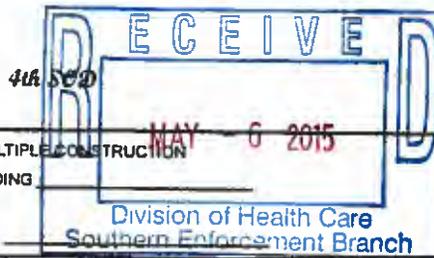


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



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OMB NO 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185352 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                        | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/12/2016 |
| NAME OF PROVIDER OR SUPPLIER<br><br>STANTON NURSING AND REHABILITATION CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31 DERICKSON LANE<br>STANTON, KY 40380 |   |

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|--------------------|---|---------------|--|----------------------|
| F 000              | INITIAL COMMENTS  | F 000         |  |                      |
| F 164<br>SS=D      | <p>An abbreviated standard survey (KY22897, KY22915) was initiated on 03/03/15 and concluded on 03/12/15. Both complaints were substantiated. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> | F 164         | <p>Response to this 2567 is not an agreement to the findings. The response is being provided to remain in compliance to state and federal requirements</p> | 5-5-15               |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*J. C. Doreland*

TITLE

*NAA*

(X8) DATE

5-5-15

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 164   | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility's policy it was determined the facility failed to maintain residents' personal privacy during toileting. The facility failed to ensure the privacy curtain was pulled and the door was closed for one (1) unsampled resident (Resident A) on 03/03/15 at 2:02 PM while care was provided for the resident.<br><br>The findings include:<br><br>Review of the facility's policy titled "Quality of Life - Dignity," with a revision date of October 2009, revealed all residents had the right to be treated with dignity and respect. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.<br><br>Record review of Resident A revealed the resident was admitted to the facility on 07/01/12 and the facility identified Resident A's Brief Interview for Mental Status assessment (BIMS) was 14 indicating Resident A was cognitively intact.<br><br>Observations from the hallway on 03/03/15 at 2:02 PM, revealed Resident A was sitting on a bedpan with his/her genitalia exposed because the privacy curtain was not pulled and the door was not closed to provide privacy for the resident during toileting. Further observation revealed Registered Nurse (RN) #3 was assisting the resident with toileting needs.<br><br>Interview with Resident A on 03/12/15 at 6:48 PM, | F 164  | All residents have the right to privacy and and confidentiality of his or her personal and clinical records as defined by 483.10(e).48375(i)(4)<br>The concern in providing privacy has been adressed with resident A by outlining the steps taken to insure this does not occur again with her or other residents of the facility. All staff providing clinical services including the named RN have been inserviced on the requirements of confidentiality in patient care and dignified care to residents including the use of privacy curtains and closing of doors when providing clinical or other services for the resident. The education of staff whas completed by the DNS and or Nurse Educator by April 2, 2015. Performance of the education will be monitored by the Quality Assurance Committe which is comprised of the | 5-5-15               |   |

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| F 164   | Continued From page 2<br>revealed, "My privacy was violated, and it made me feel uncomfortable."<br><br>Interview with RN #3 on 03/03/15 at 2:03 PM revealed the privacy curtain should have been pulled and the door should have been shut. Further interview with RN #3 revealed she was busy putting gloves on and forgot.<br><br>Interview with the Director of Nursing (DON) on 03/12/15 at 2:38 PM, revealed the privacy curtain should have been pulled and the door should have been closed to ensure privacy of the resident. Further interview revealed staff was expected to provide privacy to residents when providing care by pulling the privacy curtain and closing the door. Further interview revealed staff was in-serviced on privacy during hire and on an as-needed basis. Additional interview revealed the DON performs random rounds daily to ensure privacy is maintained during resident care and she had not identified any problems. | F 164  | Director of Nursing, Unit Managers, Social Worker, and Administrator. This will be accomplished by interviewing 35 patients each week for four weeks..<br><br>This results of those interviews will be monitored by the QA Committee for effectiveness and outcomes. The QA Committee will respond to any identified issues from the reports |                      |   |
| F 280<br>SS=D   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.  | F 280  | Residents have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care or treatment<br><br>Resident 1 The comprehensive car plan for resident one has been reviewed and revised by                                       |                      | 5-5-15  |

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| F 280   | <p>Continued From page 3</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview, record review, facility incident reports, and facility policy review, it was determined the facility failed to revise the written plan of care for two (2) of thirteen (13) sampled residents (Residents #1 and #2) related to exit-seeking behaviors for Resident #1 and fall interventions for Resident #2. Review of facility incident reports for Resident #1 revealed he/she attempted to elope from the facility on 02/01/15 and on 02/07/15. However, review of the Comprehensive Care Plan for Resident #1 dated 11/21/14 revealed no new interventions in place related to exit-seeking behaviors. Review of facility incident reports for Resident #2 revealed Resident #2 had nine (9) falls in the facility from June 2014 through March 2015. However, review of the Comprehensive Care Plan for Resident #2 dated 10/17/14 revealed no updated interventions related to noncompliant behaviors with fall interventions.</p> <p>The findings include:</p> <p>Review of facility policy titled "Change of Condition Protocol," undated, revealed change of condition is monitored by the Quality Assurance Committee five times weekly and change of</p> | F 280  | <p>appropriate disciplines . The person/ persons responsible for the care of this resident has been invited to attend the care conference.</p> <p>Resident 2 The comprehensive car plan for resident one has been reviewed and revised by appropriate disciplines . The person/ persons responsible for the care of this resident has been invited to attend the care conference.</p> <p>Patients identified for risk of falls or elopement have had comprehensive care plans reviewed and revised as required.</p> <p>The Quality Assurance Committee will monitor falls and elopment patients five times weekly The review will include the review of comprehensive care plans Areas requiring improvement will be reviewed and discussed by the QA Committe and appropriate response taken Nurse Supervisors have been educated to immediately report elopement potential to the DNS Nurse EducatorNurse Supervisors have been educated byApril 16 2015to report all falls to the DNS</p> |                      |   |

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| F 280   | <p>Continued From page 4</p> <p>condition is reported through "twenty-four" hour nursing reports, lab reports, and other indicators reviewed by the committee. Continued review of facility policy revealed upon review by the QA Committee care plans were revised to reflect the changes needed for the resident. Further review of facility policy revealed the care plan was reviewed by the QA Committee with recommendations for revisions on residents that experienced a change of condition. The MDS Nurse, as a member of the QA Committee, was responsible for completion of the revised care plan documentation.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident on 11/21/14, with diagnoses including Alzheimer's Disease, Dementia, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Hypertension.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) dated 11/27/14 revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #1 was moderately impaired cognitively. Continued review of Resident #1's MDS revealed Resident #1 did not exhibit wandering behavior.</p> <p>Review of facility incident reports revealed Resident #1 attempted to leave the facility without staff supervision on 02/01/15 and again on 02/07/15. Review of Resident #1's Comprehensive Care Plan dated 11/21/14 revealed Resident #1 was at risk for elopement due to wandering/exit-seeking behaviors. However, there were no updates or interventions present related to Resident #1's elopement</p> | F 280  | <p>The DNS has educated the MDS Nurses On the proper updating of Care Plans And quality and outcomes will be Reviewed by the Q A Committee. Education provided by DNS or Nursing Educator by April 14.</p> | 6-5-15               |   |

