STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165586	A. BUILDING _____ B. WING _____	C 09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMELY MISSION NURSING HOME	109 MISSION DRIVE BUFFALO CENTER, IA 50424

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 10-5-17 Investigation of facility complaints #68185-C , #68548-C, #69637-C, #70121-C and #70477-M resulted in the following deficiencies. A facility self reported incident #68936-I resulted in no deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 157		

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

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

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F 157	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to promptly report a resident's change of condition to the physician for 1 of 4 residents reviewed. (Resident #1) The facility identified a census of 38 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 6/12/17 indicated Resident #1 had diagnosis that included dementia without a behavior disturbance . The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, had	F 157		

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F 157	Continued From page 2 fluctuating disorganized thinking and as independent with all Activities of Daily Living (ADL's). A Care Plan with nursing diagnosis dated 6/7/17 indicated the resident had impaired physical mobility and required the use of a 4 wheeled walker for stability with independent ambulation, a self care deficit as required assistance with dressing, an alteration in thought process related to a poor short term memory deficit and forgetfulness, a potential for alteration in mood and anxiety with sleeplessness. Observation of photos on 8/17/17 at approximately 3:35 p.m. revealed the following photos as time stamped on a cell phone and described as follows: a. 4/16/17 at 9:40 a.m., a dark red bruise with a white center on the resident's left middle upper shoulder. b. 4/16/17 at 9:40 a.m., the entire posterior left arm region discolored yellow on the top portion and purple along the bottom. c. 4/16/17 at 9:40 a.m., a dark purple bruise on the inner aspect of the resident's right arm. Review of the resident's medical record revealed no assessment and/or interventions for the above described areas. Review of Nurse's Notes and a Fax Form revealed the following entries as dated and described: a. 4/29/17 at 4:04 p.m., per Nurse's Notes, documented a fax sent to the physician pertaining to a green crust draining from his/her reddened	F 157		

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F 157	Continued From page 3 eye. b. 4/29/17 at 4:04 p.m. - per a Fax Form, the resident had green crust on the tear duct area of the left eye. The tear duct had been red and the resident reported the area itched at times. The resident received Fresh Kote eye gtts 2 times a day. (BID) c. 5/1/17 at 9 a.m., a telephone order received for Polytrim one drop (gtt) to the left eye 4 times a day (QID) for one week due to conjunctivitis. Record review revealed no further assessment of the resident's eye. d. 5/2/17 at 2:40 p.m., Staff spoke with a Physician about the residents eyes and the Polytrim ordered 5/1/17. The Physician ordered Polytrim gtts to both eyes QID for 1 week. Record review revealed no further assessment of the resident's eye to date. Review of the Fax Form dated 4/29/17 at 4:04 p.m. revealed the Fax Form had been faxed to the Physician on 5/1/17 at 8:15 a.m. and received back at the facility on 5/1/17 at 8:24 p.m. and signed by the physician. During an interview 8/17/17 at 11:50 a.m., the Director of Nursing (DON) and the Medicare Coordinator confirmed the fax had not been sent to the Physician until 5/1/17. The 4/29/17 and 4/30/17 fax had been a Saturday and Sunday and that staff should have called the Physician on call.	F 157		
F 225 SS=L	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		

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F 225	Continued From page 4 (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 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	F 225		

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F 225	Continued From page 5 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 observation, record review, staff interviews and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents are reported immediately to managerial staff per facility policy and to the Iowa Department of Inspections & Appeals within 24 hours or the next business day (Resident #1, #7 #8, #9, #14, #15, #16, #17). This was scoped as widespread immediate and serious jeopardy since multiple staff witnessed a CNA (certified nursing assistant) mistreat residents and then did not report to managerial staff or the Iowa Department of Inspections and Appeals. This delay placed all residents at risk for abuse and mistreatment since the staff	F 225		

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F 225	Continued From page 6 member continued to care for residents and was not seperated from the residents living at the facility. The facility reported a census of 38 residents and the sample consisted of 22 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 6/12/17, indicated Resident #1 had unspecified dementia without a behavior disturbance, anxiety and Parkinson's disease. The assessment indicated the resident had fluctuating disorganized thinking and independent with activities of daily living. A Care Plan with a nursing diagnosis dated 6/7/17, indicated the resident had an alteration in thought process and a self-care deficit and required some assistance with dressing. The approaches included the following: Assist with dressing at night. Assist with grooming as requested. Assist with perinea cares in the morning, evening and as needed. During an interview 8/18/17 at 9:24 a.m., Staff B confirmed the resident complained that Staff C had been rude, yelled at him/her and would not assist the resident as he/she requested. During an interview 8/18/17 at 9:40 a.m., Staff R, CNA confirmed the resident complained the pregnant staff member (Staff C had been the only staff pregnant at the time) would never assist him/her and that she had been mean. During an interview 8/29/17 at 10:43 a.m., Staff A,	F 225		

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F 225	Continued From page 7 CNA confirmed there had been a time the resident cried and upset because had not wanted Staff C to put him/her to bed because he/she had been scared of her. Staff A stated the resident stated she had been so mean. 2. A MDS assessment form dated 5/15/17, indicated Resident #7 had diagnosis that included multiple sclerosis and depression. The assessment indicated the resident had a BIMS score of 14, as non-ambulatory, dependent on 2 staff members with transfers, dressing and toilet use. The assessment indicated the resident experienced occasional bladder incontinence. A Care Plan with nursing diagnosis dated 5/24/17, indicated the resident had a self-care deficit and required staff assistance with all ADL's and with an impaired physical mobility status. The approaches included the following: The resident uses the commode for the bathroom. The resident uses the EZ (mechanical) stand lift for all transfers. During an interview 8/18/17 at 11:29 a.m., the resident confirmed Staff C as unkind and further described as follows: When the resident requested to be transferred from the bed to the chair, the staff member responded by, I don't think so. The staff member had sworn at him/her and witnessed by Staff M, CNA. When Staff M heard Staff C swear at the resident she stated, I cannot believe she talked to you that way. An example of swearing had been further described as follows: We cannot get you on and off [commode] all the	F 225		

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F 225	Continued From page 8 time whenever you damn well please. As the interview continued, the resident stated he/she could not understand how the staff member worked with residents because she had not been nice. When the staff member was pregnant, she was real moody so the resident thought it had just been the pregnancy. The resident stated when the staff member left and came back, she/he felt real nervous because did not know how she/he would be treated because she had just been a (bi..ch- expletive). Another example had been further described as follows: When the resident requested to get up for the day he/she received morning cares, urinated and went to eat breakfast. After breakfast the resident again requested to go to the bathroom to have a bowel movement. When Staff C arrived she got the resident up and then yelled why can't you poop and pee at the same setting because it took too much to get the resident on and off of the commode. The resident stated this caused her/him to feel like crap [worthless, rubbish]. The resident stated, to this day, when able to defecate and urinate at the same time, she/he thinks, Staff C would be so proud of me. During an interview 8/18/17 at 9:24 a.m., Staff B confirmed she observed Staff C as she yelled at the resident and said "Why can't you poop and pee at the same time ? " During an interview on 8/2/17 at 10 a.m., Staff Q, CNA, confirmed she observed Staff C yell at the resident and said "Why can't you poop and pee at the same time ?" The staff member denied having heard Staff C swear and/or threaten the resident. The staff member stated she reported	F 225		

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F 225	Continued From page 9 the incident to an unknown staff member. The interview with the resident continued and the resident confirmed she also witnessed the staff member around other residents and mean in the lounge area. An example of this behaviors had been further described as follows: When Resident #7 said, Jesus, Jesus why did I have to come here. Staff C said, you know why. Because this is the best place for you and then the staff member turned her back to the resident and said within ear reach of other residents, "I do not know why in the f..k (expletive), he/she had to say that." 3. Review of a MDS assessment form dated 6/14/17, Resident #8 had diagnosis that included Alzheimer's disease, dementia and adult failure to thrive. The assessment indicated the resident could make self understood and understood others. The MDS identified the resident had a BIMS score of 0. A score of zero represented a severe cognitive impairment and the resident had fluctuating inattention and disorganized thinking, physical and verbal behavior towards others 1-3 days and other behavior symptoms not directed towards others 4-6 days. The assessment indicated the resident required extensive assistance of 1 staff member with toilet use, personal hygiene and dressing, required limited assistance of 2 staff with transfers, ambulation and locomotion and as occasionally incontinent of urine and frequently incontinent of bowel. According to a Care Plan with nursing diagnosis dated 6/21/17, the resident had a self-care deficit and required total hands on assistance with ADL'S and an alteration in thought processes and	F 225		

