STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145863	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF MARION	**1301 EAST DEYOUNG MARION, IL 62959**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1652951/IL85868- F315, F328, F353, F465 cited Complaint #1653070/IL85997- F157, F309, F312, F353 cited Complaint #1653210/IL86159- F353 cited	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to notify the physician and the POA(Power of Attorney) of change in pain condition for two residents (R6, R7) in the sample of 9. Findings Include: 1.) On 6/3/16 at 1:00 PM, R7 had fallen out of his wheelchair trying to reach a cup off the floor. Observed R7 tell the nurses that he had a headache, that is neck hurt, that his back was hurting, and that his left leg was sore. R7 was noted to have a swollen upper lip. On 6/3/16 at 1:25 PM, E2 DON(Director of Nursing) stated, " Anytime a resident hits their head or the fall is not witnessed, then nursing staff should always initiate neurological testing and check pupil responses. E2 stated " if the resident continues to have complaints or problems then nurses should continue to assess the resident as often as necessary and make the doctor and power of attorney aware as well. " On 6/3/16 at 4:50 PM, E7 (LPN) was in hallway with the medication cart passing evening medications, when R7 came out and asked E7 for a pain pill. E7 told R7 that he could not get a pain pill yet, because it was too early. E7 stated to R7 you had your last pain pill around 12:30 PM, you can not get your next one until around 8:30 PM. R7 told E7 I know it's not time for an another pain pill yet but I fell earlier and my head is killing me and my lip is really sore. E7 walked down the 200 hallway with the medication cart without	F 157		

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F 157	Continued From page 2	F 157		

saying anything else to R7. At this time, E7 did not assess R7 for any possible neurological issues related to the earlier fall and subsequent head injury. This writer questioned R7 what was wrong and R7 stated he had a headache at the top of his head and the base of his skull and his pain was rated at a " 10 " and his lip was just really sore and swollen.
Review of R7's MAR (Medication Administration Record) shows resident with an order for pain medication of Norco 5/325 mg(milligram) by mouth as needed every eight hours for pain. On 6/3/16 shows last dose being given at 12:30 PM on that day.
On 6/4/7/16 at 10:00 am, E21 (Corporate Consultant) stated that the Doctor was made aware of R7's possible continued problems with neurological issues and head injury and pain after the surveyor made the facility aware of issues at the daily status meeting at 5:00 PM on 6/3/16. E21 stated staff should have made the physician aware of the issues as soon as the complaint of pain had continued.
2.) On 6/3/16 at 3:05 PM to 4:00 PM, during wound care for R6, it was noted during the treatment that she was having signs and symptoms of pain as well as verbalized pain. E26 CNA (Certified Nursing Assistant) had been assisting the nurse during treatment and noted R6's pain. At 4:30 PM, E26 asked E25 (CNA) to please ask floor nurse if R6 could have something for pain because she was still assisting R6. E25 exited the room and said " OK "
On 6/3/16 at 4:45 PM, E7 (LPN) went into R6 ' s room with medication. When E7 came out this surveyor asked if R6 had received any pain medication. E7 stated that E25 had told her about R6 ' s pain but she could not give R6