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| F 280   | <p>Continued From page 5</p> <p>attempts on 02/01/15 and 02/07/15. Review of Resident #1's Nurse Assistant Care Plan, updated 10/13/14, revealed no updates or interventions present related to Resident #1's elopement attempts on 02/01/15 and 02/07/15.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 10/17/14, with diagnoses including Dementia, Depression, Transient Ischemic Attack (TIA), Diabetes Mellitus Type II, Knee Arthroplasty, Alzheimer's Disease, Anemia, Delirium, Leukemia, and Delusional Disorder.</p> <p>Review of Resident #2's Quarterly MDS dated 12/18/14 revealed the facility assessed Resident #2 to have a BIMS score of 9, which indicated Resident #2 was moderately impaired cognitively.</p> <p>Further review of the record revealed the resident was assessed to be at risk for falls related to unbalanced transfers, dementia, and fall history.</p> <p>A review of the fall investigations/incident reports revealed a sensor pad alarm was in place when the resident sustained a fall on 01/04/15. Further review of the incident reports revealed on 02/13/15 Resident #2 disabled the alarm by her/himself.</p> <p>Review of Resident #2's Comprehensive Care Plan dated 10/17/14 revealed interventions to prevent falls that included periodic medication review, ensuring safe environment, fall assessments, ensuring appropriate footwear when out of bed, and encouraging non-skid socks. However, a pressure sensor pad alarm was not included as a fall intervention on the care plan for Resident #2. There was no evidence that</p> | F 280  |   |   |

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| F 280   | <p>Continued From page 6</p> <p>Resident #2's Comprehensive Care Plan or Nurse Assistant Care Plan, updated 10/13/14, was revised to include new interventions related to a sensor pad alarm being placed as a fall intervention or related to the resident's noncompliance with the alarm.</p> <p>Interview with the Kentucky Medication Aide (KMA) on 03/12/15 at 10:32 AM revealed Resident #2 removed his/her pressure pad alarm in the past and was observed one time placing the alarm in a trash can.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 03/12/15 at 10:59 AM revealed she observed Resident #2 hide his/her pressure pad alarm box under his/her pillow.</p> <p>Interview with the Assistant MDS Coordinator on 03/12/15 at 2:41 PM revealed the MDS Coordinator was responsible for developing and/or updating resident care plans. Further interview with the Assistant MDS Coordinator revealed it was an oversight that the facility did not care plan for Resident #2's noncompliant behavior related to the pressure pad alarm and falls.</p> <p>Interview with the Director of Nursing (DON) on 03/12/15 at 4:23 PM revealed floor staff was permitted to make updates to resident care plans, but the facility preferred to have any changes brought to their "Morning Meeting" (Quality Assurance Committee). Further interview with the DON revealed when a nursing staff member observed a resident to have behaviors or any changes in condition they should report to the Unit Manager who would then report findings in the morning meeting. Continued interview with</p> | F 280  |   | 6-5-15  |

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| F 280   | Continued From page 7<br>the DON revealed once the Unit Manager reported in the morning meeting the MDS Coordinator would be responsible for ensuring the resident care plan was developed and/or updated.   | F 280  |   |                      |   |
| F 282<br>SS=E   | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure services were provided in accordance with the written plan of care for five (5) of thirteen (13) sampled residents (Residents #6, #7, #8, #9, and #10). Residents #6, #7, #8, #9, and #10 had care plan interventions to provide assistance with bathing and to receive baths/showers two times each week; however, there was no evidence these services were being consistently provided for these residents. In addition, Resident #7's care plan addressed interventions for personal grooming needs to be provided by staff but the resident was observed to have long unkempt toenails.<br><br>The findings include:<br><br>Review of the policy entitled "Change of Condition Protocol," (no date) revealed care plans are implemented on admission and readmission by the charge nurse; however, the policy did not | F 282  | The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of care<br><br>Residents 6, 7, 8, 9, and 10 written care plan has been reviewed and revised to provide for the services required by the resident. All resident care plans have been reviewed and resvised as required to meet the need of the resident.<br><br>Residents will be monitored for compliance to care plan completion each shift by the Unit Manager/DNS<br><br>Results of the compliance audits will be forwarded to th QA Commitee daily and reviewed five times weekly for accuracy and compliance The QA committee will take appropriate action as required after review of the audits |                      |   |

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| F 282   | <p>Continued From page 8<br/>address how the interventions would be implemented.</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 03/07/13 with diagnoses of Diabetes, Neuropathy, Hypertension, Dysphagia, Pain in Joints, and Anxiety. Review of the Minimum Data Set (MDS) dated 02/09/15 revealed the facility assessed Resident #6 to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #6 was cognitively intact. Further review of the MDS revealed Resident #6 required extensive assistance with bathing. Review of the Care Plan dated 02/04/15 revealed Resident #6 was to receive a shower on Mondays and Thursdays.</p> <p>Observations made on 03/03/15 at 4:30 PM revealed Resident #6 was lying on his/her left side in bed on an air pressure mattress reading his/her mail. The resident had a suprapubic catheter and stated he/she used a brief for bowel movements. The side rail was raised on the right side of the bed. Observation on 03/04/15 at 6:40 AM revealed the resident was lying in bed, and the nurse was in the room to administer medications to Resident #6.</p> <p>Interview conducted on 03/04/15 at 6:40 AM with Resident #6 revealed the resident did not receive a shower on Monday as scheduled. The resident further stated he/she was told by staff that "they were too busy." The resident also stated he/she preferred to have a bath on the scheduled bath days rather than a shower.</p> <p>Interview conducted on 03/04/15 at 10:15 AM with Certified Nurse Aide (CNA) #15 revealed</p> | F 282  | <p>All Residents Care Plans shall be reviewed and revised as required to provide for the services required by each resident<br/>The Quality Assurance Committee will review change of condition and other indicators to determine if changes occur which would require review of patient care plans and recommend review by care plan committee.<br/>This will occur five times per week with no end date. At least three patient care plans will be reviewed by the DNS or her designee weekly for four weeks<br/>Issues or concerns will be promptly reported to the Quality Assurance Committee for review<br/>The QA Committee will take appropriate steps to correct discovered issues.</p> <p>ALL SRNA and licensed nurses have been educated that Care Plans for SRNA use are available in the AccuNurse System. Licensed nurses and SRNA's have been educated that patient care plans are available for review in 3 ring binders at each nurses station. The DNS or designee updated AccuNurse care plans.</p> |                      |   |

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| F 282   | <p>Continued From page 9</p> <p>there were times when the facility was short-staffed and not all the work could be completed. The CNA further stated when this occurred on first shift, staff reported to the second shift staff so they could attempt to pick up what first shift staff was unable to complete.</p> <p>Review of the "shower sheets" for January 2015 revealed the facility staff documented only six bed baths were provided for Resident #8 on the scheduled bath days (rather than nine opportunities). During the month of February 2015 the resident only missed one bath. Review of the month of March 2015 revealed the resident had not been provided a scheduled bath on 03/09/15.</p> <p>Interviews with CNAs #4, #11, #12, and #14, and LPN #1 confirmed Resident #6 had not received baths/showers according to the resident's plan of care due to staffing problems.</p> <p>2. Review of the medical record revealed the facility admitted Resident #7 with diagnoses of Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Morbid Obesity, and Depression. Review of the MDS dated 01/29/15 revealed the facility assessed Resident #7 to have a BIMS score of 13, which indicated Resident #7 was cognitively intact. Further review of the MDS revealed Resident #7 required extensive assistance with bathing. Review of the Care Plan dated 01/23/15 revealed Resident #7 required assistance from staff with personal care.</p> <p>Observations made on 03/03/15 at 5:20 PM revealed the resident was lying in bed. Resident #7 was observed to have long fingernails. An</p> | F 282  | <p>Patient careplans as required by regulation the DNS and/or her designee is responsible for updating Accunurse care plans for SRNA's. Education was completed on all issues April 30, 2015 by the Nurse Educator.</p> <p>F282 ALL SRNAs, LPNs, and RNs that provide clinical care have been educated on how to implement the plan of care. The education included location of the written plan of care. SRNAs were educated on the use of the Accu Nurse system for use in implementation of the care plans. Education included the review and understanding of care plans. Education was completed on May 5 2015 by the DNS and or Nurse Educator. Audits will be conducted by the DNS or her designee each shift to insure care plans are being followed by Caregivers. The audits will be forwarded to the QA Committee five times weekly for review and appropriate response. Changes to the Plan of care will be communicated to caregivers as indicated.</p> |   |

