| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165248 | A. BUILDING _____ B. WING _____ | C 08/29/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PLEASANT ACRES CARE CENTER | 309 RAILROAD STREET HULL, IA 51239 |

| (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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| F 000 | INITIAL COMMENTS<br><br>Correction date: 10/6/17<br><br>The following deficiencies were identified during the investigation of complaint #68404-C, #68820-C, #69275-C, #69503-C, #70139-C, and self reported incident #70184-I and #69800-I completed on 7/20/17 through 8/29/17.<br><br>#68404-C, substantiated.<br>#70184-I, substantiated.<br>#69800-I, substantiated.<br>#68820-C, substantiated.<br>#69275-C, substantiated.<br>#69503-C, substantiated.<br>#70139-C, substantiated.<br><br>See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C. | F 000 | | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(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-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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 | F 157 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Reindl

TITLE: Administrator

(X6) DATE: 10/09/2017

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

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| F 157 | Continued From page 1<br>clinical complications);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to notify resident's family in a timely manner for 1 of 11 residents reviewed. (Resident #3) The facility identified a census of 53 current residents. | F 157 | | |

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| F 157 | Continued From page 2<br>Findings include:<br><br>1. According to the Minimum Data Set (MDS) dated 6/9/17 Resident #3 had diagnoses that included diabetes mellitus, Alzheimer's disease, cerebrovascular accident and depression. The MDS identified the resident had a Brief Interview For Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use.<br><br>The care plan initiated 7/20/17 revealed the resident on 325 mg aspirin a day and also on duloxetine which has some antiplatelet features to it. Resident will bruise easily. There may even be bruises that have very minimal/minor trauma, something that would not even be necessarily noted at the time and could cause a bruise.<br><br>Review of the Progress Notes dated 7/18/17 at 8:00 AM revealed CNA notified charge nurse of a red/purple bruise to the left posterior knee area that measured 13 centimeters (cm) by 7 cm. Also noted to have a bruise to the left top foot light blue in color and measured 2 by 2 cm. Skin intact and the resident denied pain. The resident stated he/she bumped his/her leg on the bed frame. Family and Doctor notified.<br><br>During an interview with the Director Of Nursing (DON) on 8/16/17 at 4:45 PM she stated, staff had just found the bruise to the back of the resident's knee that morning and the nurse did not have time to call the family yet . The facility also had an admission or something to cause staff to not get the family called. The family came to the facility and saw the bruise and became | F 157 | | |

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| F 157 | Continued From page 3<br>upset.<br><br>During an interview with the DON on 8/29/17 at 4:20 PM she stated the facility had no policy and procedure for family notification. She further stated she expected staff to notify the family of a change in condition or incident as soon as possible if it's a reasonable time. If a non-emergent change occurs during the night, staff wait until morning to notify the family. | F 157 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, staff interview and policy review the facility failed to ensure residents treated with dignity and respect for 3 of 11 residents reviewed. (Resident #6, #9 and #10 ) The facility identified a census of 53 current residents.<br><br>Findings include:<br><br>1. According to the MDS dated 11/3/16 Resident #6 had diagnoses that included seizure disorder, anxiety disorder, psychotic disorder, and schizophrenia. The MDS identified the resident had a BIMS score of 13 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet use and limited assistance | F 241 | | |

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| F 241 | Continued From page 4<br>with ambulation and dressing.<br><br>The care plan dated 9/11/16 directed staff to monitor for safety techniques and provide cues/prompt and increased assist as needed. The care plan also directed staff to remind the resident to use the call light and wait for assist prior to transfers. Staff should check on him/her regularly, at least every 2 hours, offer to assist and remind to wait for staff assistance.<br><br>Review of the resident's Progress Notes revealed the following documentation:<br>On 8/25/16 (late entry) the resident found lying on the bathroom floor on his/her left side, denies fall. No shortening or external rotation of bilateral lower extremities noted. The resident denied pain and injury.<br><br>On 8/25/16 at 2:00 PM the resident in the wheelchair, brought out to nurses' desk to assess vital signs, neuro's (neurological exam) and cognitive function. Resident had been resistant when in room, became agitated with staff. Explained to the resident that staff were trying to keep him safe.<br><br>On 8/25/16 at 2:30 PM the resident returned to bed and call light placed in his/her hand.<br><br>On 8/25/16 at 6:00 AM the resident in bed, shakes his/her fist at nurse and stated "you treat me like I am in a prisoner of war camp".<br><br>On 8/25/16 at 7:15 AM the resident still upset about overnight nurse having him/her sit out in the dining room for about a half hour to make sure he/she was okay after finding him/her on the floor, refused to let nurse obtain vital signs and do | F 241 | | |

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| F 241 | Continued From page 5<br>neuro assessment as still upset. Will try for 11:15 AM assessment.<br><br>During an interview with Staff E, LPN (licensed practical nurse) on 8/10/17 at 2:00 PM she stated the night nurse reported to her she had kept the resident in the dining room and she remembered the resident had been upset. The facility did not have a policy to keep a resident in sight after a fall.<br><br>2. According to the MDS (minimum data set) dated June 29, 2017 Resident #9 had diagnoses that included aphasia, cerebrovascular accident, dementia, hemiplegia, seizure disorder, anxiety disorder, depression and chronic kidney disease. The MDS identified the resident short and long term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet assistance.<br><br>The care plan dated 4/9/17 directed staff to provide total assist of 2 staff for transfers with use of a Hoyer lift.<br><br>Observation revealed Staff O, CNA (certified nursing assistant) transferred the resident from the bed to the wheelchair. The room divider curtain remained open with the residents roommate awake in bed.<br><br>3. According to the MDS dated 7/6/17 Resident #10 had diagnoses that included diabetes mellitus, dementia, depression and psychotic disorder. The MDS identified the resident had long and short term memory problems and severely impaired cognitive skills for daily | F 241 | | |

