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	165497	A. BUILDING _____ B. WING _____	C 02/23/2017

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QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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F 000	INITIAL COMMENTS w/9/17 for F220 LF SS w/12/17 for F246 Correction date ~~2/15/17 for all others~~ Investigation of complaints #65811-C, #65829-C, #65958-C, #66177-C and facility self-reported incident #66278-I resulted in deficiencies. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 223 SS=J	483.12 FREE FROM ABUSE/INVOLUNTARY 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and staff interviews, the facility failed to ensure adequate supervision to protect against resident to resident abuse. Record review identified Resident #9 nonverbal and required staff assistance for transfers. Record review identify Resident #8 had ongoing inappropriate contact (sexual at times) with Resident #9 on 2/14/17, 2/15/17, 2/16/17 and observation showed ongoing contact between these residents on 2/20/17. A reasonable person would feel uncomfortable and likely undergo mental anguish or harassment if faced with another encounter with someone that inappropriately touched them. Staff interviews revealed they were aware and	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/09/2017

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

POC accepted 2/15/17 55 minutes

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F 223	Continued From page 1 reported the incidents to nurses. The findings constitute an immediate jeopardy to resident's health and safety as the facility failed to maintain separation of two residents (Resident #9 and Resident #8) involved in abuse allegations out of 9 residents reviewed for abuse. The facility reported a census of 45 residents. Findings include: 1). The Abuse Prevention, Identification, Investigation, and Reporting Policy revised 11/28/16 included documentation of the following under Policy Statement: residents must not be subjected to abuse by anyone, including, but not limited to other residents. Resident to resident physical contact that occurs, which includes but is not limited to resident to resident sexual harassment or sexual assault is also considered abuse. The facility will assume the abuse caused physical harm or mental anguish for residents with cognitive or physical impairments. The policy defiened mental abuse as not limited to humiliation, harassment and mistreatment as inappropriate treatment of residents. 2) The Minimum Data Set (MDS) admission assessment dated 1/25/17 for Resident #9 identified the state level II PASRR (Preadmission Screening and Resident Review) diagnosis of Intellectual Disability (ID) and other related conditions. The MDS identified the resident cognitive skills for daily decision making as modified independence with no behaviors displayed. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers, locomotion on the unit, and used a wheelchair.	F 223	**F 223 483.12, Free from Abuse/Involuntary Seclusion** A) Resident 8 was moved from the ICF to the Memory Care. Resident 9 will remain on the ICF floor. Resident 8 has received addition cares by medical professionals. Progress notes documentation has been address for Resident 8 & 9. Care plans for resident 8 & 9 reviewed. A new phone number has been obtained for family member of resident 9. B) The facility does and will continue to ensure that the resident is free from abuse, neglect, misappropriate of resident property and exploitation. Continued monitoring of all residents that reside in the facility. • Dependent Adult Abuse and Mandatory Reporting C) Education was held with each associate the week of February21-26, 2017- to re-educate and reinforce understanding of abuse and mandatory reporting, need for immediate notification to Administrator and requirement in making written witness statements before leaving their shift. Nurses U & T counseled and re-educated on notification, documentation, and assessment of abuse and or all incidents. Documentation is needed on each shift, avoid late entries. DON & Social Services Designee re-educated-counseled on the proper procedures needed for any form of abuse, incidents that these incidents must be reported to Administrator and / or nurse specialist immediately.	

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F 223	Continued From page 2 The undated Summary of Findings Report documented summary of PASRR review and included a primary axis II mental health diagnosis of profound intellectual disability and medical diagnoses of Cerebral Palsy with quadriplegia and seizure disorder. The summary identified Resident #9 had difficulty with understanding verbal information conveyed by others and expressing language. Resident #9 required total assistance with bathing, dressing, transfers and toileting. Resident #9's only behavioral concern related to choosing not to participate in cares (such as eating) but otherwise had no behavioral of concern. The care plan revised 1/14/17 identified a focus area for potential impaired physical mobility related to altered mental status, disease processes, and staff to provide assistance of 2 persons for transfers. The care plan focus area dated 1/31/17 identified a potential for communication barrier related to the resident being nonverbal. The care plan for Resident #9 did not address the resident's profound intellectual disability or PASRR conditions. The Progress Notes dated 2/1/17 at 10:07 a.m. through 2/20/17 at 3:52 p.m., contained no documentation of any resident-to-resident encounters. The Progress Notes dated 2/20/17 at 4:14 p.m., documented Staff X, social service designee, tried to call the resident's family member but the number disconnected. A typed letter addressed to the resident's family member on facility letterhead dated 2/22/17, documented the facilities several attempts to	F 223	D) The Quality Assurance Team will continue to monitor progress notes, incident reports and hot charting to monitor for incidents that need immediate action, QA team will continue to review with staff through daily, weekly and monthly educations the important of resident cares, interactions and abuse, safety. All incidents will be promptly reviewed by the QA team to ensure compliance to the regulations with the results forwarded to the nurse specialist for further review and recommendation. E) Responsible Person: Director of Nursing and Administrator. Alleged Date of Compliance: March 9, 2017	

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F 223	Continued From page 3 reach and instructed the family member to call the facility for an update on the resident's cares. The MDS assessment dated 12/6/16 for Resident #8 recorded a BIMS score of 14. A score of 14 indicated intact cognition. The MDS identified the resident experienced signs and symptoms of delirium with fluctuating behaviors of inattention and disorganized thinking. The MDS documented the resident displayed indicators of psychosis with delusions and verbal behaviors directed toward others on 1 to 3 days of the assessment reference period. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers, independent with setup help only for locomotion on the unit, and used a wheelchair. The MDS documented diagnoses that included non-Alzheimer's dementia. The care plan revised date of 12/19/16 identified performance deficit related to dementia, arthritis, and post-polio syndrome. The care plan directed staff to use 2 staff for all cares due to increased behaviors and delusions. The care plan identified the resident used a wheelchair for mobility. The care plan identified the resident took psychotropic medications and had behaviors. The care plan did not identify any description of behaviors or interventions to address behaviors other than administer psychotropic medications as ordered by the physician. The care plan printed 2/21/17 contained an updated intervention dated 2/21/17. The intervention informed staff the resident: required 1:1 (one-to-one) supervision; had increased behaviors; needed to be monitored closely when around male residents; and had a UTI (urinary	F 223		

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F 223	Continued From page 4 tract infection). The Progress Notes dated 1/28/16 signed by psychologist documented impression of dementia with behavioral disturbance and associated delusional ideas, depression, and anxiety. The note identified the resident's dementia had progressed and if hostile behaviors continued and worsened, then a routine low dose antipsychotic would be warranted. a). The Progress Notes created by Staff U, Licensed Practical Nurse (LPN) on 2/16/17 at 6:51 a.m., documented a late nursing entry for 2/14/17 at 11:47 a.m. The note recorded Resident #8 kissing another resident and rubbed his/her leg. The nurse documented she reminded Resident #8 the behavior was inappropriate and removed him/her from the area. The note documented Resident #8 yelled at the nurse. The note recorded the nurse spoke to Resident #8 about the other resident's inability to make his/her own choices due to his/her diagnosis. The Progress Notes created by Staff U on 2/16/17 at 6:52 a.m., documented a late nursing entry for 2/14/17 at 11:51 a.m. The note recorded the DON (Director of Nursing) aware of the issue and stated she would speak with the Administrator regarding the issue. b). The Progress Note written by Staff U dated 2/15/17 at 1:05 p.m., documented staff had to continue to remove Resident #8 from other resident's [Resident #9] due to attempting to kiss the other resident [Resident #9]. The note recorded Resident #8 very upset and became angry with the nurse.	F 223		

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F 223	Continued From page 5 c).The Progress Note written by Staff U dated 2/16/17 at 1:22 p.m., documented Resident #8 removed away from Resident #9 twice during the shift. The note recorded Resident #8 rubbed Resident #9's leg and became angry with the nurse. In an interview on 2/20/17 at 12:05 p.m., Staff U reported she had observed Resident #8 kissing Resident #9 on the lips and rubbing his/her thigh on 2/14/17. Staff U stated she had been the only staff member in the dining room. Staff U commented Resident #9 had no capacity to make choices. Staff U stated she had reported the incident to the DON who instructed her not to document on the incident at that time. Staff U reported she later heard Staff R and Staff S, CNA, discussing a night when Resident #8 touched Resident #9's exposed genitalia. Staff U reported no physicians or families notified of the incidents for either resident. Staff U commented Resident #8 had a history of fascination with men/women and had delusions that Resident #9 was his/her new boy/girlfriend. Staff U acknowledged she documented late entries on 2/16/17 for the incident of kissing she observed on 2/14/17. The Resident to Resident Encounter Report dated 2/17/17 at 1:45 p.m. recorded on 2/14/17 at 9:00 a.m., Resident #8 at a table kissing a resident on lips/cheek and rubbed the resident's upper thigh and leg. The report documented the resident removed and the DON notified. The report form included questions about the encounter such as what actions was taken by staff when this altercation occurred/ or what action can be taken to prevent the incident from	F 223		

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happening again, and what intervention did staff take at that time. These questions were blank and lacked any written response.

An untitled typed facility investigation summary dated 2/17/17 (provided by the Administrator) identified after the incident, the Administrator started an investigation with the DON regarding Resident #8 being present in the lobby with a group of residents and Resident #9's family member/s. The social service designee (Staff X) told the DON she Staff R had observed Resident #8's private part/s exposed and this event occurred on 2/14/17.
The summary identified no staff member filled out any incident reports/ or documentation [see late entry progress note dated 2/16/17]. The summary identified the Administrator started to gather information on 2/15/17 ; and did not determined anything inappropriate. Resident #8 had been placed on 30 minute checks on 2/15/17.
The same undated form documented the following: the Administrator had been reviewing Resident #8's progress notes late on 2/16/17 and noticed a nurse had made a late entry on 2/16/17 stating Resident #8 wheeled over to Resident #9 and kissed him/her.

