 at 12:17 p.m. She was in the dining room. She had on a pair of white socks with no shoes. The socks were not skid free. An observation of Resident Z was made on 10/13/17 at 1:37 p.m. She was walking near the main dining room. She had on a pair of white socks with no shoes. The socks were not skid free. An observation of Resident Z was made on 10/16/17 at 10:49 a.m. She was sitting in a chair near the therapy room. She was not wearing any socks or shoes. An interview was conducted with the DON (Director of Nursing) on 10/16/17 at 11:13 a.m. She indicated Resident Z should have nonskid footwear on at all times, when she's up. The Fallen Resident policy was provided by the MDS Coordinator on 10/16/17 at 3:13 p.m. It did not reference interventions prior to a fall. 2. The clinical record for Resident L was reviewed on 10/19/17 at 10:45 a.m. The diagnoses for Resident L included, but were not limited to, end stage renal			

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	disease, epilepsy, hypertension and tremor. A MDS (minimum data set) assessment, dated 7/17/17, indicated Resident L needed supervision with set-up help for transfers, bed mobility and toilet use. The MDS assessment indicated Resident 9 had moderate cognition impairment, with a BIMS (brief interview of mental status) score of 12. During an interview with the MDS Coordinator, on 10/12/17 at 9:28 a.m., she indicated Resident L has had a fall within the last 30 days. A Fall Risk Assessment, no date, was received from the Nurse Consultant on 10/20/17 at 9:58 a.m. It indicated Resident L had a score of 12, which was indicative of, "...A score of 10 or more represents high risk for falls...." A Nurse's Note, dated 10/7/17 at 5:00 a.m., indicated, "Resident had a fall in dining room, [symbol for no] bruises or swelling noted, denies any complaints of pain or discomfort doctor & family aware...." There was no other documentation within the clinical record related to the circumstances surrounding the fall. During an interview with Nurse			

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	Consultant #1, on 10/19/17 at 12:31 p.m., she indicated after a resident has a fall, the nurse was to document the circumstances surrounding the fall on a incident report, then the IDT (interdisciplinary team) will review the incident to determine the root cause of the fall and then interventions will be put into place to help prevent further falls. A Fall care plan, dated 1/12/16 and remained current at the time of review, indicated an intervention of, "...Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove [sic] any potential causes if possible. Educate resident/family/caregivers/IDT as to causes...." At 1:00 p.m., on 10/19/17, the Director of Nursing indicated there was no incident report related to the fall described above. On 10/19/17 at 3:14 p.m., Nurse Consultant # 1 indicated there was no follow up by the facility/IDT to review the root cause of Resident L's fall and there should've been. On 10/19/17 at 3:55 p.m., Nurse Consultant #2 indicated there had been quite a bit of management staff turn-over recently so it was difficult to get IDT			

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	(interdisciplinary team) meetings done routinely to determine the root causes of weight changes, falls, etc. A policy titled, Fall Management, dated 11/2014, was received from the MDS Coordinator on 10/17/17 at 9:49 a.m. The policy indicated, "...The Licensed Nurse will complete: Incident/Accident Report[,] 24 Hour Report; and Initiate the Interdisciplinary Post Fall Review...The Nurse will communicate the resident fall to the IDT via the 24 Hour Report...The IDT will review all resident falls within 24-72 hours at the morning interdisciplinary Team meeting to evaluate circumstances and probable causes for the fall. The IDT modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care Plan will be reviewed/revised as indicated...The IDT will complete the Interdisciplinary Post Fall Review...." 3.1-45(a)(2)			
F 0353 SS=F Bldg. 00	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services			

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	The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			

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	(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. Based on interview and record review, the facility failed to provide sufficient staffing to meet the needs of residents that need assistance with bathing for 2 of 3 residents reviewed for assisted daily living, to follow plan of care with catheter care for 1 of 1 residents reviewed for urinary catheter, to ensure a plan of care was followed for splinting and range of motion for 1 of 2 residents reviewed for range of motion, and to implement a resident's fall intervention for 1 of 3 residents reviewed for accidents and to have the interdisciplinary (group of facility staff members from various healthcare fields) team evaluate circumstances and probable causes of a fall for 1 of 3 residents reviewed for accidents, This has a potential to effect 39 of 39 residents that need staff assistance. (Resident C, E, K, L, M, N, P, S, U, V, W, X, Y, and Z) Findings include: The Resident Census and Conditions of Residents form, signed by the MDS Coordinator on 10/13/17 indicated out of 39 residents: 13 residents were dependent on staff and 18 residents need assistance by staff for bathing. 13 residents were dependent on staff and 18 resident need assistance by staff for dressing. 8 residents were dependent on staff and 10 residents need assistance by staff for transferring 13 residents were dependent on staffing and 12 resident need assistance by staff for toileting use. An interview was conducted with the Resident Council President on 10/11/17 at 11:40 a.m. She indicated, the facility was short staff all the time.	F 0353	F353 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Personal preference questionnaires were completed for Residents S and Z as to their preferred mode(s) of bathing, time, and frequency. These preferences were updated in point of care EMR, the C.N.A. assignment sheet, and resident's care plan. Resident M was seen by the nurse practitioner on 10-16-17 related to her urine output and possible urinary tract infection. A UA C&S was ordered. The following day nursing staff noted a change in condition, physician notified, and resident was sent to the hospital where nephrostomy tubes were inserted. Resident returned on 10-29-17. Resident M's care plan was updated to reflect her current needs. Resident C was assessed by the Occupational Therapist for evaluation and treatment and is	11/19/2017

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	She reported the staffing concerns had been discussed during a resident council meeting. An interview was conducted with Resident P on 10/11/17 at 2:39 p.m. He indicated the facility was short all the time. During an interview with Resident N on 10/12/17 at 10:14 a.m., he stated the facility was always short on the weekends. During an interview with Resident W on 10/13/17 at 10:36 a.m., she indicated short staff on the evening shift. An interview was conducted with Resident K on 10/12/17 at 11:09 a.m. He stated weekends are the worse with staffing. An interview was conducted with Resident U on 10/12/17 at 11:26 a.m. She reported short staff on all shifts especially nights. During an interview with Resident Y on 10/12/17 at 11:26 a.m., she reported short staff on nights. An interview was conducted with Resident X on 10/12/17 at 2:49 p.m. She reported there was not enough staff on night shift. An interview was conducted with Resident E on 10/12/17 at 2:50 p.m. He stated he has had his call light on for 20 minutes just to be laid down in bed. He reported no one helps. During an interview with Resident V on 10/12/14 at 3:11 p.m., he indicated there have been times there had been only 1 person for the entire shift. Short staff mostly on 2nd shift. The Director of Nursing (DON) on 10/16/17 at		currently on therapy case load. Resident Z's care plan for fall potential was updated to include current interventions. The C.N.A. assignment sheet was updated to reflect the current plan of care. Resident L's fall within the past thirty days was reviewed by the interdisciplinary team and a root cause analysis completed. The resident's care plan and C.N.A. assignment sheet was reviewed and updated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Personal preference questionnaires were completed for all residents as to their preferred mode(s) of bathing, time, and frequency. These preferences were updated in point of care EMR, the C.N.A. assignment sheets and residents' care plans. Two residents receiving catheter care were assessed by the director of nursing to ensure appropriate catheter care was being rendered.	