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F 225	Continued From page 10 behaviors as occasionally resistive to ADL's. The approaches included and directed the staff to do the following: Explain what you are doing before you are doing it. Provide 1 to 1s as needed. During an interview 8/29/17 at 10:43 a.m., Staff A, CNA stated on the 6 a.m. to 2 p.m. shift during a weekday, she observed Staff C toilet the resident in the shower room across from the Medicare Coordinator's office due to the resident incontinent of feces and quite agitated and screaming. The resident refused to remain seated on the toilet to enable proper cleansing so Staff C pulled the resident's hands away from his/her pants and pushed his/her hands down in an inappropriate manner. Staff C yelled at the resident and said "J ...s Ch..st (expletive), knock it off." Staff A stated that encounter went on for a couple of minutes. At that point the Director of Nursing (DON) walked into the shower room, asked what had been going on and took over for Staff C who exited the room. 4. Review of a MDS assessment form dated 5/25/17, Resident #9 had diagnosis that included hemiplegia, a cerebrovascular accident (CVA) and specified extrapyramidal and movement disorders. The MDS indicated the resident had a BIMS score of 12, non-ambulatory and dependent on staff with bed mobility and transfers. According to a Care Plan with nursing diagnosis dated 6/7/17, the resident had a self-care deficit and required total hands on assistance with ADL's and had impaired physical mobility.	F 225		

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F 225	Continued From page 11 During an interview 8/18/17 at 9:40 a.m., Staff R, CNA, confirmed that Staff C said to the resident "God d .... it (expletive). Roll over." The resident could not roll over very well due to a CVA (stroke). 5. A MDS assessment form dated 7/29/17, identified Resident #14 had diagnosis that included diabetes mellitus, hemiplegia (paralysis of one arm and leg), depression, cerebrovascular disease, extrapyramidal (nerve concern with motor activity) and movement disorder and a benign neoplasm (tumor that is not malignant) of the brain . The assessment indicated the resident had a BIMS score of 15. A score of 15 identified the resident had no cognitive problems. The MDS indicated the resident could not walk, required extensive assistance of 2 staff members for bed mobility and depended on staff for transfers, dressing, toilet use and personal hygiene. A Care Plan with nursing diagnosis dated 5/10/17, identified the resident had a self-care deficit and required total assistance of staff with ADL's and had an impaired physical mobility. During an interview on 8/29/17 at 12:25 p.m. the resident confirmed Staff C being unkind and a bi..h (expletive). Resident #8 stated When the staff member repositioned the resident she roughly pulled on the resident's clothes to do so to the point the resident could hear the threads as they tore. The resident told the staff member to take it easy. The resident stated Staff C yelled and swore at him/her. 6. A MDS assessment form dated 7/9/17 indicated Resident #15 had diagnosis that	F 225		

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F 225	Continued From page 12	F 225		

included dementia, depression, manic depression and adult failure to thrive. The assessment indicated the resident had a BIMS score of 0, had fluctuating disorganized thinking and as non-ambulatory and dependent on 2 staff with bed mobility, transfers, locomotion, dressing, eating, toilet use and personal hygiene.

A Care Plan with nursing diagnosis dated 7/21/17 indicated the resident had a self-care deficit and required total assistance of staff with personal cares and ineffective individual coping. The approaches included and directed the staff to:

Explain all procedures before doing anything to the resident.
The resident will have intermittent outbursts and reassure at times.

During an interview 8/11/17 at 9:45 a.m., Staff D, Certified Nursing Assistant (CNA) stated she observed Staff C, CNA become upset with the resident during cares because the resident had been combative. Staff D stated she saw Staff C grab the resident' arm and leg and yanked him/her across the bed. Staff D then just walked out of the resident's room because she had been so upset. Staff D stated she failed to report the incident to any other staff member and/or management person. The resident yelled ouch.

7. A MDS assessment form dated 8/13/17, indicated Resident #16 had diagnosis that included arthritis, Parkinson's disease, depression, schizophrenia and adult failure to thrive. The assessment indicated the resident had a BIMS score of 15 and independent with transfers and ambulation but required extensive assistance of 1 staff member with bathing.

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F 225	Continued From page 13 A Care Plan with nursing diagnosis dated 8/18/17, indicated the resident had a self-care deficit, an impaired physical mobility, alteration in thought processes and a diagnosis of schizophrenia and anxiety. The approaches included the following: The resident is not always compliant with bathing 2 times a week. Assist the resident to destinations. Remind the resident to pick up feet when walking, slow down and think. Staff will be matter of fact and direct with cares. Approach the resident in a positive manner. During an interview on 8/18/17 at 9:24 a.m., Staff B,CNA confirmed she witnessed Staff C grab the resident's arm, yanked it and said "Come on". The staff member stated she reported the incident to Staff P, Registered Nurse (RN). During an interview 8/18/17 at 11:18 a.m., Staff P stated she had no allegations of abuse involving Staff C (swearing the F ...k (explicit) word to a resident and/or having yanked a resident's arm) During an interview on 8/2/17 at 10 a.m., Staff Q, CNA stated she observed Staff C grab the resident's arm, yanked it and said let go. The staff member stated she reported the incident to an unknown nurse. During an interview on 8/29/17 at 11:30 a.m., the resident could not recall any staff member having grabbed or yanked his/her arm. The resident, however, recalled an incident during the showering process when a long brown haired lady, medium height and a little more than skinny had been rough with him/her during the shampooing process. The resident stated it	F 225		

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F 225	Continued From page 14	F 225		

made him/her feel not very good. The resident told her to stop but she refused. The resident stated she/he did not report the incident to any staff member.

An observation on 8/30/17 at 2 p.m., identified Staff C with a short to medium height status, smaller stature, shoulder length brown hair with highlights.

8. A MDS assessment form dated 7/28/17 indicated Resident #17 had diagnosis that included Parkinson's disease and schizophrenia. The assessment indicated the resident had a BIMS score of 14, had continuous disorganized thinking and required extensive assistance of staff with bed mobility, transfer, ambulation, toilet use and personal hygiene.

A Care Plan with nursing diagnosis dated 5/10/17 indicated the resident had a self-care deficit and required hands on assistance with all ADL's. The Care Plan identified the resident had an impaired physical mobility and required assistance with all transfers and ambulation.

During an interview 8/18/17 at 9:24 a.m., Staff B, CNA stated she witnessed Staff C blatantly swear at the resident. Staff B stated that Staff C said "Stand the f..k (expletive) up.

During an interview on 8/29/17 at 11:40 a.m., the resident stated he/she could not recall any staff members having been rough, disrespectful and/or unkind. Then he/she went onto say "They have a country western change over and she won a Cadillac".

During an interview on 8/18/17 at 7:17 a.m., Staff

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F 225	Continued From page 15 H, CNA stated she witnessed Staff C raise her voice and hollered [yelled] at the residents and appeared rough with residents during their cares. Staff H explained Staff C would walk with residents and if the resident could not walk fast enough, she would then drag the resident so the resident would walk faster. Review of the policy and procedures titled Abuse (not dated) included the following: Abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. That also included the deprivation by an individual, including a caretaker of goods or services that were necessary to attain or maintain physical, mental and psychosocial well-being. Verbal abuse is defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families or within ear distance, regardless of their age, ability to comprehend or disability. Mental abuse included but had not been limited to humiliation, harassment, and threats of punishment or deprivation. Mistreatment meant inappropriate treatment or exploitation of a resident. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should have been reported to the Iowa Department of Inspections ad Appeals no later than 2 hours after the allegation had been made, if the events that caused the allegation involved abuse and resulted in serious bodily injury or not later than	F 225		

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F 225	Continued From page 16 24 hours if the events that caused the allegation involved abuse but do not result in serious bodily injury. Note: At the time of the complaint investigation, the complaint was coded at a "L", immediate and serious jeopardy. On 8/11/17, the Administrator had suspended Staff C. By 8/18/17, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "F" level. The Administrator provided and finished dependent abuse training on 8/18/17, to all facility staff and agency staff. The Administrator provided additional training and review of the Residents' Bill of Rights and the facility Mission Statement that employees may not be supervised by blood relatives or relatives by marriage. Staff C is a relative to the Director of Nursing and staff did not report the actions of Staff C to the Director of Nursing or the Administrator, do to fear of losing job. As of the 9/1/17 exit conference, the facility needed to: Continue to educate staff of the abuse, dignity and resident rights to employees. Continue to monitor staff to ensure the policy and procedures are followed and alleged abuse is reported per facility policy.	F 225		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		