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F 157	Continued From page 3 anything until 6:00 PM because R6 is on scheduled doses of Norco 10/325 mg(milligram) (pain medication) Review of R6 ' s chart on 6/7/15 shows E7 did not make the doctor or the POA aware of R6's pain nor did she assess the increased pain, and R6 did not receive anything for voiced complaints of increased pain on 6/3/16 On 6/8/16 at 2:10 PM, Z3(Wound Doctor) stated he has been treating R6 for several months now. Z3 stated R6's wounds could be painful. Z3 stated if R6 was complaining of pain during a treatment then they should assess what is causing the pain and question the patient if they're ok to continue, and if not they need to stop and cover the area and contact the primary care physician. They could always call him for recommendations. On 6/8/16 at 12:00 PM, Z2(Primary Care Physician) stated the nurse should always be assessing pain as needed and if the resident is in pain and needed something more for pain they(facility) needed to call and make him aware so he can evaluate possible treatments.	F 157		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 4 Based on observation, interview and record review the facility failed to assess for signs and symptoms and voiced complaints of pain and follow facility policy for pain, the facility also failed to completely and accurately assess a resident after a fall, this affects four residents, (R1, R5, R6 & R7) in a sample of 9. Findings include: 1.) On 6/3/16 at 1:00 PM, a resident was heard yelling " someone needs to come help. " This writer went into 200 hallway and R4 pointed to the end of the hallway towards the exit. This writer noted R7 to be sitting on his bottom in his bedroom doorway. Shortly after, E28 (LPN) and E27 RN(Registered Nurse) came to the resident room. R7 told the two nurses E27 & E28 that he had fallen out of his wheelchair trying to reach a cup off the floor. R7 told the nurses he had fallen on his face and he had hit his lip and head. R7 told the nurses that he had a headache, that his neck hurt, that his back was hurting, and that he his left leg was sore. At no time did either E27 or E28 do any neurological assesment, check pupil response, assess for any abnormal range of motion or possible abnormal findings with the extremities before getting R7 up off the floor into his wheelchair. On 6/3/16 at 1:25 PM, E2 DON(Director of Nursing) stated, " Anytime a resident hits their head or the fall is not witnessed, then nursing staff should always initiate neurological testing and check pupil responses. The nurses should also stabilize the resident for a possible neck injury. They should also do a head to toe assessment, check the resident's range of motion and check for any abnormal findings. " E2 stated " This should be done before the resident is ever moved to prevent further injury. " E2 stated " if	F 309		

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F 309	Continued From page 5	F 309		

the resident continues to have complaints or problems then nurses should continue to assess the resident as often as necessary and make the doctor and power of attorney aware as well. "
On 6/3/16 at 4:50 PM, E7 (LPN) was in hallway with the medication cart passing evening medications, when R7 came out and asked E7 for a pain pill. E7 told R7 that he could not get a pain pill yet because it was too early. E7 stated to R7 you had your last pain pill around 12:30 PM, you can't get your next one until around 8:30 PM. R7 told E7 he knew it was not time for an another pain pill yet, but he had fallen earlier and said "my head is killing me and my lip is really sore". E7 walked down the 200 hallway with the medication cart without saying anything else to R7. At this time, E7 did not assess R7 for any possible neurological issues related to the earlier fall and subsequent head injury. This writer questioned R7 what was wrong and R7 stated he had a headache at the top of his head and base of his skull at a pain level of " 10 " and his lip was just really sore and swollen.
Review of R7's June 2016 MAR(Medication Administration Record) shows resident with order for pain medication of Norco 5/325 mg(milligram) by mouth as needed every eight hours for pain. Entry on 6/3/16 shows last dose being given at 12:30 PM on that day.
On 6/4/7/16 at 10:00 am, E21 (Corporate Consultant) stated the Doctor was made aware of possible continued problems with neurological issues and head injury and pain after surveyor made staff aware of these problems at the daily status meeting at 5:00 PM on 6/3/16. E21 stated staff should have made the physician aware of thses issues as soon as the complaint of pain continued.
2.) On 6/3/16 at 3:05 PM to 4:00 PM, E27 (RN)

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F 309	Continued From page 6 was doing treatments per doctor ' s orders to R6's wound on left medial buttock, right lateral foot, and right heel. Prior to the treatments E27 assisted E26 (CNA) with cleaning of R6's anal area due to drainage from wound to left buttock. During the peri-anal care R6 noted to have a small amount of facial grimacing. During treatment to wound on the buttock, R6 became more tense and facial grimacing was more noticeable. During treatment to R6's foot, the residents body was very stiff, the facial grimacing was very pronounced and she was pulling the foot away from E27 during treatment. E27 asked R6 if she was hurting and R6 said " yes", however at no time did E27 offer to stop treatment, do a comprehensive pain assessment or offer to try to get any pain relief for R6. When E27 had completed the treatment, E26 asked R6 if she was still hurting and R6 shook her head yes. E26 was still assisting R6 and asked E25 (CNA) to please ask the floor nurse if R6 could have something for pain. E25 exited room and said " OK " On 6/3/16 at 4:45 PM, E7 (LPN) went into R6's room with medication. When E7 came out, this surveyor asked if R6 had received any pain medication. E7 stated that E25 had told her about R6 ' s pain but E7 could not give R6 anything until 6:00 PM because R6 is on scheduled doses of Norco 10/325 mg(milligram) Review of R6's chart on 6/7/15 shows E7 did not make the doctor aware of R6's complaints of pain nor did she assess the increased pain. R6 did not receive any medication for the complaints of increased pain on 6/3/16 until scheduled dose at 6:00 PM. On 6/8/16 at 2:10 PM, Z3(Wound Doctor) stated he has been treating R6 for several months now. Z3 stated R6's wounds could be painful. Z3	F 309		