6-6-15

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>186362 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/12/2015 |
|---|---|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STANTON NURSING AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31 DERICKSON LANE<br>STANTON, KY 40380                                 |                      |   |
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| F 282   | <p>Continued From page 10</p> <p>interview with the resident during the observations revealed he/she did not require assistance with fingernail care; however, he/she did require assistance with toenail care. Resident #7 stated he/she had not received assistance with toenail care "in months." Resident #7's toenails were observed to be long, thick, and jagged.</p> <p>Interview with Resident #7 on 03/04/15 at 6:50 PM revealed Tuesdays and Fridays were the scheduled days for Resident #7's bed baths. The resident stated he/she just wanted a bath when it was scheduled.</p> <p>Review of the "shower sheets" for February 2015 revealed the facility staff documented only four bed baths were provided for Resident #7 on the scheduled bath days (rather than eight opportunities). During the month of March 2015 the resident should have received two showers/bed baths; however, the resident had only received one on 03/06/15. In addition, there was no documentation on the "shower sheets" that nail care had been provided for Resident #7 as directed by the plan of care.</p> <p>Interviews conducted with CNAs #3, #5, and #2 revealed Resident #7 had not been provided baths/showers according to the plan of care and shower schedule due to not having enough staff. In addition, CNAs #2 and #3 stated they had never noticed Resident #7's toenails and had not provided toenail care for the resident. CNA #2 stated she did not have time due to being short-staffed.</p> <p>3. Review of the medical record revealed the facility admitted Resident #8 on 09/20/12 with</p> | F 282  |   | 05-05-15             |   |

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| F 282   | <p>Continued From page 11</p> <p>diagnoses of Cerebrovascular Accident, History of Urinary Tract Infections, Pyuria, Ataxia, Generalized Pain, Symbolic Dysfunction, Neuropathy, Late Effects of Cerebrovascular Disease, Hemiplegia affecting Dominant Side, and Hypertension.</p> <p>Review of the Minimum Data Set (MDS) dated 11/27/14 revealed the facility assessed Resident #8 to have a BIMS score of 15, which indicated Resident #8 was cognitively intact. Further review of the MDS revealed Resident #8 required extensive assistance with bathing. Review of the Care Plan dated 02/06/15 revealed Resident #8 was to receive a shower on Tuesdays and Fridays.</p> <p>Observations made on 03/03/15 at 4:27 PM revealed Resident #8 was lying in bed on a bariatric air mattress with one-fourth assist bars and working a crossword puzzle. Observation on 03/04/15 at 6:41 AM revealed the resident was sitting up in a wheelchair working a crossword puzzle.</p> <p>Review of the "shower sheets" for January 2015 revealed the facility staff documented only six of nine scheduled bed baths/showers were provided for Resident #8. During the month of February 2015, the facility staff documented three of eight scheduled showers were given.</p> <p>Interview conducted on 03/04/15 at 10:15 AM with Certified Nurse Aide (CNA) #15 revealed there were times when the facility was short-staffed and not all the work could be completed. The CNA further stated when this occurred on first shift, staff reported to second shift staff so they could be aware and could</p> | F 282  |   | 05-15                |   |

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| F 282   | <p>Continued From page 12</p> <p>attempt to complete the tasks first shift was unable to complete.</p> <p>Interviews with CNAs #1, #4, #7, #14, #20, and #21 confirmed Resident #8 had not received baths/showers according to the resident's plan of care due to staffing problems.</p> <p>4. Review of the medical record for Resident #9 revealed the facility admitted the resident on 01/09/14 with diagnoses that included Morbid Obesity, Depressive Disorder, Esophageal Reflux, Hypertension, Bipolar Disorder, Peptic Ulcer Disease, Congestive Heart Failure, Cardiomegaly, Glaucoma, Obstructive Sleep Apnea, Overactive Bladder, Irritable Bowel Syndrome, Hyperlipidemia, Neuropathy, Dysphagia, Anxiety, and Lactose Intolerance.</p> <p>Review of the annual MDS assessment dated 01/14/15 revealed the resident required extensive assistance with bathing. Further review of the MDS revealed Resident #9's BIMS score was 15, indicating Resident #9's cognition was intact.</p> <p>Review of the Care Plan dated 01/06/15 revealed Resident #9 was to receive a shower on Wednesdays and Saturdays.</p> <p>Interview with Resident #9 on 03/03/15 at 4:50 PM revealed at times his/her baths were not given as scheduled due to a shortage of staff in the facility.</p> <p>Observations made on 03/03/15 at 4:50 PM revealed the resident was lying in bed, in a scoop mattress with the head of the bed elevated and wearing oxygen. Observations on 03/04/15 at 6:44 AM revealed Resident #9 lying in bed,</p> | F 282  |   |   |

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| F 282   | <p>Continued From page 13</p> <p>wearing oxygen and talking to the ombudsman.</p> <p>Review of the "shower sheets" for January 2015 revealed the facility staff documented only five of nine bed baths/showers were provided for Resident #9. During the month of February, the resident should have received eight and only received four bed baths/showers.</p> <p>Interviews conducted with CNAs #6, #13, and #21 revealed Resident #9 had not been provided baths/showers according to the plan of care and shower schedule due to not having enough staff.</p> <p>5. Review of the medical record for Resident #10 revealed the facility admitted the resident on 04/14/14 with diagnoses including Alzheimer's Disease, Muscle Weakness, and Dysphagia.</p> <p>Review of the annual MDS assessment dated 02/10/15 revealed the resident required extensive assistance with bathing. Review of the Care Plan dated 03/03/15 revealed Resident #10 was to receive a shower on Tuesdays and Fridays. Further review of the MDS revealed Resident #10's BIMS score assessment was blank, indicating Resident #10 was severely cognitively impaired.</p> <p>Observations made on 03/03/15 at 5:10 PM revealed the resident was lying in bed on a scoop mattress looking at the ceiling. The resident did not respond to verbal stimuli. Observations on 03/04/15 at 6:50 AM revealed Resident #10 was sitting in a wheelchair at the nurses' station, wearing a code alert bracelet on the left wrist.</p> <p>Review of the "shower sheets" for February 2015 revealed the facility staff documented only five of</p> | F 282  |   |                      |   |

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| F 282   | <p>Continued From page 14</p> <p>eight scheduled bed baths/showers for Resident #10. During the month of March, the resident was scheduled for a shower on 03/06/15, but the resident did not receive a shower or a bath.</p> <p>Interviews conducted with CNAs #14, #20, and #21 revealed Resident #10 had not been provided baths/showers according to the plan of care and shower schedule due to not having enough staff.</p> <p>Interview conducted with RN #2 on 03/12/15, at 10:30 AM revealed she was the Unit Manager (UM) for the North Hall and she was responsible to monitor to ensure care needs were being provided as directed by each resident's plan of care. The RN stated she talked with the CNAs to see if they had provided showers/baths for the residents; however, RN #2 stated she had not been reviewing the shower sheets. RN #2 stated she had not identified any problems with the showers/baths not being given. RN #2 also stated she was responsible to check the Treatment Administration Record (TAR) to monitor nail care; however, she stated she had not had time to conduct this review. RN #2 stated she had not observed Resident #7's toenails and was not aware the toenails were long and needed to be trimmed.</p> <p>Interview with the DON on 03/12/15, at 1:00 PM revealed the UM and nurses were responsible to monitor direct care staff to ensure resident care needs were being provided in accordance with the plan of care. The DON stated the UM was responsible to review the shower sheets daily to ensure showers/baths were being given to the residents. The DON acknowledged staffing had been a problem; however, other staff (the UM,</p> | F 282  |   |                      |   |