The Progress Note dated 2/17/17 at 3:05 p.m., documented the Administrator requested Resident #8 be monitored for increased behaviors and outbursts. The note documented Resident #8 will be kept on 30 minute checks; and staff will obtain a urinalysis (UA); and schedule appointment with a PA (physician's assistant).
The note recorded the Administrator spoke to Resident #8 about misidentifying Resident #9 for his/her spouse. The note documented the

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F 223	Continued From page 7 Administrator instructed Resident #8 not to follow or touch Resident #9. In an interview on 2/20/17 at 11:38 a.m., Staff R, Certified Nurse Aide (CNA), reported she had witnessed 2 residents in close contact about a week prior. Staff R stated a family member of a resident in the lobby pulled her aside to assist someone in their chair. Staff R commented she looked over and saw Resident #8 and Resident #9 both touching Resident #9's exposed (genitalia). Staff R stated she separated the resident's immediately taking Resident #9 to his/her room. Staff R stated she then reported the incident to Staff T, LPN. Staff R commented she kept the residents separated the rest of the 2:00 p.m. to 10:00 p.m. shift. Staff R stated the next day or 2 she had been called to the office to speak to the DON. Staff R said the DON instructed her not to document the incident yet. Staff R reported at the time of the interview she had still not been asked to write a statement. In an interview on 2/23/17 at 9:20 a.m., Staff S, (CNA) stated she had reported an allegation of abuse on either 2/14/17 or 2/15/17 right before supper. Staff S stated a family member pointed to Resident #9 at a table in the commons area and the resident had his/her genitals exposed. Staff S stated Staff R reported she saw Resident #8 touch Resident #9's exposed genitalia. Staff S stated Staff R and her told Staff T right away. Staff S stated Staff R let everyone know to watch the residents. Staff S said they took Resident #9 to his/her room and the incident occurred around 4:30 p.m. Staff S commented Staff T told her she did not need to fill out any incident report. Staff S reported Staff T did not chart the incident. Staff S stated she later told Staff H (CNA) of the incident	F 223		

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who informed her she should have filled out papers. Staff S stated Resident #8 wouldn't leave the resident alone following him/her in the commons area and into his/her room.

In an interview on 2/20/17 at 1:03 p.m., Staff T responded she had received an abuse allegation from Staff S of Resident #8 touching Resident #9. Staff T said she had been told Resident #9's genitalia had been exposed but Staff T said she had not seen it or witnessed it herself. Staff T stated she told the DON and thought the DON had been in the facility at the time of the report. Staff T commented the DON said she would take care of it. Staff T stated she did not document anything but from that point forward; she kept a close eye on Resident #8. Staff T commented she felt the incident on the boundary line for what should be reported and both residents had been separated. Staff T stated the DON had not asked her to document anything but 30 minute checks kept on a clip board.

3). Observation on 2/20/17 at 10:55 a.m., revealed Resident #8 in a wheelchair by the nurses station next to Resident #9. Resident #9 sat in a wheelchair with his/her head down. Resident #8 faced Resident #9 and reached out to touch him/her. Resident #9 positioned with arms folded looking away from Resident #8. Resident #8 propelled his/her wheelchair away towards the 200 hall where the Administrator stood. At 11:05 a.m., Resident #8 returned to the side of Resident #9 and began talking to him/her. Resident #8 reached out and touched Resident #9's shirt at his/her stomach. Resident #8 stated to Resident #9: Are you okay baby?; I love you; am I boring you?. Resident #9 looked up and stared at Resident #8, then attempted to pull

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his/her shirt in front of his/her face. At the time of the interaction, no staff were observed present. Then Staff Y (housekeeper) came over and intervened, and assisted Resident #9 to the dining room. Observation at 11:20 a.m., (same date) revealed Staff U intervened to separate Resident #8 again from making contact with Resident #9.

A reasonable person would feel uncomfortable and likely undergo mental anguish or harassment if having another encounter with someone that inappropriately touched them.

a).The Progress Note dated 2/20/17 at 11:13 a.m., documented Resident #8 approached Resident #9 several times. The note identified the nurse removed Resident #8 but s/he wheeled right back to Resident #9. The note documented Resident #8 stated he/she wished people would leave him/her alone and let him/her be with Resident #9. The note reflected Resident #8 refused to let the nurse move him/her, he/she grabbed Resident #9's wheelchair, and then Administrator intervened and removed Resident #8 from Resident #9.

b).The Progress Note dated 2/20/17 at 12:06 p.m., documented Resident #8 in dining room at a table. The note recorded Resident #8 attempted to sit with Resident #9 and yelled he/she was his/her spouse. The note documented the nurse reminded Resident #8 he/she not married to Resident #9 and Resident #8 removed from the dining room to receive 1:1 (one-to-one) supervision by the Administrator.

The Progress Note dated 2/20/17 at 3:39 p.m., documented the Administrator spoke to Resident

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#8's family member in regards to the resident's increased behaviors and attraction to a male/female resident in the facility. The note recorded the Administrator informed the family member of the resident kissing the other resident with unknown allegation of touching.

Interviews:

In an interview on 2/20/17 at 2:55 a.m., Staff X, (social service) acknowledged she been told Resident #8 grabbed Resident #9's genitalia. Staff X reported sometime after 2/12/17, she came into work for the 2:00 p.m. to 10:00 p.m. shift., and Staff H, CNA, reported 2 girls told their charge nurse about the report but did not fill out statements. Staff X stated she instructed Staff T to fill out an [incident] report and to follow procedures. Staff X stated when she told the Administrator she was informed she should have called the Administrator. Staff X stated she did not make a report to state (DIA) because the Administrator said she would. Staff X confirmed she did not document anything.

In an interview on 2/20/17 at 1:30 p.m., the DON responded the last allegation of abuse she had received occurred on 2/14/17. The DON stated she had not actually been told until 2/15/17 and Staff R was the only person to tell her. The DON commented Resident #8 had a fixation with a previous resident whom had passed away and now Resident #8 thought Resident #9 was his/her spouse. The DON stated Staff R reported a family member called her over and Staff R seen Resident #9's exposed (genitalia). The DON said Staff R reported Resident #8 had been beside Resident #9 while he/she touched him/her(self). During the interview, the DON recalled perhaps

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more than 1 person had informed her of the incident. The DON stated prior to Staff R's report, she received report from Staff X, social service designee, who reported Resident #8 touched Resident #9's exposed (genitalia). The DON stated although Staff X contacted her before Staff R it was not before 2/15/17. The DON responded she did not get statements. The DON stated Staff R did not tell her nurse or the Administrator. The DON said she talked to Staff Ton 2/15/17. The DON said Staff T texted her and tried to retrieve the text to verify date and time but stated she must have deleted the message. The DON said she asked what happened and was told the staff took Resident #9 to the bathroom and his/her (genitals) were exposed. The DON said she and the Administrator did an investigation. The DON stated she reported the incident to her supervisor the Administrator. The DON commented she spoke to the family member that had been present in the lobby and they only saw Resident #9 playing with his/herself. The DON stated she expected the charge nurse to: document resident-to-resident incident reports in the progress notes; notify the physician; and notify families. The DON stated she was not aware of any family or doctors being notified. The DON said since 2/15/17, Resident #8 placed on 30 minute checks and when she was in the building she redirected the resident to his/her room or an activity. The DON stated she did not receive any reports of Resident #8 kissing Resident #9, but she read the nurses notes daily. The DON said she read Staff U's note about kissing and the Administrator talked to Staff U about it.

In an interview on 2/20/17 at 1:53 p.m., the Administrator stated she read the progress notes

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F 223	Continued From page 12 for Resident #8 either 2/15/16 or 2/16/17 and found Staff U's note about an incident of kissing. The Administrator said she asked Staff U why there was not an incident report. The Administrator stated possibly on 2/16/17, Staff X told her she had gone to the facility one night at 7:00 p.m. while Staff R was working. The Administrator said Staff X received report from Staff R, that when Staff R worked on 2/14/17 Resident #8 touched Resident #9's exposed genitalia. The Administrator stated neither Staff X nor Staff R called her to report anything. The Administrator commented she asked the DON to investigate. The Administrator verbalized she asked Staff X why she had not reported [sooner] since 2 days passed since Staff X received the report. The Administrator stated she called Resident #8's physician assistant on 2/17/17 and received orders for a UA. The Administrator said when she interviewed Staff T, Staff T denied receiving any reports of anything. The Administrator reported Resident #8 moved to the memory care unit at 11:40 a.m. 2/20/17. The Administrator said an incident report had been completed on 2/17/17 when directed Staff U to document it. The Administrator stated she talked with memory care aide since Resident #8 had been moved to the unit. The Administrator stated the unit had 4 males and staff would need to redirect Resident #8. The facility abated the IJ on 2/22/17 and sent the Department the following documents on 2/27/17: The Administrator updated the staffing schedule on the unit and Resident #8's care plan. The Administrator added Walkier Talkies to the Memory Care unit. The Administrator	F 223		