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F 309	Continued From page 7	F 309		

stated if R6 was complaining of pain during a treatment then they should assess what is causing the pain and question the patient if they're ok to continue and if not they need to stop and cover the area and get a hold of the primary care physician, and that they could always call him for recommendations.
On 6/8/16 at 12:00 PM, Z2(Primary Care Physician) stated the nurse should always be assessing pain as needed and if the resident is in pain and needs something more, they(facility) needs to call and make him aware so he can evaluate possible treatments
3.) On 6/2/15 at 9:05 am, E28 LPN (Licensed Practical Nurse) and E29 CNA(Certified Nursing Assistant) had put R5 into bed. E28 and E29 were doing incontinence care because R5's adult brief had been soiled with urine. During incontinence care while E29 was cleansing R5's perineal area, R5 stated " ouch that hurt so bad, that burns, that's sore, why do you have to be so rough, that burns like a boil. " E28 stated that R5 had been getting cream to her bottom and peri-area for a little while because she was excoriated. When E28 and E29 were done they exited the room. At no time did the nurse E28 assess R5's pain. This writer asked R5 on a scale of 1-10 with 10 being the worst pain she had ever experienced, what would she rate her pain as. R5 stated it was at least at a " 7 " .
On 6/2/16 at 11:10 AM, E28 was questioned if she had assessed R5's pain earlier during her incontinent care, E28 stated " No. " " But, I don't even think she has anything ordered for pain. Let me check her medications. I guess I was wrong, she does have an as needed order for Tylenol for pain. I guess I should have assessed her and I didn't. "
4.) On 6/3/16 at 11:25 am, R1 stated she had not

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F 309	Continued From page 8 received any pain medication in a couple of days. R1 stated that when she would ask nursing she was told she couldn't have one, or it wasn't time yet. R1 stated she had recently broken wrist and had pain often, and rated it at that time at a "10 out of 10". According to R1's June 2016 MAR(Medication Administration Record), R1 has orders to receive APAP/CODEINE TAB 300-30 MG(Milligram)-Take one tablet by mouth every six hours as needed. This MAR shows R1 did not receive any of this medication on 6/2/16 . According to R1's Brief Mental assessment done on 5/17/16 she scored 14 out of 15 which makes her able to answer and communicate information effectively. Also according to R1's quarterly assessment with the same date R1 has pain frequently at a pain intensity level of " 8 ".	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide assistance with ADL (Activities of Daily Living) for residents that require extensive assistance or have total dependence with transfers, toilet use, hygiene and bathing with four residents (R2, R4, R5, R8) out of 8 residents reviewed for ADL's in the sample of 9.	F 312		

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1.) On 6/7/16 at 4:40 PM, R8 was placed at the dining room table by E26 (CNA) (Certified Nursing Assistant). At 6:20 PM, R8 was still in dining room and had been fed, but had not been moved or repositioned by E34 (CNA). At 6:20 PM, E26 confirmed all the residents that required assistance with feeding had been finished and staff was now taking everyone out of dining room to bathroom, to check and change. When asked E26 is she was R8 ' s CNA she stated " Yes, but I was technically supposed to leave at 6:00 PM, so I'm getting ready to leave. At 6:25 PM, R8 was still at table in the dining room. At 7:15 PM, R8 was still in dining room and not been moved. R8 had an area between her pant legs was noted to be discolored. At 7:35 PM, R8 was still in same place in the dining room and discolored area was larger. At 7:45 PM, R8 was still same place in dining room. At 7:50 PM, R8 was taken out of dining room and pushed down hallway. At 8:20 PM, R8 was in her room still in her same soiled clothing and E35 (CNA) walked in and stated she was getting ready to change resident and put her to bed. R8's last comprehensive quarterly assessment dated 5/5/16, states R8 is totally dependent on staff for all of her activities of daily living.
On 6/3/16 at 1:30 PM, E2 DON (Director of Nursing) stated I would expect residents to be checked and changed or taken to the bathroom at least every two hours. E2 stated if a resident is totally dependent on staff for care then they need to make sure they are checked at least every two hours. E2 stated residents are to get baths or showers at least two times a week and more often if needed.
2.) According to R5's Brief Mental Status done on 5/3/16 she scored a 15 out of 15 which makes