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| F 282   | Continued From page 15<br>Activity Director, Assistant Activity Director, and others trained as CNAs) had been pulled to give showers/baths. The DON stated nail care should be documented on the shower sheets and the UM was responsible to check the shower sheets to see if staff documented nail care. The DON stated toenail care was to be provided on Sundays and as needed.  | F 282  | a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene   |   |
| F 312<br>SS=E   | 483 25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to provide necessary services to maintain grooming and personal hygiene for six (6) of thirteen (13) sampled residents (Residents #6, #7, #8, #9, #10, and #11). According to the shower schedules, Residents #6, #7, #8, #9, and #10 were scheduled to receive showers/bed baths two days per week on specific days by facility staff. However, there was no evidence staff provided showers/baths as scheduled for these residents. Residents #7 and #11 also required staff assistance for toenail care; however, the residents were observed to have long unkempt toenails.<br><br>The findings include: | F 312  | The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of care<br>Residents 6, 7, 8, 9, and 10 written care plan has been reviewed and revised to provide for the services required by the resident. All resident care plans have been reviewed and resvised as required to meet the need of the resident. Residents will be monitored for compliance to care plan completion each shift by the Unit Manager/DNS<br>Results of the compliance audits will be forwarded to th QA Committee daily and reviewed five times weekly for accuracy and compliance The QA committee will take appropriate action as required after review of the audits |   |

6.5.15

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| F 312   | <p>Continued From page 16</p> <p>Review of the Shower/Bath Policy (revision date October 2010) revealed showers/baths would be provided to promote cleanliness, to provide comfort to the resident, and to observe the condition of the resident's skin. The policy further noted the following information would be documented in the resident's medical record after the shower/bath was given: date, time, name/title of the staff, all assessment data, how the resident tolerated the bathing procedure, and/or if the resident refused.</p> <p>Review of the Fingernail/Toenail Policy (revision date October 2010) revealed nail care would be provided to clean the nail bed, to keep the nails trimmed, and to prevent infections. The policy noted this included daily cleaning and regular trimming, unless the resident was a diabetic or had problems with circulatory impairment.</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 03/07/13 with diagnoses of Diabetes, Neuropathy, Hypertension, Dysphagia, Pain in Joints, and Anxiety. Review of the Minimum Data Set (MDS) dated 02/09/15 revealed the facility assessed Resident #6 to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #6 was cognitively intact. Further review of the MDS revealed Resident #6 required extensive assistance with bathing. Review of the Care Plan dated 02/04/15 revealed Resident #6 was to receive a shower on Mondays and Thursdays.</p> <p>Observations made on 03/03/15 at 4:30 PM revealed Resident #6 was lying on his/her left side in bed on an air pressure mattress, reading his/her mail. The resident had a suprapubic</p> | F 312  | <p>All Residents Care Plans shall be reviewed and revised as required to provide for the services required by each resident. The Quality Assurance Committee will review change of condition and other indicators to determine if changes occur which would require review of patient care plans and recommend review by care plan committee. This will occur five times per week with no end date. At least three patient care plans will be reviewed by the DNS or her designee weekly for four weeks. Issues or concerns will be promptly reported to the Quality Assurance Committee for review. The QA Committee will take appropriate steps to correct discovered issues.</p> | 6-5-15               |   |

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| F 312   | <p>Continued From page 17</p> <p>catheter and stated he/she used a brief for bowel movements. The side rail was raised on the right side of the bed. Observation on 03/04/15 at 6:40 AM revealed the resident was lying in bed, and the nurse was in the room to administer medications to Resident #6.</p> <p>Interview conducted on 03/04/15 at 6:40 AM with Resident #6 revealed he/she did not receive a shower on Monday as scheduled. The resident further stated he/she was told by staff that "they were too busy." The resident also stated she preferred to have a bed bath on her scheduled bath days rather than a shower.</p> <p>Interview conducted on 03/04/15 at 10:15 AM with Certified Nurse Aide (CNA) #15 revealed there were times when the facility was short-staffed that not all the work could get done. The CNA further stated when this occurred, first shift staff informed the second shift staff so second shift staff could attempt to complete what first shift staff was unable to complete.</p> <p>According to the care plan, staff would be responsible to provide extensive assistance with bathing/showers for Resident #6. Review of the shower schedule revealed the resident was scheduled to receive showers/baths each Monday and Thursday. However, review of the "shower sheets" revealed the facility staff documented the resident only received six of eight bed baths on the scheduled bath days during the month of January 2015. During the month of February 2015 the resident missed one bath. Further review of the shower sheets revealed Resident #6 did not receive a bath as scheduled on 03/09/15.</p> | F 312  | <p>F312 ALL SRNAs, LPNs, and RNs that provide clinical care have been educated on how to implement the plan of care. The education included location of the written plan of care Grooming and Incontinence Care and Accu Nurse system for use in implementation of the care plans. Education included the review and understanding of care plans. Education was completed on May 5 2015 he DNS and or Nurse Educator. Audits will be conducted by the DNS or her designee each shift to insure care plans are being followed by Caregivers. The audits will be forwarded to the QA Committee five times weekly for review and appropriate response.</p> | 0-5-15               |   |

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| F 312   | <p>Continued From page 18</p> <p>Interviews with CNAs #4, #11, #12, and #14, and LPN #1 confirmed Resident #6 had not received baths/showers on Mondays and Thursdays as scheduled due to staffing problems.</p> <p>An interview with LPN #4 on 03/12/15 at 10:15 AM revealed she worked the 7:00 AM to 7:00 PM shift on the South Hall. LPN #4 stated she tried to check the shower sheets daily and watched to see if the CNAs took the residents into the shower rooms. The LPN stated she had not identified a problem with showers not being given.</p> <p>2. Review of the medical record revealed the facility admitted Resident #7 with diagnoses of Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Morbid Obesity, and Depression. Review of the MDS dated 01/29/15 revealed the facility assessed Resident #7 to have a BIMS score of 13, which indicated Resident #7 was cognitively intact. Further review of the MDS revealed Resident #7 required extensive assistance with bathing. Review of the Care Plan dated 01/23/15 revealed interventions for Resident #7 included a podiatry consultation and treatment as indicated.</p> <p>Observations made during a skin assessment on 03/03/15 at 6:05 PM revealed the resident was lying in bed with glasses on, and a clean face. Resident #7 did have long fingernails and stated he/she did not require assistance with fingernail care but did require assistance with toenail care.</p> <p>Resident #7 stated in an interview conducted on 03/04/15 at 6:50 PM, "They haven't touched my toenails in months, nor have I had a bath in over a week." Resident #7's toenails were observed to be long, thick, and jagged. Resident #7 stated, "I</p> | F 312  |   | 5-5-15               |   |

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| F 312   | <p>Continued From page 19</p> <p>am unable to bend over to take care of my toenails."</p> <p>According to the shower schedule, Resident #7 would receive a shower/bath on Wednesday and Saturday each week. However, review of the "shower sheets" for February 2015 revealed facility staff only provided four bed baths for Resident #7 on the scheduled bath days (rather than eight opportunities). During the month of March 2015 the resident should have received two showers/bed baths; however, the most recent bath was documented on 03/06/15.</p> <p>In addition, further review of the "shower sheets" revealed there was no documentation toenail care had been provided for Resident #7 since the resident was admitted to the facility on 01/23/15.</p> <p>Interviews conducted with CNAs #3, #5, and #2 revealed Resident #7 had not been provided baths/showers according to the shower schedule due to not having enough staff. In addition, CNAs #2 and #3 stated they had never noticed Resident #7's toenails and had not provided toenail care for the resident. Both CNAs stated toenail care was to be provided on Sundays, but CNA #2 stated she did not have time due to being short-staffed. Interview with LPN #4 on 03/12/15, at 10:15 AM revealed LPN #4 monitored and observed residents to see if nail care was being provided and had not identified any problems.</p> <p>3. Review of Resident #11's medical record revealed the facility admitted the resident on 01/15/14 with diagnoses including Ataxia, Difficulty in Walking, Hip Fracture, Hypertension, Alzheimer's Dementia, Morbid Obesity, Agitation, and Degenerative Disc Disease.</p> | F 312  |   |                      |   |