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	11:31 a.m., indicated there was only Certified Nursing Assistant (CNA) 44 on the floor, but Social Services Director and herself were assisting with the residents. The Resident Council minutes were provided by the Activities Director on 10/18/17 at 10:41 a.m. The "Resident Council Action Form" dated 8/24/17, indicated a concern or complaint assigned to the nursing department was "need more nurses". The response/resolution on the form indicated "working on interviews, please bare with me" During an confidential interview conducted 10/11/17-10/20/17, with Staff Person 36, they indicated they have worked at the facility for awhile and the staffing for the facility had declined over the last six months. Staff Person #36 indicated they weren't always able to get their tasks done in a timely manner. During an confidential interview conducted 10/11/17-10/20/17, with Staff Person 37, they indicated the staffing for the facility had gotten worse over the last six months. All shifts seem to be affected by short staffing. Everyone tries to all pitch in to get assignments completed but things still weren't able to completed. During a confidential interview conducted 10/11/17-10/20/17, with Staff Person 38 she indicated staff was short and the facility was trying to get staff in here. During an interview with Family Member 10 on 10/12/17 3:00 p.m., she reported staffing was short on all shifts. She indicated she had come into the facility to visit and found Resident S "filthy". She indicated bread crumbs were all over the floor and on the sheets of Resident S's bed.		There are no other residents currently using splint devices. The care plans for all residents with potential for falls were reviewed and updated as needed, including fall interventions. C.N.A. Assignment sheets were updated accordingly. Incident reports and nurses' notes for the past 30 days were reviewed to determine whether a root cause analysis and IDT review were conducted for any resident falls during the time period. Residents with falls in the last 30 days that did not meet the criteria, were reviewed by the IDT and a root cause analysis completed. Care plans and C.N.A. assignment sheets were reviewed and updated as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff were inserviced on honoring resident bathing preferences week of 11-5-17. Should a resident refuse or their	

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	During an interview with Family Member 80, on 10/18/17 at 12:47 p.m., she indicated the staffing for the facility has gotten worse over the last couple of months. During an interview with Family Member 35, on 10/20/17 at 9:08 a.m., she indicated she was recently in the facility and was unable to locate any facility staff that routinely worked with her family member. They were all Agency staff. The staff members available did not know specific information related to her family member's care and orders, when asked. She was the power of attorney for the Resident. During an interview with CNA 13, on 10/19/17 at 9:39 a .m., she indicated it was difficult to complete all her assignments at times, due to the lack of staff. The clinical record for Resident S was reviewed on 10/12/17 at 11:30 a.m. The diagnosis for Resident included, but was not limited to: dementia. A care plan date initiated on 2/18/16, indicated "....Name of resident (Resident S)has an ADL Self Care Performance Deficit r/t (related to) Fatigue and Limited Mobility was loss of balance r/t his left AKA (above knee amputation) and age related debility...Goal. name of resident (Resident S) will be assisted up in his w/c (wheelchair) daily as tolerates desires and be appropriately bathed, dressed and groomed every day through the next review date....Interventions. Assist with a full body sponge bath on his non-shower days..." A shower binder indicated "Shower Sheets are to be filled out daily. Fill out sheets for scheduled, unscheduled and refused showers and bed baths.		condition be such that a deviation in preference or schedule is needed, the charge nurse will be informed. Licensed nursing staff were inserviced on catheter care including irrigation, recording input/output, and signs and symptoms of related maladies week of 11-5-17. Nursing staff was inserviced week of 11-5-17 by the rehab department on restorative nursing including splint devices. Falls Policy reviewed and updated to include interventions. Nursing staff were inserviced on the Falls Prevention Program including assessment, interventions, post-fall root cause analysis, reporting, and documentation week of 11-5-17. The director of nursing or designee will conduct rounds daily on all shifts to ensure care-planned interventions are in place as a falls prevention measure. It is facility policy and practice to have sufficient nursing staff on duty to provide nursing and related	

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	Sheets are to be turned into the charge nurse. (Do not leave filled out sheets in the book.)..." The shower list indicated Resident S's scheduled shower days were Tuesdays and Fridays. An interview was conducted with Family Member 10 on 10/12/17 at 11:49 a.m. She indicated Resident S did not appear to be clean. She reported she had seen his head and neck dirty, and at times he had an odor. Family Member 10 stated during a visit, she had turned Resident S over and had seen food particles all over the sheets. The August, September, and October bathing reports for Resident S were provided by the MDS (Minimum Data Set) Coordinator on 10/17/17 at 9:49 a.m. It indicated the following days Resident S had not received bathing: August: 8/2/17 - bathing provided: response on report - not applicable 8/5/17 - bathing provided: response on report - not applicable 8/26/17 - bathing provided: response on report - not applicable 8/28/17 - bathing provided: response on report - not applicable September: 9/2/17- bathing provided: response on report - not applicable 9/3/17 - bathing provided: response on report - not applicable 9/25/17 - date was not on report 9/26/17 - date was not on report 9/29/17 - date was not on report October 10/5/17 - bathing provided: response report - not applicable		services to assure residents attain and maintain their highest practicable physical, mental, and psychosocial well-being. If it becomes necessary to supplement existing staff with "agency" staff, the facility will assure staff has the appropriate competencies and skills to meet the needs of the residents. Care is taken to request the same agency staff familiar with the residents and facility expectations; that a thorough and informative hand-off is exchanged at the change of staff; the director of nursing is on call when not physically present to address any nursing needs. A Daily Nursing Tasks and Guidelines was developed and disseminated to all nursing personnel on duty which includes: 24-hour report, incident accident reporting, documentation, MARS and TARS, physician orders, skin and open areas, labs, falls, ADLs including bathing, and restorative charting. The administrator will address staffing updates at the next scheduled Residents' Council meeting. 4. How the corrective action(s) will be monitored to ensure the deficient	