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her alert, oriented and able to answer questions appropriately. According to that same assessment she requires total assist with transfers and toilet use. On 6/2/16 at 10:10 A.M., R2 stated the last time anyone had been in her room to change her was when they got her up for breakfast this morning around 7:30 A.M. R2 Stated I can't use my call light because I can't reach it. The Call light was not easily visible , but was found tied around the top headboard, under the covers. R2 was not able to reach her call light. At this time, the surveyor told staff (E31 CNA (Certified Nursing Assistant) that R2 did not have access to a call light and needed assistance with being changed. At 10:50 A.M., R2 stated that she had put on her call light around 10:30 A.M. and a girl came in and turned her light off and asked her what she wanted. I told her I was wet and needed to go to the bathroom to be changed and she walked out and said I'll be right back. R2 stated I have to have help going to the bathroom and being changed. R2 stated that this happened over 20 minutes ago and no one has come back to help me. R2 stated my brief and clothing have been wet since about 8:00 A.m. this morning. I know this because I keep time by my watch. There was a discolored area between R2's pant legs, that had not been present at 10:10 A.M and R2 had complained about being wet and incontinent at that time. R2 stated this is a daily occurrence with her, and staff usually only change her when they get her up, before lunch and then a family member comes every night to help clean her up and put her to bed, and that night shift usually checks on her two times a night.
On 6/7/16 at 11:20 A.M, R2 stated staff had gotten her up around 7:00 A.M and her brief had been wet since around 8:15 A.M. and still had not

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F 312	Continued From page 11 been changed. It was noted R2 was not able to see or reach her call light. R2 was again noted to have discolored area between her pant legs that was visible when resident was seen in room at 9:40 A.M. 3.) On 6/3/16 at 1:20 PM, R4 stated there is never enough help at the facility, and that nights and evenings are the worst. According to R4's ADL(Activity of Daily Living) sheet for bathing, R4's sheet indicates that she did not get a bath/shower from May 3 to May 12, 2016, which is over 8 days without a shower. According to R4's last comprehensive assessment dated 5/27/16, R4 requires physical help in part of bathing activity. 4.) According to R5's last comprehensive quarterly assessment dated 5/9/16, R5 is totally dependent on staff for bathing. According to R5's ADL May 2016 bathing record reviewed on 6/3/16, R5 did not receive a bath/shower from 5/14/16 through 5/30/16, this is over two weeks without a shower.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced	F 315		

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by:
Based on observation, interview and record review the facility failed to provide proper catheter care to help prevent infections and failed to assist totally incontinent and dependent residents that were high risk for UTI's (Urinary Tract Infections) for 3 residents (R2, R3, R6) of 6 residents reviewed for catheters and loss of bowel and bladder control in the sample of 9

Findings Include:

1.) On 6/2/16 at 10:10 A.M., R2 stated the last time anyone had been in her room to change her was when they got her up for breakfast this morning around 7:30 A.M. R2 Stated I can' t use my call light because I can' t reach it. The call light was not readily visible, but was found tied around the top headboard, under the covers. R2 was not able to reach her call light. At this time, surveyor made staff (E31 CNA (Certified Nursing Assistant) aware that R2 did not have access to call light and needed assistance with being changed. At 10:50 A.M., R2 stated that she had put on her call light around 10:30 A.M., and a girl came in and turned her light off and asked her what she wanted. I told her, I was wet, and needed to go to the bathroom to be changed and she walked out and said I'll be right back. R2 stated I have to have help going to the bathroom and being changed. R2 stated that this was over 20 minutes ago and no one has come back to help me. R2 stated my brief and clothes have been wet since about 8:00 A.M this morning. I know this because I keep time by my watch. It was noted that between R2' s pant legs, there was a discolored area that was not there at 10:10 A.M. R2 had complained about being wet then. R2 stated this is a daily occurrence with her, and