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| F 241 | Continued From page 6<br>decision making. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident frequently incontinent of bowel and bladder.<br><br>The care plan updated on 4/21/17 directed staff to check and change the resident frequently to keep clean and dry during the day and night time hours. Toilet the resident as needed per request. The care plan also directed staff to approach the resident warmly and calmly and to instruct the resident on cares to be provided prior to initiating. If the resident becomes upset or agitated, place the resident in a safe environment and allow to calm before resuming cares. Provide distractions or diversions as able.<br><br>Observation on 8/16/17 at 4:15 PM revealed the resident awake in bed and lay on top of the bed covers. The resident's pants pulled down to his/her thighs. The incontinent brief not secured and able to visualize wet brief and partial groin area. Staff P, CNA entered the room and assisted Staff O to close the room divider curtain and provide incontinent care for the resident. Staff O and Staff P then transferred the resident from bed to the wheelchair with the Hoyer lift. Staff S opened the door and knocked as it opened. He failed to announce himself or wait for response to enter.<br><br>Policy and Procedure Review:<br>Review of the (undated) Resident Rights Policy and Procedure directed staff that residents have the right to be treated with dignity and respect and the right to equal care, treatment and services provided by the facility without discrimination. | F 241 | | |

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| F 241 | Continued From page 7<br><br>Review of the Policy and Procedure titled Perineal Care dated 4/13 directed staff to identify the resident, explain procedure and provide privacy. | F 241 | | |
| F 246 SS=E | 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and and resident interview the facility failed to ensure accommodation of resident needs received for residents that required use of a hoyer lift for transfers or personal supplies. The facility identified a census of 53 resident.<br><br>Findings include:<br><br>1. According to the Minimum Data Set (MDS) dated 7/6/17 Resident #10 had diagnoses that included diabetes mellitus, dementia, depression and psychotic disorder. The MDS identified the resident had long and short term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident frequently | F 246 | | |

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| F 246 | Continued From page 8<br>incontinent of bowel and bladder.<br><br>The care plan with a Revision Date of 12/27/16 and Target Date of 7/12/17 directed staff to transfer Resident #10 with assistance of 2 staff and a Hoyer lift.<br><br>During observation of cares on 8/16/17 at 4:15 PM Staff S knocked as he opened the door and stated he had been looking for the Hoyer lift.<br><br>During an interview on 8/16/17 at 4:45 PM the DON reported the facility in the process of getting a new Hoyer lift, need to get the okay. She reported the facility had 2 Hoyer lifts, but in June one lift would not hold weight and maintenance could not repair it. She further stated she was to get three quotes for the purchase of a new Hoyer lift but dropped the ball with no Administrator, or Maintenance person at the facility. The DON reported 5 residents require transfers with a Hoyer lift at this time, and residents on different halls.<br><br>Review of the Mechanical Lift Maintenance Checklist dated 1/25/17 through 5/22/17 revealed the checklist to be completed every 2 seeks. The Check list not documented completed since 5/22/17.<br><br>Review of the Large Expenditure Request dated 8/15/17 revealed a company request for new Hoyer lift.<br><br>Review of the Order Confirmation dated 8/23/17 revealed the order placed for reliant series sling, full body mesh, large, digital lift scale for reliant series floor lifts and reliant 600 series bariatric floor lift. | F 246 | | |

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| F 246 | Continued From page 9<br><br>During an interview on 8/10/17 at 8:50 AM the Maintenance person stated he started on 7/6/17, works part time 2.5 day a week and comes in on emergency situations and on call 24 hour a day.<br><br>During an interview with the Office Manager on 8/24/17 at 3:30 PM she stated the full time Maintenance personnel had a termination date of 5/26/17. A new Maintenance personnel hired full time with a start dated of 8/17/17.<br><br>The MDS assessment dated 6/9/17 documented Resident #12 had a BIMS score of 15, no cognitive impairment. When interviewed on 8/17/17 at 10:55 AM he/she stated the facility runs out of supplies at times. If they run out of liners he/she had to make due. It happens enough it irritates him/her.<br><br>During an interview with Staff I, CNA on 8/17/17 at 2:00 PM she stated the facility runs out of supplies and ran out of wipes this week. Staff improvise. | F 246 | | |
| F 248 SS=E | 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>(c) Activities.<br><br>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence | F 248 | | |

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| F 248 | Continued From page 10<br>and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to ensure meaningful activities provided for the residents. The facility identified the facility had a census of 53 residents.<br><br>Findings include:<br><br>1. Review of the Activity Calendar dated June, July, August and September 2017 revealed Sundays scheduled religious activity as cable television programs.<br><br>Observation on 8/18/17 at 9:15 AM revealed no structured coffee time activity for the residents.<br><br>During an interview with Resident #12 on 8/17/17 at 10:55 AM he/she stated he/she did the movie nights and weekend. He/she further stated activity staff and CNA's are too busy at times and unable to make the popcorn for movie night.<br><br>During an interview with the Activity Director on 8/9/17 at 3:30 PM she stated she had been hoping to do more outside activities and school students will come often to the facility. She further stated she had been working on training to drive the van. She stated she had a very small budget and did work to get an increase. She recently subscribed to an activity site on line with a 12 month subscription and had ton's of ideas to work on.<br><br>During an interview with Staff J, CNA on 8/17/17 at 2:30 PM she stated Travelogue a movie on the weekend or family come. Once in a while the residents play card bingo. She further stated no | F 248 | | |