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| F 312   | Continued From page 20<br><br>Review of Resident #11's most recent Significant Change MDS assessment, dated 12/18/14 revealed the facility assessed Resident #11 to have a BIMS score of 6, which indicated Resident #11 had severely impaired cognition. Further review of Resident #11's MDS assessment revealed the facility assessed Resident #11 to require extensive assistance with help of one staff member related to personal hygiene.<br><br>Review of Resident #11's Comprehensive Care Plan, dated 01/15/14, revealed Resident #11 had potential or actual impairment with mobility related to a fractured left hip, Degenerative Disc Disease, and Dementia. Further review of Resident #11's care plan revealed staff was to provide Resident #11 with nail care as needed.<br><br>Interview with Resident #11 on 03/11/15 at 10:50 AM revealed Resident #11 had not had his/her toenails trimmed in several days and that he/she preferred his/her toenails to be trimmed shorter than they were at the time of the survey.<br><br>Observation of Resident #11 on 03/11/15 at 10:55 AM revealed Resident #11 to have long untrimmed toenails on both feet.<br><br>Interview with CNA #5 on 03/11/15 at 3:15 PM revealed nail care was to be done on Sundays and as needed. Continued interview with CNA #5 revealed she had given Resident #11 a shower in the past, but had never provided toenail care for Resident #11.<br><br>Interview with CNA #6 on 03/11/15 at 3:20 PM revealed she provided care for Resident #11 but had never trimmed Resident #11's toenails. | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 21</p> <p>Continued interview with CNA #6 revealed nail care was to be done as needed and one day a week. However, CNA #6 was not able to recall the specific day of the week that nail care was to be performed.</p> <p>Interview with CNA #2 on 03/11/15 at 3:38 PM revealed she provided care for Resident #11 and Sunday was nail care day for residents. Further interview with CNA #2 revealed she had never cut any residents' toenails at the facility and had not noticed Resident #11 to have long toenails.</p> <p>4. Review of the medical record revealed the facility admitted Resident #8 on 09/20/12 with diagnoses of Cerebrovascular Accident, History of Urinary Tract Infections, Pyuria, Ataxia, Generalized Pain, Symbolic Dysfunction, Neuropathy, Late Effects of Cerebrovascular Disease, Hemiplegia affecting Dominant Side, and Hypertension.</p> <p>Review of the MDS dated 11/27/14 revealed the facility assessed Resident #8 to have a BIMS score of 15 that indicated Resident #8 was cognitively intact. Further review of the MDS revealed Resident #8 required extensive assistance with bathing. Review of the Care Plan, dated 02/06/15, revealed Resident #6 was to receive a shower on Tuesdays and Fridays.</p> <p>Observations made on 03/03/15 at 4:27 PM revealed Resident #8 was lying in bed on a bariatric air mattress with one-fourth assist bars, and working a crossword puzzle. Observation on 03/04/15 at 6:41 AM revealed the resident was sitting up in a wheelchair working a crossword puzzle.</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 22</p> <p>Interview conducted on 03/04/15 at 10:15 AM with CNA #15 revealed there were times when the facility was short-staffed and not all the work could be completed. The CNA further stated when this occurred first shift staff would make the second shift staff aware so they could attempt to complete what first shift staff was unable to complete.</p> <p>Review of the "shower sheets" for January 2015 revealed the facility staff documented only six of nine scheduled bed baths/showers were provided for Resident #8. During the month of February 2015 the facility staff documented three of eight scheduled showers were given to the resident.</p> <p>Interviews with CNAs #1, #4, #7, #14, #20, and #21 confirmed Resident #8 had not received baths/showers according to the resident's plan of care due to staffing problems.</p> <p>5. Review of the medical record for Resident #9 revealed the facility admitted the resident on 01/09/14 with diagnoses that included Morbid Obesity, Depressive Disorder, Esophageal Reflux, Hypertension, Bipolar Disorder, Peptic Ulcer Disease, Congestive Heart Failure, Cardiomegaly, Glaucoma, Obstructive Sleep Apnea, Overactive Bladder, Irritable Bowel Syndrome, Hyperlipidemia, Neuropathy, Dysphagia, Anxiety, and Lactose Intolerance.</p> <p>Review of the annual MDS assessment dated 01/14/15 revealed the resident required extensive assistance with bathing and toileting. Review of the Care Plan, dated 01/06/15, revealed Resident #9 was to receive a shower on Wednesdays and Saturdays. Further review of the MDS revealed Resident #9's BIMS score was 15, indicating</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 23</p> <p>Resident #9 was cognitively intact.</p> <p>During an interview with Resident #9 on 03/03/15 at 4:50 PM the resident stated at times his/her baths are not given as scheduled due to not enough staff working in the facility. Further interview with Resident #9 revealed he/she has had incontinence episodes from waiting so long for facility staff to respond to and answer call lights.</p> <p>Observations made on 03/03/15 at 4:50 PM revealed the resident was lying in bed on a scoop mattress with the head of the bed elevated, and wearing oxygen. Observations on 03/04/15 at 6:44 AM revealed Resident #9 was lying in bed wearing oxygen and talking to the ombudsman.</p> <p>Review of the "shower sheets" for January 2015 revealed the facility staff documented only five of nine scheduled bed baths/showers were provided for Resident #9. During the month of February, the resident only received four of eight scheduled baths/showers.</p> <p>Interviews conducted with CNAs #6, #13, and #21 revealed Resident #9 had not been provided baths/showers according to the plan of care and shower schedule due to not having enough staff.</p> <p>6. Review of the medical record for Resident #10 revealed the facility admitted the resident on 04/14/14 with diagnoses including Alzheimer's Disease, Muscle Weakness, and Dysphagia.</p> <p>Review of the annual MDS assessment dated 02/10/15 revealed the resident required extensive assistance with bathing. Review of the Care Plan, dated 03/03/15, revealed Resident #10 was</p> | F 312  |   | 05-05-15             |   |

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| F 312   | <p>Continued From page 24</p> <p>to receive a shower on Tuesdays and Fridays. Further review of the MDS revealed Resident #10's BIMS score was left blank, indicating Resident #10 had severe cognitive impairment.</p> <p>Observations made on 03/03/15 at 5:10 PM revealed the resident was lying in bed on a scoop mattress and did not respond to verbal stimuli. Observations on 03/04/15 at 6:50 AM revealed Resident #10 was sitting in a wheelchair at the nurses' station, wearing a code alert bracelet on the left wrist.</p> <p>Review of the "shower sheets" for February 2015 revealed the facility staff documented only five of eight scheduled bed baths/showers were provided for Resident #9. During the month of March, the resident did not receive a scheduled shower/bed bath on 03/06/15.</p> <p>Interviews conducted with CNAs #14, #20, and #21 revealed Resident #10 had not been provided baths/showers according to the plan of care and shower schedule due to not having enough staff.</p> <p>Interview with Registered Nurse (RN) #2 on 03/12/15, at 10:30 AM revealed she was the Unit Manager (UM) for the North Hall and she would talk to the CNAs to see if they had provided showers/baths for the residents. RN #2 stated she had not been reviewing the shower sheets but had not identified any problems with the showers/baths not being given. RN #2 stated she was also responsible to check the Treatment Administration Record (TAR) to monitor nail care; however, she stated she had not had time to conduct this review. RN #2 stated she had not observed Resident #7's toenails and was not</p> | F 312  |   |                      |   |

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| F 312   | Continued From page 25<br>aware the toenails were long and needed to be trimmed.<br><br>Interview with the DON on 03/12/15, at 1:00 PM revealed the UM and nurses were responsible to review the shower sheets daily to ensure showers/baths were being given to the residents. The DON acknowledged staffing had been a problem; however, other staff (the UM, Activity Director, Assistant Activity Director, and others trained as CNAs) had been pulled to give showers/baths. The DON stated nail care should be documented on the shower sheets and the UM was responsible to check the shower sheets. The DON stated toenail care was to be provided on Sundays and as needed. In addition, the DON stated a podiatrist made routine visits to the facility to provide toenail care to residents. | F 312  |  |                      |   |
| F 315<br>SS=D   | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to provide appropriate treatment and services to  | F 315  | Based upon the residents comprehensive assessment the facility must ensure that a resident who enters the facility is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible |                      |   |