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staff usually only change her when they get her up, before lunch, and then a family member comes every night to help clean her up and put her to bed. The night shift usually checks on her two times a night.
On 6/7/16 at 11:20 A.M., R2 stated the staff had gotten her up around 7:00 A.M. and her brief had been wet since around 8:15 A.M. and still had not been changed. R2 was not able to see or reach her call light.
According to R2's Care Plan with admission date of 1/8/15, shows R2 has a history of UTI(Urinary Tract Infection) and had a UTI on 12/9/15 and 2/11/16. According to R2's last quarterly review on 5/3/16, R2 is totally dependent on staff for toilet use and transfers and is always incontinent of bladder.
2.) On 6/2/16 at 9:00 A.M., E30, E31 & E32 (All CNA's) put R3 to bed, R3 has an indwelling urinary catheter. After R3 was put to bed, the staff did not put on the leg strap, use the anchor, and the catheter tubing was touching the floor.
On 6/3/16 at 1:40 PM, E21 (Corporate Consultant) stated staff should be using a leg strap and the anchor for anyone using a indwelling catheter device and it should not be on the floor and the bag itself, should be in a covered bag and not on the floor
According to R3's Care Plan with admission date of 10/17/15 he had UTIs on 10/22/15 and 3/2/16.
On 6/3/16 at 10:15 A.M., R3's catheter bag and tubing was laying on the floor. R3 had no leg strap or anchor clip. E2 DON(Director of Nursing) stated this was not how indwelling catheters and bags are to be handled.
3.) On 6/3/16 at 4:00 PM, R6 was in bed and her indwelling catheter had no leg strap or no anchor in use and the tubing was lying on the floor.
According to R6's Care Plan with problem date of

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F 315	Continued From page 14 5-18-16 shows R16 is at risk for UTI related to use of indwelling catheter and history of infection in stage four pressure ulcer/wounds.	F 315		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to safely administer oxygen according to doctors orders for three residents (R1, R2, R3) of 5 reviewed for oxygen in the sample of 9. 1.) On 6/2/16 at 9:00 A.M, E30 CNA(Certified Nursing Assistant) picked up R3's nasal cannula off his floor and put it in his nares. E30 then turned on R3's oxygen. R3's oxygen was at 3 L(liters)/min(minute) On 6/2/16 at 10:50 A.M., R3's oxygen was set on 4.5 L/min. On 6/7/16 at 9:35 A.M., R3's oxygen was set at 6L/min. According to R3's POS(Physicians Order Sheet) for June 2016, he is to have, per hospice comfort measures: oxygen 7L/min via nasal cannula	F 328		

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F 328	Continued From page 15 continuously According to R3's nurse's notes dated 6/2/16, the resident oxygen is set at 3L, on 6/3/16, R3's oxygen is set at 3L. On 6/7/16 at 5:20 PM, E33 (CNA) stated " we' re just going to have to take R3 back to his room to lay down, he's not going to eat. " E33 shut off R3's oxygen, then unplugged it from the wall, took the nasal cannula off R3's nares and took R3 and oxygen concentrator into R3's room. At 8:30 PM, R3's oxygen was set at 6L/min. On 6/2/16 at 10:05 am, E18 LPN (Licensed Practical Nurse) stated the aides and other staff are not to be doing anything with resident's oxygen, the only thing someone other than a licensed nurse can do is take the nasal cannula off or on, they cannot turn the oxygen on or off, or mess with the regulator that determines the liters per minute. E18 stated only licensed staff can do that because it is an ordered medication, so only nurses can do it. E18 stated all the aides have to do, is unplug the machine and plug it back in, and it goes right back to where it was set before so there's no need for them to touch any of the buttons or dials. 2.) On 6/3/16 at 11:25 am, R1 stated the CNA will come and take me to meals and when they do they bring my oxygen. First they turn it off then they unplug it then put me at the table and turn it back on, but I always have to check to make sure they turn it back on because sometimes they have forgotten to, and I can't breathe. R1 stated the CNAs will do the same thing when she goes back to her room and she has to make sure her oxygen is turned on. According to R1's last brief mental assessment done on 5/17/16 she scored a 14 out of 15 making her able to have appropriate conversations and answers. 3.) On 6/7/16 at 11:00 am, R2 stated the CNA	F 328		