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| F 248 | Continued From page 11<br>exercise classes available for residents. | F 248 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>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.<br><br>483.25 Quality of care<br>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:<br><br>(k) Pain Management.<br>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.<br><br>(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. | F 309 | | |

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| F 309 | Continued From page 12<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interviews, the facility failed to assess and provide timely interventions for residents with a change in skin areas and bowel conditions. Resident #6 had open areas present on the buttocks/coccyx and blisters on the bottom of feet/heel that the facility had not identified. The facility identified Resident #6 had no bowel movements for 6 days and the facility did not complete a gastrointestinal assessment. The facility identified a census of 53 residents.<br><br>Findings include:<br><br>1. Resident #6 had a MDS (Minimum Data Set) assessment with a reference date of 11/3/16. The MDS identified the resident had diagnosis including seizure disorder, anxiety disorder, psychotic disorder, schizophrenia, polyneuropathy (degeneration of peripheral nerves towards the center of the body) and atherosclerotic heart disease. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 13. A score of 13 identified the resident with no cognitive impairments. The MDS indicated the resident required extensive assistance with bed mobility, transfers and toilet use and limited assistance with walking and dressing. The MDS identified the resident always continent of bowel and bladder. The MDS indicated the resident required 2 or more staff for toileting. The MDS indicated the resident had no pressure sores.<br><br>The Care Plan dated 9/12/16 identified interventions that included and directed staff that the resident required limited assistance of 1 staff person for use of the toilet. | F 309 | | |

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| F 309 | Continued From page 13<br><br>The Care Plan identified an initiated date of 9/12/17 for the resident with the potential for alteration of skin integrity due to incontinence, age related skin changes and decreased mobility. The intervention directed staff to perform weekly skin assessment by the nurse, document in the Nurse's Notes and notify the physician of any anomalies.<br><br>Review of the BM (bowel movement) Report dated January, 2017 identified the resident had no BM documented on the following days: January 6 through January 11, 2017 (6 days).<br><br>Review of the Interagency Handoff Report dated 1/6/17 identified the following order: Milk of Magnesia 400 mg/5 mg 1 time a day as needed for constipation.<br><br>Review of the MAR (medication administration record) dated 1/1/17 through 1/31/17 identified no Milk of Magnesia administered to the resident.<br><br>Review of the Progress Notes dated 1/6/17 through 1/11/17 identified no documentation of a gastrointestinal assessment.<br><br>Review of the weekly Skin Sweep documents dated 8/10/16 through 11/18/16 identified no documented skin sweep after 11/18/16. Review of the record identified no open skin issues identified.<br><br>Review of the Progress Notes dated 1/11/17 at 10:46 AM indicated the resident left the facility per ambulance.<br><br>Review of the hospital document titled Wound | F 309 | | |

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| F 309 | Continued From page 14<br>Sheet, dated 1/11/17 at 2:15 PM, indicated the following wounds and measurements:<br><br>The right bottom foot, pre- existing, had a red area with a raised blister that measured 6 cm (centimeters) by 6 cm with blister in the center that measured 2 cm by 1.5 cm by 0.5 cm depth.<br><br>The left lateral lower heel, pre-existing, measured 2 cm by 3 cm area.<br><br>Left and right buttocks with multiple colored area to bilateral [both] buttocks and coccyx, pre-existing; multiple areas of purple and the left buttocks has blisters too.<br><br>Left Lateral Upper foot, pre-existing, a blister measuring 1 cm by 4 cm.<br><br>On 8/10/17 at 2:00 PM, Staff E, LPN (licensed practical nurse) was interviewed and stated unaware the resident had wound areas.<br><br>2. Resident #10 had a MDS with a reference date of 7/6/17. Resident #10 had diagnoses that included diabetes mellitus, dementia, depression and psychotic disorder. The MDS identified the resident had long and short term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the resident required extensive staff assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident as frequently incontinent of bowel and bladder.<br><br>The Care Plan, updated on 4/21/17, directed staff to check and change the resident frequently to keep clean and dry during the day and night time hours. The Care Plan directed staff to toilet the | F 309 | | |

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| F 309 | Continued From page 15<br>resident as needed per request and provide medications as ordered per the physician.<br><br>Review of the BM Report dated 7/26/17 through 8/24/17 identified no BM documented on the following days:<br>On 8/6, 8/7 and 8/8/17 (3 days).<br>On 8/10, 8/11, 8/12, 8/13, 8/14 and 8/15/17 (6 days).<br><br>Review of the Order Summary Report dated 8/21/17 revealed the following orders:<br><br>Milk of Magnesia 1200 mg/15 ml, give 30 ml by mouth as needed for constipation once a day only.<br><br>Bisacodyl suppository insert 10 mg rectally as needed for constipation daily as needed.<br><br>Review of the MAR dated 8/1/17 through 8/31/17 identified no Milk of Magnesia administered and Bisacodyl Suppository administered on 8/18/17 (day 6).<br><br>Review of the Progress Notes dated 8/6/17 through 8/8/17 and 8/10/17 through 8/15/17 revealed no documentation of assessment of the resident's gastrointestinal status.<br><br>During an interview with Staff E LPN (licensed practical nurse) on 8/10/17 at 2:00 PM, she stated the night nurse looks and lets the day nurse know the residents that had gone 3 days without having a BM. The day nurse then follows protocol. | F 309 | | |
| F 318 SS=E | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION | F 318 | | |