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	10/8/17 - date was not on report 10/10/17 - date was not on report 10/14/17 - bathing provided: response report - not applicable 10/15/17 - bathing provided: response report - not applicable An interview was conducted with the Nurse Consultant 1 on 10/18/17 at 3:25 p.m. She indicated she could not locate shower sheets for the missing dates or the dates the staff documented as not applicable on the bathing report. She also indicated hospice had sent over a report when their staff was in the building to provide bathing care, and the days hospice aides were in the building were not on the days that were either missing or documented not applicable. The clinical record for Resident Z was reviewed on 10/12/17 at 1:45 p.m. The diagnoses for Resident Z included, but were not limited to, dementia and schizophrenia. The 7/17/17 Annual MDS (minimum data set) assessment indicated a BIMS (brief interview for mental status) was not completed, as Resident Z was rarely/never understood. It indicated she was total dependence of one person for bathing. A telephone interview was conducted with Family Member #17 on 10/12/17 at 1:55 p.m. She indicated Resident Z did not receive the same number of baths/showers in a week as she did in the past. She indicated, the last time she saw Resident Z, in August, 2017, her clothes were dirty and her hair was greasy. The 7/25/17 bathing, dressing, and personal hygiene care plan indicated Resident Z was dependent on staff for bathing. The goal was for her to be appropriately bathed every day.		practice will not recur, i.e., what quality assurance program will be put into place: Charge nurses will monitor the completion of bathing tasks at each shift by reviewing the point of care EMR. The director of nursing will conduct point of care EMR audits weekly; and shower sheets weekly for six months and ongoing. The director of nursing/designee will review the MARs and TARs for catheter care and I/O documentation weekly for 2 months and bi-monthly for four months until continued compliance is maintained. The MDS coordinator who oversees the restorative program will check splinting devices daily for application and related documentation for one month, and monthly for six months and ongoing. The director of nursing/designee will audit the incident/accident reports, 24-hr report, nurses' notes, and physicians' orders daily as a means of monitoring the incidence of falls during the previous 24-hour period, ongoing. The IDT will review falls,	

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	Interventions were to provide staff assist with a full body sponge bath on her non-shower days, to provide staff assist with a shower and shampoo 2 times weekly, and to chart care provided on her adl (activities of daily living) flow sheet everyday. The Shower List Evening Shift-Front schedule, updated 8/3/17, located in a binder at the nurses station, was reviewed on 10/16/17 at 11:26 a.m. It indicated Resident Z's shower days were Tuesdays and Fridays. There were shower sheets included in the binder, but none for Resident Z. On 10/16/17 at 2:36 p.m., the DON (Director of Nursing) provided September and October, 2017 bathing logs for Resident Z. There was no bathing verification for the following days: 9/5/17, 9/9/17 through 9/12/17, 9/14/17 through 9/20/17, 9/22/17 through 9/24/17, and 10/3/17 through 10/15/17. An interview was conducted with the DON on 10/16/17 at 2:50 p.m. She indicated Resident Z should be provided showers on Tuesdays and Fridays, with bathing in between as needed, but not daily. She indicated she was unaware of Resident Z's care plan to provide a full body sponge bath on her non-shower days. The clinical record for Resident M was reviewed on 10/12/17 at 1:30 p.m. The diagnosis for Resident included, but was not limited to: paraplegia. A physician order dated 3/27/15, indicated staff was to irrigate Resident M's foley catheter as needed with 30 milliliters of normal saline due to low urinary output or urinary leakage. The October 2017, TAR (Treatment Administration Record) indicated there were no		including interventions and root cause analysis, as they occur, and will update the resident care plan and C.N.A. assignment sheet accordingly. A summary of falls and fall activity will be summarized and reviewed monthly. The administrator will review staffing ratios daily and assure adjustments are made in a timely manner. The results of these audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	staff signatures irrigation of Resident M's foley catheter was provided. A October 2017, "Comprehensive Intake and Output Record" indicated the following days and shifts no urine output was recorded for Resident M: 10/10/17 - evening and night shift 10/11/17 - evening and night shift 10/12/17 - evening and night shift 10/13/17 - day, evening, and night shift 10/14/17 - day, evening, and night shift 10/15/17 - evening shift 10/16/17 - evening and night shift An interview was conducted with Qualified Medication Aide (QMA) 5 on 10/19/17 at 11:00 a.m. She indicated she had worked with Resident M on Saturday, Sunday, and Monday on day shift. Resident M's urine output was low, but catheter was leaking. She reported Resident M's bed was wet, so it was hard to determine her urine amount. She indicated Resident M's urine appearance was dark and cloudy from what urine she had seen collected in the catheter bag. QMA 5 had reported to the agency staff nurse Resident M's catheter was leaking. An interview was conducted with Certified Nursing Assistant (CNA) 6 on 10/20/17 at 8:45 a.m. She reported she did take care of Resident M on Saturday and Sunday on days. She stated she did not have to empty Resident M's urine catheter, because there was no urine in the bag. CNA 6 indicated Resident M was wearing a brief, and it was soiled. She stated the agency staff nurse was in the room with her during care, and at that time had not done anything to the catheter. An interview was conducted with License Practical Nurse (LPN) 15 on 10/22/17 at 8:50			

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	a.m. She indicated she had taken care of Resident M on Sunday evening and Monday morning. She reported she had only worked at the facility a couple of times, so she wasn't too familiar with the residents. LPN 15 stated Resident M was alert and oriented. She indicated Resident M had stated to her that the catheter leaking was normal. Resident M wore a brief which was soiled. LPN 6 reported she did not irrigate Resident M's catheter. An interview with the Director of Nursing (DON) on 10/20/17 at 10:52 a.m. The DON reported she had known Resident M was going to have a urinalysis due to possible urinary track infection, but did not know her catheter was leaking with minimal urine collection in the bag. She stated Resident M's catheter had been changed September 28th. An interview was conducted with the Nurse Practitioner (NP) 50 on 10/20/17 at 12:13 p.m. She indicated she had went in and seen Resident M on Monday. NP 50 reported Resident M was alert and oriented at that time. NP 50 stated Resident M had indicated she believed she had a UTI (urinary track infection). NP 50 reported she had discussed with Resident M about a urostomy due the catheter leaking, because Resident M had mentioned the catheters leak. NP 50 indicated Resident M refused the option of an urostomy. She reported during the assessment with Resident M she had lots of covers on, but her skin was not sweaty with touch. NP 50 indicated Resident M's catheter bag was empty and there was sediment observed in tubing. Resident M had stated to her that her catheter had been replaced not too long ago. NP 50 indicated she had ordered a urinalysis. The clinical record for Resident C was reviewed on 10/13/17 at 2:35 p.m. The diagnoses for			