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F 223	Continued From page 13 documented 2/22/17, and included QA follow up as follows: All aides and nurses were re-education on Mandatory reporting. Resident #8 will receive 1:1 monitoring for the next two weeks through March 11, [2017]; if behaviors resurface 1:1 [supervision] will be restarted again. The facility updated the schedule for the overnight shift and there will be 3 aides in the building with the nurse. Staff would monitor residents daily for interactions between residents. There would b Care plans including Resident #8's, had been updated. On 2/21/17 the Administrator started education of Dependent Adult Abuse and Mandatory Reporting. The education/in-service sheet included the following provisions from the policy: all resident had the right to be free from abuse including but not limited to abuse from other residents. Resident to resident physical contact that occurs, which includes but is not limited to resident to resident sexual harassment or sexual assault is also considered abuse. The facility will assume the abuse caused physical harm or mental anguish for residents with cognitive or physical impairments. The training educated staff that all allegations of abuse (including the prior) are to be reported to DIA and the charge nurse who will immediately report the abuse to the Administrator or designated representative. The re-education also addressed the policy for all the documentation of allegation of abuse will be reviewed and immediate protection upon receiving a report of alleged abuse. With these provisions, the IJ was lowered from	F 223		

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F 223	Continued From page 14 "J" severity to a "D" with the need for ongoing monitoring.	F 223		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F 225	**F 225 483.13 (c) 1, 2-4 Investigate/Report Allegations/Individuals.** The facility does and will continue to ensure that All alleged violations involving mistreatment, neglect or abuse including unknown injuries, misappropriation of resident property is reported immediately to the administrator, and proper State agency including the investigation and outcome with appropriate corrective action taken. A) Education was held with all associates February 21-26, 2017 to ensure immediate reporting of allegations of abuse is reported immediately to the DIA. Administrator, DON and SS Designee will hold the responsibility to ensure all allegations are reported to the DIA immediately B) Business Office Manager will continue to record and track dependent adult abuse training for each employee and continued education of. Continue review of resident cares, safety and free from abuse will continue through daily, monitoring and in-service training. C) Nursing home staff were re-educated on the following guidelines: • *Facility Policy and Procedures on Dependent Adult Abuse.* • *Reporting methods to DON and Administrator Immediately.* • *Documentation of alleged reported abuse in residents* D) Human Resource Manager will monitor employee records for training / education with results given to the Administrator for further review. E) Responsible Person: Administrator, Director of Nursing, Social Services Designee. Alleged Date of Compliance: 3/15/2017	

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F 225	Continued From page 15 reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility record review and facility policy review, the facility failed to report allegations of resident-to-resident abuse to the Iowa Department of Inspections & Appeals (DIA) for two (Resident #9 and Resident #8) of nine residents reviewed for mandatory reporting. The facility reported a census of 45 residents. Findings include:	F 225		

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F 225	Continued From page 16 1). The Abuse Prevention, Identification, Investigation, and Reporting Policy revised 11/28/16 included documentation of the following under Policy Statement: residents must not be subjected to abuse by anyone, including, but not limited to other residents. Resident to resident physical contact that occurs, which includes but is not limited to resident to resident sexual harassment or sexual assault is also considered abuse. The facility will assume the abuse caused physical harm or mental anguish for residents with cognitive or physical impairments. The policy indicated all allegations of abuse are to be reported to Department of Inspections and Appeals and the charge nurse who will immediately report the abuse to the Administrator or designated representative. 2) The Minimum Data Set (MDS) admission assessment dated 1/25/17 for Resident #9 identified the state level II PASRR (Preadmission Screening and Resident Review) diagnosis of Intellectual Disability (ID) and other related conditions. The MDS identified the resident cognitive skills for daily decision making as modified independence with no behaviors displayed. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers, locomotion on the unit, and used a wheelchair. The care plan revised 1/14/17 identified a focus area for potential impaired physical mobility related to altered mental status, disease processes, and staff to provide assistance of 2 persons for transfers. The care plan focus area dated 1/31/17 identified a potential for communication barrier related to the resident	F 225		

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F 225	Continued From page 17 being nonverbal. The Progress Notes dated 2/1/17 at 10:07 a.m. through 2/20/17 at 3:52 p.m., contained no documentation of any resident-to-resident encounters. The MDS assessment dated 12/6/16 for Resident #8 recorded a BIMS score of 14. A score of 14 indicated intact cognition. The MDS identified the resident experienced signs and symptoms of delirium with fluctuating behaviors of inattention and disorganized thinking. The MDS documented the resident displayed indicators of psychosis with delusions and verbal behaviors directed toward others on 1 to 3 days of the assessment reference period. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers, independent with setup help only for locomotion on the unit, and used a wheelchair. The MDS documented diagnoses that included non-Alzheimer's dementia. The care plan revised date of 12/19/16 identified performance deficit related to dementia, arthritis, and post-polio syndrome. The care plan identified the resident took psychotropic medications and had behaviors. The care plan did not identify any description of behaviors or interventions to address behaviors other than administer psychotropic medications as ordered by the physician. a). The Progress Notes created by Staff U, Licensed Practical Nurse (LPN) on 2/16/17 at 6:51 a.m., documented a late nursing entry for 2/14/17 at 11:47 a.m. The note recorded Resident #8 kissing another resident and rubbed	F 225		

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F 225	Continued From page 18	F 225		

his/her leg. The nurse documented she reminded Resident #8 the behavior was inappropriate and removed him/her from the area. The note documented Resident #8 yelled at the nurse. The note recorded the nurse spoke to Resident #8 about the other resident's inability to make his/her own choices due to his/her diagnosis.

The Progress Notes created by Staff U on 2/16/17 at 6:52 a.m., documented a late nursing entry for 2/14/17 at 11:51 a.m. The note recorded the DON (Director of Nursing) aware of the issue and stated she would speak with the Administrator regarding the issue.

b). The Progress Note written by Staff U dated 2/15/17 at 1:05 p.m., documented staff had to continue to remove Resident #8 from other resident's [Resident #9] due to attempting to kiss the other resident [Resident #9].

c).The Progress Note written by Staff U dated 2/16/17 at 1:22 p.m., documented Resident #8 removed away from Resident #9 twice during the shift. The note recorded Resident #8 rubbed Resident #9's leg and became angry with the nurse.

In an interview on 2/20/17 at 12:05 p.m., Staff U reported she had observed Resident #8 kissing Resident #9 on the lips and rubbing his/her thigh on 2/14/17. Staff U commented Resident #9 had no capacity to make choices. Staff U stated she had reported the incident to the DON who instructed her not to document on the incident at that time. Staff U acknowledged she documented late entries on 2/16/17 for the incident of kissing she observed on 2/14/17.

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F 225	Continued From page 19 The Resident to Resident Encounter Report dated 2/17/17 at 1:45 p.m. recorded on 2/14/17 at 9:00 a.m., Resident #8 at a table kissing a resident on lips/cheek and rubbed the resident's upper thigh and leg [Resident #9]. The report documented the resident removed and the DON notified. Observation of the facilities investigation file on the resident-to-resident incident with Resident #8 and Resident #9 given to the surveyor on 2/20/17 at 3:55 p.m., revealed no evidence the incidents reported to DIA. Review of the online abuse report intake #66278-I received on 2/21/17 at 9:24 a.m., revealed the facility submitted to DIA an allegation of abuse that occurred on 2/14/17 at 6:00 a.m. Interviews: In an interview on 2/20/17 at 11:38 a.m., Staff R, Certified Nurse Aide (CNA), reported she had witnessed 2 residents in close contact about a week prior. Staff R stated she then reported the incident to Staff T, LPN. Staff R commented she kept the residents separated the rest of the 2:00 p.m. to 10:00 p.m. shift. Staff R stated the next day or 2 she had been called to the office to speak to the DON. Staff R said the DON instructed her not to document the incident yet. Staff R reported at the time of the interview she had still not been asked to write a statement. In an interview on 2/23/17 at 9:20 a.m., Staff S, (CNA) stated she had reported an allegation of abuse on either 2/14/17 or 2/15/17 right before supper. Staff S stated Staff R reported she saw	F 225		

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Resident #8 touch Resident #9's exposed genitalia. Staff S stated Staff R and her told Staff T right away. Staff S commented Staff T told her she did not need to fill out any incident report. Staff S reported Staff T did not chart the incident.

In an interview on 2/20/17 at 1:03 p.m., Staff T responded she had received an abuse allegation from Staff S of Resident #8 touching Resident #9. Staff T said she had been told Resident #9's genitalia had been exposed but Staff T said she had not seen it or witnessed it herself. Staff T stated she told the DON and thought the DON had been in the facility at the time of the report. Staff T commented the DON said she would take care of it. Staff Staff T said she did not report the incident to state DIA (Department of Inspections & Appeals).

In an interview on 2/20/17 at 2:55 a.m., Staff X, (social service) acknowledged she been told Resident #8 grabbed Resident #9's genitalia. Staff X reported sometime after 2/12/17, she came into work for the 2:00 p.m. to 10:00 p.m. shift., and Staff H, CNA, reported 2 girls told their charge nurse (Staff T) about the report but did not fill out statements. Staff X stated she instructed Staff T to fill out an [incident] report and to follow procedures. Staff X stated when she told the Administrator she was informed she should have called the Administrator. Staff X stated she did not make a report to state (DIA) because the Administrator said she would. Staff X confirmed she did not document anything.