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| F 315   | <p>Continued From page 26</p> <p>restore as much normal bladder function as possible for one (1) of thirteen (13) sampled residents (Resident #9). Resident #9 was assessed to be occasionally incontinent of bladder. The facility failed to assure the resident received assistance to prevent incontinence episodes.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Bedpan/Urinal, Offering/Removing," (undated) revealed the purpose of the procedure was to "provide the resident who is unable to ambulate an opportunity to urinate or defecate."</p> <p>Review of the medical record for Resident #9 revealed the facility admitted the resident on 01/09/14 with diagnoses that include Morbid Obesity, Depressive Disorder, Esophageal Reflux, Hypertension, Bipolar Disorder, Peptic Ulcer Disease, Congestive Heart Failure, Cardiomegaly, Glaucoma, Obstructive Sleep Apnea, Overactive Bladder, Irritable Bowel Syndrome, Hyperlipidemia, Neuropathy, Dysphagia, Anxiety, and Lactose Intolerance.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated 01/14/15 revealed the resident was nonambulatory and required extensive assistance with toileting. The MDS further stated Resident #9 was continent of bowel and occasionally incontinent of bladder. Further review of the MDS revealed Resident #9's Brief Interview for Mental Status (BIMS) score was 15, indicating Resident #9's cognition was intact. A review of the "ADL Plan of Care" for Resident #9 dated 01/06/15 revealed the resident was continent of bowel and bladder, required the</p> | F 315  | <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of care</p> <p>Residents 9, written care plan has been reviewed and revised to provide for the services required by the resident. All resident care plans have been reviewed and resvised as required to meet the need of the resident. Residents will be monitored for compliance to care plan completion each shift by the Unit Manager/DNS</p> <p>Results of the compliance audits will be forwarded to th QA Commitee daily and reviewed five times weekly for accuracy and compliance The QA committee will take appropriate action as required after review of the audits</p> |                      |   |

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| F 315   | Continued From page 27<br>assistance of two or more persons, and utilized a bedpan for toileting.<br><br>Interview with Resident #9 on 03/03/15 at 4:50 PM revealed he/she had an incontinence episode due to waiting up to 45 minutes for a call light to be answered. Further interview with Resident #9 revealed this was a result of the facility not having enough staff.<br><br>Observations of skin assessment conducted for Resident #9 on 03/03/15 at 5:30 PM revealed the resident's brief was dry with no areas of concern.<br><br>Interview with Certified Nurse Aide (CNA #21) on 03/11/15 at 12:37 PM revealed she remembered Resident #9 having an incontinence episode and stated, "It was a hectic day, and I had to look for help." The CNA further stated there was "simply not enough staff." | F 315  | All Residents Care Plans shall be reviewed and revised as required to provide for the services required by each resident<br>The Quality Assurance Committee will review change of condition and other indicators to determine if changes occur which would require review of patient care plans and recommend review by care plan committee.<br>This will occur five times per week with no end date. At least three patient care plans will be reviewed by the DNS or her designee weekly for four weeks<br>Issues or concerns will be promptly reported to the Quality Assurance Committee for review<br>The QA Committee will take appropriate steps to correct issues discovered |                      |   |
| F 323<br>SS=D   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, facility incident reports, and facility policy review, it was determined the facility failed to provide adequate supervision to prevent accidents for one (1) of  | F 323  |  |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185352 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/12/2015 |
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| F 315   | Continued From page 27<br>assistance of two or more persons, and utilized a bedpan for toileting<br><br>Interview with Resident #9 on 03/03/15 at 4:50 PM revealed he/she had an incontinence episode due to waiting up to 45 minutes for a call light to be answered. Further interview with Resident #9 revealed this was a result of the facility not having enough staff.<br><br>Observations of skin assessment conducted for Resident #9 on 03/03/15 at 5:30 PM revealed the resident's brief was dry with no areas of concern.<br><br>Interview with Certified Nurse Aide (CNA #21) on 03/11/15 at 12:37 PM revealed she remembered Resident #9 having an incontinence episode and stated, "It was a hectic day, and I had to look for help." The CNA further stated there was "simply not enough staff." | F 315  | F315 ALL SRNAs, LPNs, and RNs that provide clinical care have been educated on how to implement the plan of care. The education included location of the written plan of care. SRNAs were educated on the use of the Accu Nurse system for use in implementation of the care plans. Education included the review and understanding of care plans. Education was completed on May5 2015 the DNS and or Nurse Educator. Audits will be conducted by the DNS or her designee each shift to insure care plans are being followed by Caregivers. The audits will be forwarded to the QA Committee five times weekly for review and appropriate response. |                      |   |
| F 323<br>SS=D   | 483 25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, facility incident reports, and facility policy review, it was determined the facility failed to provide adequate supervision to prevent accidents for one (1) of   | F 323  |  |                      |   |

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| F 323   | Continued From page 28<br>thirteen (13) sampled residents (Residents #1) related to exit-seeking behaviors and attempted elopements. Review of facility incident reports for Resident #1 revealed he/she attempted to elope from the facility once on 02/01/15 and once on 02/07/15. However, review of the Comprehensive Care Plan for Resident #1 dated 11/21/14 revealed the facility failed to develop new interventions to address Resident #1's exit-seeking behaviors.<br><br>The findings include:<br><br>Review of facility policy titled "Elopement Protocol," undated, revealed those patients identified as elopement risks will have their picture placed in the elopement book which is made available at the nursing stations, front lobby, and in the department manager's office. Further review of facility policy revealed the elopement book contains head count procedure and a short list for interim steps in dealing with exit-seeking behavior. Review of facility policy titled "Elopement Prevention: Resident," undated, revealed the facility strives to provide an environment that is free from hazards over which the center has control and to provide supervision and assistance devices to each resident to prevent avoidable accidents. Further review of facility policy revealed mechanisms and procedures were used to help mitigate the risk of a resident leaving a safe area without staff supervision. Continued review of facility policy revealed the definition of adequate supervision to be as follows: "adequate supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and care plans and identified hazards in the resident environment." Further review of facility policy | F 323  | Residents have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care or treatment<br>Resident 1 The comprehensive car plan for resident one has been reviewed and revised by appropriate disciplines. The person/ persons responsible for the care of this resident has been invited to attend the care conference.<br>Resident 2 The comprehensive car plan for resident one has been reviewed and revised by appropriate disciplines. The person/ persons responsible for the care of this resident has been invited to attend the care conference. Patients identified for risk of falls or elopement have had comprehensive care plans reviewed and revised as required. The Quality Assurance Committee will monitor falls and elopment patients five times weekly The review will include the review of |                      |   |

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| F 323   | <p>Continued From page 29</p> <p>revealed the definition of elopement to be as follows: "elopement occurs when a resident with supervision needs leave a safe area without supervision may occur inside or outside the center."</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 11/21/14, with diagnoses including Alzheimer's Disease, Dementia, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Hypertension.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) dated 11/27/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #1 was moderately impaired cognitively. Continued review of Resident #1's MDS revealed Resident #1 did not exhibit wandering behavior.</p> <p>Review of facility incident reports revealed Resident #1 attempted to leave the facility without staff supervision on 02/01/15 and again on 02/07/15. Review of Resident #1's Comprehensive Care Plan, dated 11/21/14 revealed Resident #1 was at risk for elopement due to wandering/exit-seeking behaviors. However, there were no updates or interventions present related to Resident #1's elopement attempts/exit-seeking behaviors. Review of Resident #1's Nurse Assistant Care Plan, updated 10/13/14, revealed no updates or interventions present related to Resident #1's elopement attempts/exit-seeking behaviors on 02/01/15 and 02/07/15.</p> <p>Interview with Certified Nurse Aide (CNA) #16 on 03/09/15 at 3:30 PM revealed Resident #1 usually</p> | F 323  | <p>comprehensive care plans Areas requiring improvement will be reviewed and discussed by the QA Committe and appropriate response taken Nurse Supersivors have been educated to immediately report elopement potential to the DNS Nurse EducatorNurse Supersivors have been educated byApril 16 2015to report all falls to the DNS</p> <p>Education was completed byApril 162015</p> <p>Education on the elopement procedure and protocol was completed on April 8, 9, 12 and 16<sup>th</sup> by the Nurse Educator. Elopement assessments were completed for all residents on April 24, 2015 by the licensed Social Worker.</p> | 6-6-15               |   |