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F 241	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews and review of policy and procedures, the facility failed to display respect and dignity for residents when speaking with, caring for, or talking about them (Resident #1, #7, #8, #9, #10 #14, #15 #16). The sample consisted of 22 residents. The facility identified a census of 38 residents. Finding include: 1. The Resident's Bill of Rights form revised 11/16, included the following directives/information: A facility must have treated each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognized each resident's individuality. The resident had the right to make choices about aspects of his or her life in the facilities that are significant to the resident. Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 6/12/17. The MDS indicated the resident had unspecified dementia without behavior disturbances, anxiety and Parkinson's disease . The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15. A BIMS score of 0 identified the resident having a severe cognitive impairment. The MDS indicated the resident had fluctuating disorganized thinking independent with activities of daily living. A Care Plan with a Nursing Diagnosis dated	F 241		

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F 241	Continued From page 18 6/7/17, indicated the resident had an alteration in thought process and a self-care deficit and required some assistance with dressing. The approaches included the following: Assist with dressing at night. Assist with grooming as I requested. Assist with my perineal cares in the morning, evening and as needed. On 8/18/17 at 9:24 a.m., Staff B was interviewed and stated the resident complained that Staff C had been rude, yelled at him/her and would not assist the resident as requested. On 8/18/17 at 9:40 a.m., Staff R, CNA was interviewed and confirmed the resident complained the pregnant staff member (Staff C had been the only staff pregnant at the time) would never assist him/her and that she had been mean. On 8/29/17 at 10:43 a.m., Staff A, CNA, confirmed a time when the resident cried and upset because had not wanted Staff C to put him/her to bed. Staff A stated the resident was scared of her because she had been mean to the resident. 2. Resident #7 had a MDS with a reference date of 5/15/17. The MDS identified the resident had diagnosis that included multiple sclerosis and depression. The assessment indicated the resident had a BIMS score of 14. A score of 14 identified no cognitive impairment. The MDS indicated the resident depended upon 2 staff members with transfers, dressing and toilet use. The resident was identified as non-ambulatory. The assessment indicated the resident	F 241		

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F 241	Continued From page 19 experienced occasional episodes of bladder incontinence. A Care Plan with Nursing Diagnosis dated 5/24/17, indicated the resident had a self- care deficit and required staff assistance with all ADL's and with an impaired physical mobility status. The approaches included the following: The resident uses the commode for the bathroom. The resident uses EZ stand lift for all transfers. On 8/11/17 at 12:50 p.m., the resident was interviewed and stated the following: For 6 months, the staff refused to get him/her up thru the night to utilize the commode so he/she laid in bed in a soaked brief all night long which felt like "crap". The resident stated he/she went to the physician a couple weeks ago and he wrote an order to get him/her up at night. A Physician's Order form dated 8/8/17 directed the staff as follows: Wake up the patient at 3 a.m. and offer the toilet please. The resident could change the request as needed otherwise this did marvelously well. Additionally, the resident confirmed when he/she waited to enter the dining room, several residents were lined up prior to the meal service. The dining room doors had been closed and he/she felt like "Where was the trough?". On 8/18/17 at 11:29 a.m., the resident was interviewed and confirmed Staff C as unkind and further described as follows: When the resident requested to transfer from bed	F 241		

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F 241	Continued From page 20 to chair, the staff member responded by, "I don't think so". The staff member swore at him/her and witnessed by Staff M, CNA. When Staff M heard Staff C swear at the resident, she stated, "I can-not believe she talked to you that way." An example of swearing had been further described as follows: We could not get you on and off all the time whenever you damn well please. As the interview continued, the resident stated he/she could not understand how the staff member could have worked with residents because she had not been nice. When the staff member was pregnant, she thought it had just been the pregnancy. The resident stated when the staff member left and came back she had been real nervous because he/she had not known how she would be because she had just been a bit.. (expletive). Another example had been further described as follows: When the resident requested to get up for the day he/she received morning cares, urinated and went to eat breakfast. After breakfast the resident again requested to go to the bathroom to have a bowel movement. When Staff C arrived she got mad and yelled "Why can't you poop and pee at the same setting?" The resident stated this was because it took too much time to get the resident on and off of the commode which caused the resident to feel like "crap". The resident stated, to this day when he/she pooped and peed at the same time, he/she said, Staff C would have been so proud. On 8/18/17 at 9:24 a.m., Staff B confirmed she observed Staff C as she yelled at the resident and	F 241		

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F 241	Continued From page 21 said why can't you poop and pee at the same time. On 8/2/17 at 10 a.m., Staff Q, CNA confirmed she observed Staff C as she yelled at the resident and said why can't you poop and pee at the same time. The staff member denied having heard Staff C swear and/or threaten the resident. The staff member stated she reported the incident to an unknown staff member. The resident confirmed she also witnessed the staff member to and/or around other residents mean in the lounge area. An example of this behaviors had been further described as follows: 3. When Resident #10 said, Jesus, Jesus why did I have to come here. Staff C said, you know why because this had been the best place for you and then the staff member turned her back to the resident and said within ear reach of other residents. "I do not know why in the F..k (expletive) he/she had to say that. 4. Resident #8 had a MDS assessment with a reference day of 6/14/17. Resident #8 had diagnosis that included Alzheimer's disease, dementia and adult failure to thrive. The assessment indicated the resident made self understood and understood others. The BIMS score of 0 identified the resident had a severe cognitive impairment. The resident had fluctuating inattention and disorganized thinking, physical and verbal behavior towards others and other behavior symptoms not directed towards others. The assessment indicated the resident required extensive assistance of 1 staff member with toilet use, personal hygiene and dressing, required limited assistance of 2 staff with	F 241		

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F 241	Continued From page 22 transfers, ambulation and walking and occasionally incontinent of bladder and frequently incontinent of bowel. According to a Care Plan with Nursing Diagnosis dated 6/21/17, the resident had a self-care deficit and required total hands on assistance with ADL'S and an alteration in thought processes and behaviors as resistive to ADL's occasionally. The approaches included the following. Explain what you are doing before you are doing it. Provide the resident with 1-1's as needed. On 8/29/17 at 10:43 a.m., Staff A, CNA was interviewed and stated on the 6 a.m. to 2 p.m. shift during a weekday, herself and Staff C toileted the resident in the shower room across from the Medicare Coordinator's office. The resident was incontinent of feces and quite agitated and screaming. The resident refused to remain seated on the toilet to enable proper cleansing so Staff C pulled the resident's hands away from his/her pants and pushed his/her hands down in an inappropriate manner. Staff C yelled at the resident and said Jesus Christ knock it off as that encounter went on for a couple of minutes. At that point the Director of Nursing (DON) walked into the shower room, asked what had been going on and took over for Staff C, who then exited the room. 5. Resident #14 had a MDS assessment with a reference date of 7/29/17. The MDS identified the resident had diagnosis that included diabetes mellitus, hemiplegia (paralysis of a leg and arm), depression, cerebrovascular disease (heart disease), extrapyramidal (near disorder) and	F 241		

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F 241	Continued From page 23 movement disorder and a benign neoplasm (tumor and not malignant) of the brain . The assessment indicated the resident had a BIMS score of 15. A score of 15 identified the resident no with cognitive impairment. The MDS indicated the resident required extensive assistance of 2 staff persons with bed mobility, and depended upon staff with transfers, walking, dressing, toilet use and personal hygiene. A Care Plan with Nursing Diagnosis dated 5/10/17, indicated the resident had a self-care deficit and required total assistance of staff with ADL's (activities of daily living) and an impaired physical mobility. On 8/29/17 at 12:25 p.m. the resident confirmed Staff C had been kind of a b...h (expletive). The resident also confirmed the staff member yelled and swore at him/her but could not give examples. 6. Resident #15 had a MDS with a reference date of 7/9/17. The MDS identified the resident had diagnosis that included dementia, depression, manic depression and adult failure to thrive. The assessment indicated the resident had a BIMS score of 0, had fluctuating disorganized thinking and as non-ambulatory and dependent on 2 staff with bed mobility, transfers, locomotion, dressing, eating, toilet use and personal hygiene. A Care Plan with Nursing Diagnosis dated 7/21/17 indicated the resident had a self-care deficit and required total assistance of staff with personal cares and ineffective individual coping. The approaches included:	F 241		

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F 241	Continued From page 24 Explain all procedures before doing anything to me. Please reassure the resident if has intermittent outbursts. On 8/11/17 at 9:45 a.m., Staff D, Certified Nursing Assistant (CNA) was interviewed and stated she observed Staff C, CNA as she became upset with the resident during cares. Staff D stated the resident was combative so she grabbed the resident's arm and leg and yanked him/her across the bed. Staff D then just walked out of the resident's room because she had been so upset and failed to report the incident to any other staff member and/or management. 7. Resident #16 had a MDS with a reference date of 8/13/17. The MDS indicated the resident had diagnosis that included arthritis, Parkinson's disease, depression, schizophrenia and adult failure to thrive. The assessment indicated the resident had a BIMS score of 15. A score of 15 identified no cognitive impairment. The MDS indicated the resident as independent with transfers and ambulation but required extensive assistance of 1 staff with bathing. A Care Plan with Nursing Diagnosis dated 8/18/17, indicated the resident had a self- care deficit, an impaired physical mobility, alteration in thought processes and a diagnosis of schizophrenia and anxiety. The approaches included the following: Not always compliant with bathing 2 times a week. Assist to destinations. Remind resident to pick up feet when walking, slow down and think.	F 241		