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	Resident C included, but were not limited to, hemiplegia, abnormal posture and unspecified lack of coordination. During an interview with the MDS Coordinator, on 10/12/17 at 2:06 p.m., she indicated Resident C had a contracture of his left hand and he does not wear a brace or receive therapy services since he refuses. A Range of Motion care plan, dated 9/14/16 and remained current at the time of review, indicated, "...Provide PROM [passive range of motion] as ordered on his restorative program...Provide skin care to left hand and pat dry prior to applying left hand cone [symbol for each] day...." A Restorative Care Plan and Charting for PROM, indicated the goal: Resident will tolerate 10 reps x 2 sets of passive range of motion exercises as stated on restorative nursing program though next review...." It indicated Resident C refused the following dates: 10/2/17-p.m. 10/3/17-p.m. 10/4/17-p.m. 10/5/17-a.m. 10/5/17-p.m. There was no other documentation on the chart to indicate the PROM was completed or refused for the other unlisted days between 10/1/17-10/17/17. The Restorative Care Plan and Charting for Dressing/Grooming, indicated the goal: Resident will be able to perform the following tasks:"...Wash face with cupping of his hand or with support of his elbow while he is holding a wash cloth after each meal through the next review..." It indicated Resident C refused the following dates: 10/2/17-p.m.			

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	10/3/17-p.m. 10/4/17-p.m. 10/5/17-a.m. 10/5/17-p.m. There was no other documentation on the chart to indicate the goal was completed or refused for the other unlisted days between 10/1/17-10/17/17. An ADL/Total Assistance care plan, dated 6/19/17 and remained current at the time of review indicated the intervention, "...Chart refusal of care and/or agitation/delusions on his Behavior Flow Sheet for MD review...." The Behavior Management Record for October 2017, did not indicate any refusals of care. An Occupational Therapy Discharge Summary, dated 7/1/16, indicated, "...To facilitate patient maintaining current level of performance and in order to prevent decline...L [left] hand palm protector and ROM (Passive). PROM to be completed prior to application of L hand palm protector roll. Pt to wear L hand palm protector roll after breakfast for up to 3 hours and after dinner for up to 3 hours. Pt to wear the L hand palm protector roll daily if he allows staff to place it on his L hand...." During the following observations, Resident C was observed without a splint on: 10/12/17 at 10:15 a.m., 10/12/17 at 2:06 p.m., 10/12/17 at 3:00 p.m., 10/13/17 at 9:28 a.m., 10/18/2017 at 11:04 a.m. 10/18/2017 at 1:10 p.m., 10/18/2017 at 2:03 p.m. During an interview with the Director of Nursing, on 10/18/17 at 11:41 a.m., she indicated if a			

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	resident refuses a treatment or an ADL, staff should reapproach or attempt to use another staff member at another time. If the resident continues to refuse, nursing should be notified. At 12:15 p.m., on 10/18/17, CNA #6 indicated she does range of motion daily with her residents and there were only a few residents that refused. If the resident continued to refuse, I will notify nursing of the refusal. On 10/18/17 at 1:07 p.m., CNA #9 indicated Resident C's care was part of her assignment and she did not perform PROM or attempt to apply Resident C's splint that day or any other day. She further indicated she had not notified Nursing that Resident C did not receive his PROM or splinting that day. During an interview with LPN #7, on 10/18/17 at 2:04 p.m., she indicated she was unaware that PROM or splinting was not completed for Resident C that day. She was not previously notified of any refusals by Resident C for PROM or splinting. Resident C was typically pretty cooperative with care. At 2:19 p.m., on 10/18/17, OTR #8 indicated Resident C was discharged from Occupational Therapy in June 2016 and he should be getting a cone splint applied daily. She further indicated she was unaware that Resident C had not been wearing his cone or had been refusing his splint. Staff should notify therapy if there was refusals of range of motion or splinting. During an observation and interview with OTR #8, on 10/18/17 at 2:39 p.m., she looked through Resident C belongings and room and was unable to locate the soft cone splint for Resident C. She indicated a new splint will need to be ordered.			

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During a telephone interview with the Therapy Manager, on 10/18/17 at 2:45 p.m., she indicated the therapy department was unaware the soft cone splint was missing and/or that Resident C had refused splinting and PROM. She indicated Therapy will need to screen Resident C to see what type of splinting he was appropriate for since his splint was missing and the cone splint may no longer be the appropriate device for him.

On 10/19/17 at 10:11 a.m., CNA #6 indicated there used to be a restorative program with a designated staff person that would ensure PROM, ROM and splinting was done as care planned. That program had been discontinued about year ago. There was no way that all the ROM, PROM and splinting was being completed as care planned due to staffing.

A policy titled, Restorative Nursing Policy and Procedures, no date, was received from Administrator #3, on 10/20/17 at 11:00 a.m. It indicated, " Policy: It is the policy of this facility to provide restorative nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible...."

The clinical record for Resident Z was reviewed on 10/12/17 at 1:45 p.m. The diagnoses for Resident Z included, but were not limited to, dementia and schizophrenia.