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| F 323   | <p>Continued From page 30</p> <p>put on a white striped sweater, pants, and shoes, and gets his/her purse prior to attempting to exit the facility.</p> <p>Interview with CNA #17 on 03/11/15 at 5:04 PM revealed Resident #1 had been wearing a white sweater with colored stripes, pants, and shoes just prior to one of the attempted elopements. SRNA #17 stated Resident #1 will get his/her purse when preparing to attempt to exit the facility.</p> <p>Interview with the facility Director of Nursing (DON) on 03/04/15 at 7:42 AM revealed she had not had any resident elopements at the facility, but did have some incident/accident reports related to some residents with exit-seeking behaviors. The DON was again interviewed on 03/12/15 at 6:18 PM. She stated she was not aware of any residents eloping from the facility since she had been DON, which was in July of 2014. Continued interview with the DON revealed she believed the facility had put all the interventions in place that they could for Resident #1 in order to prevent elopement.</p> <p>Interview with the facility Administrator on 03/04/15 at 8:17 AM and 03/12/15 at 6:15 PM revealed he was aware of some residents having exit-seeking behaviors, but had not had any residents elope from the facility. Continued interview with the Administrator revealed he would not consider an incident with a resident that has exit-seeking behaviors to be an incident that should be reported to state agencies. Further interview with the Administrator revealed he expected staff to follow the facility elopement protocol in the event of a resident attempting to elope from the facility and that he conducts</p> | F 323  | <p>F323 All new admissions and or readmissions will be assessed for elopement risk. In addition any time the patient has a significant change of condition, quarterly and annually an elopement assessment will be completed. Assessments will be completed by Social Services and reviewed with the DNS and or her designee. The DNS will monitor for compliance. Care plans will be revised as indicated by assessment</p> <p>All staff have been educated on the elopement procedure by the DNS and or Nurse Educator on April 8, 9, 12 and 16 2015.</p> |                      |   |

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| F 323   | Continued From page 31<br>monthly elopement drills to ensure staff responds to elopements per facility protocol.  | F 323  |  |                      |   |
| F 353<br>SS=E   | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>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>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and facility policy review, the facility failed to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by | F 353  | Residents #6, #7, #8, #9 #10 and #11<br>Have been provided showers and<br>Call lights promptly answered.<br>All staff have been educated to<br>Respond to call lights promptly.<br>Care givers have been in-serviced<br>To complete showers and document<br>The showers have been given.<br>Education of staff was completed<br>By DNS and or Nurse Educator<br>By April 2 <sup>nd</sup> . In the event that a patient<br>Refuses shower the CNA have been<br>educated to report refusal to Charge Nurse<br>who has been educated to discuss with the<br>patient the reason for the refusal. A bed<br>bath will be offered of appropriate. Those<br>patients refusing both showers and bed<br>bath will be report to the DNS or her<br>Designee for follow up. Shower records<br>will be monitored by the QA<br>Committee for four weeks for compliance.<br>The QA Committee will review reports<br>and take action as needed. |                      |   |

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| F 353  | <p>Continued From page 32</p> <p>resident assessments and individual plans of care for six (6) of thirteen (13) sampled residents (Residents #6, #7, #8, #9, #10, and #11). Interviews with facility staff and alert/oriented residents revealed the facility was "short-staffed" at times and there were times when showers/baths and nail care were not provided. In addition, as a result of the facility not having enough staff, residents had to wait for extended periods of time for staff to respond to call lights, to complete bed baths, and to provide incontinence care/toileting for residents. (Refer to F282, F312, and F315.)</p> <p>The findings include:</p> <p>Review of the Staffing Policy (no date) revealed adequate staff would be provided to meet the needs of the residents. The policy indicated this would be achieved by recognizing the staffing patterns and number of caregivers assigned to each shift. According to the policy a 30-day schedule would be prepared in advance to provide adequate notice to the employees regarding the times and days they would be scheduled to work. A deviation to the scheduled number of caregivers would be handled in the following manner: a call list of employees would be available for employees available to work with short notice, employees on the schedule assigned to work overtime shift would be designated through a green dot system, bonus awards would be paid for staff working extra shifts, and as a last resort licensed staff and/or qualified department managers would be asked to complete shift duties as caregivers.</p> <p>1. Review of a Brief Interview for Mental Status (BIMS) assessment, dated 02/09/15, revealed</p> | F 353   | <p>Staffing levels are developed by the DNS and NHA using the total number of patients in house and the facility acuity levels. The DNS and NHA or designee reviews daily staffing numbers for compliance seven days a week. If daily staffing numbers fall below the scheduled numbers the DNS is notified prior to the beginning of the shift by the scheduling coordinator or her designee. Open position for the shift are filled using a pre determined sign up sheet for extra hours or by calling in employees off shift, or by requiring staff to work until a replacement is found. If no replacement is found a Supervisory Nurse and/or other qualified person is required to fill the opening shift up to and including Unit Managers and/or other licensed nurse department managers such as Medical Records.</p> |                      |   |

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| F 353   | <p>Continued From page 33</p> <p>facility staff assessed Resident #6 to have a score of 15, which indicated the resident was interviewable. During an interview with Resident #6 on 03/04/15, at 6:40 AM he/she stated, "I didn't get my bath last night; staff told me they were too busy." Resident #6 further stated he/she was scheduled to receive a bath on Monday and Thursday, but due to the staff working without a sufficient number of staff, he/she did not always get a bath as scheduled.</p> <p>Interviews with CNAs #4, #11, #12, #14, and #15 revealed baths/showers were not provided for Resident #6 consistently on the resident's scheduled bath days due to staffing shortage and not having enough time to get all the baths completed.</p> <p>In addition, Resident #6 stated sometime at the end of February (exact date unknown) a CNA came in and started giving him/her a bed bath, but left to go get another CNA to assist her with the bath. The resident stated he/she was able to wash his/her upper trunk but waited approximately one and one-half hours for staff to come and finish the bath.</p> <p>Interview with CNA #7 on 03/11/15 at 12:30 PM, revealed she was assigned to Resident #8 on 02/25/15 and only two CNAs were working on the South Hall on 02/25/15. CNA #7 stated the nurse (Licensed Practical Nurse #1) told her to set up the resident's bath water and equipment and let the resident start his/her bath. CNA #7 stated the Licensed Practical Nurse (LPN) told him/her to go take his/her lunch break and she (LPN #1) would finish the resident's bath. CNA #7 stated she took a 30-minute lunch break and when she returned to the floor she went immediately to</p> | F 353  | <p>F353 The deployment of clinical caregivers to meet the needs of residents will be based upon census and acuity of the patient population. The DNS, NHA and Human Resource Manger will meet weekly to review staffing patterns for all caregiver shifts. The review will evaluate census and current patient needs to determine the appropriate staff numbers assigned to care for residents. Adjustments to the schedule will be implemented and those changes reported to the Quality Assurance Committee for appropriate response. Training was completed by the NHA on May 5, 2015 The DNS may make adjustments to schedule as needed and those changes will be reviewed by the NHA and Human Resource Manger as soon as practical.</p> |                      |   |