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F 241	Continued From page 25 Be matter of fact and direct with cares. Approach in a positive manner. On 8/18/17 at 9:24 a.m., Staff B,CNA confirmed she witnessed Staff C as she grabbed the resident's arm, yanked it and said come on. The staff member stated she reported the incident to Staff P, Registered Nurse (RN). On 8/2/17 at 10 a.m., Staff Q, CNA was interviewed and confirmed she observed Staff C grab the resident's arm, yanked it and said lets go. The staff member stated she reported the incident to an unknown nurse. On 8/18/17 at 11:18 a.m., Staff P was interviewed and indicated no allegations of Staff C swearing the F (explicit) word to a resident and/or having yanked a resident's arm had been reported to her. On 8/29/17 at 11:30 a.m., the resident was interviewed and could not recall any staff member grabbed or yanked his/her arm. The resident stated during a showering process, a long brown haired lady, medium height and a little more than skinny had been rough with him/her during the shampooing process. The resident stated this did not make him/her feel good. The resident told her to stop but she refused. On 8/18/17 at 7:17 a.m., Staff H, CNA was interviewed and stated she witnessed Staff C raise her voice and holler at the residents as well as having been rough during cares. Staff H described an example of rough as a resident not walking fast enough , then she would drag the resident along so the resident wound walk faster..	F 241		

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F 241	Continued From page 26 8. Resident #9 had a MDS assessment with a reference date of 5/25/17. The MDS identified the resident had diagnosis that included hemiplegia, cerebrovascular disease and other specified extrapyramidal and movement disorders. The assessment indicated the resident had a BIMS score of 12 and as non-ambulatory and dependent on staff with transfers. A Care Plan with a nursing diagnosis of impaired physical mobility related to a cerebrovascular accident (CVA) and the inability to walk or transfer him/her. The approaches included the following: a. Use caution with I am transferred with a Hoyer lift device. During an interview 8/11/17 at 2:41 p.m. the resident confirmed he/she sat lined up with several other residents at meal times with the doors closed to the dining room. The resident indicated he/she had not liked it when the doors had been closed and he/she could not enter the dining area. An observation on 8/2/17 at 4:34 p.m. revealed residents lined up in a hallway and the dining room doors closed. The area had no entertainment and residents were looking around, and some residents sleeping while they waited for the dining room doors to open for the supper meal. An observation 8/10/17 at 4:50 p.m. revealed a random resident ambulated into the dining area for supper while tables set up for the meal service. Staff I, Dietary Aide, redirected the resident out of the dining area. Staff I informed	F 241		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the resident that he/she could return at 5 p.m. Staff I shut the dining room door while other residents were lined up outside the dining room.

During an interview 8/10/17 at 4:53 p.m., Staff I confirmed he redirected the resident outside of the dining area and closed the door.

On 8/3/17 at 11:25 a.m., the Dietary Manager was interviewed and stated the residents arrived to the closed dining room doors all at the same time and she would like the doors to have been opened.

During an interview 8/10/17 at 4:05 p.m., Staff A, Certified Nursing Assistant (CNA) confirmed residents had been lined up outside the closed dining room doors at meal times and felt the issue had been a dignity issue.

During an interview 8/10/17 at 4:15 p.m., Staff F, CNA confirmed residents had been lined up behind closed dining room doors but had never been given a reason and felt the issue had been a chance for dietary to set up for meals service. The staff member felt the procedure had been a dignity issue for some residents.

On 8/10/17 at 4:23 p.m., Staff O, CNA confirmed residents were lined up outside the closed dining room doors at meal times and felt the procedure had been hectic and a dignity issue.

On 8/11/17 at 9:54 a.m., Staff D, CNA was interviewed and stated residents are lined up outside the closed dining room doors at meal times. Staff D stated she has heard residents complain because they are lined up.

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F 281 F 281 SS=D	Continued From page 28 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and physician interview, the facility failed to follow physician orders for 1 of 4 residents reviewed. (Resident #1) The facility identified a census of 38 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 6/12/17, indicated Resident 1 had diagnosis that included an unspecified dementia without a behavior disturbance, anxiety and Parkinson's disease . The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, had fluctuating disorganized thinking and as independent with activities of daily living. A Care Plan with a nursing diagnosis dated 6/7/17, indicated the resident had an alteration in thought process. The approaches included the following: a. Give me my medications and observe. b. Consult with my physician. A Medication Administration Record (MAR) form dated 3/1/17 through 3/31/17 and 4/1/17 through	F 281 F 281		

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F 281	Continued From page 29 430/17 indicated the resident had a physician's order for an Exelon Patch 24 hour applied 9.5 milligrams (MG's) transdermal one time a day related to senile dementia and to change every 24 hours. The patch placement included the following as dated: a. 3/3/17 at 6 a.m. to the left upper middle back. b. 3/4/17 at 6 a.m. to the right forearm. c. 3/5/17 at 6 a.m. to the left upper back. d. 3/6/17 at 6 a.m. to the right upper back. e. 4/11/17 at 6 a.m. to the left upper middle arm. f. 4/12/17 at 6 a.m. to the front left. Observation of photos on 8/17/17 at approximately 3:35 p.m., revealed photos taken on 4/12/17 at 7:06 p.m. as time stamped on a cell phone which revealed a Exelon patch dated 4/11/17 on the resident's left middle upper arm and the resident's front left chest area. During an interview 8/15/17 at 10:28 a.m., the Director of Nursing (DON) confirmed there had been a situation in the past where the resident had been found with more that one Exelon patch placed on his/her body at the same time.	F 281		
F 309 SS=H	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 30 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews and review of the policy and procedures, the facility failed to provide timely resident assessments and interventions when a resident had a change in condition (Resident #1, #2, #3 and #4). The sample consisted of 5 residents and the facility identified a census of 38 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form	F 309		

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dated 6/12/17 indicated Resident #1 had diagnosis that included dementia without a behavior disturbance . The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, had fluctuating disorganized thinking and as independent with all Activities of Daily Living (ADL's).

A Care Plan with nursing diagnosis dated 6/7/17 indicated the resident had impaired physical mobility and required the use of a 4 wheeled walker for stability with independent ambulation, a self-care deficit as required assistance with dressing, an alteration in thought process related to a poor short term memory deficit and forgetfulness, a potential for alteration in mood and anxiety with sleeplessness.

A Fall Incident Report form dated 4/8/17 at 1:45 P.M. revealed the resident rolled out of bed with no injuries.

Observation of photos on 8/17/17 at approximately 3:35 p.m. revealed the following photos as time stamped on a cell phone and described as follows:

On 4/16/17 at 9:40 a.m. - A dark red bruise with a white center on the resident's left middle upper shoulder.

On 4/16/17 at 9:40 a.m. - The entire posterior left arm region discolored yellow on the top portion and purple along the bottom.
On 4/16/17 at 9:40 a.m. - A dark purple bruise on the inner aspect of the resident's right arm.