In an interview on 2/20/17 at 1:30 p.m., the DON responded the last allegation of abuse she had received occurred on 2/14/17. The DON stated she had not actually been told until 2/15/17 and

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F 225	Continued From page 21 Staff R was the only person to tell her. The DON stated Staff R reported a family member called her over and Staff R seen Resident #9's exposed genitalia. The DON said Staff R reported Resident #8 had been beside Resident #9 while he/she touched him/her(self). During the interview, the DON recalled perhaps more than 1 person had informed her of the incident. The DON stated prior to Staff R's report, she received report from Staff X, social service designee, who reported Resident #8 touched Resident #9's exposed (genitalia). The DON stated although Staff X contacted her before Staff R it was not before 2/15/17. The DON responded she did not get statements. The DON stated Staff R did not tell her nurse or the Administrator. The DON said she talked to Staff Ton 2/15/17. The DON said she and the Administrator did an investigation. The DON stated she did not report the incident to state (DIA). In an interview on 2/20/17 at 1:53 p.m., the Administrator stated she read the progress notes for Resident #8 either 2/15/16 or 2/16/17 and found Staff U's note about an incident of kissing. The Administrator said she asked Staff U why there was not an incident report. The Administrator stated maybe 2/16/17, Staff X told her she had gone to the facility 1 night at 7:00 p.m. while Staff R worked. The Administrator said Staff X received report from Staff R, that when Staff R worked 2/14/17 maybe Resident #8 touched Resident #9's exposed genitalia. The Administrator stated neither Staff X nor Staff R called her to report anything. The Administrator commented she asked the DON to investigate. The Administrator verbalized she had been upset when she asked Staff X why she had not reported because 2 days had passed since Staff X	F 225		

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F 225	Continued From page 22 received the report. The Administrator stated she did not report to DIA because there was no evidence the incident happened. The Administrator said when she interviewed Staff T, Staff T denied receiving any reports of anything. The Administrator said an incident report had been completed on 2/17/17 when she made Staff U document it.	F 225		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, the facility failed to ensure a resident was assisted to bed as desired and failed to ensure the bedroom window was secured. (Resident #4) The facility census was 45 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/25/17, documented Resident #4 had diagnoses that included urinary incontinence, generalized muscle weakness and low back pain and had a Brief Interview for Mental Status score of 11, indicating moderately impaired cognition. The MDS documented the resident required the limited assistance for bed mobility, transfers, walking in room, dressing and toilet use.	F 246	**F 246 Reasonable Accommodations of Needs/ Presences** The facility does and will continue to ensure that the resident shall be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. A) A daily 30 minute check log for each hour was established for resident 4 to ensure aides are monitoring resident needs more frequently in the absence of resident 4 personal care giver not being present and to ensure residents care giver does not need assistance when present. B) All residents whom reside in the facility are monitored for reasonable accommodations and preferences to ensure safety and health. A quality assurance, tasks sign off for rounding every 2 hours at a minimum was added to the c.n.a point click care to aid in monitoring.	

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F 246	Continued From page 23 The care plan revised 12/15/16, directed staff to provide assistance with activities of daily living and toileting, provide pericare with incontinence episodes, toilet the resident before and after meals and as needed and provide assistance with wheeled walker for transfers. During interview on 2/14/17 at 9:10 a.m., the resident reported he/she recalled maybe a month prior they slept in a chair over night because they were not assisted to bed that night. During interview on 2/14/17 at 5:25 a.m., Staff D, housekeeper, confirmed there was a time she found Resident #4 in his/her room with the window open at 6:00 a.m. Staff D stated the incident occurred approximately 3 or so weeks ago. Staff D reported the resident sat in a chair with his/her head over the table sleeping. Staff D said the resident was dressed in a nightgown and brief. Staff D reported the resident called to her saying they were freezing to death. Staff D said the resident's window was wide open. Staff D stated she informed Staff F, licensed practical nurse, LPN and they assisted the resident to bed. Staff D reported the resident kept saying he/she was so cold. During interview on 2/14/17 at 10:40 a.m., Staff F, LPN reported she came in early around 6:00 a.m. when Staff D summoned her stating the resident had been up all night. Staff F stated she observed the resident in his/her easy chair. Staff F said the resident reported staff never came to put him/her to bed. Staff F stated she wrote a note to the administrator and looked into who put the resident to bed. Staff F reported the resident normally went to bed around 9:30 p.m.	F 246	C) Nursing staff and housekeeping staff was as re-educated on ensuring residents have reasonable accommodations for the preferences but to ensure safety as well. Education provided on monitoring room temperatures and outside air temperatures, closing windows appropriately, and daily rounding of checking on residents to monitor redesign comfort while in bed; include windows, curtains. An Ambassador Program weekly program was established on February 20, 2017 for residents whom reside in the facility to have better communication and follow up to cares and staff communication. D) The Quality Assurance Department Team will continue to monitor for resident accommodations through the Ambassador Program with results forwarded to the nurse specialist for further review and recommendation. E) Responsible Person: Administrator and or Director of Nursing. Alleged Date of Compliance: 3/13/2017	

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F 246	Continued From page 24 During interview on 2/16/17 and 12:35 p.m., the director of nursing, DON reported there was an issue with the resident being up in a chair all night and not being put to bed. The DON stated the resident was not ready to go to bed on the 2:00 p.m. to 10:00 p.m. shift and at one point the overnight shift did not follow up. The DON commented she felt staff did not do it intentionally, they just did not realize the resident needed help. The DON said she held an in-service education on 2/15/17 to inform staff that even though the resident had a (personal) caregiver they really needed to check on him/her as the resident was unable to tell them. During interview on 2/16/17 at 1:30 p.m., the Administrator stated the resident was reported to have been left in a chair and not put to bed overnight. The Administrator reported she had heard the resident's window was open but did not know if it had been all night.	F 246		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a	F 279		

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F 279	Continued From page 25 comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 279	**F 279 Develop Comprehensive Care Plans** A) Resident # 8 and 9 care plans have been reviewed and revised. Resident # 8 care plan revised to show the resident has delusional thoughts of other residents being her husband and interventions to be put in place when resident is experiencing delusional thoughts. B) MDS Coordinator will continue to review each resident's care plan in the facility to ensure the cares and services of each resident are listed on the care plan. The facility ensures that the care plan describes the services that are to be furnished to attain the highest predictable physical, mental and psychological well-being. C) MDS Coordinator and Department Managers who enter data in to the care plans in serviced on the importance of reviewing each care plan to ensure all services and updates are recorded and accurate. Importance of ensuring accuracy during care plan meetings for the periodic review of care plan to see if interventions are still necessary. MDS coordinator will continue to educate c.n.a. and nursing associates on how to read and follow the care plan and document cares provided. D) MDS Coordinator will complete periodic audits of the assessments, care plans with the results forwarded to the Quality Assessment and Assurance Team for further review and recommendation. E) Responsible Party: MDS Coordinator and Director of Nursing Alleged date of Compliance: 3/15/2017	

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F 279	Continued From page 26 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to develop a care plan to address a resident's behavior of delusional thoughts other residents were his/her spouse seeking inappropriate contact for 1 of 9 residents reviewed for comprehensive care planning (Resident #8). The facility reported a census of 45. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/6/16 for Resident #8 recorded a Brief Interview for Mental Status (BIMS) score of 14, indicating intact memory and cognition. The MDS identified the resident experienced signs and symptoms of delirium with fluctuating inattention and disorganized thinking. The MDS documented the resident displayed had delusions during the assessment period and verbal behaviors directed toward others on 1 to 3 days of the assessment reference period. The MDS documented diagnoses that included Non-Alzheimer's dementia. Resident #8 did not walk and used a wheelchair for locomotion. The resident's care plan, printed on 2/20/17, informed staff the resident to have 2 staff in the room for all cares due to increased behaviors and delusions. The care plan identified that Resident #8 used psychotropic medications related to	F 279		

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disease process of Alzheimer's disease and behaviors associated with the disease process. The care plan did not contain any description of his/her behaviors or interventions to address behaviors other than administer psychotropic medications as ordered by the physician and direction for staff to praise any progress/improvement in behavior. .

A psychologist's Progress Note dated 1/28/16 documented the impression of dementia with behavioral disturbance and associated delusional ideas, depression and anxiety. The psychologist suggested an opinion the dementia had progressed and if the hostile behaviors continued and worsened then consideration of routine low dose antipsychotic would be warranted and staff non-pharmacological interventions were appropriate.

The Progress Notes created by Staff U, Licensed Practical Nurse (LPN) on 2/16/17 at 6:51 a.m., documented a late nursing entry for 2/14/17 at 11:47 a.m. The note recorded Resident #8 kissing a male/female resident and rubbed his/her leg. The nurse documented she reminded Resident #8 the behavior inappropriate and removed him/her from the area. The note documented Resident #8 yelled at the nurse you are just jealous I have a boyfriend/girlfriend and called the nurse (derogatory comment). The note recorded the nurse spoke to Resident #8 about the other resident's inability to make his/her own choices due to his/her diagnosis.

The Progress Note dated 2/15/17 at 1:05 p.m., documented Resident #8 continued to have to be removed from male/female resident due to attempting to kiss the resident. The note

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recorded Resident #8 very upset and became angry with the nurse.

The Progress Note dated 2/16/17 at 1:22 p.m., documented Resident #8 removed away from Resident #9 twice during the shift. The note recorded Resident #8 rubbed Resident #9's leg and became angry with the nurse.

The Progress Note dated 2/17/17 at 4:58 a.m., documented Resident #8 continued on 30 minute checks (frequent observations) with no inappropriate contact made with male/female peer. The note recorded the resident verbally aggressive toward staff at times.

The Resident to Resident Encounter Report dated 2/17/17 at 1:45 p.m. recorded on 2/14/17 at 9:00 a.m., Resident #8 at table kissing a resident on lips/cheek and rubbed leg and upper thigh. The report documented the resident removed and the DON notified.