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| F 318 | Continued From page 16<br><br>(c) Mobility.<br><br>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview and policy review the facility failed to ensure restorative care provided per recommendation for 4 of 7 residents reviewed. (Resident #4, #6, #10 & #11) The facility identified a census of 53 residents.<br><br>Findings Include:<br><br>1. According to the MDS (minimum data set) dated 7/25/17 Resident #4 had diagnoses that included septicemia, chronic obstructive pulmonary disease, tachycardia and dyspnea. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility and limited assistance with transfers and toilet use.<br><br>The care plan dated 5/10/17 directed staff to provide a restorative program for the resident.<br><br>Review of the Nursing Rehab plan dated July and | F 318 | | |

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| F 318 | Continued From page 17<br>August 2017 revealed the following Nursing Rehab activities:<br>a. Active ROM upper extremities 2 to 3 times per week for 15 to 30 minutes. Pulley: use only 1 wheel of the pulleys 1 to 2 times per week per resident desire.<br>b. Active ROM lower extremities 2 to 3 times per week for 15 to 30 minutes. 1 seated abduction with green theraband. 2. NuStep for 15 minutes. Nursing Rehab documented completed.<br><br>During an interview with the resident on 8/24/17 at 10:20 AM he/she stated he/she had not received restorative services or exorcizes. A staff member told him/her they would start exercises today.<br><br>2. According to the MDS dated 11/3/16 Resident #6 had diagnoses that included seizure disorder, anxiety disorder, psychotic disorder, schizophrenia, polyneuropathy and artherosclerotic heart disease of the native coronary artery. The MDS identified the resident had a BIMs score of 13 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet use and limited assistance with ambulation and dressing. The MDS did not identify restorative services. According to the MDS dated 8/16/16 the resident required limited assistance with bed mobility, transfers and toilet use.<br><br>The care plan dated 11/2/16 directed staff to provide a restorative program. Review of the Intervention/Task flowsheets dated November, December and January revealed the following:<br>a. Active ROM<br>b. Nustep 15 minutes. | F 318 | | |

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| F 318 | Continued From page 18<br>c. Ambulate 100 feet with 4 wheeled walker, gait belt and assist. Cue for posture.<br>Nursing Rehab documented completed.<br><br>3. According to the MDS dated 7/6/17 Resident #10 had diagnoses that included diabetes mellitus, dementia, depression and psychotic disorder. The MDS identified the resident had long and short term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident<br>received restorative nursing programs for at least 15 minutes 5 days in the last 7 calendar days.<br><br>The care plan updated on 4/21/17 directed staff resident on a restorative program and see restorative flowsheets.<br><br>The flow sheets documented completed.<br>a. Active ROM (range of motion): Resident to do ROM to upper extremities per exercises, balloon ball, large group exercises as tolerates, verbal and tactile cueing every shift.<br>b. Bed mobility: Resident to participate bed mobility with cues and assist every shift.<br>c. Resident to do active range of motion to lower extremities, kick ball every shift.<br>e. Resident to do stretching to bilateral hamstrings with 30 second holds. Seated active ROM to lower extremities without resistance 1 to 2 times a week.<br>Nursing rehab documented completed.<br><br>4. According to the MDS dated 6/1/17 Resident #11 had diagnoses that included atrial fibrillation, coronary artery disease, heart failure, prostatic | F 318 | | |

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| F 318 | Continued From page 19 | F 318 | | |

hyperplasia, arthritis, dementia, anxiety disorder, depression and chronic obstructive pulmonary disease. The MDS identified the resident had a BIMs score of 6 which indicated severely impaired cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, ambulation, eating and toilet use. The MDS identified the resident experienced 1 fall without major injury since the last assessment set. According to the MDS the resident received restorative nursing programs for passive range of motion at least 15 minutes a day in the last 7 calendar days. The MDS dated 3/9/17 identified the resident required limited assistance with ambulation in the room and corridor.

The care plan with a revision date of 4/13/16 directed staff to complete restorative program per occupational therapy and to see restorative flow sheets.

Review of the Nursing Rehab flowsheets dated May, June and July 2017 revealed the following:
a. ROM to upper extremities 2 to 3 times a week
b. ROM with 0-1 pound weights as tolerates, arm bike.
c. Walking 2-3 times per week 150 feet with front wheeled walker and gait belt.
Nursing rehab documented completed.

During an interview with Staff D, CNA on 8/10/17 at 2:30 PM she stated the CNAs are responsible to do there own restorative for residents and sometimes can't get to it. She further stated she documents NA in the restorative documentation.

During an interview with Staff M, CNA on 8/18/17 at 11:20 AM she stated staff try to do range of

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| F 318 | Continued From page 20<br>motion when residents get up and dressed. All personal cares have residents do themselves for range of motion.<br><br>During an interview with The Director of Rehab on 8/18/17 at 12:30 PM she stated she started in the building 2 weeks ago. They had identified restorative needs work and have discussed working on a solution to move forward. She further stated she did not know what they did prior to 2 weeks ago and range of motion with cares would be considered a part of a restorative program.<br><br>Review of the Policy and Procedure titled Restorative Nursing dated 5/14 directed staff to do the following:<br>a. Discuss with therapy when to begin restorative program. Restorative program may begin while resident is still receiving therapy.<br>b. Review any recommendations from therapy on providing range of motion or splint/brace assistance.<br>c. Complete the nursing evaluation.<br>d. Develop the Restorative Program Plan and Summary with recommendations from the interdisciplinary team and the resident and family/responsible party.<br>e. Communicate individualized interventions to the caregiving team. Provide specific directions and training as needed.<br>f. Document resident daily participation, including actual number of minutes participation, on the restorative care flow record.<br>g. Evaluate effectiveness of interventions and document progress towards goals weekly.<br>h. Re-evaluate range of motion at least quarterly and with change in condition using the range of motion data collection. | F 318 | | |