Review of the resident's medical record identified

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F 309	Continued From page 32 no assessment and/or interventions for the above described areas. During an interview on 8/17/17 at 10:41 a.m., Staff S, Registered Nurse (RN) stated she never witnessed any bruising on the resident post fall. During an interview on 8/17/17 at 10:47 a.m., Staff P, RN confirmed she performed full body assessment post falls and never witnessed any bruising. During an interview on 8/17/17 at 10:54 a.m., Staff T, Licensed Practical Nurse (LPN) stated she never witnessed any substantial bruising on the resident but she had never completed a full body assessment because she had never been informed of such bruising. During an interview on 8/17/17 at 1:50 p.m., Staff U, Restorative Aide, confirmed she observed a bruise on the resident's hip but could not recall if the bruise had been following a fall. Review of the Nurse's Notes and a fax form revealed the following entries as dated and described: On 4/29/17 at 4:04 p.m. - Per Nurse's Notes, A fax had been sent to a Physician pertaining to a green crust draining from his/her reddened eye. On 4/29/17 at 4:04 p.m. - Per a Fax Form, The resident had green crust on the tear duct area of the left eye. The tear duct had been red and the resident reported the area itched at times. The resident received Fresh Kote eye gtts 2 times a day. (BID)	F 309		

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F 309	Continued From page 33 On 5/1/17 at 9 a.m. - A telephone order had been received for Polytrim one drop (gtts) to the left eye 4 times a day (QID) for one week due to conjunctivitis. There had been no further assessment of the eye status. On 5/2/17 at 2:40 p.m. - Staff spoke with a Physician about the resident's eyes and the Polytrim ordered 5/1/17. The physician ordered Polytrim gtts to both eyes QID for 1 week. The record identified no further assessments of the resident's eye status prior to discharge on 6/15/17 in the resident's medical record. Review of the Nurse's Notes revealed the following entries as described: On 6/5/17 at 8:30 a.m. - Received a telephone order from a physician to obtain a urinalysis (UA) with a culture and sensitivity (C&S) due to increased confusion, frequency and incontinency. There had been no further assessment of the resident's actual urine pain with urination and/or vital signs. On 6/5/17 at 10 a.m. - staff obtained a UA and sent it to the Physician. There had been no further assessment of the resident's actual urine pain with urination and/or vital signs. On 6/5/17 at 11 a.m. - results of the UA obtained and the physician informed. On 6/6/17 at 3 p.m. - the physician observed the results of the UA and requested to await the results of the C&S. From the above entry and until 6/9/17, the record noted no further assessment of the resident's	F 309		

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F 309	Continued From page 34 actual urine pain with urination and/or vital signs. On 6/9/17 at 9:45 p.m. - the facility received the results of the C&S and informed the physician. The notes indicated no further assessment of the resident's actual urine pain with urination and/or vital signs. From the above entry until 6/12/17 at 10:50 a.m. no further assessment of the resident's actual urine pain with urination and/or vital signs. The note indicated the resident sent for an appointment due to a fall and never returned. A Urinalysis with Microscopic Auto form dated 6/5/17 at 10:29 identified the following abnormal values: 1 + bacteria and mucus in the urine. 3-5 Squamous Epithelial Cells and White Blood Cells in the urine. (normal values 0-5) 2. Resident #2 had a MDS assessment with a reference date of 5/29/17. The MDS indicated the resident had diagnosis that included Alzheimer's disease and dementia. The assessment indicated the resident had a BIMS score of 0, fluctuating inattention and disorganized thinking and ambulated independently. The BIMS score of 0 identified the resident with a severe cognitive impairment. A Care Plan with Nursing Diagnosis dated 6/7/17, indicated the resident had a self- care deficit, impaired physical mobility and had an alteration in thought process with a mood disturbance. Review of the Nurse's Notes, Patient Communication Form and a Fall Incident Report identified the following entries as dated and	F 309		

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F 309	Continued From page 35 indicated the following: On 5/23/17 at 4:20 p.m. the following entry in the Nurse's Notes - The resident returned from an physician appointment with a new order to discontinue Gentamycin eye gtts (antibiotic) and start Tornado ophthalmic suspension 1 gtt to the right eye 4 times a day (QID) until clear. There had been to assessment related to the status of the eye. Review of the resident's medical record indicated no further documentation about the resident's eye status thru 8/1/17. On 7/26/17 at 8:10 a.m. the following entry on a Fall Incident Report Form - The resident had been found on the floor by staff and complained of knee pain. On 7/26/17 entries revealed the resident's left pupil a delayed at 8:10 a.m., 8:25, 8:40, 8:55, 9:10, 9:40, 10:10, 11:10, 12:10 p.m., 1:10 p.m.. 3:10 p.m., 6:10 p.m., 10:10 p.m. and on 7/17/17 at 8:10 as delayed. On 7/26/17 at 9:33 a.m. the following communication/directive to the facility staff from the physician - The facility staff called and stated the patient fell that morning and hit his/her head. The staff stated the resident's pupil delayed. Per verbal order the Physician directed the staff to watch the level of consciousness, if more tired than usual and to continue to observe the pupils. An appointment reserved for him/her in case there had been changes. Review of the resident's medical record revealed no further assessments as directed above.	F 309		

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F 309	Continued From page 36 3. Resident #3 had a MDS assessment with a reference date of 4/25/17. Resident #3 had diagnosis that included benign prostatic hyperplasia, non-Alzheimer's dementia, depression and mild cognitive impairment. The assessment indicated the resident had a BIMS score of 9, had fluctuating disorganized thinking, non-ambulatory, and dependent on 2 staff with toileting and had a bladder indwelling catheter. A Care Plan with nursing diagnosis dated 7/21/17 indicated the resident had an alteration in bladder elimination. The approaches included the following: Make sure to measure output. Catheter irrigation as needed if bleeding or not functional. Review of the Nurse's Notes included the following documentation: On 4/27/17 at 10 p.m. - Foley draining dark red blood with clots. On 4/27 at 11 p.m. - The Foley catheter continued to drain dark red blood with stringy red clots. On 4/28 at 12:45 a.m. - Foley continued with frank blood in the catheter bag. On 4/28 at 2 a.m. - Foley continued with dark red blood. On 4/28 at 3 a.m. - The resident complained of pressure and the need to void. The nurse performed a catheter irrigated with continued return of dark red clots. On 4/28 at 4:50 a.m. the nurse irrigated the catheter with no clots observed. The note indicated the blood in the urine was described as a lighter color.	F 309		

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F 309	Continued From page 37 On 4/28 at 8 a.m. - frank blood remained in the catheter bag. On 4/28 at 9:30 p.m. - 275 cubic centimeters (cc's) of frank blood noted in the catheter bag. On 4/29 at 3 a.m. - Foley continued to drain dark red fluid without clots. On 4/30 at 9:30 a.m. - Foley catheter irrigated with 275 cc output. The note had no documented description of the urine. On 5/1 at 2:45 a.m. - Foley drained yellow urine. On 5/1 at 12 p.m. - Foley drained yellow urine. Review of the resident's medical record identified no further documentation about the Foley catheter and/or urine until 8/7/17 at 3:35 a.m. At this time, the resident hollered for assistance to urinate. The staff member explained to the resident he/she had a catheter which drained clear yellow urine. 4. Resident #4 had a MDS assessment with a reference date of 6/12/17. The MDS indicated the resident had diagnosis that included a urinary tract infection, depression, mild cognitive impairment, muscle weakness and an abnormal gait and mobility. The assessment indicated the resident had a BIMS score of 11 which identified a moderate cognitive impairment. The MDS indicated identified the resident as non-ambulatory, required extensive assistance of staff with toilet use and experienced frequent episodes of urine incontinence. A Care Plan with the Nursing Diagnosis dated 6/29/17, indicated the resident had a self-care deficit and required assistance with ADL's, impaired physical mobility and an alteration in bowel and bladder elimination. The approaches included the following:	F 309		

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F 309	Continued From page 38 Provide me with morning, evening and PRN perineal cares. Consult with the physician. A Lab Result Report dated 6/15/17 at 7:40 a.m.. revealed the resident had greater than a 100,000 colonies of Escherichia Coli (bacteria-generally found in the colon). Review of the facilities Nurse's Notes included the following entries as dated: On 6/12/17 at 6:30 p.m. - Temperature (T) 98.7 (normal 98.6) degrees, blood pressure (B/P) 160/94 (elevated), pulse (P) 79 (normal 60-100), respirations (R) 20 (normal 16-20), oxygen saturation rate 02 sat 94% at room air (normal 97-100%). Alert and oriented (A&0) times 3 (person, place and time), pleasant affect. Incontinent of bladder with frequency noted. Abdominal soft and non-tender, bowel sounds (BS's) active times 4 quadrants [of abdomen]. The resident had no complaints of pain or discomfort. The record identified no further assessment of the resident's urinary status. On 6/12/17 at 10:30 p.m. - T 98.6, 158/89, 82, 20, 02 sat 94% at room air. Alert and oriented times 3, pleasant affect. The resident rested in bed without complaints of incontinency. The note indicated no further assessment of the resident's urinary status. On 6/13/17 at 2:30 a.m. - T 97.5, 159/88, 97, 20, 02 sat 91% at room air. Resting in bed eyes closed no complaints. There had been no further assessment of the resident's urinary status. On 6/13/17 at 6:30 a.m. - T 99, 141/89, 82, 20, 02 sat 92% at room air. No complaints of	F 309		