The Progress Note dated 2/17/17 at 3:05 p.m., documented the Administrator requested Resident #8: be monitored for increased behaviors and outbursts; be kept on 30 minute checks; have UA (urinalysis) collected; and have appointment scheduled with the PA (physician's assistant). The note recorded the Administrator spoke to Resident #8 about his/her mistaken thoughts Resident #9 was his/her spouse. The note documented the Administrator instructed Resident #8 not to follow or touch Resident #9.

Observation on 2/20/17 at 10:55 a.m., revealed Resident #8 in a wheelchair by the nurses station next to Resident #9, who sat in a wheelchair with his/her head down. Resident #8 faced Resident

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#9 and reached out to touch him/her. Resident #9 positioned with arms folded looking away from Resident #8. Resident #8 propelled his/her wheelchair away towards the 200 hall where the Administrator stood. At 11:05 a.m., Resident #8 returned to the side of Resident #9 and began talking to him/her. Resident #8 reached out and touched Resident #9's shirt on his/her stomach. Resident #8 stated to Resident #9: are you okay baby?; I love you; am I boring you?; and hello?. Resident #9 looked up and stared at Resident #8 then attempted to pull his/her shirt in front of his/her face. At the time of the interaction, no staff observed. Then Staff Y, housekeeper, came, intervened, and assisted Resident #9 to the dining room. Observation at 11:20 a.m., revealed Staff U intervened to separate Resident #8 again from making contact with Resident #9. Resident #8 resisted being removed from the area and the resident stated everyone wanted him/her to be moved from Resident #9.

The Progress Note dated 2/20/17 at 11:13 a.m., documented Resident #8 approached Resident #9 several times. The note recorded the nurse removed Resident #8 but s/he wheeled right back to Resident #9. The note documented Resident #8 stated he/she wished people would leave him/her alone and let him/her be with Resident #9. The note reflected Resident #8 refused to let the nurse move him/her, he/she grabbed Resident #9's wheelchair, and then Administrator intervened and removed Resident #8 from Resident #9.

In an interview on 2/20/17 at 11:38 a.m., Staff R, Certified Nurse Aide (CNA), reported she had witnessed 2 residents in close contact about a week prior. Staff R commented at that time she

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looked over and saw Resident #8 and Resident #9 both touching Resident #9's exposed (genitalia). Staff R stated she separated the residents immediately.

In an interview on 2/20/17 at 12:05 p.m., Staff U reported she had observed Resident #8 kissing Resident #9 on the lips and rubbing his/her thigh on 2/14/17. Staff U commented Resident #8 had a history of fascination with men/women and had delusions that Resident #9 was his/her new boy/girlfriend.

The Progress Note dated 2/20/17 at 12:06 p.m., documented Resident #8 in dining room at a table. The note recorded Resident #8 attempted to sit with Resident #9 and yelled he/she was his/her spouse. The note documented the nurse reminded Resident #8 he/she not married to Resident #9 and Resident #8 removed from the dining room to receive 1:1 (one-to-one) supervision by the Administrator.

In an interview on 2/20/17 at 1:30 p.m., the DON commented Resident #8 had a fixation with a previous resident whom had passed away and now Resident #8 thought Resident #9 was his/her spouse.

In an interview on 2/20/17 at 1:53 p.m., the Administrator reported she told the memory care unit aide to be mindful of Resident #8 with the 4 men/women in the unit due to difficulties redirecting Resident #8 and Staff U's reports the resident thought a previous resident had been his/her spouse.

The Progress Note dated 2/20/17 at 3:39 p.m., documented the Administrator spoke to Resident

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F 279	Continued From page 31 #8's family member in regards to the resident's increased behaviors and attraction to a male/female resident in the facility. The note recorded the Administrator informed the family member of the resident kissing the other resident with unknown allegation of touching. The care plan printed 2/21/17 contained an updated intervention dated 2/21/17. The intervention informed staff the resident: required 1:1 (one-to-one) supervision; had increased behaviors; needed to be monitored closely when around male residents; and had a UTI (urinary tract infection). In an interview on 2/23/17 at 9:20 a.m., Staff S, CNA, reported Resident #8 had a history of thinking a previous resident was his/her husband. Staff S stated Resident #8 wouldn't leave the resident alone following him/her in the commons area and into his/her room.	F 279		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services 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	F 353		

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F 353	Continued From page 32 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. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident council meeting minutes, observation, staff interview, clinical record review, and resident interview, the facility failed to ensure requests for assistance with cares completed in a timely manner to prevent occurrences of incontinence and discomfort for 13 residents in	F 353	**F 353 SUFFICIENT 24 NURSING STAFF** The facility does and will continue to ensure that it provides sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental and psychosocial; well-being of each resident which is evident by the following: A) Resident # 3 & 4 are on daily 30 minute checks for an ongoing basis through March and then as needed with follow up with each resident. Resident # 5 & 7 are being interviewed weekly with responses noted with their facility ambassador and Administrator spot checks. B) An Ambassador tool was developed for all residents to monitor call light response times and to record resident feedback from interviews of call light response by staff. The Administrator asked for permission to also attend the next resident council on March 28, 2017. The facilities staffing policy was updated on February 20, 2017 to provide 3 aide associates to the overnight shift. C) The facility policy and procedure on Call Light Response will be reviewed with nursing staff between March 13-20, 2017. Communication was presented to all nursing associates on March 8 -10, 2017 as a reminder of cell phone policy with discipline up to 3 day suspension for violation of. Use of Concern Reporting Logs reviewed with all Department Managers on March 14, 2017 to ensure documentation of concerns are noted and followed up on with Administrator signing off the concern was addressed.	

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F 353	Continued From page 33 attendance at a group meeting and 4 of 7 residents reviewed for call lights (Resident #3, #4, #5, #7). The facility reported a census of 45 residents. Findings include: 1. The Resident Council Meeting Minutes dated 1/27/17 documented 13 residents attended the meeting. The minutes recorded old business topics that included resident care concerns. The minutes recorded the residents' report of staff unresponsive to call lights; staff turned off call lights multiple times citing getting help with no follow through; or lengthy times for staff to respond. Under miscellaneous, the minutes recorded nursing staff provided appropriate care and caring nature, but aide staff less than sufficient in responding. Observation on 2/14/17 at 3:50 a.m., revealed Staff C, Certified Nurse Aide (CNA), sat in the memory care unit in a chair using her personal cell phone. In an interview on 2/14/17 at 4:00 a.m., Staff A, Licensed Practical Nurse (LPN), stated she honestly felt there was not enough help on the 10 p.m. to 6 a.m. shift when assigned 1 nurse, 1 aide on the floor, and 1 aide in the memory care unit. Staff A said she worked for the facility since November 2016 and worked 2:00 p.m. to 10:00 p.m. also. Staff A stated if something serious happened with a resident and another resident required assistance of 2 persons, she did not believe she would be available to help. In an interview on 2/14/17 at 4:20 a.m., Staff B, CNA, stated she did not feel there was enough	F 353	D) The Administrator and Assigned Department Managers will monitor timing of call lights, and interviewing residents with the aid of the Ambassador Program responses with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing / Administrator Alleged Date of Compliance: March 9, 2017	

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staff when only 1 aide available on the floor on over nights. Staff B reported if someone required assistance of 2 persons, she did her best to clean them up and get the nurse for second assist.

Observation on 2/14/17 at 4:30 a.m., revealed Staff C charted on the computer in the memory care unit with her phone plugged into a phone charger and tucked by her side.

In an interview on 2/14/17 at 4:32 a.m., Staff C stated she did not feel there was enough help on the overnight shift. Staff C said one aide for the unit fine, but out on the floor most rounds done by self with no help. Staff C reported call lights may take ½ hour when staff on break. Staff C reported they used to have 3 aides on overnight shift but that just stopped.

In an interview on 2/14/17 at 4:55 a.m., Staff A stated phones for the most part should not be used as staff should be focusing on the residents.

In an interview on 2/14/17 at 11:00 a.m., Staff E, Certified Medication Aide, (CMA), reported Staff C is on the phone and listens to music constantly when working the 2:00 p.m. to 10:00 p.m. shift. Staff E stated she had reported it before. Staff E said the Administrator responded she would talk to Staff C but stated Staff C still used the phone. Staff E reported the residents have complained about the night shift staff frequently. Staff E commented she had seen Staff W, LPN, playing computer games. Staff E stated she had reported her concerns to the Administrator about Staff W.

In an interview on 2/15/17 at 6:00 a.m., Staff H, CNA, stated breaks occurred around 11:30 p.m.,

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1:30 a.m., and 4:00 a.m. Staff H said the overnight shift half hour break occurred around 1:30 a.m. Staff H reported the facility had quite a few blue dots on resident doors that indicated alarmed residents. Staff H said there were handfuls of residents that required assistance of 2 persons for bed repositioning. Staff H stated she did not feel there was enough staff with only 1 aide on the floor 10:00 p.m. to 6:00 a.m. shift. Staff H reported she had seen Staff W playing games and told the administrator prior to 1/7/17. Staff H stated Staff W continued to work since that date. Staff H reported she also had concerns with Staff Q, LPN, not knowing what to do.