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| F 318 | Continued From page 21<br>i. Review resident in care management. Modify goals and interventions as needed.<br>j. Communicate any modifications to the caregiving team. | F 318 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview and policy review the facility failed to ensure resident transferred in a safe manner for 3 of 11 residents reviewed. (Resident #3, #5 and | F 323 | | |

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| F 323 | Continued From page 22<br>#9). The facility identified a census of 53 residents.<br><br>Findings include:<br><br>1. According to the MDS (minimum data set) dated 6/9/17 Resident #3 had diagnoses that included cerebral vascular accident, dysphagia, diabetes mellitus, Alzheimer's disease and hypothyroidism. The MDS identified the resident had a BIMS (brief interview for mental status) score of 5 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet use.<br><br>The care plan dated 6/23/17 directed staff to:<br>a. Attempt to get the resident up before breakfast every AM; if he/she refuses, check and change for incontinence then continue to go in and encourage him/her to get up regularly (every 30 minutes to 1 hour) until he/she agrees. Have different staff members/preferred staff members offer assist as he/she sometimes takes a liking to certain staff and will respond better to them.<br><br>b. The resident does not like to be told "good morning".<br>c. The resident requires up to extensive assist of 1 staff participation with transfers.<br>d. The resident requires up to extensive assist of 1 staff participation to reposition and turn in bed.<br>e. Determine staff members the resident prefers and have 1 of them assist with AM cares whenever possible. Sometimes it goes better to just have 1 staff go in to assist him/her and may be less threatening to him/her; however ensure enough assist to be safe with AM cares.<br>f. 7/20/17 resident on 325 mg aspirin a day and | F 323 | | |

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| F 323 | Continued From page 23<br>also on duloxetine which has some antiplatelet features to it. Resident will bruise easily. There may even be bruises that have very minimal/minor trauma, something that would not even be necessarily noted at the time and could cause a bruise.<br><br>Review of the Incident reports revealed the following bruises to the residents hands.<br>a. 9/3/16, Bruising on left and right hands.<br><br>b. 1/8/17, Large bruise red and purple to left top of hand. No swelling, increased warmth noted. CNAs report resident wedges hands between the wall and bed when laying on his/her right side so left hand against the wall.<br><br>c. 1/28/17, CNA reported resident had a large purple bruise 5.6 cm by 6 cm to the top left hand when up out of bed in the AM. The resident stated bumped his/her hand on the assist bar.<br><br>d. 4/5/17, Resident noted with dark purple bruise to the top of his/her left hand that measured 4 by 6 cm. Denied pain, no swelling or warmth noted. The resident uncooperative during AM cares and attempted to strike at the CNA. The CNA attempted to move out of the way but he/she made contact with the CNA's arm.<br><br>e. 5/25/17, Weekly skin assessment completed, 2 cm by 2 cm bruise purple in color to top of right hand. No drainage noted, no signs or symptoms of infection and skin intact. Doesn't know how it happened.<br><br>f. During skin assessment new bruises noted. 1.1 cm by 1.2 cm to top of left hand, dark purple in color. 4 cm by 3 cm dark purple bruise to top of | F 323 | | |

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| F 323 | Continued From page 24<br>left hand. 2 cm by 2 cm purple bruise to left forearm. No signs or symptoms of infection, skin intact. Will continue to monitor. Resident stated he/she bruised easily and did not know how he/she got them.<br><br>g. 7/18/17, CNA (certified nursing assistant) notified charge nurse of a red/purple bruise to the left posterior knee area that measured 13 cm (centimeters) by 7 cm. Also noted to have a bruise to the left top foot light blue in color and measured 2 by 2 cm. Skin intact and the resident denied pain. The resident stated he/she bumped his/her leg on the bed frame.<br><br>Review of the Progress Notes dated 8/10/17 at 1:35 PM revealed the resident noted to have a large 9 centimeter (cm) by 8 cm bruise to the top of the left hand. The resident unsure of how it happened. Staff questioned and did not witness the resident hit his/her hand on anything. CNAs reported the resident had been combative while they were getting him/her up this morning. CNA reported she had been scratched multiple times on her arm by the resident. Staff reminded that if the resident becomes combative to leave him/her in a safe place with alarm on and try again later.<br><br>During an interview with the resident on 8/10/17 at 3:00 PM he/she identified the bruise on the top of the right hand. He/she stated staff pull on his/her hands all the time. He/she demonstrated the motion staff grab around both his/her hands with the thumbs to the top of the hands around the residents hands. He/she further demonstrated a backward pulling motion while gripping his/her hands.<br><br>During an interview with Staff Q, CNA on 8/22/17 | F 323 | | |