The 7/17/17 Annual MDS (minimum data set) assessment indicated a BIMS (brief interview for mental status) was not completed, as Resident Z was rarely/never understood. It indicated Resident Z required limited assistance of one person for dressing. It indicated her functional status to walk in room, walk in corridor,

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	locomotion on and off unit were supervision of one person. It indicated her balance during walking and turning around and facing the opposite direction while walking was not steady, but able to stabilize without human assistance. An interview was conducted with DON on 10/11/17 at 1:33 p.m. She indicated Resident Z had no falls in the last 30 days. The 10/1/17 Nurse's Note read, "Resident was found sitting on buttock in dining room (sic) resident alert (sic) ROM (range of motion) to all extemities...faxed doctor, notified family in the a.m., neuro (neurological checks) started (sic) will continue to observe." The 7/25/17 falls care plan for Resident Z read, "Resident is at high risk for falls: tends to bend over & pick up pieces of lint, dirt, or little pieces of anything she may find on the ground with her fingers/hands." The goal was for Resident Z to be free from falling over. An intervention was to make sure she had skid free shoes during waking hours. Another 7/25/17 falls care plan indicated Resident Z had potential for falls related to confusion, wandering, and gait/balance problems. An intervention was to ensure she was wearing appropriate footwear or non-skid socks when ambulating or mobilizing. An observation of Resident Z was made on 10/12/17 at 12:02 p.m. She was in the lobby area. She had on a pair of white socks with no shoes. The socks were not skid free. An observation of Resident Z was made on 10/13/17 at 12:17 p.m. She was in the dining room. She had on a pair of white socks with no			

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	shoes. The socks were not skid free. An observation of Resident Z was made on 10/13/17 at 1:37 p.m. She was walking near the main dining room. She had on a pair of white socks with no shoes. The socks were not skid free. An observation of Resident Z was made on 10/16/17 at 10:49 a.m. She was sitting in a chair near the therapy room. She was not wearing any socks or shoes. An interview was conducted with the DON (Director of Nursing) on 10/16/17 at 11:13 a.m. She indicated Resident Z should have nonskid footwear on at all times, when she's up. The Fallen Resident policy was provided by the MDS Coordinator on 10/16/17 at 3:13 p.m. It did not reference interventions prior to a fall. The clinical record for Resident L was reviewed on 10/19/17 at 10:45 a.m. The diagnoses for Resident L included, but were not limited to, end stage renal disease, epilepsy, hypertension and tremor. A MDS (minimum data set) assessment, dated 7/17/17, indicated Resident L needed supervision with set-up help for transfers, bed mobility and toilet use. The MDS assessment indicated Resident 9 had moderate cognition impairment, with a BIMS (brief interview of mental status) score of 12. During an interview with the MDS Coordinator, on 10/12/17 at 9:28 a.m., she indicated Resident L has had a fall within the last 30 days. A Fall Risk Assessment, no date, was received from the Nurse Consultant on 10/20/17 at 9:58 a.m. It indicated Resident L had a score of 12,			

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	which was indicative of, "...A score of 10 or more represents high risk for falls...." A Nurse's Note, dated 10/7/17 at 5:00 a.m., indicated, "Resident had a fall in dining room, [symbol for no] bruises or swelling noted, denies any complaints of pain or discomfort doctor & family aware...." There was no other documentation within the clinical record related to the circumstances surrounding the fall. During an interview with Nurse Consultant #1, on 10/19/17 at 12:31 p.m., she indicated after a resident has a fall, the nurse was to document the circumstances surrounding the fall on a incident report, then the IDT (interdisciplinary team) will review the incident to determine the root cause of the fall and then interventions will be put into place to help prevent further falls. A Fall care plan, dated 1/12/16 and remained current at the time of review, indicated an intervention of, "...Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove [sic] any potential causes if possible. Educate resident/family/caregivers/IDT as to causes...." At 1:00 p.m., on 10/19/17, the Director of Nursing indicated there was no incident report related to the fall described above. On 10/19/17 at 3:14 p.m., Nurse Consultant # 1 indicated there was no follow up by the facility/IDT to review the root cause of Resident L's fall and there should've been. On 10/19/17 at 3:55 p.m., Nurse Consultant #1 indicated there had been quite a bit of			

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	management staff turn-over recently so it was difficult to get IDT (interdisciplinary team) meetings done routinely to determine the root causes of weight changes, falls, etc. A policy titled, Fall Management, dated 11/2014, was received from the MDS Coordinator on 10/17/17 at 9:49 a.m. The policy indicated, "...The Licensed Nurse will complete: Incident/Accident Report[,] 24 Hour Report; and Initiate the Interdisciplinary Post Fall Review...The Nurse will communicate the resident fall to the IDT via the 24 Hour Report...The IDT will review all resident falls within 24-72 hours at the morning interdisciplinary Team meeting to evaluate circumstances and probable causes for the fall. The IDT modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care Plan will be reviewed/revised as indicated...The IDT will complete the Interdisciplinary Post Fall Review...." An interview was conducted with the Administrator 3 on 10/18/17 at 3:00 p.m. He had indicated the facility was short staff, but the staff was working together as a team. We are in the process of replenishing staff. The Administrator 3 reported he had to weave out the bad attitudes and terminate quite a few employees. The Administrator 3 reported agency was being used to compensate for the staffing loss. He stated using agency was not consistent with the same staff providing care, but the facility was working on hiring new staff. An interview was conducted with the DON and the Nurse Consultant 1 on 10/20/17 at 11:45 a.m. She indicated the facility was short staff, but utilizing agency staffing to make up for the missing staff. She reported she had two full time			

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	nursing staff change their working status from full time to as needed. She indicated she had been interviewing individuals and was in the process of getting more staff hired. The Nurse Consultant 1 stated someone from the corporate office plans to come in next week and focus on just hiring more staff. This federal tag relates to Complaint IN00241249 and Complaint IN00243838. 3.1-17(a)			
F 0412 SS=D Bldg. 00	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;			

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	(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on interview and record review, the facility failed to address a resident's recommended dental treatment plan for 1 of 3 residents reviewed for dental. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 10/12/17 at 3:30 p.m. The diagnoses for Resident 10 included, but were not limited to: paranoid schizophrenia and dementia. A dental exam for Resident 10 dated 4/20/17, indicated a recommendation to obtain impressions if approved for Resident 10 to receive new dentures. A nutrition care plan for Resident 10 dated 7/14/17, indicated Resident 10 had ill fitted dentures with mouth pain. The care plan goal, indicated "...Get dentures fixed (symbol for and) live free of sore gums...Interventions...Set denture appt (appointment) SS/N (social services, nursing)..."	F 0412	F412 1.After receiving the dentist's recommendation for replacing ill-fitting dentures, following the 4-20-17 examination, Resident 10's family declined treatment since Medicaid would not pay for new dentures. Resident 10's family was contacted to determine whether they wish to reconsider. Facility is awaiting word and social services will follow up. Nursing performed an oral assessment including any conditions which may cause pain or hamper the resident's ability to chew. 2.There are no other residents needing dental services now. When the need for dental services arises, social services will assist with arranging the services needed. 3.The regional director of operations inserviced the social worker on 11-3-17 regarding the policy and procedure: Inquiries regarding the services and availability of ancillary practitioners (i.e. dentist, podiatrist, optometrist) will be made to social services who will maintain a referral log for each practitioner and will arrange such services in coordination with the	11/19/2017