In an interview on 2/15/17 6:15 a.m., Staff G, CNA, reported she did not feel there was enough staff. Staff G stated she worked hard and did not like to fall short. Staff G said they could have 1 nurse answering a call light and 1 aide doing rounds, if someone's alarm going off she would not be able to hear it and no one available to watch for call lights. Staff G stated it was not safe when it's not calm for those unsteady residents. Staff G said there was not enough staff to get proper care and some things were not getting done. Staff G reported at times she could not properly wipe residents. Staff G stated eventually staff cut corners and it's not right. Staff G reported the DON and Administrator had been aware and even mentioned 1 of her notes in a meeting. Staff G expressed Staff W and Staff Q not doing the job. Staff G commented when she reports residents not feeling well to Staff W, she does not check on them. Staff G said Staff W either gave no response or said she would and did not go. Staff G said Staff W continued to work since she voiced her concerns to the Administrator who had known for months. Staff

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G reported staff W played games on the computer. Staff G stated she had reported concerns that Staff Q refused to go into room to assist her when residents had shingles and MRSA (methicillin resistant staphylococcus aureus - a type of bacteria resistant to antibiotics).

On 2/15/17 at 2:00 p.m., the Director of Nursing (DON), provided a Resident Room Listing. The DON designated on the list the residents in the facility that required assistance of 2 persons for transfers or bed mobility. The list documented 15 residents required the assistance of 2 persons and 1 resident required the assistance of 3 persons out of 45 total residents listed.

In an interview on 2/15/17 at 3:15 p.m., the DON responded she had had some issues with concerns about call lights and staffing on the overnight shift. The DON confirmed she had also heard complaints related to Staff C being on the phone and not being attentive to the residents.

In an interview on 2/15/17 at 3:30 p.m., Staff Q stated she had worked for the facility for five months. Staff Q verbalized she did not feel staffing fair as 8 CNA's scheduled on the dayshift and only 1 CNA for memory care unit and 1 on the floor for the overnight shift. Staff reported there were times 3 call lights on and not fair a resident had to wait to get their light answered. Staff Q stated when staff took breaks it left only 1 CNA on the floor to run everything. Staff Q reported they used to have 3 CNA's but management took 1 CNA away on the overnight shift. Staff Q said it was not possible for the 1 CNA on the memory care unit to be pulled to help on the floor. Staff Q reported she had told the

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DON and they received extra help for 1 month only. Staff Q said sometimes work was so hard because residents need help like turning (in bed) and can't turn them because someone else wanted on the toilet.

In an interview on 2/16/17 at 12:35 p.m., the DON reported the overnight shift generally had 2 CNA's and 1 nurse staffed. The DON stated 1 aide added if census at certain point but would have to check with the Administrator as she did the scheduling. The DON said she thought the extra aide added at a census of 45. The DON acknowledged she had received reports from Staff H and Staff G who worked the overnight shift. The DON stated the staff wanted to have 3 CNA's scheduled. The DON said she informed the staff she would discuss it with the Administrator. The DON acknowledged she had received complaints about Staff W: sitting on the computer all night; never starting a bi-pap (breathing machine) in a timely manner; not assisting CNAs; and not getting treatments done until midnight a couple of weeks ago. The DON reported a staff member had called 2 to 3 weeks prior to complain that Staff C and Staff Q watched TV, used cell phones, and we're not helping. The DON reported she had talked with Staff C about not using a cell phone and probable sleeping while at work previously, approximately around November 2016. The DON stated recently it was reported Staff Q would not go into residents rooms where shingles or MRSA present.

In an interview on 2/16/17 at 1:30 p.m., the Administrator stated she had not really received any complaints about staffing concerns except overnight shift wanted 3 CNA's. The Administrator commented she wanted 3 CNA's

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also, but the owner had directed to cut the extra CNA because the budget too high. The Administrator stated if the census at 43 residents, she wanted 3 CNA's; however with 1 resident going out to the hospital and pushing 44 census, she agreed to let the third person go. The Administrator reported she had spoken to the staffing agency regarding Staff W playing computer games, being on the Internet, and the need for her to help the aides.

Observation on 2/20/17 at 11:00 a.m., revealed the posted schedule assigned only 2 CNA's for the overnight shift.

Observation on 2/22/17 at 1:45 p.m. revealed blue dots observed on the name plates by the residents' room doors. Observation of the 100 hall revealed 3 residents with blue dots; 200 hall contained 8 residents with blue dots; and 500 hall contained 5 residents with blue dots; a total of 16 out of 45 total residents.

In an interview on 2/22/17 at 1:00 p.m., the DON confirmed a blue dot outside the residents' room door meant the resident in the room had an alarm for a safety intervention.

2. The Minimum Data Set (MDS) assessment dated 1/6/17 for Resident #3 recorded a Brief Interview for Mental Status (BIMS) score of 15 without signs or symptoms of delirium. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, and total dependence of 2 persons for toilet use. The MDS identified diagnoses that included heart failure, chronic lung disease, obesity, and generalized muscle weakness. The

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F 353	Continued From page 39 MDS documented a weight of 329 pounds. The care plan revised 12/12/16 identified a focus area for potential for injury, impaired physical mobility. The care plan directed staff to use EZ-stand (mechanical lift) with 2 person assist for transfers, toileting when up assist of 2 to the commode, and toileting in bed assist with 1 using bariatric bedpan. In an interview on 2/13/17 at 2:18 p.m., Resident #3 stated he/she had been keeping track of his/her concerns on a list. Resident #3 said his/her documentation did not include the aide scheduled in the memory care unit (Hall 300); just the staff scheduled on the floor (Halls 100, 200, 500). Resident #3 commented night after night the facility had 1 aide (certified nurse aide, CNA) for the whole building and 1 nurse; Resident #3 documented this occurred 2/3/17 - 2/6/17. Resident #3 reported a couple of nights before 1 aide tried to assist him/her up in bed but the nurse refused to help as the nurse playing video game. Resident #3 stated it took 3 hours until the girl from the unit took break and helped to pull him/her up in bed. Resident #3 said he/she felt some days no one cared. Resident #3 stated the night he/she waited for 3 hours occurred on 2/7/17 or 2/9/17 when Staff H, CNA, worked. Resident 3 said Staff H informed him/her Staff W refused to help because Staff W was playing a video game. Resident #3 reported the Administrator aware and told the resident the facility would not hire (the agency nurse) again; the resident stated Staff W remained on the schedule. Resident #3 reported on 2/11/17 he/she put his/her call light on at 7:40 a.m. but no one answered. Resident #3 reported he/she called the facility at 8:15 a.m. and told the	F 353		

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housekeeper that answered to get someone to help. Resident #3 documented on his/her list on 2/11/17, Saturday 6:00 to 2:00 didn't answer call light, no one came and he/she pooped bed.

In an interview on 2/14/17 at 4:20 a.m., Staff B, CNA, reported Resident #3 as aware and credible.

In an interview on 2/14/17 at 4:00 a.m., Staff A, LPN, reported Resident #3 had been told at suppertimes he/she needed to wait for the commode because 3 to 5 CNA's needed to assist in the dining room. Staff A said 1 nurse stays in the dining room and 1 nurse kept around the nurses' station to answer lights. Staff A stated if a resident required assistance of 2 persons he/she needed to wait till staff done assisting the dining room. Staff A said its possible Resident #3 waited up to 30 minutes on over nights for call lights to be answered.

In an interview on 2/14/17 at 4:32 a.m., Staff C, CNA, stated she did not know if Resident #3 was credible because the resident complained a lot. Staff C reported she had a hard time working out on the floor the previous night. Staff C said she started rounds at 4:30 a.m., Resident #3's call light on but the other aide on break, and the nurse on the unit. Staff C stated by the time she got to the resident's room, the resident needed the bed stripped because it was wet. Staff C reported the resident normally used a bed pan and could tell staff when he/she needed to go to the bathroom. Staff C responded she wouldn't know the call light was on because she can't see the light outside of the resident's room when on the 200 hall.

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In an interview on 2/15/17 at 6:00 a.m., Staff H stated there was a time in the last week at 2:45 a.m. when Resident #3 had his/her call light on. Staff H reported she had not started rounds yet and they were supposed to start at 2:30 a.m. Staff H reported Staff W playing video games when she asked for assistance to pull the resident up in bed. Staff H said Staff W gave no answer. Staff H attempted to move the resident by herself, but only moved the resident an inch. Staff H stated when she came out of the resident's room, Staff W was going down the hallway with coat towards the break room.

In an interview on 2/15/17 at 6:37 a.m., Staff I, CNA, reported Resident #3 had complained about Staff C and Staff Q not doing cares. Staff I stated the Assistant Director of Nursing (ADON) went with her to talk to the resident on 2/13/17. Staff I reported the resident stated the staff ignored his/her call light for quite a while and they would not help him/her roll. Staff I stated the resident was concerned about the lack of help on over nights when only 2 aides scheduled.

In an interview on 2/15/17 at 3:15 p.m., the DON stated Resident #3 reported concerns most recently the morning of 2/13/17. The DON confirmed staff had directed the resident to wait for bathroom assistance until other residents were done eating and acknowledged that was not right.

In an interview on 2/15/17 at 3:30 p.m., Staff Q, LPN, the overnight shift had problems with no help available for pulling Resident #3 up in bed or rolling Resident #7 in bed.

In an interview on 2/16/17 at 12:35 p.m., the DON

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reported she had received concerns from Resident #3, three (3) or four (4) times since she took over as DON in August 2016. The DON reported Resident #3 felt people did not want to help him/her and he/she waited a long time to have a 2nd person available to pull him/her up in bed. The DON stated Resident #3 complained that Staff C and Staff Q did not want to help do anything.

In an interview on 2/20/17 at 11:15 a.m., Resident #3 reported he/she continued to have the same problem of getting assistance from 2/16/17 through 2/19/17 despite the facility being notified of concerns on 2/16/17.