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| F 323 | Continued From page 25<br>at 1:20 AM she stated they approached the resident a little after 6:00 AM and he/she not ready to get up so left in bed. Around 6:30 AM went in and he/she still did not want to get up. She reported to the nurse and the nurse instructed them to use the Stand lift. The resident had been combative with the cares and started hitting her. She stated she did not know if in the commotion if he/she hit something. She reported seeing no bruise.<br><br>During an interview with Staff T, CNA on 8/24/17 at 11:10 AM she stated she assisted another CNA transfer the resident. The resident violently hit the other CNA (Staff Q) The reported to the nurse and she instructed to use the Stand lift. The resident had flailing arms and continued to fight. She further stated she thought staff would stop but she kept on going.<br><br>2. According to the MDS dated 5/11/17 Resident #5 had diagnoses that included congestive heart failure, pleural effusion, aphasia, cerebral vascular accident and acute kidney disorder. The MDS identified the resident had a BIMs score of 13 which indicated intact cognition .<br><br>The care plan dated 5/3/17 directed staff to provide limited to extensive assist of 1 staff for bed mobility and extensive assistance for transfers.<br><br>Review of the Resident Transfer Determination Form dated 4/13/17 revealed the resident required minimum assistance with gait belt. May use walker for transfers. Bears full weight less that 4 seconds. Has upper body strength. Sits up with assistance. Unsteady. Follows directions. | F 323 | | |

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| F 323 | Continued From page 26<br>Review of the Rehabilitation assessment summary dated 5/10/17 revealed staff not lifting his/her up by his/her arms since signs have been posted in his/her room.<br><br>Review of the Consultation/Clinic Referral dated 5/11/17 revealed the resident complained of right shoulder pain. The resident stated staff member repeatedly rough with him/her. Now he/she can't raise the arm up hardly at all. Right shoulder x-ray negative for fracture. New order included follow up 1 month and will do injection in right shoulder. Please be careful with the right arm and shoulder.<br><br>Review of the Consultation/Clinic Referral dated 5/19/17 revealed the diagnoses of right shoulder pain, osteoarthritis and rotator cuff tear, left forearm skin tears and blood pressure running high.<br><br>Review of the Order Summary Report dated 4/1/17 through 4/30/17 revealed the order for acetaminophen give 650 mg by mouth every 4 hours as needed for pain/fever.<br><br>Review of the MAR dated 4/1/17 through 4/30/17 revealed no acetaminophen required for pain.<br><br>Review of the Medication Administration Record (MAR) dated 5/1/17 through 5/31/17 revealed Acetaminophen 650 mg every 4 hours as needed for pain/fever administered for pain rated from 0 to 10 as follows:<br>Review of the May 2017, MAR revealed the resident required Acetaminophen<br>a. 5/02/17 at 3:14 PM for pain scale of 4.<br>b. 5/13/17 at 11:53 AM for pain scale of 3.<br>c. 5/16/17 at 8:25 AM for pain scale of 4.<br>d. 5/16/17 at 8:24 PM for pain scale of 2. | F 323 | | |

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| F 323 | Continued From page 27<br>e. 5/17/17 at 8:04 AM for pain scale of 3.<br>f. 5/18/17 at 2:20 PM for pain scale of 1.<br>g. 5/23/17 at 7:16 PM for pain scale of 3.<br>h. 5/27/17 at 5:24 PM for pain scale of 5.<br>i. 5/28/17 at 8:26 PM for pain scale of 5.<br><br>During an interview with Staff F, CNA on 8/16/17 at 2:00 PM she stated she had seen different staff pull on residents pants and arms for transfers.<br><br>During an interview with the residents family on 8/23/17 at 10:00 AM he/she stated the resident stated on 2 different occasions that staff pull on his/her arms. The family emailed the facility. Again during a visit the resident stated staff again pulled on his/her shoulder. The resident transferred to the hospital 1 to 2 weeks after that. The family further stated the resident had an injury prior to admit to the facility but the pulling on the arm/shoulder exacerbated the pain.<br><br>During an interview with the Physician on 8/24/17 at 8:30 AM he stated the resident entered the facility with a chronic tear in the right shoulder and arthritis, however did not have pain and ability to use it. The resident and family reported staff had been rough with him/her. I wrote a note to the facility in May. We did not do imaging so he/she may have either had a larger tear or inflammation of the shoulder. He further stated he knew the rough treatment happened again after the note had been written and increased his/her pain and decrease of function compared to what he/she had before.<br><br>During in interview with Staff D, CNA on 8/10/17 at 2:30 PM she stated she had not witnessed staff pull on resident's arms during transfers but residents had reported to her and she told | F 323 | | |

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| F 323 | Continued From page 28<br>nursing staff.<br><br>Resident Interviews<br>During an interview with Resident #13 on 8/17/17 at 10:00 AM he/she stated staff usually use the gaitbelt but may take his/her arm or hands and pull up at times and it is not a good thing. He/she stated he/she had not been hurt by it.<br><br>During an interview with Resident #14 on 8/17/17 at 10:30 AM he/she stated sometimes staff pull on him/her with no gait belt. It can hurt but did not have bruises or injury.<br><br>3. According to the MDS dated 6/29/17 Resident #9 had diagnoses that included aphasia, cerebrovascular accident, dementia, hemiplegia, seizure disorder, anxiety disorder, depression and chronic kidney disease. The MDS identified the resident short and long term memory problems and severely impaired cognitive skills for daily decision making. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet assistance.<br><br>The care plan dated 4/9/17 directed staff to provide total assist of 2 staff for transfers with use of a Hoyer lift.<br><br>Review of the Resident Transfer Determination Form dated 4/7/17 revealed the resident required a total mechanical lift (Hoyer type) for all transfers. The form also identified the resident had special considerations that included he/she may be combative or mentally impaired and may require more staff to assist during transfers.<br><br>Observation on 8/16/17 at 4:15 PM revealed Staff O, CNA (certified nursing assistant) transferred | F 323 | | |