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	An interview was conducted with Resident 10 on 10/12/17 at 3:07 p.m. She stated her bottom dentures hurt. An interview was conducted with the Social Services Director on 10/18/17 at 10:46 a.m. She reported she was unaware of Resident 10's ill-fitted dentures. She indicated she had not reviewed Resident 10's dental recommendation nor had she spoken to the dietician regarding Resident 10's dentures not fitting. A dental policy was provided by the Administrator 2 on 10/20/17 at 9:35 a.m. It indicated "...Policy Statement. Oral healthcare and dental services will be provided to each resident...Policy Interpretation and Implementation...3. Social Services will be responsible for making necessary dental appointments...5. Inquiries concerning the availability of dental services should be referred to Social Services or the Director of Nursing..." A Social Services policy was provide by the Administrator 3 on 10/20/17 at 11:00 a.m. It indicated, "...Policy Statement. Our facility provides medically-related social services to ensure that each resident can attain or maintain his/her highest practicable physical, mental, or		practitioner and the resident and or resident representative. When a practitioner's recommendation is under consideration or declined, social services will leave the referral open for follow up or closed. 4.The administrator will review the ancillary practitioner log monthly for six months to ensure compliance. The results of the audit will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	psychosocial well-being...Policy Interpretation and Implementation. 1. The director of social services is a qualified social worker and is responsible for: a. Consultation with other departments regarding program planning, policy development, and priority setting of social services; b. Consultation to allied professional health professional health personnel regarding provisions for the social and emotional needs of the resident and family;...f. Assistance in meeting the social and emotional needs of residents...2. Medically -related social services is provided to maintain or improve each resident's ability to control everyday physical needs (eg. appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identify , coping abilities, and sense of meaningfulness or purpose)...." 3.1-24(a)(1)			

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	155721	A. BUILDING 00 B. WING	10/20/2017

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F 0431 SS=D Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration			

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	date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on interview and record review, the facility failed to ensure a lantus insulin vial was labeled with resident's identification and open date. The facility also failed to discard a lantus insulin flex pen for a resident that was discharged for 1 of 3 medication carts reviewed. (Resident 46) Findings include: An observation was made of the back hall medication cart with Registered Nurse (RN) 14 and Qualified Medication Aide (QMA) 5 on 10/20/17 at 10:40 a.m. They provided a white basket which contained the residents' insulin vials and flexpens. It included 1 vial of lantus that was not labeled with whom it belong to or an open date. It also contained a lantus flex pen with an expired date of 10/16/17 for Resident 46. An interview was conducted with RN 14 and	F 0431	F431 1.The open vial of lantus and the lantus flex pen were disposed of. 2.Drugs and biologicals were audited to ensure manufacturer guidelines with respect to expiration dates for opened medications were followed; medications with a shortened expiration date have a label with the date opened recorded; and, medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed or returned to the pharmacy. 3.Licensed nursing staff and QMAs were inserviced week of 11-5-17 regarding labeling medications with a shortened	11/19/2017

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	QMA 5 on 10/20/17 at 10:43 a.m. RN 14 reported all insulin vials and flex pens should be marked with the resident's name, open and/or expired date. QMA 5 stated Resident 46 had been discharged from the facility 2 weeks ago. An interview was conducted with the Nurse Consultant 1 on 10/20/17 at 10:45 a.m. She reported nursing staff should be looking at insulin labeling daily prior to giving. She indicated discharged residents insulin should be removed. She reported Resident 46 was discharged on 9/30/17. A "Storage and Expiration of Medications, Biological's, Syringes, and Needles" policy was provided by the Nurse Consultant 1 on 10/20/17 at 11:10 p.m. It indicated "...Procedure...4. Facility should ensure that medications and biological: 4.1 Have an Expiration Date on label;..5. Once any medicating or biological package is opened. Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened....15. Facility should ensure that medications and biological for expired or discharged residents are stored separately, away from use, until destroyed or returned to the provider...." 3.1-25(j)b		expiration date with the date opened recorded; and, medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed or returned to the pharmacy. 4.The director of nursing and or designee will audit the medication storage areas weekly for six months and ongoing to ensure compliance. The results of the audit will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	
F 0465	483.90(i)(5)			

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SS=E Bldg. 00	SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation, interview, and record review, the facility failed to maintain appropriate water temperatures and rooms in good repair for 8 of 30 residents whose rooms were observed. (Residents K, L, M, R, T, V, W, and X) Findings include: 1. An observation of Resident L's room was made on 10/12/17 at 11:12 a.m. The hot water running from the sink in her room was cool to touch. An interview was conducted with Resident L on 10/12/17 at 11:12 a.m. She indicated the water did not get hot. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The Maintenance Director retrieved the water temperature from Resident L's sink at 83 degrees Fahrenheit. The Maintenance Director indicated the temperature should be around 105 to 110 degrees Fahrenheit. 2. An observation of Resident X's room was made on 10/12/17 at 2:49 p.m. The hot water	F 0465	F465 1.The hot water temperatures in resident rooms L, X, M, and W were regulated at the time of survey. The cold water tap in resident room X was repaired. The scratches on the wall near resident M's headboard were refinished. Gouges on the wall near the foot of the bed for resident V were refinished. The scratches on the wall by resident T's bed and window were refinished. The walls chipped and peeling in resident room R were refinished and the closet door put back on track. 2.Environmental rounds were conducted by the administrator and maintenance person and any resident rooms with walls chipped or marred were identified and refinished; closet doors were checked for proper operation; and water temperatures were checked and regulated as needed. The frequent use/high traffic areas of the bathrooms and	11/19/2017