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F 309	Continued From page 39 pain/discomfort. Skin warm and dry. Good appetite. Usually continent of bladder during the day. Dribbles so wore pull ups. A&O times 3, got confused at times. The record identified no further assessment of the resident's urinary status. On 6/13/17 at 8 a.m. - Per Physician obtain a UA and C&S due to being more incontinent with increased frequency and T. On 6/13/17 at 8:30 a.m. - UA obtained and sent to the clinic. No further assessment of the resident's urinary status. On 6/13/17 at 10:30 a.m. - T 97.5, 140/78, 69, 20, 02 sat 93% at room air. No complaints of pain/discomfort, pleasant and cooperative. The record indicated no further assessment of the resident's urinary status. On 6/13 at 2:30 p.m. - T 98.4, 140/80, 78, 20, 02 sat 93% at room air. No complaints of anything. The record and notes indicated no further assessment of the resident's urinary status. On 6/13/17 at 11:35 p.m. - Resident resting in bed at that time. Scheduled pain medication provided. Resident denied pain. Respirations deep and easy. The record and notes identified no further assessment of the resident's urinary status. On 6/14/17 at 3:45 a.m. - Resident rested quietly thus far in the shift. Had offered no complaints and incontinent of bladder. The resident changed and perineal care provided. The resident denied pain. The record and notes indicated no further assessment of the resident's urinary status.	F 309		

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F 309	Continued From page 40 On 6/14/17 at 3:30 a.m. - T 98.6, 121/71, 80, 18, 02 sat 93% at room air. The resident had no complaints of pain/discomfort, A&O times 3 with moments of confusion. Continent of bowl and bladder with periodic dribbles. The record and notes identified no further assessment of the resident's urinary status. On 6/15/17 at 5 a.m. - Resting quietly in bed with eyes closed. No complaints of pain/discomfort. The resident A&O times 3 and incontinent of bladder. Fluids encouraged. The notes and record identified no further assessment of the resident's urinary status. On 6/15/17 at 6 p.m. - The resident pleasant throughout the shift. There had been no further assessment of the resident's urinary status. On 6/15/17 at 9 p.m. - T 98.6, 174/98, 71, 20, 02 sat 97% at room air. No complaints of pain/discomfort. A&O times 3. Fluids encouraged. The record and notes identified no further assessment of the resident's urinary status. On 6/16/17 at 6 a.m. - No complaints of discomfort. A&O times 3. Incontinent of urine. Fluids encouraged. The record and notes identified no further assessment of the resident's urinary status. On 6/16 at 6:30 p.m. - T 98.9, 187/97, 80, 18, 02 sat 90% at room air. Complained of slow response to orientation questions. Lung sounds with fine crackles at bilateral bases, no cough, and shortness of breath or wheezing. Heart rate strong without noted abnormal sounds. A trace of	F 309		

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edema noted on the bilateral lower extremities. Denied pain or other concerns at that time. The note and record identified no further assessment of the resident's urinary status.

On 6/17/17 at 3:15 a.m. - No concerns noted. No complaints of pain or discomfort. A&O times 3. The record or notes identified no further assessment of the resident's urinary status.

On 6/17/17 at 9 a.m. - The resident refused to eat any breakfast or take medications. Increased confusion noted with a decreased mental and physical status. T-100, 119/60, 79, 18 O2 sat 90% at room air. The notes and record identified no further assessment of the resident's urinary status.

On 6/17/17 at 10 a.m. - Updated the Physician and received an order for Bactrim DS (antibiotic) 1 tablet twice a day for 10 days. The notes and the record did not have further assessment of the resident's urinary status from the above stated entry until 6/19 at 9:55 a.m. when the results of the C&S obtained and reported to the physician.

On 6/19/17 at 10:10 a.m. - T 98.4, 111/65, 72, 18, 02 sat 91% at room air. Denied pain or discomfort. A&O times 3. Denied shortness of breath. Ate 2 pancakes without difficulty. No further emesis. Resident stated he/she felt much better. Resident continued receiving Bactrim DS. The note and record identified no further assessment of the resident's urinary status.

On 6/19/17 at 2:20 p.m. - A telephone order received to change the resident antibiotic from Bactrim DS to Ceftin (antibiotic) 250 mg twice a day for 10 days. The note or record identified no

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F 309	Continued From page 42 further assessment of the resident's urinary status until from the above entry until 7/27/17 at 11:30 a.m. after a failed catherization attempt to obtain a UA. The nurse obtained an order to flush and irrigate the catheter and send to the ER (emergency room) if unsuccessful. On 7/27/17 at 12:40 p.m. - The resident was transported to the ER. On 7/27/17 at 8:50 p.m. - The resident returned to the facility with a new order for Cipro 500 mgs twice a day for a UTI (urinary tract infection). A written statement provided by a physician dated 8/17/17, identified the following: The physician expected staff to assess the resident's vital signs, mental status and gastrointestinal complaints when a resident exhibited signs and symptoms of a UTI. The physician expected staff to continue the assessments until the resident had gone 24 hours asymptomatic. UA results had been available the same day if sent to the clinic. If the results had been sent to the hospital the results had been available the following day, unless on Friday in that case the results had been available on Monday. The physician expected the facility staff to call him right away with abnormal results. If the facility had not received results from a UA he would have expected them to call the clinic for the results but not the hospital. Signs and symptoms of a UTI included a change in condition, frequency, dysuria, incontinence, fever and chills. On 6/13/17 the resident exhibited signs and symptoms of a UTI, however the physician had	F 309		

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not been consulted until 6/17/17 and at which time he started the resident on an antibiotic. The physician confirmed he would have expected staff to have consulted him earlier.

On 6/19/17 the physician changed the antibiotic ordered on 6/17/17 as a result of the C&S report but the facility did not assess the resident's urinary condition and/or health status until 7/27/17 which ultimately resulted in an emergency room visit. The physician confirmed he would have expected staff to have properly assessed the resident.

A policy and procedures titled Timely Mission Nursing Home Procedure on Charting Change of Condition with Resident (not dated), included the following:

a. Needed to chart and take vitals every 4 hours for the first 24 hours with the assessment of the residents.
1. Bowel sounds
2. Lung sounds
3. Response to stimuli verbal or tactile.
4. Orientation.
5. Any unusual behavior and interventions utilized.
6. Doctor and family notification.

b. Needed to continue charting every shift for 48 hours at a total of 72 hours and longer if the condition did not improve

c. When you charted DO NOT leave a time gap in charting . Chart findings also at the end of the shift and the beginning of the shift.

A form titled STAFF NURSES (not dated) directed the staff when residents are assessed the following things needed to be done:

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F 309	Continued From page 44 a. Blood pressure, pulse, respirations and temperature. b. Lung sounds. c. Bowel sounds x (times) all 4 quadrants [of abdomen]. d. Oxygen saturation level. e. Blood sugars. f. Mental status. g. Skin color. h. Skin dry or diaphoretic. i. Dependent edema.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure staff provided complete and timely oral care for 3 of 38 residents observed. (Resident # 6, #11 and #12) The facility identified a census of 38 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 7/3/17 Resident #6 had diagnosis that included non-Alzheimer's dementia. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0, with fluctuating inattention and disorganized thinking and required extensive assistance of staff with personal hygiene. A Care Plan with nursing diagnosis dated 7/10/17	F 312		

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indicated the resident had a self care deficit and required total assistance of staff with all activities of daily living (ADL's). The approaches included the following:

a. Set up my grooming supplies and assist me as needed.

2. A MDS assessment form dated 7/5/17 indicated Resident #11 had diagnosis that included a cerebrovascular accident and glaucoma. The assessment indicated the resident had a BIMS score of 14 and as independent with personal hygiene.

A Care Plan with a nursing diagnosis dated 7/10/17 indicated the resident had a self care deficit.

3. A MDS assessment form dated 6/15/17 indicated Resident #12 had diagnosis that included depression, mental disorders due to a known physiological condition. The assessment indicated the resident had a BIMS score of 0, had fluctuating inattention and disorganized thinking and required extensive assistance of staff with personal hygiene.

A Care Plan dated 6/21/17 indicated the resident had a self care deficit and required assistance with ADL's. The approaches included the following:

a. Groom me every morning and afternoon, I would help if I can.