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| F 323 | Continued From page 29<br>the resident from the bed to the wheelchair alone, without assistance as directed on the care plan dated 4/7/17.<br><br>Policy Review<br>Transfer Techniques dated 1/13 directed staff to safely transfer a resident while minimizing the risk of injury to the resident and caregiver. The procedure directed the equipment used as resident specific and gait belt as indicated.<br>a. Review any special precautions or approaches to take when transferring a resident. Obtain assistance as needed. Utilize a gait belt as indicated.<br>b. Identify resident, explain procedure and provide privacy.<br>c. Assemble equipment as needed in the resident room.<br>d. Wash hands.<br>e. Complete transfer as indicated.<br>f. Document any observations made during transfers. Observations may include, but are not limited to: Refusal of transfer, changes in clinical condition, complaints of pain or discomfort, resident level of participation in transferring, resident response.<br>g. Notify the physician of any changes or concerns in resident response to transferring, ability to participate, or changes in condition.<br>h. Review and revise resident transferring plan as indicated. | F 323 | | |
| F 353 SS=E | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to | F 353 | | |

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| F 353 | Continued From page 30<br>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).<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(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:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(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.<br><br>(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.<br><br>(a)(4) Providing care includes but is not limited to | F 353 | | |

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| F 353 | Continued From page 31<br>assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident interview the facility failed to provide nursing services to ensure resident call lights answered in a timely manner for 2 of 11 residents reviewed. (Resident #13 & #14). The facility identified a census of 53 residents.<br><br>Findings include:<br><br>1. Review of the Alarm Event Report dated 8/12/17 through 8/13/17 revealed 74 call light alarms with greater than 15 minute response time. Twenty one (21) of those call light alarm response times were 25 minutes or greater with the longest recorded response time at 46 minutes.<br><br>During an interview with Resident #13 on 8/17/17 at 10:00 AM he/she stated sometimes it takes a long time for staff to answer a call light.<br><br>During an interview with Resident #14 on 8/17/17 at 10:30 AM he/she stated it can take about 20 minutes for staff to answer call lights. | F 353 | | |
| F 490 SS=C | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | F 490 | | |

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| F 490 | Continued From page 32<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to provide detailed documents ensuring required time for administrative duties. The facility identified a census of 53 current residents.<br><br>Findings include:<br><br>1. No documents available to review for Interim Administrator presence in the building.<br><br>During an interview with the Director of Nursing on 8/10/17 at 10:15 AM she stated the Interim Administrator in the facility 1 day a week since the previous administrator's last day of 6/27/17. The corporate personal also at the facility every week but not daily. The Interim Administrator located in a facility 20 miles away and available to call when needed. She further stated the full time administrator started on Monday (8/7/17). | F 490 | | |

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.

F 157:

It is the practice of Pleasant Acres Care Center to notify resident family members of change in a timely manner.

#1- For resident #1, Nursing Staff were educated by the Director of Nursing on 09/29/2017 regarding the importance of timely notification for family members when a change is identified.

#2- For all similar residents, staff were educated the Director of Nursing on 09/29/2017 regarding the importance of timely notification for family members when a change is identified.

#3- The Director of Nursing or designee will conduct audits for resident change and timely family notification a minimum of 3 times weekly for 1 month then weekly for 2 months to ensure compliance is achieved.

#4- The Director of Nursing or designee will report progress of this plan of correction to the QAPI Committee for a minimum of 3 months to ensure ongoing compliance.

Date of compliance F 157 is: 09/29/2017

F 241:

It is the practice of Pleasant Acres Care Center to ensure that residents are treated with dignity and respect.

#1- For resident #6, #9 and #10, staff were educated by the Director of Nursing on 09/29/2017 regarding the importance of ensuring privacy when performing cares and assessments. Staff also educated on the importance respecting resident requests.

#2 For similar residents, staff were educated by the Director of Nursing on 09/29/2017 regarding the importance of ensuring privacy when performing cares and assessments. Staff also educated on the importance respecting resident requests.

#3- The Director of Nursing or designee will conduct audits 3 times per week for 1 month observing personal cares/assessments to ensure compliance and weekly for 2 months. The Administrator or designee will conduct a minimum of 5 random interviews each week for 1 month and weekly for 2 months to ensure residents are satisfied with the dignity and respectful care they are receiving.

#4- The Director of Nursing, Administrator and/or designee will report on the progress of this plan of correction for a minimum of 3 months to the QAPI Committee to ensure ongoing compliance.

Date of compliance F 241 is: 09/29/2017

F 246

It is the practice of Pleasant Acres Care Center to ensure accommodation of resident needs are met.

#1- For resident #10 a new hoyer lift was obtained by the facility on 08/28/2017. The Director of Nursing did an audit of Incontinence supplies on 10/05/2017 to ensure that resident needs would be met. The DON was educated by the Administrator on monitoring in house incontinence supplies, and the ordering system on 10/05/2017.

#2- For similar residents, new hoyer lift was obtained by the facility on 08/28/2017. The Director of Nursing did an audit of Incontinence supplies on 10/05/2017 to ensure that resident needs would be met.

#3- The facility now has available 2 hoyer lifts, this will ensure there is always a backup available. Mechanical lift checklist was initiated 8/31/2017 and is ongoing to identify quickly any mechanical needs or repairs necessary. The Director of Nursing will be auditing Incontinence supplies on a weekly basis for the next 3 months to ensure compliance.

#4- Director of Nursing or designee will report on the progress of this plan monthly for 3 months to the QAPI Committee to ensure ongoing compliance.