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	running from the sink in her room was cool to touch. The cold water faucet handle did not work. An interview was conducted with Resident X on 10/12/17 at 2:49 p.m. She indicated there was never any hot water. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The Maintenance Director retrieved the water temperature from Resident X's sink at 91 degrees Fahrenheit. He turned the cold water faucet, and no water came out. 3. An observation of Resident M's room was made on 10/11/17 at 2:24 p.m. The hot water running from the sink in her room was cool to touch. There were multiple scratches on the wall near her headboard. An interview was conducted with Resident M on 10/11/17 at 2:24 p.m. She indicated the water was always cold. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The Maintenance Director retrieved the water temperature from Resident M's sink at 77 degrees Fahrenheit. The scratches on the wall near her headboard remained. 4. An observation of Resident W's room was made on 10/11/17 at 3:04 p.m. The hot water running from the sink in his room was cool to touch. An environmental tour was conducted with Administrator #3 and the Maintenance Director		dining rooms were put on a more frequent daily check and clean schedule. 3.The administrator inserviced maintenance and housekeeping supervisor on 11-3-17 regarding the use of a daily/weekly audit tool to monitor the building and ensure it is in good repair, functional, and operating properly. Housekeepers were inserviced on identifying and reporting building repairs week of 11-5-17. 4.The maintenance person or designee will use the daily/weekly audit tool daily for six months and ongoing. The results of the audit will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	on 10/17/17 at 11:50 a.m. The Maintenance Director retrieved the water temperature from Resident W's sink at 87 degrees Fahrenheit. 5. An observation of Resident V's room was made on 10/12/17 at 3:21 p.m. There were gouges on the wall near the foot of his bed. An interview was conducted with Resident V on 10/12/17 at 3:21 p.m. He indicated the gouges had been there since he moved in. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The gouges on the wall at the foot of his bed remained. Administrator #3 indicated Resident V's room was on the list to be overhauled. 6. An interview was conducted with Resident K on 10/12/17 at 11:04 a.m. He indicated the building was not clean, specifically the bathrooms. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The back hall restroom door was opened and clearly visible from the hall was a wipe on the ground near the trash, a used glove hanging over the side of the trash can, and several gnats resting on the trash heaping from the trash can. The bottom of the outside of the door was chipped 6 inches up. 7. An observation of Resident T's room was made on 10/12/17 at 8:59 a.m. There were scratches on the wall by her bed and window. An interview was conducted with Resident T on 10/12/17 at 8:59 a.m. She indicated the scratches on the wall had been there since she'd been in that			

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	room. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. There were 2 feet of scratches near the head of Resident T's bed. 8. An observation of Resident R's room was made on 10/12/17 at 1:27 p.m. The walls were chipped and the paint was peeling. The closet door was off it's track. The restroom door was chipped on the bottom. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The walls were chipped and the paint was peeling. The closet door was still off it's track. The restroom door was chipped one foot from the bottom, in the right corner. 9. A telephone interview was conducted with Family Member #17 on 10/12/17 at 2:05 p.m. She indicated the building was not clean. She indicated the tables were dirty, and she had to push crumbs out of the way, when she sat down. She indicated the restroom was not very clean either. An environmental tour was conducted with Administrator #3 and the Maintenance Director on 10/17/17 at 11:50 a.m. The main dining room was observed. There were crumbs on the far left table. There was a white, sugary substance on the front left table. No meals were being served at this time, and none of the 4 residents in the dining room were eating at this time. An interview was conducted with Administrator #3 at this time. He indicated the tables were normally wiped down. The Water Temperatures policy was provided by			

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	Administrator #3 on 10/17/17 at 3:45 p.m. It read, "Water coming from the faucets and showers in this facility will be maintained at a safe temperature between 110 and 120 degrees per State Regulations to avoid injury to Residents and/or staff." The Maintenance Service policy was provided by Administrator #3 on 10/19/17 at 11:21 a.m. It read, "The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times....The following functions are performed by maintenance, but are not limited to: ...Maintaining the building in good repair and free from hazards." 3.1-19(f)			
F 0502 SS=D Bldg. 00	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to obtain labwork as ordered for 2 of 5 resident reviewed for	F 0502	F502 1.Resident K's physician was notified and the A1C was ordered	11/19/2017

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	unnecessary medications (Resident K and Resident 2) 1. The clinical record for Resident K was reviewed on 10/18/17 at 2:45 p.m. The diagnoses for Resident K included, but were not limited to, diabetes mellitus and advanced degenerative joint disease. A Physician's Order dated, 8/25/17, indicated an order to draw a hemoglobin A1C (long term measurement of blood glucose level) on the the next lab day. Labs dated, 8/30/17, were located in the clinical record. A hemoglobin A1C was not located located in the clinical record. During an interview with the Director of Nursing, on 10/19/17 at 11:00 a.m., the DON indicated the hemoglobin A1C was not drawn as ordered. A policy titled. Laboratory Management, dated 6/2015, was received from the MDS Coordinator on 10/19/17 at 9:30 a.m. 2. The clinical record for Resident 2 was reviewed on 10/12/17 at 3:30 p.m. The diagnosis for Resident 2 included, but was not limited to: schizoaffective disorder.		and drawn and results reported to the physician. The physician for Resident #2 was notified and an order for a CBC with dif and a BMP was received; labs drawn; and results reported to the physician. 2.Physician orders and lab requisitions were audited for the previous 30 days and no irregularities were identified. 3.Licensed nursing staff were inserviced week of 11-5-17 on receiving physician orders for lab work; completing requisitions timely; and transcribing the order to the MAR (medication administration record); and flagging resident refusals for lab draws for follow up. The director of nursing or designee will review physician orders daily ongoing; and verify lab orders were requisitioned, transcribed to the MAR, and flagged for follow up as applicable, daily for one month and weekly for six months. 4.The director of nursing or designee is responsible for auditing physician orders and ensuring timeliness of lab services. The results of the audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	A physician order dated 7/25/17, indicated a weekly cbc with diff (complete blood count with differential) and a bmp (basic metabolic panel) for Resident 2 was to be obtained every Wednesday. The September 2017, Treatment Administration Record (TAR) for Resident 2 indicated no staff signature a cbc with diff or bmp was obtained for Wednesday, September 20th. The October 2017, TAR for Resident 2 indicated no staff signature a cbc with diff or bmp was obtained on Wednesday, October 4th. A lab report dated 9/20/17, indicated Resident 2 had refused lab work that day. The report stated there would be two more attempts to obtain the cbc and bmp. An interview was conducted with the Director of Nursing on 10/16/17 at 3:01 p.m. She reported after reviewing the lab computer system the refused lab on 9/20/17, was not attempted two more times as stated on the lab report. The Director of Nursing also indicated the lab on 10/4/17, was missed and not obtained. A lab policy dated 7/2015, indicated "...Overview. Residents requiring			

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	laboratory services will receive accurate and timely laboratory services so that the utilization of laboratory testing for diagnosis, treatment, prevention, or assessment is maximized. The facility is responsible for quality and timely laboratory services whether or not services are provided by the facility or an outside agency..." 3.1-49(a)			
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			