During an interview and observation 8/15/17 at 11:36 a.m., the Director of Nursing (DON) confirmed Resident #6, #11 and #12 required

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F 312	Continued From page 46 assistance with oral cares and confirmed the resident's toothbrushes and equipment were dry and not utilized. The DON stated she expected staff to assist residents with oral cares in the mornings, after meals and at their hour of sleep (HS). During an interview 8/29/17 at 10:43 a.m., Staff A, CNA confirmed oral cares as an issue and not routinely performed. The staff member indicated staff just placed resident's dentures in cups which contained plain water and failed to brush the teeth. During an interview 8/16/17 at 4:19 p.m.. Staff F, CNA confirmed oral cares as not always been performed for hour of sleep (HS) cares. During an interview 8/16/17 at 4:36 p.m., Staff V, CNA confirmed oral cares as not always performed during HS cares. An undated Oral Hygiene policy included but not limited to the following directions: 1. Having had a clean and fresh mouth is part of the dignity to which each resident is entitled. 2. Every resident should received oral hygiene twice daily. 3. Brush the dentures with toothpaste or powder, under cool running water. 4. Assist resident to rinse mouth.	F 312		
F 353 SS=F	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	F 353		

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F 353	Continued From page 47 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 353		

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F 353	Continued From page 48 (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 observation, clinical record review, resident and staff interviews and facility policy review the facility failed to ensure sufficient staff were available to answer resident call lights in a timely manner (within 15 minutes). (Resident #7,#13, #14 #18) and maintained the resident's call lights as in reach for 5 of 38 residents. (Resident # 14 #19, #20, #21 and #22). The facility identified a census of 38 residents. Findings include: 1. A MDS assessment form dated 5/15/17, indicated Resident #7 had diagnosis that included multiple sclerosis and depression . The assessment indicated the resident had a BIMS score of 14, as non-ambulatory, dependent on 2 staff members with transfers, dressing and toilet. The assessment indicated the resident as occasionally incontinent of his/her bladder. A Care Plan with nursing diagnosis dated 5/24/17, indicated the resident had a self care deficit and required staff assistance with all ADL's and with an impaired physical mobility status. The approaches included the following: a. Make sure my call light had been in reach. During an interview 8/11/17 at 12:50 p.m., the resident confirmed his/her call light on longer than 15 minutes. He/she stated in the later part of	F 353		

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2016 he/she used the clock on the wall in his/her room and timed the call light on for 40 minutes which made him/her feel like crap and it had been upsetting because he/she had not wanted to pee his/her pants. The resident stated there had been another time the staff left him/her on the commode for 40 minutes which caused pain which resulted in crying so he/she loosened the ropes on the EZ stand device to relieve some pressure. Lastly, the resident confirmed having been incontinent waiting for staff to answer the call light which made him/her to feel awful.

An observation 8/11/17 at 2:06 p.m., revealed the resident's call light as on while the resident waited to go to the bathroom. At 2:22 p.m. the Director of Nursing (DON) walked past the resident's room 2 times while the resident's call light remained on. This observation had been confirmed by the resident at the same time. At 2:26 p.m. the resident confirmed he/she started to feel ticked. At 2:29 p.m. assistance had been offered to obtain assistance, the resident confirmed. At 2:30 p.m. 2 unknown CNA's began up the hallway and passed gowns to resident's rooms. The observation had been confirmed by the resident. At 2:33 p.m. the CNA's responded and stated, it had been hard to see the resident's call light as on.

2. A MDS assessment form dated 8/2/17 indicated Resident #13 had diagnosis that included . The assessment indicated the resident had a BIMS score of 15 and required extensive assistance of 2 staff with transfers and toileting.

A Care Plan with nursing diagnosis dated 5/10/17 indicated the resident had a self care deficit and

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F 353	'Continued From page 50 required extensive assistance of staff with ADL's. The approaches included the following: a. Have my call light in reach. b. Assist me with the bed pan or commode as needed. c. Provide me with proper perineal care in the morning, afternoon and as needed. During an interview 8/11/17 at 2:46 p.m., the resident confirmed staff failed to place his/her call light in reach so he/she could not ask for help and soiled the bed so he/she rolled over and used his/her gown to cover up the dampness in the bed. The resident confirmed he/she had not always had control of his/her bladder since childhood so attempted to space out the requests to urinate. 3. A MDS assessment form dated 7/29/17, indicated Resident #14 had diagnosis that included diabetes mellitus, hemiplegia, depression, cerebrovascular disease, extrapyramidal and movement disorder and a benign neoplams of the brain . The assessment indicated the resident had a BIMS score of 15, as non-ambulatory, required extensive assistance of 2 staff with bed mobility and dependent of staff with transfers, locomotion, dressing toilet use and personal hygiene. A Care Plan with nursing diagnosis dated 5/10/17, indicated the resident had a self care deficit and required total assistance of staff with ADL's and an impaired physical mobility. The approaches included the following: a. Please have my call light in reach.	F 353		

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F 353	Continued From page 51 An observation 8/3/17 at 1:29 p.m., revealed the resident's call light as on with the resident positioned in his/her room. An observation 8/3/17 at 1:50 p.m., revealed the resident's call light as still on and the resident remained in his/her room. During an interview at the same time, the resident confirmed the call light as on for 20 minutes and so far, no staff members had responded. An observation 8/3/17 at 1:53 p.m., revealed Staff K, CNA answered the resident's call light who requested to go to Bingo. 4. During a Resident Group Interview 8/15/17 at 9:30 a.m., Resident #18 indicated there had been times he/she timed his/her call light as on form 1/2 to 3/4 of an hour using the call lock on the wall in the room which had not made him/her feel very good. 5. During an observation 8/10/17 at 2:30 p.m., the Administrator confirmed the following resident's call lights positioned not in reach of the resident's as indicated: a. Resident #14 - Clipped to the wall mount in the resident's room. b. Resident #19 - Clipped to the resident's pillow positioned between the bed and the wall. c. Resident #20 - Clipped to the sheet on the bed under the covers of the bed. d. Resident #21 - Clipped to a pillow positioned on the resident's bedside stand as he/she sat in the recliner. During an interview at 2:40 p.m. the resident confirmed he/she used the call light and the Administrator placed in within reach of the resident in the recliner.	F 353		

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F 353	Continued From page 52 e. Resident #22 - Clipped to the light string between the resident's bed and wall. 6. During an interview 8/3/17 at 3:08 p.m., Staff L, Restorative Aide confirmed staff had not always been able to answer call lights within 15 minutes and their had been resident's that complained. 7. A Call Light policy (not dated) included the following: a. Always place the call light within reach of the resident whether in bed or chair. b. NEVER place a call light out of reach or remove it from a resident. c. Always answer the light promptly. Anyone could and should assist with answering call lights. During an interview 8/10/17 at 3:49 p.m., Staff N, Certified Nursing Assistant (CNA) confirmed there had been times staff had been unable to answer call lights within the allotted 15 minute time frame. During an interview 8/11/17 at 9:54 a.m., Staff D, CNA confirmed there had been times staff had been unable to answer call lights within the allotted 15 minute time frame. During an interview 8/16/17 at 4:36 p.m., Staff V, CNA confirmed there had been times staff had been unable to answer call lights within the allotted 15 minute time frame.	F 353		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink	F 364		

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	165586	A. BUILDING _____ B. WING _____	C 09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 364	Continued From page 53 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, staff and resident interview and facility policy review, the facility failed to maintain the proper food temperatures during meals observed. (Resident #18) The facility identified a census of 38 residents. Findings include: A MDS assessment form dated 5/15/17, indicated Resident #7 had diagnosis that included multiple sclerosis and depression . The assessment indicated the resident had a BIMS score of 14, cognitively intact. During an interview 8/11/17 at 12:50 p.m., Resident #18 stated the hot food served at meals is cold all the time. During a Resident Group Interview 8/15/17 at 9:30 a.m., Resident #18 indicated sometimes the hot food had been hot and the cold food cold but not all of the time. An Acceptable Holding Temperatures For Foods form (not dated) included the following documentation: a. Eggs, scrambled - 140 to 150 degrees. b. Hot cereal - 160 to 170. c. Entree -150-160.	F 364		

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F 364	Continued From page 54 d. Potatoes or substitute - 160 to 170. e. Vegetable - 160 to 170. f. Soup - 160 to 180. g. Cold food - 41 or under h. Cold beverage - 40 to 45. i. Hot beverage - 140 to 160. j. Pureed foods - 100 to 110. An observation 8/10/17 at 5:55 p.m. revealed Staff J, Cook check the temperature of the soup per request after he served several bowls. The soup temperature read 150.4 degrees. The staff member then proceeded to turn up the burner under the soup. At 6:06 p.m. the staff member rechecked the soup temperature which read 161.2 degrees. Review of the facilities Food Temperature Record forms from 7/16/17 through 7/29/17 revealed the following: a. No food temperatures taken for dinner on 7/17/17. b. No food temperatures taken for breakfast on 7/21/17. c. No food temperatures taken for lunch on 7/21/17. During an interview 8/10/17 at 4:05 p.m., Staff A, Certified Nursing Assistant (CNA) confirmed there had been times residents verbalized concerns the hot foods had not always been served hot and cold foods not always served cold.	F 364		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at	F 387		