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F 328	Continued From page 16 had turned off her oxygen this morning, unplugged it, taken it and her to the dining room and plugged it back in. R2 stated "it's a good thing I know how to turn it on because they didn't and I was starting to have a little trouble breathing before I realized the problem. I don't know why the CNA' s mess with my oxygen". According to R2's last brief mental assessment done on 5/3/16 she scored a 15 out of 15 making her appropriate for conversations and answers. According to R2's POS for June 2016 she may have 2-3 L/min oxygen via nasal cannula for respiratory distress.	F 328		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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.	F 353		

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F 353	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure sufficient nursing staff were available to provide assistancewith transfers, toilet use, bathing, and, answering call lights in a timely manner. These failures have the potential to affect all 86 residents in the facility. Findings Include: According to the facility document titled "Report of Staff Directly Responsible for Resident Care" shows the facility census for 6/2/16 is 86 residents 1.) On 6/2/16 at 1:45 AM there were 2 CNAs Certified Nursing Assistants on the 100/200 hallway and one nurse. On the 300/400 hallway there were 2 CNAs and 2 nurses. 2.) On 6/2/16 at 3:10 AM, E3 DON (Director of Nursing) stated for night shift they try to schedule on the 100 hallway, 2 CNA's,with one CNA on the 100 hallway and one CNA on the 200 hallway with one nurse covering the 100/200 hallways. E3 stated a good staffing for nights for the 300/400 hallway would be two CNA's for 300 hallway and one CNA for 400 hallway and one nurse each for 300 and 400 hallway. E3 stated that she didn't think that this actual staffing had occurred in over 3 months due to lack of staff. E3 stated there was probably not any way night shift could get everything done with the current staff they had on that night. 3.) On 6/2/16 at 3:00 am, E8 and E9 both	F 353		

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F 353	Continued From page 18 CNA(Certified Nursing Assistant) stated they were the regular night shift CNA's and there was never enough help. E9 stated in the past week there had been two nights where the 300/400 hall had only 1 CNA and 2 nurses, so a nurse had to work as a CNA and Nurse. E8 stated they only had one nurse and two CNAs for 100/200 side and it is the heavier care side and they only always have one nurse. E9 stated 300 hall is difficult because there are a lot of vital signs to be taken and the biggest thing that keeps 300/400 busy is the call lights. E8 stated they have been staffing nights short like this for while but evenings can get pretty bad too. E9 stated if the regular 100/200 nurse is working, all she usually does is sit up at the desk and she won't answer the lights she just lets them go off. E9 stated that means if we're at the end of 100 hall in a room doing our 3 person bed check and a light goes off at the other end of 200 then it more than likely is going to be going off for a long time. E8 stated some of the staff on other shift will go in and shut the light off but won't do anything or come back. E9 stated one of our jobs on nights is to have nightly schedules to clean chairs and we have been so short we haven't been able to do that in over a month. 4.) On 6/3/16, R6 was to have had her treatment done before lunch however, R7 had fallen and E 27 (RN) was taking care of this situation as well as doing other nursing duties of :medication pass, helping CNAs, answering call lights, and assisting with the lunch meal. E27 stated to this surveyor, "I'm sorry we didn't not get to this until this afternoon, it should have been done before lunch but there just doesn't seem to be enough time or help to be able to get everything done." E27 also	F 353		

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F 353	Continued From page 19 stated "Normally R6 is to lay down after each meal because of her pressure ulcer I'm not sure if the girl "CNA's" just got too busy or what happened. 5.) On 6/7/16 reviewed R1 ' s ADL (Activity of Daily Living) for May 2014 shows R1 has showers/baths on only 5/2, 11, 14, 19 & 28/16. That is over a week without a shower According to R1 ' s Quarterly Comprehensive assessment dated 5/17/16 her brief mental status is scored 14 out of 15 which make her able to answer questions appropriately, according to same assessment R1 is on a diuretic medication. 6.) According to R5's last comprehensive quarterly assessment dated 5/9/16, R5 is totally dependent on staff for bathing. According to R5's ADL May 2016 bathing record reviewed on 6/3/16, R5 did not receive a bath/shower from 5/14/16 through 5/30/16, this is over two weeks without a shower. According to R5's last Brief Mental Status done on 5/3/16 she scored a 15 out of 15 which makes her alert, oriented and able to answer questions appropriately. 7.) On 6/2/16 at 4:40 A.M., R2 stated there is not enough staff at the facility. R2 stated the CNA s that are here try hard but there just not enough of them. R2 stated that usually on a daily basis she has to sit in wet clothes because they will get her up for breakfast around 7:30 A.M., take her to the dining room, bring her back to her room then not check or change her until right before lunch around 11:30 A.M. When questioned about her call light to request help, R2 stated " Well half the time they put it where I can ' t reach it and then they ' ll answer it and say they ' ll be right back	F 353		

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with help and don't come back until it is time for the meal. R2 stated all shifts need to have more staff.