Date of compliance for F 246 is: 10/05/2017

F 248

It is the practice of Pleasant Acres Care Center to provide activities that meet the needs and interests of the residents.

#1- For resident #12 an activities data collection evaluation was completed on 10/05/2017.

#2-For similar residents, an activities data collection evaluation was reviewed on 10/05/2017. The activities department compiled the data from these evaluations to develop an activities calendar that included programs to meet the needs and interests of residents residing at Pleasant Acres Care Center. Education provided by the Administrator to the Activity Coordinator on 10/05/2017 regarding the importance of completing and activities data collection evaluation on admission and with significant changes then using that information to develop individualized activities plans that meet the needs and interests of each resident.

#3-The Administrator or designee will audit new admissions and residents with a significant change weekly for the next 3 months to ensure compliance. The Administrator or designee will also conduct an interview with 5 random weekly for the next 2 months to ensure their satisfaction with the activities programs being presented. Any concerns identified will be addressed.

#4-The Administrator or designee will report progress of this plan of correction to the QAPI Committee for a minimum of 3 months to ensure ongoing compliance.

Date of compliance for F 248 is: 10/05/2017

F 309

It is the practice of Pleasant Acres Care Center to assess and provide timely interventions for residents with a change in skin areas and bowel conditions.

#1- Resident #6 was discharged and no further action necessary. For resident #10 bowel records were reviewed on 09/28/2017 and interventions immediately put into place. Beginning 9-28-2017 all nursing staff were provided education by the Director of Nursing on bowel monitoring and intervention expectations prior to working their next scheduled shift as well as facility skin policies and expectations.

#2- For similar residents, a head to toe skin sweep was conducted on 9-28-2017. Any skin abnormalities identified were addressed and interventions put in place. For similar residents, bowel records were reviewed on 9-28-2017, appropriate interventions were initiated for any resident identified with a need. Beginning 9-28-2017 all nursing staff were provided education by the Director of Nursing on bowel monitoring and intervention expectations prior to working their next scheduled shift as well as facility skin policies and expectations.

#3- The Director of Nursing or designee will conduct 5 random skin sweeps and bowel record monitoring each week for the next 1 month and then weekly for 2

months to ensure compliance. Any concerns identified will be immediately addressed.

#4- The Director of Nursing or designee will report the progress of this plan of correction to the QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.

Date of compliance for F 309 is: 9-28-2017

F 318

It is the practice of Pleasant Acres Care Center to allow residents the ability to maintain mobility and remain at the highest level of function.

#1- Residents #6 and #11 were discharged and no further action necessary. For residents #4 and #10 staff were educated 10/5/2017 regarding the importance of completing the restorative rehab program as outlined. For residents #4 and #10 on 10/6/2017 current restorative plans were reviewed and updated.

#2- For similar residents, staff were educated on 10/5/2017 regarding the importance of completing the restorative rehab program as outlined. On 10/6/2017 each resident was reviewed for an appropriate restorative plan. If on a current restorative plan, plan was updated and revised. Each appropriate resident has an implemented restorative plan. A full-time restorative aide was hired on 10/06/2017.

#3- The DON or designee will conduct 3 restorative program audits weekly for the next 1 month and weekly for 2 months to ensure compliance has been met.

#4- The DON or designee will report progress of this plan of correction for a minimum of 3 months to the QAPI Committee to ensure ongoing compliance.

Date of compliance for F 318 is: 10/6/2017

F 323

It is the practice of Pleasant Acres Care Center to ensure that residents are transferred in a safe manner.

#1- Resident #3, #5 and #13 no longer resident at Pleasant Acres and no further action is necessary.

#2- For similar residents, staff were educated on 10/05/2017 regarding appropriate transfer techniques including gait belt use for manual transfers and mechanical transfer procedures.

#3- The Director of Nursing or designee will audit proper transfer techniques a minimum of 3 times per week for 1 month and then weekly for 2 months to ensure compliance has been met.

#4- The Director of Nursing or designee will report the progress of this plan of correction to the QAPI committee for a minimum of 3 months to ensure compliance has been met.

Date of compliance for F 323 is: 10/05/2017

F 353

#1- For the residents #13 and #14, education was provided by the Director of Nursing to nursing staff regarding timely call light response on 09/29/2017.

#2- For similar residents, education was provided by the Director of Nursing to nursing staff regarding timely call light response on 09/29/2017.

#3- Call light response times will be added to the daily Stand-Up meeting for review, any concerns will be identified and addressed. The Administrator or designee will perform a minimum of 5 call light audits per week. Resident interviews will be conducted a minimum of 5 times per week to evaluate satisfaction with call-light response times. Any concerns identified will be addressed.

#4- The Administrator or designee will monitor progress toward this plan of correction and report to the QAPI committee for a minimum of 3 months to ensure ongoing compliance.

Date of compliance for F 353 is: 09/29/2017

zF 490

It is the practice of Pleasant Acres Care Center to provide Administrator presence in the facility.

#1- The Business Office was educated on 10/05/2017 regarding the importance of ensuring there is documentation present to validate administrative requirements are being met, and the procedures if an interim Administrator is needed in the future.

#2- A permanent full time Administrator was hired and started on 08-07-17.

#3- Should there be a need in the future for Interim Administrator coverage, the Business Office Manager will be responsible for ensuring documentation is present to validate the coverage requirements are met.

#4- The facility will discuss this plan of correction monthly for 3 months at QAPI to ensure all departments are aware of this requirement for ongoing compliance.

Date of compliance for F 490 is 10/05/2017.