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F 387	Continued From page 55 least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure regular 60-day physician visits for 2 of 5 sampled residents (Resident # 5 and #8). The facility census was 38 residents. Findings: 1. A Minimum Data Set (MDS) assessment form dated 5/25/17 indicated Resident #5 had diagnosis that included adult failure to thrive, chronic kidney disease and depression . The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive impairment), had fluctuating inattention and disorganized thinking. The MDS documented the resident as non-ambulatory and dependent on staff for all activities of daily living (ADL's). A Care Plan with nursing diagnosis dated 6/7/17 indicated the resident with a self care deficit and required total assistance of staff with ADL's. Review of the resident's medical record on 8/2/17 revealed the resident had not been seen and/or assessed by a physician between 7/19/16 and 3/12/17. During an interview at the same time the facilities Medicare Coordinator confirmed. 2. Review of a MDS assessment form dated 6/14/17 Resident #8 had diagnosis that included	F 387		

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F 387	Continued From page 56 Alzheimer's disease, non-Alzheimer's dementia and adult failure to thrive . The assessment indicated the resident had a 0 (zero) BIMS score, with fluctuating inattention and disorganized thinking, physical and verbal behavior towards others 1-3 days and other behavior symptoms not directed towards others 4-6 days. The assessment indicated the resident required extensive assistance of 1 staff member with toilet use, personal hygiene and dressing, required limited assistance of 2 staff with transfers, ambulation and locomotion and as occasionally incontinent of urine and frequently incontinent of bowel. According to a Care Plan with nursing diagnosis date 6/21/17 the resident had a self care deficit and required total hands on assistance with ADL's and an alteration in thought processes and behaviors as resistive to ADL's occasionally. A review of the resident's medical record revealed the resident had not been seen and/or assessed by a physician between 4/25/17 and 8/15/17. During an interview at the same time the facilities Medicare Coordinator confirmed.	F 387		
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 maintain medical records on each resident that are- (i) Complete;	F 514		

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F 514	Continued From page 57 (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 observation, staff and family interviews and facility policy review, the facility failed to maintain complete and accurately documented medical records for 1 of 4 residents reviewed, (Resident #1). The facility identified a census of 38 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 6/12/17 indicated Resident #1 had diagnosis that included dementia without behavior disturbance. The assessment indicated the	F 514		

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F 514	Continued From page 58 resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, (severely impaired cognition) with fluctuating disorganized thinking and as independent with all Activities of Daily Living. A Care Plan with nursing diagnosis dated 6/7/17 indicated the resident had impaired physical mobility and required the use of a 4 wheeled walker for stability with independent ambulation, a self care deficit as required assistance with dressing, an alteration in thought process related to a poor short term memory deficit and forgetfulness, a potential for alteration in mood and anxiety with sleeplessness. A Fall Incident Report form dated 4/8/17 at 1:45 P.M. revealed the resident rolled out of bed with no injuries. Observation of of photos on 8/17/17 at approximately 3:35 p.m. revealed the following photos as time stamped on a cell phone and described as follows: a. 4/16/17 at 9:40 a.m., a dark red bruise with a white center on the resident's left middle upper shoulder. b. 4/16/17 at 9:40 a.m., the entire posterior left arm region discolored yellow on the top portion and purple along the bottom. c. 4/16/17 at 9:40 a.m., a dark purple bruise on the inner aspect of the resident's right arm. Review of the resident's medical record revealed no assessment and/or interventions for the above described areas. During an interview 8/17/17 at 10:41 a.m., Staff S, Registered Nurse (RN) indicated she never	F 514		

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F 514	Continued From page 59 witnessed any bruising on the resident post fall. During an interview 8/17/17 at 10:47 a.m., Staff P, RN confirmed she performed full body assessments post falls and never witnessed any bruising. During an interview 8/17/17 at 10:54 a.m., Staff T, Licensed Practical Nurse (LPN) indicated she never witnessed any substantial bruising on the resident but she had never completed a full body assessment because she had never been informed of such bruising, During an interview 8/17/17 at 1:50 p.m., Staff U, Restorative Aide confirmed she observed a bruise on the resident's hip but could not recall if the bruise had been following a fall.	F 514		

Plan of Correction
Timely Mission Nursing Home
Date of Correction 10/5/2017

F157

1. Resident #1 no longer resides in our facility.

2. All Nursing Staff have been educated on the Nursing Assessment and documentation protocol.

3. Director of Nursing and/or designee will be responsible for ensuring that staff have completed the assessments and documentation appropriately.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F225

1. Residents #1 does not reside in our facility any longer. Residents 7,8,9,14,15,16,17 and all similarly situated residents were talked to by staff and reported to staff that they do not feel that they are currently in danger of being hurt by any of the staff mentally, physically, or emotionally. Staff member C was immediately removed from the floor and put on suspension until the facts could be sorted out. Upon resolution of the facts, Staff C was terminated from Timely Mission Nursing Home.

2. All of the staff were re-educated on Resident Rights, Abuse, and maintaining quality of life for all. Staff were also re-educated on the procedure for reporting abuse and all issues that could be considered abuse. A new policy was developed in our facility that staff may not be supervised by a relative (either a blood relative or by marriage).

3. The Social services Director or designee will continue to speak to various residents on a random basis to make sure that they are being treated properly.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F241

1. Residents #1 does not reside in our facility any longer. Residents 7,8,9,14,15, & 16 and all similarly situated residents were talked to by staff and reported to staff that they do not feel that they are currently being treated in an undignified way.

2. Staff were re-educated about speaking to residents in a manner that it respectful and dignified.

3. The Director of Nursing and/or designee with continue to monitor staff for their interactions with residents to verify that they are speaking to residents in a dignified manner.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F281

1. Resident #1 is not a resident in our building any longer. Any other resident with medication in a patch form will also be monitored carefully.

2. Nursing staff have been educated on the placement and removal of medication dispensed through patches.

3. The Director of Nursing or designee will be responsible for doing random checks ensure that all the nurses are dispensing and removing patches properly.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F309

1. Residents #1 is no longer in our facility. Residents #2, #3 and #4 and all other similarly situated residents have been assessed by nursing.

2. Nursing will continue to assess all residents with any condition of change per protocol.
   Protocol consists of:
   1.) Assessments every 8 hours and prn with condition change.
   2.) 72 hours of total charting with copy to the D.O.N. for review
   3.) Dr. and family will be notified of change
   4.) Antibiotics ordered-when series complete; post assessment to be done.

Nursing Assessment for re-admits, post-hospital.

1.) Vitals every 8 hours x 24 hours with assessments charting with post 72 hours-copy to D.O.N.
2.) Assess with skin evaluation every 8 hours x 24 hours

Nursing Assessment for falls/protocol

1). Fall assessment to be completed with addition of 24 hours skin assessment follow-up
2). Skin assessment sheets are filled out by C.N.A. 2x week with baths. Evaluated by charge nurse & D.O.N.
3).Nursing protocols for catheters to chart, color, amount, & comfort every shift.
4).Protocols will be reviewed with nurses & C.N.A.s

3. The Director of Nursing and/or designee with continue to monitor the nursing staff assessments and their documentation.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F312

1. Residents #6, #11, & #12 remain in our facility. They have been reviewed by our interdisciplinary team as have all resident who need assistance with oral cares and other ADLs.

2. Staff were re-educated about providing ADLs to residents in a manner that it respectful and dignified.

3. The Director of Nursing and/or designee with continue to monitor staff for their ability to provide ADLs including oral care with residents.

4. Any issues discovered will be brought to the Quality Assurance Committee to be resolved immediately.

F353

1. Residents #7, #13, #14, #18 continue to reside at this facility.
2. Staff have been re-educated on answering call lights in a timely manner, call lights being within reach and the need of all staff to answer call lights.
3. The Director of Nursing and/or designee will monitor the call lights, call lights being within reach, and the timeliness of the staff answering them.
4. Any issues discovered will be brought immediately to the Quality Assurance Committee to be resolved immediately.

F364

1. Residents #7 & #18 remain in the facility.
2. All kitchen staff were re-educated proper food temperatures.
3. Dietary manager will monitor the food temperatures and randomly speak to residents and make sure that their food is being served at the correct temperature.
4. Any issues discovered will be brought immediately to the Quality Assurance Committee to be resolved immediately.

F387

1. Residents #5 & #8 remain in the facility.
2. All nursing staff reviewed the policy regarding the time frame for resident physician visits.
3. Director of Nursing and /or designee will continue to monitor call light times and make sure staff are answering them in a timely manner.
4. Any issues discovered will be brought immediately to the Quality Assurance Committee to be resolved immediately.

F514

1. Residents #1 no longer resides in our building.
2. The Director of Nursing and/or designee re-educated nursing on resident assessment as well as proper chart documentation.
3. Director of Nursing and/or designee will continue to monitor nursing assessments, assessment documentation and chart documentation.
4. Any issues discovered will be brought immediately to the Quality Assurance Committee to be resolved immediately.