8.) On 6/2/16 at 10:10 A.M., R2 stated the last time anyone had been in her room to change her was when they got her up for breakfast this morning around 7:30 A.M.. She stated I can' t use my call light because I can't reach it. The call light was not easily visible but was found tied around the top headboard under the covers. R2 was not able to reach her call light. At this time surveyor made staff (E31 CNA (Certified Nursing Assistant) aware that R2 did not have access to call light. At 10:50 A.M., R2 stated that she had put on her call light around 10:30 A.M and a girl came in and turned her light off and asked her what she wanted. I told her I was wet and needed to go to the bathroom to be changed and she walked out and said I'l l be right back, because she had to have help. R2 stated that was over 20 minutes ago and still hasn't had anybody comeback to help her. R2 stated my brief and clothes have been wet since about 8:00 am this morning. I know this because I keep time by my watch. R2 stated this is a daily occurrence with her and staff usually only change her when they get her up, before lunch and then a family member comes every night to help clean her up and put her to bed. The night shift usually checks on her two times a night.

9.) On 6/3/16 at 1:20 PM, R4 stated there is never enough help at the facility and nights and evenings are the worst. R4 stated on night shift her and her roommate have to wait 45 minutes to an hour sometimes before they answer a call light and by that time my bed is saturated in urine. R4 stated it has not gotten any better in the last two weeks. R4 stated people have to sit and wait in the big dining room for help for 3-4 hours from the

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time they are put there to the time they eat, then to the time they put them to bed. R4 stated that even then only half of them are not bring changed or laid down they' re just being put in their rooms out of the way. The staff try hard, there are just not enough, and the only time the Administrator and some other people come out to help is when you' re here. "If you were not here there wouldn't be near the amount of people here helping the residents." I ' m just sick of this, all of these resident's deserve better and the CNA s should not be worked liked dogs, and not appreciated. Also they can tell you the nurses ' help the CNA's on the hallways, but very few do. R4 stated at the beginning of the month of May she wasn ' t even getting any showers until she got upset and threw a fit about not getting one. R4 stated staff would tell her they were busy or didn't have enough help
10) According to R4's ADL(Activity of Daily Living) sheet for bathing, R4 sheet indicates she did not get a bath/shower from May 3 to May 12, 2016, which is over 8 days without a shower
11.) On 6/7/16 at 2:00 PM, E18 (LPN) stated the facility needed more staff especially evenings and nights
12.) On 6/7/16 at 6:30 PM, E26 (CNA) stated I hate to leave because I know how short staffed they are right now especially because everyone was not done eating, or out of the dining room yet, or had been taken to the bathroom and some of them she knew she had put there right around 4:30 P.M. and they really shouldn't be sitting there for more that two hours at a time.
13.) On 6/7/16 at 11:20 am, R2 stated staff had gotten her up around 7:00 A.M. and her brief had been wet since around 8:15 A.M, and still had not been changed, she was pretty sure she was wet through her clothing. It was noted R2 was not able to see or reach her call light. R2's pants