3. The MDS assessment dated 1/25/17 for Resident #4 recorded a BIMS score of 11. A score of 11 indicated moderate cognitive impairment. The MDS reflected the resident displayed no behaviors during the assessment reference period. The MDS revealed the resident required the limited physical assistance of 1 person for bed mobility, transfers, walking in room, dressing, and toilet use. The MDS documented the resident experienced frequent episodes of urinary incontinence. The MDS identified diagnoses that included urinary incontinence, generalized muscle weakness, and low back pain.

The care plan revised 12/15/16 identified focus areas of self-care deficit and potential for injury/impaired physical mobility related to history of UTI (urinary tract infection), weakness, and debility. The care plan directed staff to provide assist of 1 with ADL's (Activities of Daily Living and toileting, provide peri-care with incontinence episodes, toilet the resident before and after

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F 353	Continued From page 43 meals and as needed and provide assist of 1 with wheeled walker for transfers. In an interview on 2/13/17 at 3:30 p.m., Staff E, Certified Medication Aide (CMA), reported Resident #4 room lights on in the a.m. that day. Staff E stated the resident's caregiver reported the resident in bed on top of the bed in the same clothes as the day before with a room tray in front of the recliner left untouched. Staff E stated she told the DON when she saw it. In an interview on 2/14/17 at 4:00 a.m., Staff A, LPN, reported she had problems with 2 staff working together, Staff Q, LPN, and Staff C, CNA. Staff A reported Staff Q and Staff C sat around doing nothing. Staff A reported Staff Q and Staff C worked an overnight when Resident #4 did not have clothes changed or the supper food tray removed from the room. Staff A said 30 minute checks (frequent observations) started for the resident and referred to a written note about checks on the nurses' station. In an interview on 2/14/17 at 4:32 a.m., Staff C reported she was familiar with Resident #4's care. Staff C said the resident was changing lately getting more confused. Staff C reported she worked an overnight the previous Saturday or Sunday when the food tray left in the resident's room because the resident did not want her to take the food tray. Staff C reported she did not assist the resident to bed that night because the 2:00 p.m. to 10:00 p.m. shift always laid the resident down. Staff C stated she checked on the resident and the resident had 2 pads on, dry, and the resident okay the rest of the night. Staff C said she would not consider the resident to be a "heavy wetter" as the resident sometimes goes	F 353		

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F 353	Continued From page 44 thru the night without peeing. In an interview on 2/14/17 at 4:55 a.m., Staff A reported the 30 minute checks for Resident #4 started on 2/ 13/17 due to the resident's physical decline and after 2 times the resident not assisted to bed. Staff A said the first time occurred about a month ago when the resident left up in a chair on 2:00 p.m. to 10:00 p.m. shift and did not get assisted to bed. The second time occurred 2/12/17 when the resident found on top of the bed with clothes on. Staff A stated they wanted everyone aware the resident not pulling his/her call light anymore. Staff A reported the resident now needed help with toileting and all cares. In an interview on 2/14/17 at 5:25 a.m., Staff D, housekeeper, confirmed there was a time she found Resident #4 in his/her room with the window open at 6:00 a.m. Staff D stated the incident occurred approximately 3 or so weeks ago. Staff D reported the resident sat in a chair with his her head over the table sleeping. Staff D said the resident dressed in a nightgown in diaper (brief). Staff D stated she informed Staff F, LPN, and she assisted Staff F to get the resident to the bed. Staff D said when Staff F stood the resident she could see the resident soaked with urine from brief up to the low back. Staff D reported the resident kept saying he/she was so cold. Staff D stated within 15 minutes, the resident's personal caregiver arrived and Staff F informed the care giver of findings. Staff D said she suspected the resident to be in the chair all night because the resident stated she had been left in the chair all night. Staff D stated she felt the resident still had her mind. Staff D said she knew the DON and Administrator aware of the situation because Staff F reported it to them.	F 353		

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F 353	Continued From page 45 In an interview on 2/14/17 at 9:10 a.m., Resident #4 reported he/she recalled maybe a month prior he/she slept in a chair and not assisted to bed that night. Resident #4 commented he/she would prefer to be in the bed, wouldn't you (indicating the surveyor). Resident #4 stated he/she could not recall any other specifics. In an interview on 2/14/17 at 10:40 a.m., Staff F, LPN, recalled an event with Resident #4. Staff F reported she came in early around 6:00 a.m. when Staff D summoned her stating the resident had been up all night. Staff F stated she observed the resident in his/her easy chair. Staff F said the resident reported the staff never came to put him/her to bed. Staff F reported the resident had been very incontinent with his/her depends, nightgown, robe, and soaker pad on chair, all soaked through. Staff F recalled the incident occurred 2 weeks prior and found the resident the morning of 1/30/17. Staff F reported she heard Staff E, CMA, and Staff I, CNA, telling the Administrator they found the resident on 2/13/17 laying on top of the bed with clothes on. Staff F stated Staff V, CNA, and Staff J, CNA, reported the resident wore the same clothes they dressed him/her in the day before. Staff F said she had never seen the resident go to bed without a nightgown, be resistive, aggressive, or refuse to lie down. Staff F reported she thought the resident knew what was going on despite his/her decline since being sick with influenza, and felt the resident was credible. In an interview on 2/15/17 at 6:37 a.m., Staff I reported last Sunday (2/12/17) there was a problem with Staff C and Staff Q assisting	F 353		

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Resident #4. Staff I stated the resident had been on top of the bed completely dressed including shoes. Staff I said the resident expressed s/he had not been touched or taken to the bathroom since his/her caregiver had left the night before. Staff I stated the resident reported the staff only checked his/her brief by pulling up waistband but did not offer the bathroom or to get into a nightgown. Staff I reported the resident prefers to get ready for bed with his/her own nightgown. Staff I stated the resident seemed upset with facial expressions of anger and disgust. Staff I said the resident commented she/he could always tell who was working.

In an interview on 2/16/17 at 11:10 a.m. the personal caregiver for Resident #4 recalled an incident that occurred the night of 1/29/17. The caregiver reported the resident had been left up in a chair all night (with the window wide open). The caregiver reported he/she arrived that morning and Staff D informed him/her the resident left in chair with the window open.

4. The MDS assessment dated 12/15/16 for Resident #5 identified a BIMS score of 15 without signs or symptoms of delirium. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bathing and documented the presence of an ostomy. The MDS identified diagnoses that included generalized muscle weakness and morbid (severe) obesity.

In an interview on 2/14/17 at 9:50 a.m., Resident #5 stated the facility is short staffed on the overnight shift. Resident #5 reported the longest he/she had waited for help an hour and he/she

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had a clock to time the wait. Resident #5 stated the most recent episode occurred approximately 2 weeks prior when he/she called for assistance with his/her colostomy bag. Resident #5 reported his/her bag full and popped open. Resident #5 stated the 2 staff working over the weekend, 1 nurse and 1 CNA, were awful. Resident #5 said the staff did more watching TV out in the commons area together than doing anything else. Resident #5 stated management aware. Resident #5 stated the 1 aide on the 10:00 p.m. to 6:00 a.m. shift entered his/her room, turned off his/her call light, turned and left room, and never said a word to him/her. Resident #5 stated he/she did not know the staff members name but it had happened more than once. Resident #5 reported he/she was able to transfer him/herself into an electric wheelchair. Resident #5 stated he/she goes into the commons area and sees staff playing video games or watching TV and not taking care for residents that need it or looking out for residents who were fall risks.

5. The MDS assessment dated 11/15/16 for Resident #7 identified a BIMS score of 14. A score of 14 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, and toilet use. The MDS documented the presence of an indwelling catheter and the resident experienced incontinence of bowel at all times. The MDS identified diagnoses that included urinary tract infection (UTI), spinal stenosis, morbid obesity, and generalized muscle weakness. The MDS recorded a weight of 430 pounds.

The care plan revised 12/19/16 identified a potential for infections related to indwelling

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catheter, impaired skin integrity, potential for injury/impaired physical mobility related to morbid obesity; and altered comfort-potential for pain. The care plan directed staff to provide catheter care per facility protocol assist of 1 person and assist the resident to reposition frequently with assistance of 2 persons. The resident required transfers with the bariatric Hoyer (mechanical lift) and assist of 3 persons to the w/c (wheelchair)/shower-chair; and turn and reposition the resident with assist of 2 minimum , could use 3 aides.

In an interview on 2/13/17 at 3:50 p.m., Resident #7 reported Staff W, LPN, Staff Q, LPN, and Staff Q's sister-in-law, who worked for the facility also, did nothing. Resident #7 stated the staff did not assist the good staff members and it took 2 people to roll him/her. Resident reported a couple weeks ago at 3:00 a.m., Staff W unable to turn him/her and his/her catheter leaked. Resident #7 stated he/she did not want to lie in urine but had to wait until 5:30 a.m. to get turned. Resident #7 said he/she reported to the Administrator on 2/9/17.

In an interview on 2/15/17 at 6:00 a.m., Staff H, CNA, stated Resident #7 required assistance of 2 persons for bed repositioning. Staff H reported Resident #7 had nights where his/her call light not on much and other nights light on a lot. Staff H recalled she had times where she told the resident he/she had to wait till 6:00 a.m. to 2:00 p.m. shift came because Staff W too small to assist and she was not able to assist the resident alone. Staff H reported Resident #7 knew what was going on.

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In an interview on 2/14/17 at 4:00 a.m., Staff A, LPN, reported Resident #7 aware and able to report what he/she needed. Staff A said if the resident slumped over in the bed he/she definitely needed assistance of 2 persons to reposition because 1 person could not do it alone. Staff A stated the resident able to call for assistance. Staff A reported the resident had issues with his/her catheter plugging the previous week with the resident's pad changed due to getting wet.