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| F 353   | <p>Continued From page 34</p> <p>check on Resident #6 and found the resident the same as when she left for lunch break. The CNA stated she obtained fresh bath water and completed Resident #6's bath. CNA #7 stated the LPN said she had been "tied up" with another resident and could not get to Resident #6 to finish the bath. CNA #7 stated the resident's entire bath time was approximately 35-40 minutes.</p> <p>Interview with LPN #1 on 03/11/15, at 4:20 PM, confirmed she had told the CNA to go to lunch and she would finish the bath for Resident #7. LPN #1 stated she did go to Resident #6's room to check on him/her and the resident was bathing him/herself, so LPN #1 went across the hall and provided incontinence care to another resident. However, the LPN was then called to several other residents' rooms and did not get back to Resident #6 before CNA #7 returned from lunch. LPN #1 added she did not think it was one and one-half hours, but the delay was a result of working with only two CNAs on the floor.</p> <p>2. Review of a BIMS assessment, dated 01/29/15, revealed facility staff assessed Resident #7 to have a score of 13, which indicated the resident was interviewable. In addition, the MDS further revealed Resident #7 required extensive assistance with bathing and personal hygiene.</p> <p>Interview conducted with Resident #7 on 03/03/15 at 5:20 PM, revealed the resident had not received a bath "in over a week" and he/she just wanted "to get my bath on the days I am supposed to have them." In addition, the resident stated his/her toenails had not been "touched in months." The resident stated he/she could trim his/her own fingernails but was unable to bend</p> | F 353  |   |                      |   |

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| F 353   | <p>Continued From page 35 over to take care of the toenails.</p> <p>Interviews conducted with CNAs #3, #5, and #2, revealed Resident #7 was not provided baths/showers according to the plan of care and shower schedule due to not having enough staff. In addition, CNAs #2 and #3 stated they never noticed Resident #7's toenails and had not provided toenail care for the resident. CNA #2 stated she did not have time due to not having enough staff at the facility.</p> <p>3. Review of Resident # 11's medical record revealed the facility admitted the resident on 01/15/14 with diagnoses including Ataxia, Difficulty in Walking, Hip Fracture, Hypertension, Alzheimer's Dementia, Morbid Obesity, Agitation, and Degenerative Disc Disease.</p> <p>Review of Resident #11's most recent Significant Change MDS assessment dated 12/18/14 revealed the facility assessed Resident #11 to have a BIMS score of 6, which indicated Resident #11 had severely impaired cognition. Further review of Resident #11's MDS assessment revealed the facility assessed Resident #11 to require extensive assistance of one staff member related to personal hygiene.</p> <p>Review of Resident #11's Comprehensive Care Plan, dated 01/15/14, revealed Resident #11 was assessed to have potential or actual impairment with mobility related to fractured left hip, Degenerative Disc Disease, and Dementia. Further review of Resident #11's care plan revealed staff was to provide Resident #11 with nail care as needed.</p> <p>Interview with Resident #11 on 03/11/15 at 10:50</p> | F 353  |   | G-5-15               |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185352 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/12/2015 |
|---|--|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STANTON NURSING AND REHABILITATION CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>31 DERICKSON LANE<br>STANTON, KY 40380                                 |                      |   |
| (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 353   | <p>Continued From page 36</p> <p>AM revealed Resident #11 had not had his/her toenails trimmed in several days and that he/she preferred for toenails to be trimmed shorter than they were at the time of the survey.</p> <p>Observation of Resident #11 on 03/11/15 at 10:55 AM revealed Resident #11 to have long untrimmed toenails on both feet.</p> <p>Interview with Certified Nurse Aide (CNA) #5 on 03/11/15 at 3:15 PM revealed nail care is to be done on Sundays and as needed. Continued interview with CNA #5 revealed she does not have time to do nail care on residents as needed because there is not enough staff working on her shift.</p> <p>Interview with CNA #2 on 03/11/15 at 3:38 PM revealed she provided care for Resident #11 and Sunday was nail care day for residents. Further interview with CNA #2 revealed she knew she was to provide nail care for residents, but did not have enough time to provide the care because there was not enough staff working to complete tasks.</p> <p>4. Review of the MDS for Resident #8 dated 11/27/14 revealed the BIMS score for the resident was 15, which indicated Resident #8 was cognitively intact and interviewable. Further review of the MDS and Care Plan for the resident revealed the resident required extensive assistance from staff for bathing and toileting.</p> <p>During an interview with Resident #8 on 03/03/15 at 4:27 PM, the resident stated he/she does not always get showers or they are late due to the facility not having enough staff. Further interview with Resident #8 revealed he/she had an</p> | F 353  |   | 05-15                |   |

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| F 353   | <p>Continued From page 37</p> <p>incontinence episode from waiting so long for the call light to be answered by facility staff due to not having enough staff.</p> <p>Interviews with CNAs #1, #4, #7, #14, #20, and #21 revealed baths/showers were not provided for Resident #8 consistently on the resident's scheduled bath days due to staffing shortage and not having enough time to get all baths/showers completed.</p> <p>5. Review of the MDS assessment for Resident #9 dated 01/14/15 revealed facility staff assessed Resident #9 to have a BIMS score of 15, which indicated Resident #9 was cognitively intact and interviewable. Further review of the MDS and care plan revealed Resident #9 required extensive assistance from staff for bathing.</p> <p>An interview with Resident #9 on 03/03/15 at 4:50 PM revealed at times his/her baths are not given as scheduled due to not enough staff working in the facility.</p> <p>Interviews conducted with CNAs #6, #13, and #21, revealed Resident #9 was not provided baths/showers due to a shortage of staff and not having enough time to get all assignments completed.</p> <p>6. Review of the MDS assessment dated 02/10/15 and Care Plan dated 03/03/15 for Resident #10 revealed the resident required extensive assistance with bathing. Review of the BIMS score revealed the section was blank indicating Resident #10 was not interviewable. Review of "Shower Sheets" for Resident #10 revealed the resident was not provided four scheduled showers during the months of</p> | F 353  |   | 6-5-15               |   |

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| F 353   | Continued From page 38<br>February and March 2015.<br><br>Interviews conducted with CNAs #14, #20, and #21 revealed Resident #10 had not been provided baths/showers due to working without a sufficient amount of staff and not having enough time to complete basic care needs.<br><br>Interview with the Director of Nursing (DON) on 03/12/15, at 1:00 PM, revealed the numbers of staff were based on acuity levels of residents and individual staff competencies. The DON acknowledged the facility had a staffing shortage. The DON stated several employees either had been terminated or had left the facility without notice. The DON further stated the facility was attempting to recruit and retain staff for the facility including bonuses and they had started seven new CNAs in a training class that would be employed at the facility. The DON stated when call-ins occurred, the facility utilized a "dot system" on the schedule for staff to work overtime to cover the shift.<br><br>Interview with the facility Administrator on 03/12/15 at 4:49 PM revealed the facility had a "dedicated scheduler" on staff that created and posted a master staffing schedule. Once the master schedule was created, he looked at requests for time off to see if they had enough staff to cover the positions if the staff was granted the request for time off. The facility Administrator revealed the facility had a daily schedule that the Human Resources Department was responsible for that tracks which staff was actually working on a particular day, and he looked at the schedule for weekends and holidays to make sure the facility had enough staff scheduled to take care of residents. The facility Administrator stated he | F 353  |   |                      |   |

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| F 353   | Continued From page 39<br>scheduled the amount of staff that he believed was needed to provide care for residents at the facility, and if needed he asked qualified office staff to provide care to residents in order to ensure residents were cared for. The facility Administrator revealed the facility set up a "green dot" system that allowed staff some flexibility on when they chose to work overtime if needed, and staff members that work on their "dot day" were paid a monetary bonus for working. Continued interview with the facility Administrator revealed the facility paid a monetary bonus to each employee per pay period if they came to work on time, did not call in for any shifts, and did not take extra-long breaks. The facility Administrator revealed he had a continual struggle with staffing. | F 353  |   |                      |   |

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