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were noted to have an area between her legs that were discolored.
14.) On 6/8/16 at 5:00 PM, R9 stated there is never enough staff or help at the facility. R9 stated she does a lot for herself but she sees other residents sitting for hours at a time without being moved. R9 stated she usually just goes to the nurses station and asks for stuff, because if she puts her light on she'd wait for hours like the rest of the people on her hallway.
15.) On 6/7/16, R8 was brought into the dining room at 4:50 PM. R8 was not moved from 4:50 PM until 7:45 PM at which time she was wheeled to her room. The staff did not start assisting with changing or putting to bed until 8:20 PM. At 6:00 PM, there is a shift change, and according to schedule this is when there are less scheduled CNAs per the master schedule.
16.) On 6/14/16 at 4:30 PM, R4 stated I haven't had any disposable adult briefs to put on since this weekend, and they are putting things together so we can have them. I can't believe it, first they won't take us to the bathroom, now we don't have anything to help keep us even a little dry.
17.) On 6/14/15 at 4:40 PM, writer asked E39 (LPN) if they were out of adult briefs. E39 stated yes, since Friday, but they had got a shipment in today (Tuesday). When asked what they had been using E39 said was basically we are using the bariatric size, and were managing the best they could. When asked why they ran out, E39 stated probably because the DON quit and the ADON is on vacation.
18.) On 6/14/16 at 5:00 PM, when asked E1 (Administrator) if she was aware of being out of adult briefs over weekend she stated no one had made her aware. E1 was asked who did staffing, she stated she did. When asked why it took her over two days to get the surveyor the staffing and

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F 353	Continued From page 23 schedule? E1 stated because the DON was new and the ADON was on vacation. The surveyor stated she thought the administrator had said she did staffing and staffing numbers. E1 stated then that she just did that on a weekly basis and nursing did the daily. When asked how she knew on a daily basis if she had enough staffing she said she depended on the DON and the ADON to make sure the staffing was correct. E1 was asked who had done the daily staffing in the 4 days after her DON quit and her ADON was on vacation. E1 stated she had E39 (LPN) do it . When asked how and when E39 had been trained to do staffing, E1 stated she had went over it with him. 19.) On 6/14/16 at 5:30 PM, E39 LPN(Licensed Practical Nurse) stated he had been doing the schedule. E39 was then asked if he was making sure if he had the correct number of staff based on his census and E39 did not answer the question. When asked E39, if E1 had showed him how to do staffing, E39 stated he had just done the schedule	F 353		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain the building and its furnishings clean,orderly, odor free and in good repair This failure has the potential to affect	F 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 24 all 86 residents Findings include: According to the facility document titled "Report of Staff Directly Responsible for Resident Care" shows the facility census for 6/2/16 is 86 residents. On 6/2/16 at 1:55 A.M., in the 200 hallway common bathroom there was a strong smell of urine and the floor was wet. On 6/2/16 at 2:15 A.M., in the common bathroom on hallway 100, the trash can was overflowing and there were gloves, paper towels and other debris on the bathroom floor. On 6/2/16 at 2:20 A.M., in the main dining room, there were 3 meal trays with food on them still sitting out on the dining room table. By the door leading to the outside courtyard under the air conditioner was a large wet blanket on the floor. In the opposite corner there was an oxygen concentrator with tubing and cannula lying across it uncovered and with no name. When questioned, E11 CNA (Certified Nursing Assistant) said she wasn't sure who it belongs to, and it might just be a spare they kept there if they needed it for someone. There was also a pair of pink shoes in the dining room window seal at this time. On 6/2/16 at 2:45 A.M., on the 400 hallway in the common bathroom, in the bathtub there were spots and specks of a black substance. E3 ADON (Assistant Director of nursing) stated she would make sure the staff would get this area cleaned. On 6/2/16 at 2:47 A.M., in the resident/common laundry room there were several table cloth linens	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145863	A. BUILDING _____ B. WING _____	C 06/17/2016

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F 465	Continued From page 25 on the floor. On 6/2/16 at 10:00 A.M, R3 had been put to bed by E29, E30, E31 (Certified Nurse Aides)Prior to being put to bed R3 stated " Something smells like sh#* in here " , all staff stated they did not know what R3 was talking about. After staff exited room R3's bottom sheet on the side by the doorway was noted to have a large light brown discolored area. An odor of feces could noted at that time. On 6/3/16 at 10:00 A.M, there were dishes on the floor of the doorway in the small dining room leading to the 300/400 hallway nursing station On 6/7/16 at 9:30 A.M. the 200 hallway had strong urine odor. On 6/7/15 at 8:00 PM, room 222 had a strong urine odor. On 6/9/16 at 8:00 PM, R6 ' s chair cushion noted to have a foul odor, yellow and green liquid substances and small amount of hard green substance and several small unidentifiable particles were observed on the cushion. According to grievance form dated 5/24/16 by Z6 (POA)Power of Attorney for R8 states that everything in the room is dirty and needs to be cleaned.	F 465		