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	(iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure clinical records were complete and accurate for 1 of 20 residents records reviewed. (Resident) Findings include: 1a. The clinical record for Resident M was reviewed on 10/12/17 at 1:30 p.m. The diagnosis for Resident M included, but was not limited to: paraplegia. A physician order dated 2/4/17 indicated "apply optifoam 4x4 dsg (dressing) nonadhesive topically to open wounds on buttocks (symbol for and) rt (right) lt (left) ischium prn only if abd (abdominal) pads not avail (available)."	F 0514	F514 1.Resident M's physician notified regarding skin status and orders clarified. The resident's current physician's orders for skin care and treatment were updated on the physician's order sheet and the medication and treatment records. Contact information for Resident M's family representative was updated on the face sheet and in the electronic record data base. 2.Current treatment records for all residents were reviewed to ensure reconciliation with residents' current condition and physician's orders for treatment. The resident representative	11/19/2017

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	A physician order dated 2/4/17 indicated "..sacrum apply calcium alginate to wound bed cover w/abd pad; secure with paper tape." A physician order dated 6/9/17, indicated "..Apply saline soaked collagen to wound bed, cover w/ gauze (symbol for and) secure with tape once a day (left great toe)." The October 2017, TAR (Treatment Medication Record) indicated Resident M's great toe, buttocks, right and left ischium were healed. A skin assessment dated 10/2/17, indicated Resident M's skin was intact. A skin assessment dated 10/9/17, indicated Resident M's skin was intact. An interview was conducted with the Director of Nursing (DON) and Nurse Consultant 1 on 10/17/17 at 3:45 p.m. The DON reported Resident M did not have any open areas. The dressings should have been removed off the October orders. The Nurse Consultant 1 indicated the open areas on the great toe and the ischium were healed on 8/18/17. 1b. An interview was conducted with Family Member 80 on 10/18/17 at 2:30 p.m. She reported she was Resident M's POA (Power of Attorney) and had not been notified Resident M was sent to the hospital. She stated she had to be notified by word of mouth, because another family member was notified. She was told the facility did not have her current phone number or address to reach her. Family member 80 stated she had given her current address and phone number to the facility and had been contacted by the staff regarding changes with Resident M in the past. She indicated she visits the facility weekly, and		contact information data base was audited to ensure accuracy of the information. 3.Licensed nursing staff were inserviced on complete and accurate record keeping including the resident treatment administration record to ensure the TAR reflects the resident's current care needs and physician treatment plan the week of 11-5-17. 4.Director of nursing or designee will audit daily the records of residents receiving wound care to ensure the clinical record is complete and accurate and reflects residents' status, ongoing. Resident skin/wound status is reported monthly to the QAPI committee overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not met action plans will be revised to ensure compliance.	

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	155721	A. BUILDING 00 B. WING	10/20/2017

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	she had not been at the address or the phone number that was on file for 2 years. Resident M's clinical record was reviewed on 10/20/17 at 12:50 p.m. The face sheet indicated emergency contact information for Family Member 80. There was also a index size white torn piece of paper paperclipped to the face sheet hand written "new info" with a different cell phone number and different office phone number for Family Member 80 dated 10/17/17. A Social Services progress note dated 4/14/17, indicated the Social Services Director had spoken to Resident M regarding needing her POA's signature on some paperwork and had been trying to reach her but had not been successful. An interview was conducted with the Social Services Director on 10/19/17 at 9:42 a.m. She reported the care plan invitations were sent to the POA's address that was typed on the face sheet. An interview was conducted with the Nurse Consultant 1 on 10/20/17 at 1:00 p.m. She indicated the residents typed face sheets with the emergency contact information are to be updated. The emergency contact information should be confirmed correct during care plan meetings. 3.1-50(a)(2)			

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F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a	F 9999	F9999 1.C.N.A. #31 was administered the tuberculin skin test and results recorded in the employee file. C.N.A. #31 received Dementia training and Residents' Rights training and completion was recorded in the employee file. 2.All employee files were audited to ensure the annual tuberculin skin tests were current. All employee files were audited for completion of annual Dementia training and Residents' Rights training. Employees in need of Dementia training and/or Residents' Rights training were provided training on 11-8-17. 3.The office manager/HR will maintain a calendar log of employees and their due dates for annual administration of the tuberculin skin test. The office manager/HR will establish a system for record keeping ensuring employee education is complete and timely. The administrator is responsible for oversite of employee education and employee health records. The administrator inserviced department heads on 11-7-17 on required annual employee education and administration of the tuberculin skin test annually. 4.The office manager/HR will	11/19/2017

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	department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within		monitor the tuberculin skin test log and employee annual inservice attendance tracking monthly ongoing. The results of the audits will be reviewed at the monthly QAPI committee meeting overseen by the administrator and forwarded to corporate compliance. If threshold of 100% is not achieved action plans will be revised to ensure compliance.	

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	thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide staff members an annual tuberculin skin test for 1 of 10 employee personal files reviewed and the facility also failed to provide annual dementia and resident rights training/inservices for 1 of 10 employee personal files reviewed. (CNA #31) Findings include: The Employee Record for CNA #31 were reviewed on 10/20/17 at 11:30 a.m. The Employee Records form indicated CNA #31's start date was 8/25/16. The employee personnel file for CNA #31 indicated his last inservice on Resident Rights and Dementia was on 8/26/16. The last tuberculin skin test in CNA #31's file was 8/23/16.			

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	During an interview with the Business Office Manager, on 10/20/17 at 11:53 a.m., she indicated the facility was unable to determine if CNA #31 had any resident rights and dementia training after the above date. She also indicated the facility was unable to determine if CNA #31 had any tuberculin skin tests after 8/23/16. The Individual Employee Time Card for CNA #31 were provided by the Business Office Manager on 10/20/17 at 12:03 p.m. The indicated CNA #31 had worked over 20 hours per week since September 1, 2017. A policy titled Abuse & Neglect Policy, dated 8/5/16, was received from Administrator #2 on 10/12/17 at 1:42 p.m. It indicated, "...Annual resident rights and abuse prevention in-service training programs are conducted and it is mandatory that all personnel attend such training programs...." A policy titled Health Requirements, dated 9/1/14, was received from the Business Office Manager, on 10/20/17 at 12:03 p.m. It indicated "Policy Each employee may be required to meet applicable health regulations....:			

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