In an interview on 2/13/17 at 3:30 p.m., Staff E, CMA, reported Resident #7 had concerns, same as other residents. Staff E stated residents complained of the night shift having no help when they ask for it.

In an interview on 2/14/17 at 4:20 a.m., Staff B, CNA, reported Resident #7 as aware and credible.

In an interview on 2/14/17 at 4:32 a.m., Staff C, CNA, stated Resident #7 was credible.

In an interview on 2/15/17 at 3:30 p.m., Staff Q stated the overnight shift had problems with no help available for rolling Resident #7 in bed.

In an interview on 2/16/17 at 12:35 p.m., the DON reported Resident #7 had mentioned 2 or 3 times that Staff Q and Staff C stood and did nothing to assist Staff G, CNA, since she took over. The DON stated she had discussed the concerns with the Administrator. The DON reported she had made no documentation of the residents' concerns, not even sticky notes, as the conversations were more informal. The DON stated it was her fault there was no documentation of complaints made by Resident

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F 353	Continued From page 50 #3, Resident #5, or Resident #7. In an interview on 2/16/17 at 1:30 p.m., the Administrator stated Resident #7 had reported Staff W did not help.	F 353		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, dietary menu review, staff and resident interviews, the facility failed to serve food at a preferred temperature and ensure palatability for resident satisfaction for 15 residents interviewed (Residents #3 & #5). The facility census was 45 residents. Findings include: 1. Observation on 2/14/17 at 7:30 a.m., revealed Staff O, dietary cook measured the temperature of the breakfast food items before starting meal service as follows: a. pancakes 208 degrees Fahrenheit (F) b. sausage patty 206 degrees F c. oatmeal 205 degrees F	F 364	**F 364 Nutritive Value/Appearance/Palatable/ Preferred Temperature** The facility does and will continue to ensure that it provides sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental and psychosocial; well-being of each resident which is evident by the following: A) Resident # 3 is on daily 30 minute checks for an ongoing basis through March 2017 and then as needed with follow up. Resident # 5 & 7 are being interviewed weekly with responses noted with their facility ambassador and Administrator spot checks. B) An Ambassador tool was developed for all residents to monitor for food concerns and room trays response if they receive a room tray and to record resident feedback from these interviews.	

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F 364	Continued From page 51 At 7:46 a.m., Staff O plated 7 room trays with 1 test tray and covered the plates with plastic lids. At 7:51 a.m., Staff E, certified medication aide, CMA passed the first tray. At 8:00 a.m., Staff E served Resident #3 a room tray. At 8:01 a.m., with the Assistant Director of Nursing, ADON present, the test tray food items measured at the following temperature: a. pancake 93 degrees F b. sausage patty 99.5 degrees F c. oatmeal 141.6 degrees F During testing of the breakfast tray the surveyor found the pancakes and sausage cold and the toast was limp and cold. The ADON confirmed the temperature readings and touched the food to verify the items were cold to touch. During interview on 2/14/17 at 8:05 a.m., the ADON stated residents had complained of food tasting bad. During interview on 2/14/17 at 8:20 a.m., Staff P, Dietary Service Manager (DSM), stated most days the facility had 2 persons to pass room trays. Staff P said when she came to the facility in December 2016 the residents complained of cold food temperatures for both room trays and in the dining room. Staff P commented she had not heard the concern lately and room trays were hard to keep hot when multiple trays were done at once.	F 364	C) The facility did put in a 5 week menu rotation that was completed at the beginning of February 2017, with the aide of residents # 3, # 5, #7, nursing associates, dietary associates and the facility dietitian. Ongoing training has been implemented with a new DM hired on February 9, 2017 and a new position created for a DM Supervisor on February 9, 2017. New equipment and dining room design was implemented in February and March. A review of residents receiving room trays is reviewed each week with DM with updates to the dietary team and care plan committee. Dietary changed its procedures in preparing 1 room tray at a time for passing to aid in ensuring room trays hold proper temperatures. Communication was presented to all nursing associates on March 8 - 10, 2017 as a reminder who receive room trays by their care plans, who to request a room tray if not on care plan and how to deliver room trays. D) The Administrator and Assigned Department Managers will monitor timing of call lights, and interviewing residents, call light response with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Dietary Manager / Director of Nursing /Administrator Alleged Date of Compliance: 3/15/2017	

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F 364	Continued From page 52 2. The Minimum Data Set (MDS) assessment dated 1/6/17, documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During interview on 2/14/17 at 8:10 a.m., the resident stated his/her pancake that morning tasted cold but that was a normal thing. The resident said the coffee cake was dry and the sausage was cold. The resident stated it affected his/her appetite especially when he/she received cold eggs, cold food and no variety. 3. The MDS assessment dated 12/15/16, documented Resident #5 had a BIMS score of 15, indicating intact cognition. During interview on 2/14/17 at 9:50 a.m., the resident reported his/her food tasted okay that morning but there was no variety available in the food. The resident said he/she reported his/her complaint and the facility said they would work on it but no one had. During interview on 2/16/17 at 2:10 p.m., the Administrator stated she would admit when she first arrived (6/2016) the food had been rough around the edges. The Administrator commented since that time, she had started new menus, went to 5 week menu rotation, and revamped training new cooks.	F 364		
F 514 SS=D	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	F 514		

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F 514	Continued From page 53 maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interview, the facility failed to ensure staff accurately documented treatments for one resident and failed to promptly document resident-to-resident contact for two residents. (Resident #8, #9 & #5) The facility census was 45 resident.	F 514	**F 514 Records Complete/Accurate/Accessible** A) Resident's #8 & #9 progress notes were reviewed and revised to include documentation of resident to resident encounters which took place February 14- 20, 2017. A review of the TAR of resident # 5 was conducted by the Administrator. B) All residents residing in the facility will have their clinical records maintained in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. C) All Nursing Staff re-educated on proper reporting, incident filing, documentation for all allegations of abuse and incidents. All supporting document must be completed at the time of the occurrence and entered into the permanent record. Associate U & T Counseled on not documenting at the time of occurrence and following all protocols associated with an incident. Associate Q counseled on ensuring documentation matched MARS and TARS record to ensure accuracy and integrity to avoid assumption and / or evidence of falsification of resident records. D) The Director of Nursing and / or designee will review progress notes, MARS and TARS for each day to ensure accuracy of documentation and charting with concerns addressed with the Administrator and the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing / Administrator Alleged Date of Compliance: 3/15/2017	

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F 514	Continued From page 54 Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/15/16, documented Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Order Review Report dated 12/2/16, revealed an order for multiplex powder apply into deep wound creases of buttocks, posterior thighs and mycolog cream to excoriated areas. Cover with kerafoam dressings and change every morning. An additional order was for xeroform to the residents left abdominal fold, cover with mepilex foam and ensure the foam was tucked into creases as far as possible and change every morning. During interview on 2/14/17 at 9:50 a.m., the resident stated the overnight nurse was to do his/her treatments behind his/her legs but the nurse was so lazy she watched television and never did the treatment Saturday or Sunday night. The February 2017 Treatment Administration Record (TAR) documented Staff Q, Licensed Practical Nurse, LPN documented completion of the multiplex powder and the xeroform treatments to the residents buttock/thigh wounds and the left abdominal wound at 5:00 a.m. on 2/12/17 and at 5:00 a.m., on 2/13/17. During interview on 2/15/17 at 3:30 p.m., Staff Q reported the previous weekend the resident did not put on his/her call light for her to complete the treatments. Staff Q commented she completed a fingerstick (blood sugar check) for the resident at 5:00 a.m. Staff Q said when she did the	F 514		

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fingerstick, the resident was asleep in his/her chair so she did not complete the treatments. When asked why the treatment had been charted as completed, Staff Q responded she thought maybe she had charted the resident refused.

During interview on 2/15/17 at 3:50 p.m., the Assistant Director of Nursing, (ADON), stated if the treatment record contained a checkmark with initials it meant the treatment was completed. The ADON confirmed the resident's treatment record was marked with a checkmark and Staff Q's initials on 2/12/17 and 2/13/17 for the 5:00 a.m. treatments.

2. Progress Notes for Resident #8 created by Staff U, LPN on 2/16/17 at 6:51 a.m., documented a late entry for 2/14/17 at 11:47 a.m. The note recorded Resident #8 was kissing a male/female resident and rubbed his/her leg. The nurse documented she reminded Resident #8 the behavior was inappropriate and removed him/her from the area. The note documented Resident #8 yelled at the nurse you are just jealous and called the nurse a derogatory name. The note recorded the nurse spoke to Resident #8 about the other resident's inability to make his/her own choices due to his/her diagnosis.

Progress Notes created by Staff U on 2/16/17 at 6:52 a.m., documented a late nursing entry for 2/14/17 at 11:51 a.m. The note recorded the DON aware of the issue and stated she would speak with the Administrator regarding the issue.

Progress Notes dated 2/16/17 at 1:22 p.m., documented Resident #8 removed from Resident #9 twice during the shift. The note recorded

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F 514	Continued From page 56 Resident #8 rubbed Resident #9's leg and became angry with the nurse. The Resident to Resident Encounter Report dated 2/17/17 at 1:45 p.m. recorded on 2/14/17 at 9:00 a.m., Resident #8 at table kissing a resident on lips/cheek and rubbed leg and upper thigh. The report documented the resident was removed and the DON notified. 3. Progress Notes dated 2/1/17 at 10:07 a.m. thru 2/20/17 at 3:52 p.m., for Resident #9 contained no documentation of a resident-to-resident encounter.	F 514		